UNITED STATES
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March 14, 1996

MEMORANDUM TO: Those On Attached List

FROM: James L. Milhoan
Deputy Executive Director
for Nuclear Reactor Regulation,
Regional Operations and Research

SUBJECT: TASK ASSIGNMENTS FROM THE JANUARY 17-18, 1996
SENIOR MANAGEMENT MEETING (SMM)

Attached is a listing of the task assignments resulting from the subject SMM and subsequent Commission Briefing. Your action to address these tasks is requested. In addition, I have attached a copy of the SMM meeting summary to those of you whom I felt it was appropriate to do so. Please note that the meeting summary contains sensitive information that should not be released outside of key NRC management and staff.

Attachments:
1. Task Assignment
2. Meeting Summary

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Attachment 1

TASK ACTIONS FROM JANUARY 17-18, 1996 SMM

. Conduct an historical review of the indicators of safety performance for those plants that have been previously identified for enhanced agency oversight (i.e., watch list plants). The goal of this review is to develop additional structure (based on measurable data) that can be used to enhance the objectivity of the problem plant identification process and to support further agency action to address the performance of those plants that remain on the watch list for a considerable period of time. **ACTION: NRR (lead)/AEOD**

2. Schedule a meeting with Commonwealth Edison representatives to discuss the risk implications (e.g., impact on station blackout, EDG reliability, and early containment failure) of the recent electrical equipment failures at Quad Cities. **ACTION: NRR (lead)/RIII: Status - COMPLETE**

3. In response to the radwaste problems recently identified at Millstone Unit 1, identify and propose generic follow-up actions to address any similar problems that may exist in other plants. **ACTION: NRR**

4. Develop a plan to inspect and evaluate the methods and processes that Northeast Utilities has employed at Millstone Station and at the Haddam Neck plant to handle degraded and non-conforming plant conditions, including issues affecting the operability of plant equipment. This plan should include the formation of a team to examine the adequacy of the JCO's, LERs, 50.59 evaluations, and artifacts from other internal licensee processes (i.e., reportability evaluation forms) that the licensee has developed over the past two years. The team should conduct interviews of licensee personnel, particularly those in the licensing and engineering organizations, to further understand and assess the licensees use of these processes. **ACTION: NRR (lead)/RI**: Status-Complete

5. Evaluate the adequacy of the qualifications and training for those inspectors designated to review and evaluate the results of licensee steam generator tube inspections. **ACTION: NRR/AEOD**

6. Respond to the recommendation that the agency initiate action to make voluntary fitness for duty (FFD) testing available for inspectors. **ACTION: DEDR**

7. Review the progress of actions to resolve the concerns associated with ASCO solenoid valves. **ACTION: AEOD**

8. Determine whether a probationary period exists (or can be developed) for supervisors. **ACTION: OP**

Attachment 2

NRC SENIOR MANAGEMENT (SMM) SUMMARY
January 17-18, 1996
NRC Headquarters

Following the June 1985 loss of feedwater event at Davis-Besse, one resulting NRC action was that senior NRC managers periodically meet to discuss the plants of greatest concern to the agency and to plan a coordinated course of action. On January 17-18, 1996, the NRC senior managers held their twentieth such meeting in NRC Headquarters. The last meeting was held in Region I in June 1995. The meeting in Headquarters was structured to review the status of the problem plants identified at the last meeting and to review the performance of other plants to determine if any changes should be made to the list of problem facilities which require close monitoring by NRC.

In preparation for the meeting, NRR and NMSS, in conjunction with the four regional offices, AEOD, OE, and RES, prepared background documents on the plants and licensees to be discussed. Inputs for each operating reactor plant included a summary of the most recent SALP and SALP history, a discussion of current operating experience, current NRC and licensee activities, and performance indicator data. Data pertaining to safety significant hardware issues at the plants were also provided. This information was distributed to meeting attendees prior to the meeting. It provided the basis for review and discussion of each plant's performance and for senior management identification of those plants warranting increased NRC attention.

In reviewing the reactor plants that have experienced significant performance problems, the NRC managers have set the following categories of performance based upon plant actions to date to correct the problems and to achieve improved operations.

1. Plants removed from the list of problem facilities.

   Plants in this category have taken effective action to correct identified problems and to implement programs for improved performance. No further NRC special attention is necessary beyond the regional office's current level of monitoring to ensure improvement continues.

2. Plants authorized to operate that the NRC will monitor closely.

   Plants in this category have been identified as having weaknesses that warrant increased NRC attention from both headquarters and the regional office. A plant will remain in this category until the licensee demonstrates a period of improved performance.

