UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION

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BRIEFING ON RESULTS OF THE AGENCY ACTION REVIEW MEETING

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PUBLIC MEETING

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Nuclear Regulatory Commission

One White Flint North

Rockville, Maryland

TUESDAY

May 4, 2004

The Commission met in open session, pursuant to notice, Chairman Nils J. Diaz, presiding.

COMMISSIONERS PRESENT:

NILS J. DIAZ, Chairman of the Commission

EDWARD MCGAFFIGAN, Member of the Commission

JEFFREY MERRIFIELD, Member of the Commission

(This transcript produced from electronic caption media and audio and video media provided by the Nuclear Regulatory Commission.)

STAFF AND PRESENTERS SEATED AT THE COMMISSION TABLE:

JAMES CALDWELL, Regional Administrator for Region III

JAMES DYER, Director of the Office of Nuclear Reactor Regulation

BRUCE MALLETT, Regional Administrator for Region IV

HUBERT MILLER, Regional Administrator for Region I

LUIS REYES, Regional Administrator for Region II

STU RICHARDS, Chief of the Inspection Program Branch for NRR

JACK STROSNIDER, Director of the Office of Nuclear Materials and Safety and Safeguards

MARTY VIRGILIO, DEDO

(This transcript is produced from electronic caption media and audio video media provided by the Nuclear Regulatory Commission.)

P R O C E E D I N G S

CHAIRMAN DIAZ: Welcome, Mr. Reyes. It's good to see you, Jim, Stu, Jack, a lot of almost new faces, not yours but a lot of new faces. We'd like to give you a warm welcome to one of the key meetings that the agency holds every year.

We are being briefed by the results of Agency Action Review Meeting, which was held on April 14th. I believe that the results show that reactor safety performance continues to be sound around all of the reactors in the nation. Safety measures, including performance indicators and inspection findings, are quite good at most plants, but safety measures for themselves are not enough. We all know that it is essential to maintain a high level of attention and commitment to safety and competence in safety.

The NRC maintains its vigilance over reactor safety performance through the Reactor Oversight Program, which includes performance indicators, inspection findings, and safety at sites associated with cross-cutting issues. The Agency Action Review Meeting is a vital part of our processes to maintain our vigilance and our safety focus. It is one of the tools we use to evaluate how our licensees are performing and also how we can improve our regulatory processes.

The agenda for today's meeting looks at industry trends and actions from the ROP self-assessment. It also covers facilities that merit individual discussions, such the as Davis-Besse, Point Beach, and Cooper plants, and the Honeywell uranium conversion facility. I'm personally, of course, interested in hearing about the progress in the engineering design inspection processes and risk performance indicators. I look forward to a very, very informative hearing. And Commissioner McGaffigan, do you have anything?

COMMISSIONER MCGAFFIGAN: I just wanted to clarify the two panels, the two staff panels, are you intending to have them go through both panels, and then we ask

questions or do you intend to ask questions after each?

CHAIRMAN DIAZ: No, I think we should ask questions after each panel because I think it will be a lot more effective. Commissioner Merrifield.

COMMISSIONER MERRIFIELD: I'm all right with that Mr. Chairman.

CHAIRMAN DIAZ: All right. Then, Mr. Reyes, please?

MR. REYES: Thank you, Chairman Diaz, and good morning. We're pleased to be here today to provide the Commission with information on the recently conducted Agency Action Review Meeting. I'm also pleased to address the Commission for the first time as the acting EDO.

As you're aware, the reaction oversight process has now completed its fourth year of use to monitor and assess licensee performance and guide NRC resource utilization on those areas that pose the highest risk. Over the last four years, the revised oversight program has matured significantly as the staff has incorporated lessons learned in the implementation process.

Today, we report on the results of the Agency Action Review Meeting. The annual meeting serves as an important function by providing senior managers an opportunity to review actions taken under the ROP action matrix, as well as in the materials arena, and verify that this action is both appropriate and consistent with the NRC's strategic goals.

Before we proceed, let me introduce those at the table. Joining me on my left is Jack Strosnider, and Jack today is in front of the Commissioner for the first time as a Director of the Office of Nuclear Materials and Safety and Safeguards. On my right is Jim Dyer the Director of the Office of Nuclear Reactor Regulation, and to his right is Stu Richards, the Chief of the Inspection Branch for NRR.

And I would like to turn the meeting over to Jim to start the presentation.

MR. DYER: Thank you, Luis. Good morning Chairman, Commissioners. The Agency Action Review Meeting or AARM, as it's referred to, is an integral part of the evaluative process used by the agency to ensure the operational safety performance of its nuclear licensees. The AARM is governed by Management Directive 8.14, which outlines the objectives and organizational responsibilities associated with this process.

We should be on Slide 2. The purposes of the AARM are (1) to review the agency actions resulting from the performance of nuclear reactor licensees for plants with significant performance problems, (2) to review the results of the annual Reactor Oversight Program Self- Assessment Report, (3) to review industry-wide performance trends, and (4) to review the agency actions concerning fuel cycle facilities and other material licensees with significant performance problems.

During this first panel, we'll brief you on the results of the first three Agency Action Review Meeting topics identified on Slide 2. The second panel will review the individual plant performance issues.

First, Stu Richards, Chief of the Inspection Programs Branch in the Office of Nuclear Reactor Regulation will present the review of the reactor industry trends program and the key results from our reactor oversight process self-assessment. Afterwards, I'll provide a discussion on the status of the Mitigating Systems Performance Indicator Pilot Program. I will then turn the presentation over to Jack Strosnider, the new Director of Nuclear Materials Safety and Safeguards, for his presentation.

So without any further delay, I'd like to introduce Stu Richards to begin the briefing.

MR. RICHARDS: Good morning. Slide 3, please. Slide 3 talks to the Industry Trends Program. It provides a brief overview. The Industry Trends Program provides a means to monitor the long-term safety performance of the industry. It also contributes to

public confidence by making the trend information available to the public, and it provides an input into the ROP to potentially help us focus the inspection program.

Next slide, please. Each year, we report the results of the Industry Trends Program to Congress in the Performance and Accountability Report. The results for fiscal year 2003 were that there were no statistically significant adverse trends in safety performance. However, three of the parameters we trend did exceed our prediction limits.

With regard to automatic scrams, there were a total of 77 scrams in fiscal year 2003. Of those 77, 23 were related to grid issues or problems in switch yards. Of those, nine were related to the August 2003 northeast blackout. Of course, the sites weren't blacked out. Their diesel started. So they maintained power.

If you look back at the previous six years of baseline information, the average for grid related scrams on a per year basis is about four. So you can see that in the past year, the grid related scrams contributed significantly to that increase above where we thought it would normally be.

Safety system actuations tend to follow automatic scrams. For instance, during the northeast blackout, of course, all of the diesel generators at the affected plants started. And there were about 12 safety system actuations, which accounts largely for that particular parameter exceeding what we would normally expect.

In the area of forced equipment outage rate, that issue was largely driven by the reporting of one plant, and I think that has to do with their interpretation of the reporting requirements. We're working with that facility to try and clarify that.

Next slide, please. Another input into the Industry Trends Program is the Accident Sequence Precursor Program. The data for that program is relatively flat since 1994. We're also considering the potential that in the future we'll be using the reactor oversight

process indicators for the Industry Trends Program, but because we only have about four years of experience on the ROP performance indicators, that's is not sufficient for long-term trending. So we're not using those yet.

Next slide, please. Developments in the Industry Trends Program include looking at more risk-informed indicators. As I previously mentioned, we're considering using some of the indicators that we used for the ROP program.

Also, under development is the initiating event performance indicator, also referred to as the BRIIE. BRIIE stands for Baseline Risk Index for Initiating Events. We are working with Research to develop this particular indicator.

The intent of the BRIIE is to develop a risk-informed indicator on an industry-wide basis. The BRIIE would look at nine to ten initiating events, weigh the combined totals based on risk information, and produce one result per BWRs and one for PWRs.

We are also looking at the results of the Operating Experience Task Force Report and considering how we can incorporate that into our Industry Trends Program.

Next slide, please. The reactor oversight process has a built in self-assessment process, as defined in Inspection Manual Chapter 0307. As you can see from this slide, Slide 7, we have a number of diverse inputs into the self-assessment process. We have our internal metrics, which are described in the ROP SECY paper. We have the internal feedback process by which we receive comments largely from our inspectors in the field so that we can improve the program based on what's happening on the front end of the process.

We have a number of independent evaluations that occur. For instance, we were looked at by OMB. We've been looked at by the Office of the Inspector General and by the Davis-Besse Lessons Learned Task Force. Each year we also put out a Federal Register

notice seeking comments from our public stakeholders; and this year, we got about 18 responses. We also get feedback from the various meetings and conferences that we attend.

We also get direction from the Commission. For instance, we are presently undertaking a licensee satisfaction survey, which was directed by the Commission. We should have the survey completed by the end of May, and then we'll analyze those results.

Of course, one aspect of our self-assessment is the Agency Action Review Meeting where the senior management of the agency have the opportunity to consider the program and whether it's accomplishing its goals.

Next slide, please. The overall results of our assessment is that the Reactor Oversight Program is effective in monitoring plant activities and focusing our inspection resources. However, we note that there are improvements that can be made as indicated by the Davis-Besse Lessons Learned Task Force Report and by the other inputs we received to the process. We feel the ROP is supporting agency goals.

We do have a robust feedback process, and we're learning from our experiences and incorporating that learning back into the process. In general, most of our metrics were met. We continue to focus on stakeholder involvement through our public meetings, our web site, and our efforts to solicit their input. The input again that we received from our stakeholders was mixed. Generally, licensees were favorable with some comments, and comments from others spanned a range of views.

Next slide, please. This slide talks to our Performance Indicator Programs, the PIs. One of the topics I think of today's discussion is the Mitigating System Performance Index (MSPI). I'd just like to say that we following the Commission guidance that was issued to us in the Staff Requirements Memorandum, following the NRR program review

Commission meeting. Jim Dyer is going to speak to the MSPI more fully in a later set of slides.

Another performance indicator that we're focused on is the scram with loss of normal heat removal or complicated scrams PI, as it's listed here. The industry had suggested that we delete this performance indicator. The staff feels it has value, and we responded to the industry in writing to that effect. We're in disagreement on this particular issue, and we're working with the industry through our normal monthly meetings to see if we can resolve this.