3. Shutdown plants requiring NRC authorization to operate and which the NRC will monitor closely.

   Plants in this category have been identified as having significant weaknesses that warrant maintaining the plant in a shutdown condition until the licensee can demonstrate to the NRC that adequate programs have been established and implemented to ensure substantial improvement.

The following chart lists conclusions reached by the senior managers at this meeting and from the previous meeting for nuclear power plants:

Meeting Dates	Category 3	Category 2	Category 1
JAN 17-18, 1996	Browns Ferry 1	Browns Ferry 3 Dresden 2&3 Indian Point 3 Millstone 1,2&3	
JUN 6-7, 1995	Browns Ferry 1&3	Dresden 1,2&3 Indian Point 3	

The following chart lists conclusions from this meeting and from the previous meeting for materials licensees:

Meeting Dates	Facilities for Priority Attention
JAN 17-18, 1996	None
JUN 6-7, 1995	None

NRC senior management will continue to hold meetings to review the status of all reactor and other licensees on an approximate six-month frequency. Recommendations will be made during those meetings to add or delete licensees from the list of facilities requiring increased NRC attention based on demonstrated performance. This program represents a concerted effort by the NRC senior management to focus NRC resources on those plants and issues of greatest safety significance and risk.

Specific Discussion of Problem Facilities

Category 1: Plants That Have Been Removed from the List of Problem Facilities

none

Category 2: Plants Authorized to Operate that the NRC Will Monitor Closely

BROWNS FERRY 3

All three Browns Ferry units were placed on the NRC Watch List as Category 3 plants during the October 1986 Senior Management Meeting (SMM) because of a history of poor performance, significant enforcement actions, several operational events, equipment failures, and the inability of management to identify and correct problems. TVA implemented an improvement program to address the corporate weaknesses identified in TVA's nuclear program. Browns Ferry Unit 2 restarted in May 1991 and was removed from the NRC's Watch List in June 1992, while Units 1 and 3 remained defueled and required NRC authorization to operate (Category 3).

In 1991 TVA submitted to the NRC its corrective action plan for returning Browns Ferry Units 1 and 3 to service, and in April 1992 NRR determined that TVA's plan was acceptable. TVA began implementing this plan almost immediately for Unit 3. In general, TVA adopted for Unit 3 the same methods, criteria, and technical positions that were approved by previous SERs for the Unit 2 restart. Unit 3 construction activities included conduit installation and support, cable pulling, and large and small bore piping support hangers.

The NRC staff monitored Unit 3 activities closely since TVA recovery efforts began in 1991. A Restart Panel was created in accordance with Inspection Manual Chapter 0350 on February 1, 1995. Fuel load was completed on October 28, 1995. The NRC Staff and TVA briefed the Commission on Unit 3 restart readiness on November 9, 1995. On November 15, the Commission authorized the NRC Region II Regional Administrator to allow restart of Browns Ferry 3. The Regional Administrator authorized restart of Browns Ferry on November 19, 1995 and Browns Ferry 3 achieved criticality that day. TVA completed power ascension testing on December 14, 1995. The restart of Browns Ferry 3 was well executed and the performance at both Browns Ferry 2 and 3 has been generally good.

Although TVA's performance at Brown's Ferry has improved, Browns Ferry 3 will remain a Category 2 facility requiring close monitoring by the NRC until a period of successful plant operation at power has been demonstrated.

DRESDEN 2 & 3

Dresden was first placed on the NRC Watch List in June 1987 (removed in December 1988) and then again in January 1992. Significant contributors to Dresden being placed on the Watch List a second time included weaknesses in: procedure quality and adherence, communications, execution of management expectations, plant material condition, supervision and control of work activities, work performance, and engineering and licensing support.

In response to station management's faltering approach to issues early in 1995, corporate management increased its attention to Dresden over the past six months. The Senior Vice-President for BWR operations relocated to the site and assumed direct control of site activities, and management changes were made in a number of key positions. As result of an increased emphasis on the conduct of safe plant operations, positive results have been observed in the control room, where the reaction of operators to events and personnel accountability has improved. Because both units were in outages for most of the last six months, there has been little opportunity to observe operations at power, however, several startups of Unit 3 were conducted safely and without error.