For calendar year 2003, 12 of 18 of our performance indicators were green for all of our plants. This could be judged two ways. You can view that as licensee performance being good. It also begs the question of should we be looking at other things through our performance indicator programs. So for the coming year, we going to take a little harder look at our performance indicators and see what it's telling us and if there are improvements to be met.

We met all our self-assessment metrics, except for one. There was some concern that the PIs are not able to detect declining licensee performance. Challenges for the future include, as I mentioned, a further assessment of the PI program and improvements to individual PIs, including the RCS leakage PI, safety system failure PI. We're looking at whether we should be using the WANO fuel reliability PI and considering whether power changes that are averted because we issue a notice of enforcement discretion, whether they should count or not. Presently, they don't count.

Next slide, please. In the area of our Inspection Program, we did complete the Baseline Inspection Program for 2003. We implemented a number of lessons learned from the Davis-Besse Lessons Learned Task Force action items. Some of the key ones

include revisions we made to the problem identification and resolution procedure and that inspection process. We did issue temporary instructions to do inspections of the vessel heads, and we have done training of inspectors on various technical aspects. In addition, we had training on maintaining a questioning attitude.

We looked the all of our inspection procedures this year. We did make some changes based on that assessment. In this area, all our self-assessment metrics were met. Going forward, some of the challenges are to continue to meet and complete our Davis-Besse Lessons Learned Task Force actions. In the area of engineering design inspections, we're considering modifications to how we do our engineering design inspection approach. As you are aware, we presently have a paper before the Commission laying out our considerations in that area.

Next slide, please. In the area of the Significance Determination Process (SDP), there are a number of activities going on. We have an improvement plan that largely comes out of a Significance Determination Process Task Force effort of several years ago in a review by Office of the IG. We are working through that improvement plan.

Recent accomplishments include base -- we completed bench marking of the phase 2 SEP notebooks. We're continuing development of the SDPs, both new and revised SDPs. Revisions are occurring to the physical protection SDP, the fire protection SDP, and the containment integrity SDP. And we're working on new SDPs in the areas of the maintenance rule, steam generator tube integrity, shut down risk, and spent fuel.

Two of our self-assessment metrics were not met: SDP timeliness and a perception that the SDPs across the various cornerstones are not consistent. We are working fairly hard on the SDP timeliness issue with a lot of focus going on there, and we've managed to close out some of the older SDPs that we had in the backlog.

Challenges going forward include development of the pre-solved tables for the phase 2 process of the SDPs, and, again, finalizing some of the work we have on-going in this area.

Next slide, please. In the area of assessment of licensee performance, significant activities include enhancements that we made to our 0350 process based on experience from Davis-Besse. We did in the past year evaluate the action matrix thresholds, based on comments from the industry at last year's meeting. I think the primary issue there was whether we should have three white findings instead of two to cross to a degraded cornerstone. The staff concluded that the existing threshold was appropriate. We sent the Commission a written response on that in the fall of last year.

We have increased the flexibility of the regions in conducting our public meetings for the Column 1 and 2 plants so that can be spread out, thereby being less of an impact on regional management and the inspection staff. All of our self-assessment metrics in this area were met.

Challenges going forward include monitoring the recent changes that we have made in the Inspection Manual Process. In the area of substantive cross-cutting issues, we have made recent changes in that guidance. We need to ensure the guidance is specific enough to provide consistent application across the regions and to ensure licensees understand our concerns and what they need to do to address those concerns.

Next slide, please. We're continuing to incorporate new improvements to our Self-Assessment Process in the Inspection Manual Chapter 0307, including modifying some of our metrics and doing a more detailed job of documenting our inspection procedure reviews. Three of 19 overall metrics in the program were not met. Those were whether our SDPs were risk-informed. This is the issue about how we do SDPs for the areas of

emergency preparedness, security, and radiation protection, which is somewhat deterministic versus a more risk-based approach for some of the other cornerstones.

Independent evaluations include the review we had of OMB through their PART process. We were given an effective rating. To put that into perspective, only 6 percent of those programs assessed under the PART process in 2003 were given a rating of effective. I believe about 50 percent of the programs were rated in the category of "Not Rated", meaning that they were not sufficiently performing to even receive a rating. So we're pretty proud of that accomplishment.

The Office of the Inspector General has audited us in two different areas recently. They looked at 2002 audit of the SDP, which I mentioned previously. In 2003, they completed -- or they were looking at an audit of completion of the 2002 inspection program. We're still waiting for the results of that audit to come out. And, of course, we're still working on the Davis-Besse Lessons Learned Task Force action items.

Next slide, please. In the area of resources and resident demographics, we were again challenged in 2003 to complete the inspection program largely because of the activities going on at Davis-Besse and supporting Region I with Indian Point. We have increased the budget resources to the regions by about roughly 15 FTE, and we feel that as the regions bring those personnel on board and they get qualified, a lot of the challenges we faced in the past will be taken care of.

In the area of demographics of our resident inspector staff, we had a relatively high turnover rate this year. We had roughly a third of the senior residents and about a third of the resident inspectors change positions. By and large those individuals were either promoted within the agency or reassigned to other jobs. I think we had two people leave the program, and I believe they were both due to retirement. So I think it's good news that

demonstrates that we're retaining people, and it also demonstrates that we're hiring good people under the resident program because they are good candidates to be promoted.

Next slide, please. This I'll turn it over to Jim Dyer.

JIM DYER: Thank you, Stu. Slide 15, please. The Mitigating System Performance Indicator Pilot or piloted MSPI, as we refer to it, effort was briefly discussed at the NRR Program Review Commission Meeting on March 24. The staff had just concluded that the piloted MSPI was not suitable for full scale implementation.

After that meting, the staff received a Staff Requirements Memorandum from the Commission that directed us to address this issue at this Commission meeting, consider creative and practical approaches to achieve the intended purpose of this effort, continue to involve all stakeholders in our reviews, and to not allow resource considerations alone to prevent transition to a more risk-informed basis for the Reactor Oversight Program.

In our assessment of the piloted MSPI, we concluded that it provided a number of improvements over the safety system unavailability indicator that it was planned to replace, including that it's more risk-informed and plant specific, considers both unavailability and unreliability, is consistent with the maintenance rule, and data collection would be improved through the use of the INPO Consolidated Data Entry System.

However, the staff identified a number of concerns that were summarized in the Reactor Oversight Program Self-Assessment Paper 0453 and described in more detail in some of the background information we provided separately to the Commission. The chief concern is that the piloted MSPI represents a fundamental shift in how the NRC inspects and assesses licensee performance. It's more than just a replacement for the safety system unavailability performance indicator because it replaces the significance determination process for single mitigating systems failures covered by the MSPI.

Where the current oversight program utilizes the safety system unavailability indicator and the significance determination process to determine NRC follow-up activities, the piloted MSPI is designed to detect statistically significant adverse trends over a three-year period without regard to the underlying performance deficiency. We could conduct the limited baseline follow-up inspections, but there would be no significance determination process evaluation, or color determination, or the supplemental inspection to determine the extent of conditions until the three-year average threshold is crossed.

This fundamental shift drove the staff concerns about cost, communication, and overall effectiveness, identified in the Commission paper. The staff, led by the four regions, concluded that the piloted MSPI was not ready for full scale implementation at this time.

Slide 16, please. The staff activities going forward are moving in parallel paths to resolve these concerns. We're working with our internal stakeholder to solicit any creative and practical approaches to move forward with an improved performance indicator. At the same time, we're preparing a more detailed explanation of the staff concerns beyond that described in the Commission paper and will present that during the May 2004 monthly Reactor Oversight Program Meeting with the public.

In June, we intend to present the results of the staff solicitation and to take new input from our public stakeholders on approaches for resolution of our concerns and will consider modifying the piloted MSPI or suitable approaches to achieve the intended goal of improving the performance indicator for mitigating systems by making it more risk-informed.

I've personally had discussions with the NRR, Research, and regional managers and staff concerning this issue before, during, and after the Agency Action Review

Meeting. I want to assure you that we are moving forward towards a solution to this issue that is fair to all of our internal and external stakeholders.

The SRM also asked the staff to address the lessons learned from the MSPI pilot. We discussed this also at the Agency Action Review Meeting. The staff and the industry worked long and hard to try to make the piloted MSPI work. The Office of Research support was of very high quality and did what we asked of them.

We concluded that the pilot, as planned, in fact, we delayed our original decision to try to find a way to make it work. If we have any lessons to be learned, it would have been to come to a decision earlier because this fundamental shift in the inspection assessment process could have been identified earlier as being unacceptable to the staff and management. Again, this is sort of 20/20 hindsight on our part, but we tried as much as we could to find a success path for the piloted MSPI, but at this time, we could not.

That concludes my presentation, and I'll turn the meeting over to Jack Strosnider.

JACK STROSNIDER: Good morning. I'm going to present a summary of the Material Licensee Trends Program. If I could have Slide 17. This program is implemented in accordance with the guidelines that were approve by the Commission in SECY-02-0216. As part of this program, the staff analyzes industry data on a quarterly basis. Then we also provide an annual report to the Commission summarizing the results of those reviews.

Could I have Slide 18. The purpose of the program is to identify candidate material licensees for discussion at the Agency Action Review Meeting and also to identify significant trend issues and performance trends. Of course, this helps us to confirm the adequacy of our programs.

Slide 19. Results of the most recent reviews and going into the Agency Action Review Meeting a few weeks ago, one plant, one licensee facility, that's the Honeywell

facility, was identified for discussion. Luis Reyes is going to provide more detail on that during the next panel discussion.

If you look at the view graph, there's five different areas or sub-bullets that are listed on that slide that are included in the review. These are the areas that we collect information from. The main conclusion of the review of the fiscal year 2003 data from those areas is that there's no discernible adverse trends in safety performance. I would like provide a brief summary of the findings in each of these areas.

The first area is the abnormal occurrence data, and this refers to events that are included in the Abnormal Occurrence Report that's provided to Congress. There were no discernible trends identified in the '03 data. There were five abnormal occurrence events. Four of those were medical events, and one was reported as those to an embryo or fetus. The dominant root cause of the events was found to be human error, such as failure to verify sources in their proper position or failure to ensure correct dosages. The NRC's actions in response to these events, include inspection, enforcement where appropriate, and review of licensee corrective actions.

The second area that we looked at in this program to collect information is performance goals and measures. This refers to the goals and measures that are in the Strategic and Performance Plans. All goals were met. There was no discernible performance trend. However, when we look at this, we challenge ourselves, and we look to see if there are any areas that may have exceeded 80 percent of the established goals. And there were two areas identified in that regard.