The material condition of both units continues to be a problem. Although progress has been made in this area, the pace of improvements was slow. The licensee has met its goals set in early 1995 to reduce the number of operator work-arounds, control room work requests, and temporary modifications. These gains have been met through work conducted during extended outages. However, maintenance errors, poor work control and planning, poor maintenance craft skill, the slow pace of accomplishing work, and preventive maintenance weaknesses continue to impede overall improvement in the area of material condition. A large maintenance backlog continues to strain available resources. The licensee has taken significant measures to improve the entire work control process, however, the effectiveness of the changes has yet to be demonstrated.

Operations performance continued to improve, especially in the control room. The improved performance appeared to be the result of management initiatives that included reinforcing standards and expectations to operations staff and making some personnel changes. Management's response to events has also improved, including the critical questioning of performance and immediate response to events to prevent recurrence.

Configuration control and out-of-service (OOS) errors continue to adversely effect plant operations. The licensee initiated action in late June to aggressively address OOS problems, including suspending all OOS activities and performing a complete field verification of current OOS cards. Despite this action, problems in this area have continued. Although no significant plant events have resulted from these problems, the frequency (10/month) of these errors remains a concern, particularly as it relates to personnel safety.

There was improved performance in the area of engineering support to the station. Improved response to plant problems and self-identification of some engineering weaknesses were evident. Engineering support for outage work scopes, the reduction of control room deficiencies, and operator work-arounds demonstrated a concerted effort by engineering to improve overall material condition. However, hidden engineering problems continue to surface. Recent examples include the Unit 3 turbine blade failures and SCRAM discharge instrument volume logic problems.

Problems in radiation protection continue to be a concern. Radiation work practices and RPT performance continue to be poor as exhibited by numerous radworker errors during the last six months, and poor RPT performances on high dose work. Radiological source term reduction efforts have shown some positive results in overall station dose reduction, including successful

chemical decontamination and effective ALARA planning on high dose work. While station management has taken some actions to address recent radiological problems such as replacement of all first line supervisors and some mid-level managers, an effective and lasting resolution to these recent radiological problems has not been demonstrated.

Dresden was continued on the Watch List as a Category 2 plant.

INDIAN POINT 3

This is the eighth time that the Indian Point 3 (IP3) Nuclear Power Plant has been discussed since it was first considered at the June 1992 SMM. Many of the problems identified during the Diagnostic Evaluation Team (DET) inspection at FitzPatrick in the Fall of 1991 were found to exist at IP3, particularly in the quality of management oversight and the effectiveness of the corrective action program.

In January 1993, the licensee (NYPA) submitted a Performance Improvement Plan to address performance weaknesses at IP3. In March 1993, NYPA placed the plant in cold shutdown in response to the inoperability of the anticipated transient without scram (AMSAC) system and a growing list of performance concerns. A special inspection in May 1993 further confirmed the existence of significant fundamental weaknesses at IP3, and the facility was placed on the Watch List in June 1993.

In April 1995, the NRC completed a Readiness Assessment Team Inspection (RATI), which observed that management expectations regarding safety had been clearly communicated to the plant staff. The RATI concluded that the plant equipment, staff, management, programs, and processes were in place to support a safe restart and continued operation of Indian Point 3. The plant was restarted in June 1995. Performance during restart was generally good; however, there have been a number of material condition problems and operator performance issues identified since restart that have prevented the plant from operating at power for an extended period of time.

Equipment problems with the main boiler feedwater pumps, pressurizer power-operated relief valves (PORVs) and safety valves, charging system valves, main generator hydrogen cooler, Appendix R emergency diesel generator (EDG) turbocharger, and weld channel and containment penetration pressurization system components have been identified. Three operational events have further indicated that improvements in the conduct of shift activities is required. In July 1995, following a turbine runback event which was complicated by PORV and safety valve leakage, the plant was operated at power while at reduced pressure for an extended period. This placed the plant outside its accident analysis and resulted in a Severity Level III violation with no civil penalty. In October, while heating the plant from cold shutdown conditions, the reactor coolant system was allowed to exceed 200°F without the required recirculation and containment spray pumps operable. This event was notable because of poor procedural adherence and a lack of questioning attitude by operations personnel. A Severity Level III violation with a $50,000 civil penalty was issued. Finally, in December 1995, a component cooling water heat exchanger relief valve stuck open during a plant heatup, leaked 1,500 gallons to the containment sump and was not detected through two shift changes.

Although there were a number of changes in site and corporate management in 1993 and 1994, the organization remained relatively stable as it approached restart. However, recently there have been significant additional management changes, including several which were made to bolster the operational experience of site management and to facilitate problem solving within the organization.
While there have been some successes in engineering programs, there has not been measurable improvement since restart. The engineering backlog is growing, weaknesses in the setpoint control program persist, and long-term improvement activities are being deferred due to the continuing need to focus on emergent plant issues.

Though management has made a significant effort to instill an attitude fostering attention to detail and a questioning approach toward activities, this attitude has not yet permeated throughout the organization. There appears to be an improved willingness to identify, stop, and correct problems. The QA program appears strong, though department self-assessments and the management observation program have had limited impact. Weaknesses continue in areas such as procedure usage, knowledge of the licensing bases, and implementation of corrective actions.

As a result of the problems that have been manifested during the period, the licensee has undertaken substantial action to strengthen the operations organization and correct the identified deficiencies. NYPA has obtained the services of outside shift mentors, developed a tactical assessment group to provide around the clock shift observation and replaced several managers. Additionally the licensee has undertaken remedial training for the operators and has reviewed key operating procedures to further strengthen and clarify them. Also during the outage the licensee has aggressively corrected material problems that have surfaced. Prior to plant restart, NRC will confirm the adequacy of the corrective actions taken by the licensee and will conduct an augmented inspection of restart activities.

In summary, because NYPA has not yet demonstrated the capability to resolve Indian Point 3 performance problems and sustain safe and reliable operations, the senior managers concluded that the facility should remain on the Watch List as a Category 2 plant.

MILLSTONE 1, 2 and 3

This is the ninth SMM since June 1991 during which a Millstone facility has been discussed. In early 1992, in response to an overall decline in performance, the licensee implemented a Performance Enhancement Program (PEP) as a long-term effort to ensure the effective use of resources and implement the recommendations of four internal performance assessment task forces. Despite the PEP effort, significant operational performance problems continued, particularly at Unit 2 and more recently at Unit 1. Following the January 1995 SMM, NRC senior managers met with the Northeast Utilities' (NU) Board of Trustees to communicate the NRC's concern over Millstone's continued poor performance. This meeting took place on March 17, 1995.

In response to an August 1993 Unit 2 forced shutdown, caused by a non-isolable reactor coolant system leak, and other indications of declining performance, NU made a number of programmatic and management changes. A substantial

reorganization of the corporate and Millstone site management structure was initiated. Despite these efforts, NU has had limited success in addressing significant performance concerns such as procedural adherence, work control, and tagging problems, ineffective communications and teamwork between organizations, continued weaknesses in identifying and correcting performance problems, and poor self-assessment and quality verification. Changes to the site and corporate engineering organization resulted in corporate engineers moving to the sites. The move of engineering to the site was intended to enhance engineering's accountability and responsiveness to site issues, and incorporate a system engineering concept at the Millstone site. Although limited improvements in engineering involvement and resolution of operational issues have been observed, the continued propensity to resolve the immediate safety issue without assuring regulatory requirements are met remains a concern. A pending corporate reengineering will eliminate the position of vice president of Millstone Station, (as well as the other NU sites) and assign corporate vice presidents to be responsible for overall utility operations, work services, technical services, and safety and oversight at all NU sites.

Unit 2 shut down for refueling in November 1994, experienced several significant performance errors, and extended the outage for nine months, during which numerous performance improvement initiatives were implemented. A readiness assessment team inspection (RATI) conducted in May 1995, noted several successes, including effective root cause evaluations, quality assessment audits, and a conservative approach towards ensuring safety significant work items were completed prior to restart.

The Unit 1 plant staff has not yet shown the same level of recognition and depth of response to performance challenges and deficiencies as Unit 2. Unit 1 is currently in a refueling outage that started in November 1995. It is noteworthy that there have been few significant performance problems during the outage. However, quality of procedures, procedure adherence, and work control practices have been continuing problems, particularly in the maintenance area. The impact of system engineers on site is leading to the identification of numerous design deficiencies. During the outage, the Unit 1 refueling floor was cluttered, with almost the entire floor posted as contaminated, indicating weak housekeeping controls. Further, the material condition of radwaste storage and processing systems was extremely poor, evidencing a substantial period of inadequate maintenance, engineering involvement and management oversight.

The NRC remains concerned about the volume of allegations received and the continued evidence of unresolved safety concerns at Millstone. The licensee has enhanced training for managers and supervisors, replaced a number of supervisors, and established a more responsive Nuclear Safety Concerns Program. However, the continuing volume of allegations received by the NRC and two 10 CFR 2.206 petitions filed in the last year to express safety concerns to the NRC, especially a petition related to core offloading practices at Millstone Unit 1, indicate that the licensee is still struggling to appropriately address safety concerns raised by its personnel. In light of these difficulties, NRC's Executive Director for Operations has directed NRR to conduct an independent historical evaluation of the handling of employee concerns and allegations.