One was medical events. Again there's no discernible trend there, but it did exceed 80 percent of the goal. The second was the loss of sources of concern. There five events there. I would mention all of those were radiographic sources. All five were recovered.

Four had been lost. One was stolen, and I want to point out there was no evidence that theft was for malevolent use.

The third area that we looked at is escalated enforcement actions. There were 58 escalated enforcement actions in fiscal year 2003. Again, there's no statistical trend in five years of data with regard to enforcement actions.

The fourth area in which we get information is a significant threshold. This refers to criteria that were identified in the SECY that I mentioned earlier. It provides guidance for identifying licensees to be discussed at the Agency Action Review Meeting. As I mentioned earlier, Honeywell was the one licensee facility that was identified.

The annual report that we provided talks about some other facilities, provides discussion on those, including Nuclear Fuel Services in Erwin, Tennessee, and Safetylight in Bloomsburg, Pennsylvania, but those facilities did not cross the thresholds for the AARM. There is some discussion in the annual report.

The fifth area that we looked at is nuclear materials events database. This involved reviewing 16 quarters of data, over 2,000 events in that database that are reported by NRC licensees and Agreement State licensees. A breakdown of those 2000 events shows that 44 percent were due to loss of control of material, 25 percent resulted from equipment problems, and 8 percent are due to leaking sources. Again, there were no discernible trends.

That's a fairly quick and brief overview of the program and the results. There's more detail in the annual report that was provided to the Commission. I think the two main conclusions there is that there were no discernible performance trends in any of the data that we looked at, and one licensee, Honeywell, was identified for discussion.

With that, I'll turn it back to Luis.

MR. REYES: Thanks, Jack. Chairman, that concludes our formal presentation, and now the panel is available for questions.

CHAIRMAN DIAZ: Thank you very much. We're going to turn this to Commissioner McGaffigan. Now the Commission has enjoyed for some time now the fact that there's only three of us, and we have more time. But since we have two panels, we're going try for about ten minutes each on each panel. If then if we need more time, we'll do it.

COMMISSIONER MCGAFFIGAN: I'm going to start with Jack. I didn't intend to do this, but I think Jack said something that's very important, and I'd want to underline and that's the five sources that would meet the IAEA threshold as a significant Category 2 source radio-nuclide of concern. Only five sources were lost last year, and all five were recovered.

There's an article in the USA Today quoting Peter Zimmerman of King's College in London, former Senate Foreign Relations Committee staffer at an American Physical Society Meeting yesterday in Denver. And Peter, as he has done repeatedly since his national defense university study, talks about the 1500 sources lost over some period of time. He's mixing up trivial sources with sources that are of real concern. The 1500 -- we've documented that the sum total of all those sources put together does not breach the IAEA threshold for a source of concern.

All of the sources that have been lost and unrecovered, most of them are tritium exit signs and things like that, where they have millicurie quantities of radioactive material rather than curie quantities of radioactive material. I think it's very important that the public understand that there are five sources, all of which were recovered during this calendar year period that the staff looked at.

We're very serious about controlling high risk radioactive sources. The entire

government is very serious about this. And we are as I said before, we're leading the world in efforts to, among other things, have full inventories of such sources and having an export and import control regime that makes sense. So I just underlined what Jack said. I didn't even know he was going to say it this morning, but the USA Today article obviously bugged me. I thought I'd mention it.

Turning to Mr. Dyer, the MSPI.

MR. DYER: Yes, sir.

COMMISSIONER MCGAFFIGAN: We may need to clarify the SRM from the previous meeting because I think a fair reading of that is that we wanted you to try to recover the MSPI before going off and inventing something entirely new.

I think that's your intent, but on this issue that you mention of this fundamental change because we wouldn't apply the SDP to safety system un-availabilities, my understanding having talked to a very frustrated Tony Pietrangelo after he came from a meeting with you guys a week and a half ago, is that he is absolutely willing to let you apply either the SDP or the PI, and use whichever is worse in the action matrix. And he's speaking for the industry in that fall back position of his, which he's had in his pocket, he says, for months.

It strikes me that that solves most of the problem. It strikes me that the first action you guys should have taken, having heard the Commission talk and obviously maybe not communicated perfectly in our SRM, would have been to find out what NEI's fall back positions are compared to the PI as piloted. And, you know, see whether they solve your problems or what problems remain having -- I negotiated many a time with the House Armed Services Committee in Defense authorization conferences.

Part of negotiating is you try to pocket all the other guy's concessions and then see

where you are. Maybe we can make this provision work or maybe you can't. Does the staff know what Tony's fall back positions are on these various issues and whether in light of Tony's fall back positions, assuming he is speaking for the industry, whether the PI as piloted with these modifications is straight forwardly okay or what? Where do we stand?

MR. DYER: Let me direct that to Stu Richards since he's been in the public meetings with Mr. Pietrangelo.

COMMISSIONER MCGAFFIGAN: Okay.

MR. RICHARDS: Commissioner, I think the devil's in the details. I don't know what NEI's fall back position is. Let me just run the clock back a little ways. When we were working up to reaching a decision on MSPI, the topic of continuing to do the SDP for the systems capture in MSPI was specifically broached in the meeting. Some of the industry people thought, well, maybe we can just leave that in because it was clear the staff had problems with that.

COMMISSIONER MCGAFFIGAN: You're talking about a year and a half or two years ago?

MR. RICHARDS: No, sir. This was in the fall -- this was when the industry told us, "You have enough information to make a go, no go decision."

COMMISSIONER MCGAFFIGAN: Okay.

MR. RICHARDS: This was in the fall, probably October or November, and we agreed. We have enough information. But just before we said, "Okay, we'll go internal and think this through," this issue of continuing to do the SDP came up in a meeting. And the industry said, "Well, we are going to go off and caucus, and we'll get back to you." So they called us back in a day or two, and they said, "Absolutely not."

COMMISSIONER MCGAFFIGAN: Okay. Part of the negotiation is also is standing

tall. You guys have stood tall, and you called their bluff, and turns out it was a bluff. And now, they're willing to talk to you and cede that fundamental point. It just strikes me you've to get on with the discussion.

MR. RICHARDS: Yes, sir. We agree. We agree.

COMMISSIONER MCGAFFIGAN: Like I said, I would find out, if I were you -- Tony implied he had other fall backs on other matters that would solve most or all of the staff's problems as he understood them and he was frustrated that your first notion was given that you've already have laid all this out in the SECY paper that's before us, what the staff's problems and in other documents, what the staff's problems with the PI as piloted are, and he fully understands the staff position, why your first action was to go back and huddle more with internal stakeholders as opposed to huddling with him in the industry and find out what their fall backs are.

Because at the moment, you're huddling with the staff and presumably everybody's going to say four square, I'm with the position that I had before. But you don't know what -- the ground has shifted. By you all hanging tough and saying, "Hell no. We won't do it as piloted," you've brought out what the fall backs are.

MR. DYER: Commissioner, I think one of the things, and it was my decision --

COMMISSIONER MCGAFFIGAN: Right.

MR. DYER: -- so I'll take it. One of the things I wanted to do was make sure we had the regions and all the staff on board. I didn't want to make it look like we were cutting any deals or anything like that with NEI in a small group or at the last minute. And we'd gone through the process of soliciting input from all four regions, and so I felt that we needed to go back to develop, you know -- what are the bid positions? So I directed the staff to go back and work with the regions and our internal stakeholders to develop -- make

sure we understand before we go to the negotiating table, as you would say, with NEI to make sure we had a consensus understanding of what the staff's concerns were.

COMMISSIONER MCGAFFIGAN: Okay. Well, as I said, I heard the concerns last time. I've heard a solution -- the main concern you mentioned today, I've heard a solution to it. I understand there were cost concerns, but I think a lot of those costs are costs that would be incurred if we simply become a more risk-informed agency. And I think in some ways, were unfairly lumped all on the MSPI indicator.

So, I just look forward to seeing further development. But I think it's a fair reading, I mean, Donald Dube is quoted from -- the Office of Research is quoted in "Inside NRC" this week as saying -- talking about the million dollars and all the FTEs spent on developing the MSPI, just from NRC's perspective. To abandon that in my opinion would be silly. I think the Commission didn't intend for to you abandon it. I think the Commission intended for you to try to salvage this and that's why we talked about giving up the front stop. Research feels very strong the front stop shouldn't be given up, but there's this other solution that would retain the front stop but allow you to use the worst of the SDP or the PI for action matrix purposes.

I think that solves most of the problems that I've heard. Now, there may be more problems. There may be some other issues that haven't fully emerged yet, but it strikes me that the right thing to do is to try to savage what's there and then figure out whether you -- if it's not salvageable, come back to us and tell us. And tell us you have to spend another large amount of money in FTEs to develop something different.

MR. DYER: And that's our intent. I mean for sure. We are moving ahead to savage what we've done. We're not going to throw it out and start over again.

COMMISSIONER MCGAFFIGAN: Let me switch subjects, cross-cutting issues.

The paper talks about the fact, and you guys talked at the AARM meeting, that we have a lot of issues coming up in problem identification resolution, PINR. And you talked about there being a new module for inspecting that and all that. One of the fundamental premises of the reactor oversight process is that these cross-cutting issues that don't have their own cornerstone, and don't have their own EPIs and whatever, that those will manifest themselves somewhere.

And in one of the places where we are keeping score and, you know, the ROP will catch it, I have some doubt to be honest with you whether in this issue of problem identification resolution, essentially this core issue of licensee corrective action, whether we don't need something more than what the ROP currently provides. So I'd by interested in what your reaction to that is.

MR. DYER: I guess, Commissioner, from my reaction and this is really been an informed reaction, as we discussed as you've said at the Agency Action Review Meeting. Going back and coming up with definitive criteria for the cross-cutting issues to define when we have a substantive cross-cutting issue, in this last revision, we identified on the last revision to the manual chapter, we identified some thresholds or characteristics of it. But coming up with definitive criteria for a substantive cross-cutting issues is an area that we still need to evolve. And collective with that is what are we going to do about it? And I think that's sort of the next step in this evolutionary process.

If I go back through the cross-cutting issues, we had 14 cross-cutting issues in the problem identification and resolution area this past year. We took a look at the dispersal among the different regions to look for consistency of application, but seven of the 14 had a greater than green cornerstone. And so --

COMMISSIONER MCGAFFIGAN: The seven of the 14 correlates with something

that happening somewhere else.