In view of the history of serious operational problems at the site, and managements' inability to consistently sustain performance improvements across all three units and to effectively resolve many employee safety concerns, the senior managers concluded that the Millstone Station should be placed on the Watch List as a Category 2 facility. In addition the senior managers decided to conduct an inspection at Millstone Station to evaluate the methods and processes that Northeast Utilities has employed to handle degraded and non-conforming plant conditions, including issues affecting the operability of plant equipment.

Category 3: Shutdown Plants Requiring NRC Authorization to Operate and which the NRC will Monitor Closely

BROWNS FERRY 1

All three Browns Ferry units were placed on the NRC Watch List as Category 3 plants during the October 1986 SMM because of a history of poor performance, significant enforcement actions, several operational events, equipment failures, and the inability of management to identify and correct problems. TVA implemented an improvement program to address the corporate weaknesses identified in TVA's nuclear program. Browns Ferry Unit 2 restarted in May 1991 and was removed from the NRC's Watch List in June 1992, while Units 1 and 3 remained defueled and required NRC authorization to operate (Category 3).

In 1991 TVA submitted to the NRC its corrective action plan for returning Browns Ferry Units 1 and 3 to service, and in April 1992 NRR determined that TVA's plan was acceptable. While, as discussed above, TVA has implemented this plan for Unit 3, TVA does not have a formal schedule or plan for returning Unit 1 to service and for completing its construction. TVA has indicated that the future of Unit 1 will be determined as part of the TVA Integrated Resource Plan, which is still under development.

Browns Ferry Unit 1 will remain on the Watch List as a Category 3 plant.

Other Plants Discussed

[redacted]

[redacted]

HOPE CREEK

This is the first time Hope Creek has been discussed at a SMM. Hope Creek's performance has been declining, primarily due to weaknesses in the control of plant activities, inadequate communications and ineffective resolution of plant problems due to weak root cause determinations.

Performance problems have manifested themselves over the past year in several events. In April 1995, poor control of testing and operation of the decontamination solution evaporator (DSE) contributed to an unmonitored release from the south plant vent. This event was compounded by ineffective internal and external communications. For this event, the licensee was issued a Severity Level (SL) III violation, with no civil penalty due to their prompt and comprehensive corrective action and since it was their first SL III violation in the previous two years.

In July 1995, a partial loss of shutdown cooling occurred as a result of inadequate procedural guidance, poor operator training and inadequate staff performance. Other factors that contributed to this event were poor on-shift communications and procedural adherence. Also, senior plant management failed to properly assess the significance of this event in a timely manner, delaying the start of a comprehensive evaluation of the event and proper notification of the NRC. This was their second SL III violation in a two year period, and since no credit was provided for either identification or corrective action, a $100,000 civil penalty was proposed.

As a result of mixed performance in the operations department, the licensee has recently reorganized in an effort to improve its effectiveness. The new

plant manager reassigned the operations manager and operating engineer elsewhere in the organization and two new operating engineers have been selected. A temporary operations manager has been loaned to Hope Creek from Peach Bottom while the search for a permanent replacement continues. Additionally, three shift supervisors have been removed from their operational duties and several crews have been reconstituted to better match individual talents. Efforts to improve communications, procedural adherence, technical specification knowledge and implementation, and reduce the number of operator work-arounds and control room deficiencies have been instituted.

Although the material condition at Hope Creek is generally better than that of the Salem Units, there are similar performance problems and there are indications that the material condition at Hope Creek may be deteriorating. A review of recent Licensee Event Reports (LERs) indicates an adverse trend in safety system failures, supporting NRC concerns that weak root cause determinations have hampered the licensee's ability to resolve plant problems. Recurrent failures of the high pressure coolant injection system, emergency diesel generators, and vital equipment room cooling and ventilation have occurred. Non-safety related equipment degradation has led to more frequent challenges to the operators. Increased management attention is needed to address the growth in the backlog of both corrective and preventive maintenance.

The unit is currently in an outage that began in November 1995. The initial scope of work was significantly expanded (about 3200 new work activities have been added) to include work that would minimize challenges to the operators. A management meeting was held on January 18 to discuss performance during the outage and how the licensee plans to assess its readiness for restart. A readiness assessment team inspection (RATI) is scheduled for the near future to assess the effectiveness of the licensee's improvement initiatives and to determine readiness to restart Hope Creek.