MR. DYER: Yes, sir.

COMMISSIONER MCGAFFIGAN: But seven of the 14 don't.

MR. DYER: Right.

COMMISSIONER MCGAFFIGAN: And the question is do those seven plants deserve something more than what they're currently getting under the action matrix. They may be merrily in Column 1 or 2 and getting relatively modest NRC inspection resources, and yet there could be a fundamental problem with their corrective action program. Our history is if somebody has a problem with their corrective action program, eventually it will show up. But in some ways this may by a better -- you're always looking for leading indicators -- this may be a better a leading indicator.

Getting some way to score problem identification and resolution problems within the action matrix, rather than waiting for them to show up somewhere else, strikes me as something you guys have to continue to think about. I don't have a solution. You're mush closer to the problem than I am. If our regional administrators -- those seven plants that didn't manage to get a degraded cornerstone or greater than green cornerstone, I'd probably have my eye tilted towards them a little bit. So, whatever, I just mention it.

MR. DYER: They bent my ear about looking for an alternative.

COMMISSIONER MCGAFFIGAN: So this is coming from regional administrator.

MR. DYER: Yes, sir.

COMMISSIONER MCGAFFIGAN: So they all have their eyes tilted in that direction?

MR. DYER: Yes, sir.

COMMISSIONER MCGAFFIGAN: Good. Last issue, demographics. I'd just

mention very briefly, Luis was a man of his word. Last year, he told me Region II would regress do the mean, and it did because of all of his rotations down there. I do think that when I look at sort of qualified resident time being less than a year and stuff like that, we have to really manage this. And I hope the regional administrators manage it. I do worry. I know you have this double encumbering thing. I don't think it's been used very often. It's hard to use when somebody suddenly gets promoted.

I think we have to think about whether we use the residents. I mean, the residents are our eyes and ears. They're the front line at the 64 sites, and they're very good people. But if the only way they can get promoted is to come into a region or come into headquarters and that leads to turbulence out there and people relatively new to the sites, then that maybe isn't the best agency thing. Not that I don't want them to be promoted, but I think it's something that really has to be managed. And some of this demographic data doesn't make my feel very good. So I'll just leave it at that.

MR. DYER: I guess, Commissioner, one of the other things that has occurred too beyond the double encumbering is we have gone to reassignments back to the sites until a qualified resident can get there, a qualified inspector can get back to the site, at some pain to NRR when we detail them for six and eight months.

COMMISSIONER MCGAFFIGAN: That's a good thing too. I mean, anything that you can do of that sort, I think, is good.

MR. REYES: Commissioner, I think this is a regional administrator talking. It's three elements. First of all, you're right on. We're keeping an eye on those. Those are very important. We have had, you heard it today, more FTE allocated to the region. What allows us to do is to bring people on board and put them on the training and qualification process. So we have people in the region in the bench qualified, certified ready to be

residents. That's the first phase.

The second one is the provision to have overlap between a departing and incoming person, both seniors and residents. I think we have used total of four so far. I can tell you in Region II, there's two more planned for this summer when the things do happen.

And the third one is, and Jim deserves the credit, is that when a promotion does happen, in the case of NRR, we agree that he won't have that individual until the replacement is on-site and we are -- have a comfortable factor.

COMMISSIONER MCGAFFIGAN: Can you get that agreement with all the other offices who poach you?

MR. REYES: Well, since the bulk is going to NRR, that's what we have done. I think the four regional administrators, the three others and myself, will tell you we have been working closely to resolve the issue. In the long run, I think the assignment of additional FTE and the overlap is going to really help us a lot. You can't have overlap if you don't have the people on board. You don't have the overlap if the people are not on board and fully trained. So the solutions were put in place. It's going to take a little bit of time to get the people on board and getting them certified, in the bench, ready to go. I see a positive horizon on this.

COMMISSIONER MCGAFFIGAN: I promise I'll take less time on the second go around.

CHAIRMAN DIAZ: Commissioner Merrifield.

COMMISSIONER MERRIFIELD: Thank you, Mr. Chairman. I want to follow-up on a direction that Commissioner McGaffigan made relative to PINR. I think to start off, I do want to commend the staff on the presentation that we had this morning and on the explanation that was provided in SECY 04-0052 on the trends program.

Now, I want to acknowledge that there was a very detailed explanation on the increasing indicators for automatic scrams and safety systems actuations, which in part was attributed to the various grid related problems but not just to the northeast blackout. I thought this distinction was useful.

Now, we have a meeting next week where we're going to be discussing grid related problems, and I certainly look forward to that meeting where we can get more into a level of detail. That having been said and this goes back to Commissioner McGaffigan's comment, when I sat down last night and was looking once again at the charts as it relates to, for example, automatic scrams while critical, in 2003 we were at a point in the numbers where the industry average brought us back to a level, which was really back to about 1996.

In the case of safety system failures, it's an up trend over the last two years from 2001, which is not the right direction. Safety system actuations, again 2003 looked more like where we were in the 1995 or 1996 time range. And also forced outage rates were going in the wrong direction.

I don't know -- there's a tendency among some to sort of throw out various buzz words we like to use around here. Is it complacency? Is it production pressure? Is it a decrease in margins? Is it a safety culture issue? Is it just the greater significance of grid issues? I'm not really certain. What is certain to me is that these trends in 2003 went in the wrong direction, and one of the things that we did today in this presentation -- in times past, we have had NEI come before us and also appear in front of the panel. We didn't do that and as I sit here now, I somewhat regret that.

I do think we need to focus on this issue. I would like to have a better understanding from NEI what it is doing and what its members are doing in this regard. I

would like to see if our staff has any comments because the trend's the wrong way. So what do you think about that?

MR. DYER: Yes, sir. Commissioner, I think from my perspective, the trends are in the wrong way. We spoke about it. We put it out to the industry at the Regulatory Information Conference, and I haven't spoken to NEI regarding this. We did speak INPO on a recent senior management meeting visit, and they have their own set of indicators, which would pretty much confirm our trend information.

So, it's not a data scatter or the problem with the matrix if you would. It's an actual performance issue. And so, they're looking into it. We're looking into it. We were the drivers as Stu said, and is in the paper, is are grid issues with respect to safety system actuations and the scrams. The safety system failures were an up tick also, but it was within the prediction range. So we're not watching that one as close as addressing the grid issues that we've had. But it is an area that we are following and concerned.

COMMISSIONER MERRIFIELD: Okay, I appreciate that. To say again, I'm not suggesting anybody needs to jump off a cliff or anything else on these, but it's a concern. And they are in the wrong direction, and I think -- I certainly would like to see a greater demonstration on our licensees and an explanation how they're going to turn that around.

In the material that was presented at the AARM, I want to go to the issue of the length it takes to complete the significance determination process. One example we had was relative to the two aux feed water issues that occurred at Point Beach. And we have a goal of completing the SDP in 90 days but that goal covers only a percentage of the determinations.

I'm wondering if you can discuss the timeliness of the two significance determinations for Point Beach and our position on the timeliness of SDP and

determinations in general? I'm wondering if we need a second goal to cover the remainder of the significance determinations similar to the goal for completing 100 percent of the licensing actions in two years?

MR. RICHARDS: I can talk, Commissioner, to the general timeliness of this issue. I can't speak specifically to what happened with Point Beach. As you said, our goal is to complete them in 90 days. I think what we are finding is that there are certain technical issues that come up for which we don't have existing SDP documents to guide us. They have to be looked at in detail that require a lot of technical work, and one of the concerns is you have to balance timeliness off of trying to come to a reasonable answer.

Because if we are premature in a finding that is yellow or red, the consequences in redirecting our resources in the inspection area is pretty significant. So one of the things that we're talking about a little bit internally is maybe we need to reconsider these goals. Maybe for issues that appear to be white, maybe 90 days is right. If they're yellow, maybe we need more time. If it's red, maybe even a longer period of time is acceptable, something like that.

But we are quite concerned about SDP timeliness. Jim Dyer has given us very specific guidance to focus on this. We have closed out a number of old issues that I mentioned before. We're just working hard on it. As we gain more experience with SDPs and put these new ones in place, I think that's going to help our timeliness.

COMMISSIONER MERRIFIELD: Well, I don't see what you call it here. I mean I don't mean to beat up on anyone in particular, but I do want to reflect on your answer. The answer you've just given is the more significant we think the finding may be in the end, the longer it's going to take us to come to resolution on that. And that does not increase the confidence of our stakeholders. We ought to be in a position where we can get to those

issues earlier, not rather than later.

MR. REYES: Can I address that because I think we got lost in a very important issue. When you're in the field and you have an event or you find a condition, the immediate corrective action by the licensee and the field inspector is ASAP, is right now. And safety's first. It will always be first. That's what we all huddle around and make sure it's getting fixed.

The problem -- the perception could be that we don't take any action as an agency until whatever color needs to be posted is posted. And that's not necessarily true. We take care of the issues right away. Unfortunately, what I have seen, and I'll speak from my experience from Region II, is that we are finding issues that are difficult. And in some cases, have not been well analyzed through risk analysis before, fire protection and others, the shut down conditions, etc. Those do take time. Now, I agree with you. We're taking too long. We need to move that up.

I just need to make a point that the color posting on the web page does not indicate the time that it takes us to deal with the safety part. That gets done right away. The regions and NRR help us. We deal with that right away. It's unfortunate that some of the issues get complicated, and we have to do the risk and calculate all those things and then consider all these issues.

And sometimes we are breaking new ground. I can give you a few examples where it was unique shut down cases. We have to invent it as we went along. But I agree with you. It's too long. It takes too long.

COMMISSIONER MERRIFIELD: I would like to thank our new EDO for an excellent answer and putting that into perspective, and I think that's useful to articulate. You've articulated the most important principle and that is that safety is first. And despite the

length for which we have to determine what the significance of it is, we're going to take action early. I'm glad you framed it in that particular way.

That having been said, I also recognize you understand that there are some difficulties -- and I appreciate that. I mean, I know the staff does through a lot and know things do take time. But you understand my point there, and I appreciate it.

During the course of the staff's meeting, I think there was a significant discussion among senior managers about emergency preparedness and security cornerstones. My understanding is that there was additional attention that was given to those during the Agency Action Review Meeting. I think that's appropriate given the actions and discussions of the Commission and Chairman, and the increased emphasis by the Commission in these areas, I think that's well regarded.

Can you share with me anything regarding the discussions of these cornerstones and where we see ourselves going?

MR. DYER: I'll take a shot as I recollect. Some of the drivers certainly with the emergency preparedness issues that came out from both the materials discussions and the reactor discussions, most notably, the issues that came out as we'll hear later in the second panel on the Point Beach emergency preparedness concerns that came out of the 95003 inspection, as well as some of the concerns that were raised with the Honeywell facility in the emergency preparedness.

And from the reactor standpoint, the concerns were we have site specific concerns but also whether the laxity, if you would, of how we've been controlling the emergency plans, the changes to the emergency plans once originally issued transitioned to the NUMARC guidance in that, and whether or not the staff was getting the right information to review whether we were doing the thorough reviews, and whether or not we were actually

executing the inspection program the way we intended for it to be done, and whether we had the right resources applied to that.

And we are still taking a look at that and to our new Emergency Preparedness Project Office to look at making the further changes to whether or not we need to enhance the inspection program once we reconcile what is the appropriate level of detail and expectations for receiving the plans for our review.

I don't know if that answered your question, Commissioner, but that was a lot of the dialogue that I remembered.

MR. REYES: Yeah, and did a discussion of short term lessons learned out of the Point Beach situation. We re-emphasized that with the utilities, and the regions we took some looks to make sure that, in fact, we didn't have those issues. So, in terms of short corrective actions out of that quick lessons learned from Point Beach, we took some action. Jim is, I think, relating the longer term things that we also need to consider.

MR. STROSNIDER: And just if I could add from a materials perspective that there are some challenges there, particularly when you consider the chemicals that are on some of these sites, and Honeywell was an example of that. And so we recognize from some of these materials facilities that the coordination with other agencies and the understanding of roles and responsibilities there was very important. That's an area that we're looking at more broadly than just at Honeywell.

COMMISSIONER MERRIFIELD: Thank you, Mr. Chairman.

CHAIRMAN DIAZ: Thank you, Commissioner Merrifield. Let me try to start with a couple of comments. I think that my fellow Commissioners have already framed a lot of the discussion.

Let me just start with the issue of cross-cutting issues. I think many years ago when

we started to converse on the ROP, I keep insisting that there was almost like a defense-in-depth part of the ROP, and that was the corrective action matrix and that there was no way that we could maintain the comprehensive safety evaluation of our systems without putting the emphasis that the corrective action matrix requires.

And I think what we learned today is that it still a major requirement and emphasis on the corrective action matrix and how robust it is. And how do we receive the right information from it continues to be -- let's call it the -- defense-in-depth or redundancy to all the other systems. And that matches with what Mr. Reyes said. When we look at this better performance indicators of all of those things, we always have to be sure that the decisions that we made are associated that they have other means of making sure that the safety has been taken into consideration.

And I think that will not change regardless of how we change performance indicators or how we advance in our use of risk-informed regulations. I wonder if you care to comment on that, Mr. Reyes.

MR. REYES: I agree with the backbone of the revised over sight program and the implementation of the corrective action programs. And the discussion we had had an element of, and Jim mentioned it, a threshold. We are taking a very hard look at that program. There is no question about it. And I mentioned in my opening remarks that the ROP has been in existence for four years.

But we are getting very, very smart. We have a lot of intelligent people out there in the field with a lot of experience. So we're taking a very hard look at corrective action programs. We need to take a look at ourselves to make sure we're deciding on cross-cutting issues at the same threshold, at the right threshold. But if anything, my impression is that not only are they going to take a have a hard look, we are reacting quickly to things

that we see could be done better and in an anticipatory mode before you see it on the PIs.

So if do your corrective action program well, and you prevent things from happening, that's success. And you may not see it in the PIs. They may remain green. That may be that we're engaging real early. If the licensee's successful, they will engage early and get it resolved. And then if you go into some of the details on the discussions, which we don't have time here, I think the regional administrators and their staff are engaging those utilities early on to make sure that in fact the corrective action program remains robust. And if we see some areas that need improvement, we will highlight those.

CHAIRMAN DIAZ: Okay. Thank you. I'll jump immediately from that into the MSPI. We'll go back to the first part. There is no doubt that there is an issue that is always foremost when we make determinations and that, you know, where does this fall in our establishing reasonable assurance of adequate protection? And what I think the Commission has been saying and not even with MSPI from before is we just want to move forward with better indicators, with better associated evidence that we conform to reasonable assurance of adequate protection.

And if there is something new, even if it's a little bit scary that can help us get there, then we want to do that. However, it is not a matter, and I'm having not worked in the Congress of the United States, I don't know if it's right word, it is not a matter of eventually a negotiation that will take place. It is that we need to establish what are our requirements, and then strong discussion, engagement, bringing in different points of view, that's what we want to do. I wonder if that is clear where the Commission is coming from in this issue?

MR. DYER: Yes, sir. I believe it is clear and that's what we are trying to do. When I gave my direction to staff, I didn't want to cut off any participation. I think to step back and just take a sense of where we at and so we can adequately represent the staff concerns,

particularly the regions --

CHAIRMAN DIAZ: Of course, eventually you senior managers get paid the big bucks to make those decisions, and we expect you to do that.

MR. DYER: That's right. No problem.

CHAIRMAN DIAZ: Thank you, sir. I think the issue of demographics has been an issue that we all continue to be worried about it. There are other changes. There are pressures coming the security and so forth. So I agree with Commissioners McGaffigan and Merrifield that's an area that deserves special attention.

Now, let me just lean back and hear -- and I was looking at all of this, 15 very specific questions, which I'm going to drop into one long question that any of you or all of you might want to answer. When you meet and discuss all of these plants, and we will get to the specific plant discussion, but at this level, are you getting all the information that you need to make your determinations? Have you looked at whether all the things that you need are there? And on the issue of taking prompt actions, have you been getting the information when you need to take prompt action when you need to get it? So that's a two-part question.

MR. DYER: Let me start off, Chairman, by saying that by the time we get to the Agency Action Review Meeting, it's a confirmatory review, if you would, that there has been so much dialogue back and forth. And since I moved from the region to headquarters, the extent of the dialogue between the regional administrators and the office directors and the deputy EDOs, I was familiar with it from a one-region perspective. But it's that way I sense in all of them.

So that information when we bring it all together, it's almost -- at the time we are making the decision, it's almost a confirmatory review that you had all the information.

CHAIRMAN DIAZ: I'm sorry, Jim, I understand that. I mean even from before, is the information that you're getting even before, because this a confirmatory action, have you looked at it and say, "Is this all I need?" Are you satisfied 90 percent -- I don't need a percentage. But is what you need to be able to do the confirmatory action, is all the portions that you need, are they there?

MR. DYER: I would say yes, Chairman, because if they're not, we go get them.

CHAIRMAN DIAZ: Okay.

MR. REYES: I just reinforce what Jim said. On a daily basis, we get a lot of information from the field through our inspection program. We share that not only internally to the unit, whatever region it is, but we share that across the regions. We have periodic calls at all levels from the Deputy Regional Administrator, Division Directors, Branch Chiefs, and with the Program Office. So we feel we do get a lot of the information to make decisions.

What we wrestle with all the time is the thresholds. And we check with each other a lot. We use everybody else as a sounding board. And the four regions have a good working relationship in doing that, in trying to make sure that we're all executing at the right thresholds. And that's probably the bigger issue in my mind than getting the information. We have excellent spies. We do have a lot of workers that feel free to call us. I mean, we have a wealth of information.

Now, execution is an issue in my mind -- and are we executing at the right level?

CHAIRMAN DIAZ: So if you would then say, what could we do better for next year, it is to have better assessment or indication of what the right thresholds are and that should be an improvement in the process.

MR. REYES: Correct. And I think some the issues are embodied in the Davis-

Besse Lessons Learned Task Force. If you go back to those action items out of the task force, I think a lot of what we are talking about are embodied. You know, it's hard to pinpoint each one of them, but as a group, I think it's where we want to go.

MR. DYER: Particularly the operating experience part of the Davis-Besse lessons learned in the task force, the subsets of task force results that we are still working on right now.

CHAIRMAN DIAZ: Alright. Thank you very much. I think we now will go to the next panel. We'll take a two-minute break.

(Break.)

CHAIRMAN DIAZ: Alright, Mr. Reyes, let's continue. Thank you.

MR. REYES: Okay. Good morning again. And we're ready for the second panel. What we'll try to do on this panel is to follow-up on the previous one. We're going into specific discussions of the plants that merited our attention in the AARM.

Before we start, I would like Jim to briefly refresh us on the ROP process, and then we'll go on each individual. With me at the table is Jim Caldwell, the Regional Administrator for Region III; Dr. Bruce Mallett, the Regional Administrator for Region IV. To my right is Jim Dyer, Director of the Office of Nuclear Reactor Regulation, and to his extreme right is Hub Miller, the Regional Administrator for Region I.

And then, when we get to Honeywell, part of our travel cost reductions, I will do the Region II presentation. And maybe that will save some money. Jim?

MR. DYER: Thank you, Luis. Let me briefly go over the assessment process under the Reactor Oversight Program (ROP), and this is Slide 2. As we work up for the annual Agency Action Review Meeting, that we begin, of course, with the end-of-cycle meetings where the regions and NRR collectively review the performance at all plants, the summary

of performance indicators, and inspection results and make their preliminary conclusions. As a result of the conclusions made at the end-of-cycle meetings, then an end-of-cycle summary meeting is held between the regional administrators and the Director of Office Nuclear Regulation, myself. We discuss specific plants. Those plants are the plants that are in the degraded cornerstone or greater, or have a substantive cross-cutting issue. And we conducted that.

After that, then, an agreement is made, and we issue the annual assessment letters and schedule the annual public meetings for all the plants. Those meetings are right now going on for many of the facilities throughout the nation.

Additionally, as a result of that, then we work up the background packages for the Agency Action Review Meeting. Get the packages out to all the senior managers and meet for a day, this year in Leesburg, Virginia, to discuss the performance of those specific plants in the multiple degraded cornerstone -- that have been in the multiple degraded cornerstone within the past year. This year there was three reactor plants that we discussed, the Cooper Nuclear Station and the Point Beach Nuclear Station, which were in the multiple degraded cornerstone, and also as a result of Davis-Besse, we also had an information briefing on the Davis-Besse facility. As a result of the Agency Action Review Meeting, we deemed that we concluded that there was no additional actions that were required for any of these three facilities.