In summary, while Hope Creek's performance appears to have declined and will be closely monitored, addition to the Watch List is not warranted at this time. The senior managers determined that because the performance at Hope Creek is trending downward, Public Service Electric and Gas Company should receive a letter requesting a meeting to inform the President of the Company of NRC concerns.

[redacted]

[redacted]

Additional Topics Discussed

1. EDO's Opening Remarks

The EDO opened the meeting by briefly discussing the budgetary issues that have affected the agency and provided an overview of how these issues could further impact NRC resources and FTE. However, he encouraged the senior managers to maintain their focus on plant safety despite these concerns. The EDO also reviewed the (generic) implications of the regulatory issues represented by the recent allegations regarding the potentially fraudulent small break LOCA analysis and containment design pressure analysis at Maine Yankee and the troublesome issues surrounding several events at the Millstone station, including the operation of the SFP cooling systems and refueling practices.

2. Chairman Jackson's Opening Remarks

Chairman Jackson greeted the senior managers and indicated that the meeting served as a valuable opportunity to meet and discuss issues, evaluate various regulatory programs and develop an integrated safety picture. She indicated that since the last SMM, has she met with and spoken to each regional office staff and visited several reactors and fuel cycle facilities, all of which were informative and provided a better understanding of some of the regional staff concerns.

Chairman Jackson discussed her vision for the agency -- it includes three fundamental elements: affirmation of the NRC's fundamental health and safety mission, regulatory effectiveness and positioning for change. A synopsis of her comments in these three areas follows:

- Affirmation of NRC's Mission - needs to be guided by a strategic vision. The ongoing strategic assessment undergirds our mission and our regulatory approach, allows us to develop and maintain the appropriate programmatic focus, facilitates resource planning, and allows us to respond to diminishing resources in a changing environment.

- Regulatory Effectiveness - is manifest when we focus on the agency's overall and primary goal - protecting public health and safety. It is apparent when we act to determine whether certain regulations are necessary, implementable, non-duplicative, fair, and consistent. Three issues that are directly related to regulatory effectiveness are technical specifications, exemptions to regulations and the 10 CFR 50.59 process.

- Recent Initiatives - include additional emphasis placed on the development of standard review plans for probabilistic risk assessment and digital instrumentation and control.

Chairman Jackson also made the following comments on specific topics:

- International Research - research areas associated with the aging process are important and common to reactors in all countries relying on nuclear power. Consideration is being given to an international reactor research program focused on aging and risk assessment methodologies, where the regulatory research activities of other countries would be integrated within a formal, structured, international research program.

- Strategic Assessment and Rebaselining - a most important institutional effort requiring serious commitment to the process. She is encouraged by the quality of the interim product of the steering group and has received positive feedback from the leading members of the agency's Congressional Oversight Committees & OMB whom she has briefed in this regard.

- Senior Management Meetings - recognizes the important judgments made during these sessions. She expressed concerns about the function of the Watch List, particularly in terms of the impact (or the consequences) for a facility to be placed on the Watch List. The Chairman directed the staff to conduct an historical review of the indicators of safety performance for those plants that have been previously identified for enhanced agency oversight (i.e., Watch List plants). The goal of this review is to develop additional structure (based on measurable data) that can be used to enhance the objectivity of the problem plant identification process and to support further agency action to address the performance of those plants that remain on the Watch List for a considerable period of time.

3. Status of Strategic Assessment Initiative

The senior managers discussed the status of the Strategic Assessment and Planning Steering Committee which was established by the Commission in August 1995. The Committee is currently in the first phase of its four-phase task -- strategic assessment. During this phase, the Committee is taking a bottom-to-top look at the way the NRC does business. As part of this process, the Committee is also developing strategic issues for Commission consideration. Due to the iterative nature of this effort, the Committee provided an interim Phase I product (pre-decisional) to the Chairman in December 1995. A final report on Phase I is planned for March 1996. The Committee plans to begin its work on the remaining phases -- Phase II (Rebaselining), Phase III (Strategic Plan), and Phase IV (Implementation) -- in March 1996.

4. NRR Selected Topics

The senior managers deferred discussion of inspection program issues. This issue will be discussed at a meeting between NRR and the Regional

Administrators on February 1, 1996. However, the following specific issues were discussed:

- PRA Implementation Plan: the senior managers briefly reviewed the status of activities associated with this plan. Although deterministic approaches to regulation have always contained some explicit consideration of probability (e.g., single failure criterion, design basis events) the current plan focuses the staff efforts on a more quantitative consideration of risk. The senior managers discussed the framework for the regulatory application of PRA; identification and characterization of regulatory activities, deterministic considerations, probabilistic considerations, integration of deterministic and probabilistic considerations. In response to direction from the Chairman, the staff has accelerated the schedule of implementation of the plan such that activities will be completed by November 1997. The senior managers noted that licensees should not use PRA as a substitute for -- or to justify non-compliance with -- NRC regulations. PRA insights should be used as supportive background information to complement the traditional defense in depth philosophy to assuring plant safety.

- Steam Generator Issues: the senior managers discussed the recent field experience related to steam generators, including the detection of large circumferential tube crack indications and free span tube cracking at a number of different plants. It was noted that an alternate repair criteria for circumferential cracking requires the construction of a database -- for demonstration of inspection techniques and the development of structural correlations, quantification of crack growth rates and an analysis of severe accident implications. The senior managers reviewed the status of the steam generator tube rulemaking activities and noted that enforcement guidance is also under development in this regard; the final rule and regulatory guide are scheduled for issuance in January 1997. The senior managers also discussed the fact that the NRC has not, in the past, analyzed High Pressure/ High Temperature core melt sequences coincident with steam generator tube rupture -- and thus containment bypass. There are studies in progress, one of which will be performed on (radioactively clean) artificially degraded tubes at Argonne National Laboratories to facilitate an assessment of this potential problem. The senior managers also questioned the level of skill that NRC inspectors possess in assessing licensee steam generator tube inspections. As a result, an action was assigned to NRR and AEOD to evaluate the adequacy of the qualifications and training for those inspectors designated to review and evaluate the results of licensee steam generator tube inspections.

- Dry Cask Storage Action Plan: the senior managers briefly reviewed the status of this plan. The office responsibilities for various activities under the plan have been clearly delineated, with NRR holding responsibility for the casks until they are stored at the pad at which point NMSS assumes responsibility. NMSS also has the lead in the development of the standard review plan and the

inspection plan. NMSS and NRR will discuss this issue at the Regulatory Information Conference in April 1996 and NMSS will conduct a workshop shortly thereafter.

5. NMSS Selected Topics

The following topics were discussed:

- MIT and NIH Events - the senior managers briefly reviewed the generic implications of recent events involving the ingestion of radioactive material at research facilities. The events, which were most likely the result of deliberate acts by a knowledgeable person(s), revealed weaknesses both in the licensee's programs to secure and control radioactive material and in the management oversight of the radiation protection program. The events also revealed inconsistencies in the NRC's regulatory standards and guidance for the security and control of byproduct material and a need to improve the specificity of NRC reporting requirements regarding the deliberate misuse of material (e.g., intentional contamination), regardless of resulting internal or external doses. Future actions by the staff include: a proposed rule to address the aforementioned reporting concern, an evaluation of security and controls regulations and guidance, a determination regarding the need for requirements inventory and accounting of radioactive material in use and, an evaluation of current regulations and guidance regarding restricted, unrestricted and controlled areas.

- Fuel Cycle Licensee Performance Review Program - an NMSS initiative to review licensee performance relative to key functional areas using a standardized approach. The objective of this initiative is to provide appropriate information to senior managers on licensee performance, in the form of an integrated functional assessment, that can also be used to facilitate decisions regarding resource allocation and inspection planning. The senior managers discussed the plan for implementing this initiative, including the development of a draft inspection manual chapter (IMC 2604) and pilot performance reviews at major fuel cycle facilities. The plan calls for completing the review of major facilities by the end of FY 96 and issuance of IMC 2604 by mid-1996; annual performance assessments would be conducted thereafter.

- NMSS Event Review and Follow-up - the senior managers discussed an initiative to develop a Regional Coordination and Events Section within NMSS to enhance event response capabilities. The staff within this organization would interact daily with the Regions and brief the NMSS Director on events and follow-up activities. This change is also meant to enhance root cause analysis, improve the coordination of generic communications and support of AITs and IITs, and centralize the enforcement coordination within NMSS. w

- NMSS Materials Licensing Business Process Redesign Project (BPR) - the senior managers briefly discussed the status of this project,

which is a key component of the materials program strategies to implement recommendations of Phase II of the National Performance Review. The Build and Test (Prototype) stage of this effort, involving a wide-range of activities, is ongoing and should be completed by mid-1996; a one to two year Implementation (Field) period follows.