And right now I will move on and pass the discussions over to Bruce Mallett, who'll discuss the Cooper Nuclear Station.

DR. MALLETT: Good morning, Chairman Diaz, Commissioner McGaffigan, Commissioner Merrifield.

For the next few minutes, I'm going to discuss the performance for the licensee

operating the Cooper Nuclear Power Station since we last discussed their performance at this meeting about one year ago. The Cooper Nuclear Station, as you probably recall, is a boiling water reactor, MARK I containment structure. It has had its operating license since 1974, and it's operated by the Nebraska Public Power District. Since we discussed this licensee's performance in the year 2002 and 2003, I proposed to provide our current assessment by discussing three areas.

First is how we arrived where we are today, a brief discussion of the history so we can frame the current. The second part of this discussion is what do we assess as their current performance. The third part will be where we go from here.

Before I go into those three, I wanted to highlight a few items that occurred since we last discussed this licensee's facility performance. The licensees has multiple changes in key management positions since we last discussed them, all the way from the vice president, chief nuclear officer, down through the operations manager.

The nuclear plant has also experienced two manual scrams and one automatic scram during the assessment period, which caused the licensee's performance to cross the green to white threshold in the performance indicator for unplanned scrams per 7,000 critical hours. This occurred in the fourth quarter of 2003. The licensee has also experienced several power reductions due to equipment and human performance problems during the period.

Now, I would like to discuss how we arrived where we are today. In late 2000-2001 time frame, we identified performance issues in the area of emergency preparedness in that cornerstone. Later in the year 2002, we identified more issues in that area, which were characterized as low to moderate safety risks in the white color range in our reactor oversight process.

As a result of that, the licensee was placed in the multiple degraded cornerstone in April 2002 because the EP cornerstone had been degraded for greater than five consecutive quarters. In response to these issues in emergency preparedness and a long history of problems in other areas, the licensee created and provided a strategic improvement plan in the June 2002 time frame.

In August 2002, we performed a comprehensive, what we call a 95003 inspection, at the facility. And we identified several areas where their performance issues, some in addition to what the licensee found. In response to this, they provided us with a more comprehensive strategic improvement plan in the November 2002 time frame. And we confirmed what we believed were necessary key actions in that improvement plan in a January 2003 confirmatory action letter for the facility.

And if you look at Slide 3, the confirmatory action letter felt that there were six key areas -- I'm sorry, Slide 4 -- there were six key areas that those actions should be confirmed in. And I'll frame my discussion of their current assessment in those six areas.

Since January 2003, the NRC has been taking step to monitor the licensee's steps to improve their performance in these six areas. We've had quarterly inspections of the licensee's facilities specific to these six areas. We started those in February 2003. We've also been holding quarterly public meetings with the licensee to discuss that performance at the end of each of those inspections.

We have also continued the baseline inspection program at this facility, and we held our end-of-cycle meeting on April 4, as a public meeting near the site. Ellis Merschoff, the new Deputy Director for Reactor Programs, participated in that end-of-cycle meeting.

We are continuing to review our NRC performance indicators of the licensee. They've also established their own performance indicators, which we think is a good thing.

And we continue to monitor how they believe they're performing in those. And last, we have looked at them by looking at their self-assessments, whether they believe their performance is adequate in these six areas.

Now, I would like to go into what is our assessment of the licensee's current performance. Overall, they've operated the station in a manner that has preserved public health and safety, and they have improved their performance in several areas since the last time we discussed. But their performance continues to show issues in several areas of these six areas of the confirmatory action letter, which I will highlight in a moment.

I'd like to discuss what we believe is their current performance in each of these areas. One of the things before I start the discussion, I would indicate we established what we thought would be our criteria for judging success. And I wanted to highlight that for just a moment. We had specific actions in our confirmatory action letter that the licensee agreed to, and we agreed they need to complete.

Another area for success is they need to conduct their own self-assessments and make sure we believe that they are adequate self-assessments.

The third area is they need to conclude and we need to conclude that they have established programs and put them in place that this will become a practice performance rather than just on paper.

And in the last area is we'll do an independent assessment to make sure that we think their program's adequate when they are all done.

Now, if you look at the six areas in Slide 4. Emergency preparedness is the first area. We believe their actions have been effective, and they have demonstrated that they have corrected the problems that led to their being placed in the multiple degraded cornerstone. We believe that it is a practice there now in emergency preparedness and

not just on paper. We consider their performance in this area sufficient to discontinue our enhanced oversight in this piece of the program.

The second area of the confirmatory action letter on Slide 4 is human performance. We believe they have the programs in place, and they have the indicators to monitor whether they're achieving success in that area. They believe as a licensee that they have improving trends. We conclude they're not effective yet, and we're still noting human performance problems leading to plant problems.

In the third area of material condition and equipment reliability, we believe that they have not set the appropriate priorities in fixing some equipment issues at the plant, but they have taken strong actions during this period to implement standards, expectations in monitoring this area. We still are seeing some recurrent equipment problems that not resolved and showing up during this performance assessment period.

I would add in this area though we have seen significant improvements in some areas of the station in the equipment by them focusing on improving that equipment.

In the area of plant modifications and configuration control, we believe they've made significant improvements in the modifications process, which was part of the issue that was a problem in the first place. They have completed actions on the specific items in the confirmatory action letter. We are still noting some, what I would call, isolated problems in their configuration control in the plant and some problems with upper ability decisions. So we are continuing to follow their performance in that area.

You mentioned, Chairman and the other Commissioners, one of the most important backbones of the Reactor Oversight Program is the corrective action program, the problem identification and resolution portion. The next part of this confirmatory action letter was confirming that they put a program in place to make that effective. They have done that.

We're just starting to observe that program that's in place, and we are seeing that it is being embraced by the employees and not just on paper.

I don't to paint a glowing picture, however. We do think there's still some problems we are noting at the plant in this area. They are also improving experience of -- operating experience from other sites, which was an issue at this plant. So in summary, I would say that we're noting improvement. A corrective action program is in placed, but we're not convinced it will be long term yet.

The last area of the confirmatory action letter in Slide 4 is the implementation of engineering programs. The licensee has corrected the specific confirmatory action items in this area. They've established clear expectations. We believe they have good leadership that's strong in setting standards, and it's instilling an active role of engineering in the operations of this plant. The only area we are monitoring in this part of the confirmatory action letter is whether the performance will be sustained.

Before I go into where we go from here, I wanted to highlight a couple of other items that have occurred during the period in the area of performance. One as I mentioned earlier, the unplanned scrams for 7,000 critical hours across the threshold from green to white in the fourth quarter of 2003. Late in the year 2003, they also had, and they identified this, an excessive failure rate on the written portion of their exams that the operators took as part of the requal program.

The licensee reviewed this, and they have developed an effective corrective action for this problem. We performed a specific inspection to follow up on this issue at the site, and we conclude that their corrective actions are appropriate. And we just completed that in April of this year. We determined that most importantly, the operators on shift are qualified and that they have good remediation of the individuals that did not pass the re-

qualification exam, in most cases. We did note deficiencies in their training program. They have noted those also, and they need to address those to correct them.

Lastly, and let me tell you what we believe is where we go from here. The licensee continues to make progress in improving their performance but is not sustained in some of the areas of the confirmatory action letter, as I indicated. We do believe the confirmatory action letter and the licensee's strategic improvement plan are excellent road maps that have proven to be good road maps for guiding the licensee's performance for improvement and NRC's assessment of that success in that area.

I would highlight again the area of emergency preparedness. We believe sufficient progress has been made and sustained performance has occurred to close the white findings that was that part of the confirmatory action letter. And based upon this, we requested and just recently received approval from the NRR and EDO to close those white findings in the emergency preparedness. But given the other problems in other areas and not having closure in some areas in the confirmatory action letter, we would leave the licensee in the enhanced oversight actions equivalent to those in the multiple degraded cornerstone column for the action matrix for the other five areas.

We will continue in this to perform our quarterly inspections and hold public exits with the licensee. The licensee's plan is to have overall self-assessment completed in the May to June time frame of this year. Region IV, in conjunction with NRR will follow-up shortly after that to assess our performance. I would conclude with that the senior managers discussed the licensee performance, and they received follow-up actions at the Agency Action Review Meeting that was held on April 14 and concluded that the actions taken and planned are appropriate. And they are consistent with the Reactor Oversight Process. And those taken are similar ones that we've taken for other licensees with similar

performance problems.

This concludes my remarks, and I will be glad to answer any questions at the appropriate time.

MR. REYES: Thank you, Bruce. And now, Jim Caldwell is going to brief us on the two plants, Point Beach, which we discussed in the AARM, and a very brief update on Davis-Besse.

MR. CALDWELL: Good morning, Chairman Diaz, Commission McGaffigan, Commissioner Merrifield. Thank you, Bruce.

As Luis mentioned, I have two plants to talk about today. The first is Point Beach, which is under the ROP process and discussed in the AARM, and the other is Davis-Besse, which is not under the ROP process. It's under the Manual Chapter 0350, oversight process. Since both of these facilities were discussed at the last Commission meeting, I plan only to provide a brief update of the licensee's activities and performance.

As indicated on the slide, I will begin with Point Beach. As you notice, a duel unit site. Both units are two-loop Westinghouse pressurized water reactors. They're owned by Wisconsin Energy, but they're operated under a contract from the Nuclear Management Company. As discussed in the last Commission meeting, Point Beach is in Column 5 of the ROP action matrix that's entitled the Multiple Repetitive Degraded Cornerstone column.

As you recall, they were placed in this column as a result of a red findings associated with the aux feed water, specifically the recirculation line components. And Commissioner Merrifield, you asked about the time frame it took to get to the color finding, and Reyes was correct in that we made sure that these things were fixed right away. They took procedural actions and equipment corrections to put the plant back into the appropriate condition. So they were taken care of even though it took quite some time get

to the red finding. The actual fixes were done right away. The licensee understood that they needed to be fixed. It was just a disagreement on the overall risk that we had to get through.

As a result of these findings and other issues, Region III in coordination with NRR provide enhanced oversight of Point Beach. We assigned a dedicated manager for the oversight and performance of the inspection activities, including the conduct of inspection procedure 95003.

In addition, a group of individuals led by the Director of the Division Reactor Projects with participation from NRR was established to conduct periodic reviews of the inspection results and licensee performance, as well as conduct quarterly, public meetings. In parallel with the agencies' activities, the licensee developed their own performance improvement plan, entitled the PBNP Excellence Plan.

Since the last meeting, we have completed the inspection procedure 95003 as prescribed by Column 4 of the action matrix and developed by Region III and NRR. The inspection identified problems in the following areas: engineering design and control, engineering ops interface, emergency preparedness in the corrective action program.

Additionally, as discussed in the end-of-cycle assessment letter, a substantive cross-cutting issue was identified in the area of human performance. Consequently, the region in coordination with NRR issued a confirmation of action letter just recently in the last two weeks, committing the licensee to the areas in their excellence plan that addressed the issues identified as a result of 95003, including the area of human performance.

Currently, Unit 1 is operating at full power, and Unit 2 is in a refueling outage. Both units have operated well since our last discussion, and they continue to demonstrate the

ability to operate safely, as regularly assessed by Region III and NRR and documented in the quarterly assessment reports.

However, in this most recent outage, Unit 2 is experiencing a number of human performance problems. Additional examples, they have done a number of stand downs and slowed down the outage to do a much more deliberate process in order to correct these human performance errors. And this indicates, they still have more work to do in the human performance area of their excellence plan.

As I discussed earlier, we have conducted public meetings to status our inspection activities and our assessment of the licensee's performance. To date, we have conducted seven public meetings, including a meeting between the EDO and NMC senior managers in February of this year and the end-of-cycle meeting in April, both which I attended.

On April 14th, the agency senior managers discussed Point Beach's performance, the proposed actions going forward, and concluded the actions were consistent with the ROP for a plant in the Column 4 of the action matrix. Consequently, Region III will continue the enhanced oversight and augmented inspection of Point Beach. This enhanced oversight and inspection activity will consist of additional inspections above the baseline in the areas discussed in the CAL, periodic assessment of licensee's progress to determine if enhanced oversight continues to be appropriate, and periodic public meetings to discuss the status of the CAL, and our activity, and assessment of the licensee's performance.

This concludes my remarks on Point Beach. I will transition on into Davis-Besse.

Again, Davis-Besse is under the 0350 process. Slide 6, please. As you are aware, Davis-Besse is a single unit site, is a duel loop Babcock and Wilcox pressurized water reactor and owned and operated by First Energy Nuclear Company. As I discussed earlier,

Davis-Besse inspection oversight comes under the auspices of the Manual Chapter 0350. The plant was placed under the 0350 oversight process in 2002, following the review of the AIT findings associated with the discovery of a significant degradation to the vessel head.

Currently, Davis-Besse is operating at full power. The licensee was notified on March 8, 2004, that we had removed our restriction on restart of the reactor. The decision was made in accordance with Manual Chapter 0350, following the completion of the CAL and the restart checklist items, review of the licensee's restart reports and commitments, obtaining reasonable assurance that the licensee could start up and operate the plant safely, and in consultation with Jim Dyer, Sam Collins, and Bill Travers, as well as keeping the Commission aware of the decisions that were made.

Attached to the notification removing the hold on restart was a confirmatory order issued by Jim Dyer, requiring the licensees to conduct independent assessments of operations, engineering, corrective action program, and safety culture annually for the next five years, and to conduct a mid-cycle outage to inspect the vessel upper and lower heads for leakage. Also, the letter confirmed the licensee commitment for safe restart operation and continued improvement in many areas of facility operation. These commitments are contained in the restart letters provided by the licensee, and as discussed, were a part of the basis for the restart decision.

Following the notification of the removal of restart restrictions, the licensee commenced the restart of Davis-Besse and successfully achieved full power on April 4, 2004. Throughout the power ascension activities, we provided around the clock inspection resident inspector coverage. Davis-Besse performance during the restart activities was positive overall and good operations control and communications and appropriate actions were taken for emergent equipment conditions.

On April 14th of this year, the agency senior managers discussed Davis-Besse's performance and the proposed actions going forward and agreed that the plant should remain under Manual Chapter 0350 inspection oversight. Consequently, the 0350 oversight panel will remain in effect, providing oversight of facility performance and coordination of agency activities, including assessment, inspection, and the conduct of periodic public meetings.

The site resident office has been augmented with a third resident inspector, and inspection activities above the baseline will be augmented in the area of performance indicators, where those indicators are no longer valid due to the extended shut down. The evaluation of compliance with the order, assessment of the licensee's improvement initiative commitments in response to any adverse trends or operational problems. That concludes my remarks for both Point Beach and Davis-Bess.

MR. REYES: Thanks, Jim. We're going to go Slide 7. I'll briefly discuss the Honeywell facility. Honeywell is a conversion facility located in Metropolis, Illinois. The plant's been operating since the late '50s. On December 22, 2003, there was an event at the facility in which uranium hexafloride was released outside of the boundaries of the facility. Licensee immediately shut down the facility, declared a site area emergency, and took emergency preparedness actions.

The NRC responded to the site area emergency. We sent a team on-site, followed up with a maintenance inspection team. Issued a confirmatory action letter to confirm that the licensee would not restart the facility until the event was understood and corrective actions were put in place. Licensee put in a team of experts from the whole company, not only from the site, and incorporated from other Honeywell international facilities and did a thorough review of the event.

The root causes and the contributing causes were very similar to those identified by the NRC augmented inspection team. Subsequent to that, we followed an implementation of the corrective actions. We held three public meetings, and we were satisfied that the corrective actions were satisfactory.

We oversaw the licensee recovery in three phases. As of today, the plant has returned to normal operations and continues to implement the long-term corrective action program. Prior to this event, Honeywell had identified they needed to do some improvements, and they did have a long-term improvement plan. They had experienced chemical releases, but they were confined to working area buildings. They remained on site. It's clear that the event on December 22 highlighted that there were more issues and needed more aggressive action from the licensee.

We're satisfied of the corporate commitment to continue the improvements at the station. We continue to monitor the facility, and it's our intention to also continue to have public meetings in the area as a way of making sure that long-term actions are implemented. That's is a brief presentation of Honeywell.

Before I turn over the meeting to the Commission, I just wanted to highlight that Hub Miller is with us today. I believe this will be his last Commission meeting presentation as regional administrator. I had the honor of working with Hub for many, many years. I think he has been a valuable asset to the agency. I do want to wish him well on his retirement. Chairman, we are done with our presentation.

CHAIRMAN DIAZ: Thank you very much. Commissioner McGaffigan.

COMMISSIONER MCGAFFIGAN: Thank you, Mr. Chairman. I'm going to bring up an issue that really comes from Bruce's discussion, the issue of deviations from the action matrix. I want to make sure I have the facts right. So I'm looking for corrections if I have it

wrong.

Currently, we have two deviations from the action matrix, one for Cooper that Bruce has outlined and that we were notified of earlier today. One at Indian Point, at which Mr. Miller, and I fully concur with Mr. Reyes that you have done a great job here, but that you asked for Indian Point back in March.

Last year, there was one in calendar year at 2003, again at Indian Point No. 2. And the prior year, I think may have been one at Oconee, where it was Region II's view that the action matrix over did it given the nature of a couple of the findings there. Are there any other deviations in the history of the Reactor Oversight Process?

MR. REYES: Not that I'm aware of -- in the last four years, I think those are the only three.

COMMISSIONER MCGAFFIGAN: I'm going to encourage -- I'm going to get Mr. Miller a speaking role at this meeting. I think it will be worthwhile for him to outline the -- I've obviously read his March memo -- but outline why the deviation from the action matrix at IP2. And given that these are relatively rare events, I throw out for my Commission colleagues and the staff's consideration whether we should highlight deviations from the action matrix in future years.

In this with case, Cooper is already covered. It would be rotating out of Column 4 into something like Column 2 but for this memo from Mr. Mallet that has been approved by the EDO. And IP, the one question I will lead into, as I give Mr. Miller a speaking role here, in Region IV's memo, it's clear they want to maintain Cooper in Column 4. In your memo of March 16, it's clear that you want to maintain Indian Point at something above Column 2, but it wasn't exactly clear whether they are in Column 3 as far as you're concerned or whether they are in column 4 as far as you're concerned.

The punch line on your memo said, “Therefore, the region believes the continued heightened oversight at a level above Column 2 is appropriate for IP2 throughout the upcoming calendar year. So, where are they?

MR. MILLER: Well, the key thing of that memo is what’s on the last page. I can't recall from memory.

COMMISSIONER MCGAFFIGAN: That’s right. I’m looking at the March memo of 2003. There is an early April memo for this year.

MR. MILLER: Our deviation memo this year outlines as number of very specific things.

COMMISSIONER MCGAFFIGAN: Right.

MR. MILLER: They’re in the column that they’re in by virtue of the findings and the performance indicators. Nothing changes that in that deviation memo.

COMMISSIONER MCGAFFIGAN: They are in column 2 based on --

MR. MILLER: I believe they’re in Column 2, and here I'm going from memory, on Unit 3, I believe, because of scrams.

COMMISSIONER MCGAFFIGAN: They’re in Column 2, right.

MR. MILLER: So, what we’ve asked for is a deviation in terms of some of the specific things that we’re doing in the way of oversight. We continue to have an expanded resident staff at the site. There are still two full staffs there. We have continued to be high on the side of the PIR samples, the Problem Identification and Resolutions samples, that we’re taking. Design control has been a continuing issue. They’re involved in a multi-year program on reconstituting aspects of the design, and we wanted to continue an elevated level oversight of that.

The basis for this is written in our annual reports, last year and this year. There are

no surprises here. The company has continued to make progress. It has been slow progress. They have contended with the effort of merging two units. And in merging two units, there is the additional work associated with that. So they've contended with backlogs that in our view, require a level of inspection that goes beyond just the minimum.

Among the other things, I attended the annual meeting this past week as a part of our needing to emphasis or our emphasis of what remains to be done at Indian Point to strengthen the programs there. But back to your question, where are they in the action matrix. They're right where the process would dictate they are by virtue of the indicators. What we've added are inspection actions and management actions that go above the baseline or the other supplemental inspections that would be called for in a very straightforward way by the action matrix.

COMMISSIONER MCGAFFIGAN: But why a deviation memo at Indian Point. I mean, you're clearly conducting, for instance, extra inspections at Salem Hope Creek at the moment. And you have some very aggressive actions underway there that I fully support that are in some sense outside the action matrix. But Region IV sort of declared a column. Cooper is still in Column 4 as far as Region IV is concerned, even though once the white findings get wiped out in emergency planning, they theoretically would be in Column 2.