- National Academy Study (*Radiation in Medicine*) - the senior managers discussed the potential implications of this study. If implemented by the Congress, all aspects of the NRC's Medical Use Program would be eliminated. The staff is developing short term and long term activities to analyze the recommendations in the study.

6. OSP Selected Topic -

The senior managers discussed the initiative to consolidate the Regional State Agreement Officer (RSAO) resources in headquarters. In response to the Congressional and GAO observations regarding in 1993 regarding the agreement state program, the Commission directed several changes the program, including the return of the program review portion of the RSAO FTE to headquarters. The senior managers discussed the importance of maintaining solid lines of communication between the regional State Liaison Officers and their points-of-contact within their assigned agreement states despite any reallocation of resources and changes in OSP program responsibilities.

8. Regional Selected Topics

- Individual Training Plans - the senior managers discussed a recommendation by Region I to require managers to develop an Individual Training Plan (ITP) for each member of their staff. It was noted that, whereas the development of an Individual Development Plan (IDP) is optional, managers have an obligation to assure that employees are properly trained -- an ITP provides a tool to facilitate the planning and scheduling of training. Region I agreed to provide additional information on ITPs to the other regions and NRR for use as they deem appropriate.

- FFD Testing for Inspectors - the senior managers discussed a recommendation by Region I for the agency to initiate action to make voluntary alcohol fitness-for-duty (FFD) testing available for inspectors. The recommendation followed several instances where NRC inspectors were accused of being under the influence of alcohol while on licensee-controlled property but were unable to refute the claims because no testing facilities were available to them. The senior management discussion centered around the seriousness of this problem (and how widespread) as well as the practical, legal and policy issues associated with the possible use of licensee alcohol testing facilities. The DEDR agreed to consider and respond to this recommendation.

- Regional Reorganization Lessons Learned - the senior managers briefly discussed several lessons learned from the recent regional reorganization: define objective criteria that (alone) guide the

development of the organizational structure and; promote and hire personnel with the attitudes and values, as well as the skills, that fit the needs of the organization.

- FY95 Employee Performance Appraisals - the senior managers briefly discussed the disparity and distribution of performance appraisals among various NRC offices and the region. It was noted that Labor-Management Partnership discussions in February 1996 are expected to include discussion of options to improve the performance appraisal system that would address this among other concerns. Further discussion on this issue was suspended until a new appraisal system is agree upon between management and the labor union.

9. AEOD Selected Topics

The senior managers discussed the implications of less prescriptive NRC requirements on industry guidance, standards and codes. There is a discernable trend towards diminished NRC and industry participation in the development of codes and standards. Suggestions to ameliorate this concern include a greater role of NRC in coordinating rules, guides, standards and codes, and taking a more active role with NEI and INPO on this subject. The senior managers reviewed the accident precursor insights from 1994 and a comparison of the ASP insights from 1982-83 and 1993-94. The senior managers also reviewed data from AEOD's common-cause failure event data base and a summary of the 1995 Prompt Reports.

10. Other Topics

- The senior managers concluded that, in response to the radwaste problems recently identified at Millstone Unit 1, the staff should identify and propose generic follow-up actions to address any similar problems that may exist in other plants.

- In light of the regulatory concerns at the Millstone station, the senior managers directed that a plan be developed to inspect and evaluate the methods and processes that Northeast Utilities has employed at the Millstone Station to handle degraded and non-conforming plant conditions, including those issues affecting the operability of plant equipment. This plan should include the formation of a team, to examine the adequacy of the JCO's, LERs, 50.59 evaluations, and artifacts from other internal licensee processes (i.e., reportability evaluation forms) that the licensee has developed over the past two years. The team should conduct interviews of licensee personnel, particularly those in the licensing and engineering organizations, to further understand and assess the licensees use of these processes.

- The senior managers concluded that the staff should review the progress of actions to resolve the concerns associated with ASCO solenoid valves.

- The senior managers requested that OP determine whether a probationary period exists (or can be developed) for supervisors.

- Research Efforts to Develop Risk-Informed, Performance Based Approaches to Regulation
- License Renewal - GEIS in final rulemaking stages
- Site Cleanup Standards

11. Date and Location of Next Senior Management Meeting

The next SMM will be held June 4-5, 1996 in Region III.

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ADDRESSEES FOR MEMORANDUM DATED: March 14, 1996

SUBJECT: TASK ASSIGNMENTS FROM THE JANUARY 17-18, 1996 SENIOR MANAGEMENT MEETING (SMM)

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