You have a plant that's theoretically in Column 2, based on PIs and inspection findings. And you're doing some extra stuff, but it sounds like you all do some extra stuff, and I applaud that, at times for plants but PINR plants were discussed earlier, the ones that don't have a white cornerstone. You're probably giving some extra attention to them.

It strikes me that the difference between the two current deviation memos is that Region IV is saying we're they treating Cooper as if it still remains in Column 4, and you

really haven't declared a column for IP. It sounds like their Column 3, or I mean the sum total of all this stuff, but I just --

MR. MILLER: We have not worried excessively about what column they're in. We're following the program --

COMMISSIONER MCGAFFIGAN: No. I applaud that.

MR. MILLER: -- as it's laid out in terms of -- white finding calls for a supplemental inspection. And we're doing all those things just as the action matrix would call for us to do them. But beyond that, beyond those specific things, which is following the action matrix to a tee, we have added this extra level of inspection, and it goes to the points that we've laid out in our annual letter.

COMMISSIONER MCGAFFIGAN: I'm just looking for -- we don't have very many of these. Maybe it's something for the new EDO to take a look at but some standardization in the process and the memo process. And then what is the threshold for declaring something where you're asking for a deviation from the action matrix, like IP, as opposed to Salem and Hope Creek, where they aren't formerly in any sort of deviation from the action matrix, that you're clearly doing some extra inspection activity that I again applaud.

I toss it back to you guys, but I do think the one thing I would urge my colleagues to consider is given that these are relatively infrequent events, should deviations from the action matrix be presented to us in some sort of formal way at this meeting every year, or should be just get it on paper.

MR. MILLER: I think there is one other thing I here, and I can say this because it is a matter of public record, but to some extent allegations, in addressing allegations, can influence this. This is not something that plays out in the action matrix. It is something that is responding to that -- I don't know that there is ever a way that you'd want to try to write

that in as a descriptive thing. It is very much situation dependent. So to some extent, that explains Salem and Hope Creek. Not entirely, but in a great measure, that's what's going on.

COMMISSIONER MCGAFFIGAN: Okay.

MR. REYES: If I could address. I wrote down standard deviation matrix memos, and put a question mark there. But let me reflect for a minute. When we wrote the revised oversight program together, one of the issues we were responding to was that a regulator was not predictable. Okay. And we put an action matrix as pretty specific. It tells you exactly what the response is in terms of inspections and the communication level. And that goes to a level of detail and tells you which manager can be where, etc.

Now, within that matrix, there's a little bit of maneuvering room, and I think what we are trying to search is we're trying to remain a predictable regulator, but the matrix cannot envision every situation we have. And some of the situations are rather complicated. So the attempt is to say, in a very open process internally with all the checks and balances, to say at this particular time certain performance indicators may be timed out, but it's in the interest of the licensee and NRC to remain engaged at a different level.

We can probably do better in the documentation of the memo, but what we're looking for is to make sure we have the right oversight about what's going on with the site for a successful outcome of the situation.

COMMISSIONER MCGAFFIGAN: I agree, and I'll just let it be. I think that the bias that comes across is a good bias. The bias of the staff is that we don't let these plants go necessarily very easily even if they get themselves on PIs and inspection findings alone back into Column 2 or 1. And I think that's not a bad bias to have. That shows we're a very responsible regulator, and we need extra convincing. If you've managed to get

yourself discussed at this meeting in the past, it's going to take some extra measure of convincing before we're totally willing to go back to whatever the rote application of the action matrix would imply.

And I think that's a good bias for us to be. I think we have to be transparent, and these are relatively rare occurrences, we need to be transparent when we do them. And I think you have been transparent. I think we had a good discussion. Thank you Mr. Chairman.

DR. MALLETT: I want to make one more comment on that to make it clear that what we were doing at the Cooper Nuclear Station was to remove the white findings. We could leave them with white findings and emergency preparedness and keep them in Column 4 because the process would allow us to do that. We didn't think the optics looked right.

COMMISSIONER MCGAFFIGAN: Right. Because you just told us they solved their -- that's the one area you're not worried. So to keep them in Column 4 as a result of rote application, that isn't the right way. So you're being much more transparent. Much more straightforward, and I commend you for it.

MR. DYER: Commissioner, I can't resist. I have to say something on this subject. We did have a lot of dialogue at the Agency Action Review Meeting about this. And although it's a small number of plants that have done this, it is almost every one that's entered Column 4, and Point Beach is right on their heels. And part of the issues that came up is when you end up in Column 4 for whatever reason, then you end up getting the 95003 and the extent of condition, which goes -- you know, it's in a diagnostic level of review. And a lot of times they'll uncover a lot of issues that require a lot of corrective actions that go beyond the reason that they ended up in Column 4.

And that's the issue we struggled with. But I think as we're evolving -- Indian Point and then Cooper, we've come up with an increased amount of specificity, if you would, to what does it take to close out those items. And I think that at Point Beach, we've gone yet another step beyond Cooper in looking at an exit matrix, if you would, as to what are the clear expectations for Point Beach to exit that column. So we are learning as we go, but this may be a programmatic issue.

COMMISSIONER MCGAFFIGAN: You've recognized it, and it's a commendable bias that you're demonstrating that if you've managed to get yourself Column 4, it's going to be hard to lose your attention, and that is a good place to be. Thank you.

CHAIRMAN DIAZ: Commissioner Merrifield.

COMMISSIONER MERRIFIELD: Thank you, Mr. Chairman. I would want to start off in adding my voice to those expressing thanks for the significant actions that Hub Miller has undertaken for our agency for many, many years. He is a tremendous asset, and he's had a large burden over the last few years. We've had a lot of I dialogue on it. I'm sure we will see him before he leaves in June, but certain I would want to add my voice to those recognizing your significant commitment and achievement, and the fact that you'll be missed.

MR. MILLER: Thank you, Commissioner.

COMMISSIONER MERRIFIELD: On the issue of the action matrix, I had a question I was going to put together. Given the dialogue we just had, I guess the only observation I would have, and this may go to last comment that Jim Dyer made, if we are finding ourselves in a position where once you get yourself into a Column 4 plant, we're going to treat you differently coming out of that.

I think that part of what Commissioner McGaffigan may be going to and if it is, I

agree with it, we need to make sure we're transparent in that. And if we need evolve our program a little bit more to capture that, we ought to think about doing that rather than simply keep having these deviations. Maybe part of what coming out of Column 4 is that you have this detail that goes with it.

I don't want to go into detail on Davis-Besse given the fact that we have a lot of discussions on it. I would want to again, thank you, Jim and your staff, for the significant amount of effort and time it took to work through that process. That's one, obviously, you're going to be continuing to take a look at, but I did want to make one specific note.

I think one of the positive things that came out of our experience with Davis-Besse, we had I think from my standpoint, a very significant increase in our communication efforts, relative to a variety of stakeholders at that site, formal correspondence, local meetings, web sites, many techniques that we used to enhance our ability to get the message out of what we were doing and how we are accomplishing our safety mission in serving the public interest.

Looking a little bit differently, we have before us today a site which has generated a lot of public interest and that's Vermont Yankee. And I'm wondering if we could perhaps maybe Hub or Luis could elaborate on how we're reaching out to stakeholders there, and are their things that we learned at Davis-Besse that may be useful in your approach in dealing with our stakeholders up in the northeast.

MR. MILLER: Well, I would say first of all in the northeast, we have a very active public. And so we like to fancy ourselves as being somewhat practiced at this business of outreach. It's a very important part of what we do in the northeast. Vermont Yankee, we've had a number of interactions with people, and you're referring in this case to the power uprate. There was a visit I believe to the Vermont State Nuclear Safety Panel,

VSNSP, earlier in the year with promises to come back. We got snowed out on one occasion when we were going to go back and make another attempt. So we've had outreach to the state.

We also recently had our annual meeting, and I think our annual meetings, and I'm sure that this is true in the other regions as well, that when there are topical issues that are important, we make those far more than the normal routine annual meeting, which is giving the results that people have pretty much already read in our letters. But we make them opportunities to present on an issue and hear comment. And we did that in this case. We had our annual meeting, have two parts, a second part which in fact addressed and allowed the public to speak to this issue of power uprate.

I think that we expect that as we need to further explain our program, we go back to the state, I think Jim and I have talked about that, and have additional discussions, perhaps even with the public service board if that would be appropriate, to explain our program and to explain how we believe we are addressing the concerns that at least the state has in this case.

So we've used these different vehicles, and we stand ready to do more. I'm sure that after I leave that Sam and Jim, as the power uprate activity goes on, there will be other opportunities to have additional discussion and opportunity for public meetings in the State of Vermont on that important issue.

COMMISSIONER MERRIFIELD: Thank you, sir.

MR. DYER: And Commissioner, from the headquarters perspective too and in working close with Hub's team, we do have a communication's team specifically designated for the Vermont Yankee site. It was a much smaller team before the missing fuel pin issue occurred two weeks ago. And we staffed up with some additional support

there, but it's clear that is going to be a challenge going forward.

MR. MILLER: In fact, if I could just add on that. Within several days after the steam generator tube failure in 2000 at Indian Point, we put in place a coordination team. That team has had some change up in staff members as time has gone along, but that team has been in place since that time. And as various issues have arisen, whether its emergency preparedness or the multiple degraded cornerstone issue and the public meetings associated with that security after 9/11, that coordination team has proved to be invaluable as issues emerged to have quick response to those issues.

And so, Jim's mentioning that in the Vermont Yankee case reminds me of this. We take it for granted at this point. It's a big part of our strategy on a case like Indian Point. You can't do it in all cases, obviously, but when you've got a situation that you know is long standing of that nature, it's an invaluable tool.

COMMISSIONER MERRIFIELD: I know you've been working hard on that. I was trying to reflect is there any other things we can learn from some other activities and obviously, that's something that I'm sure you in consultation with the Director of NRR and the EDO will further reflect on that.

In terms of Honeywell, I had the pleasure, and I don't know if it's my luck of the timing when the Chairman gives me the permission to be the Acting Chairman, but I happened to be Acting Chairman on the day we had the Honeywell event. And I do want to reflect on what I thought was very good work on the part of regional staff and your team there, Luis, and obviously the folks here as well in our responding to that.

But I guess coming out of that issue recognizing that we do have a small number of non-reactor facilities that are thought to benefit from issues similar to what we did at that site, have we've had any thinking about evolving the Manual Chapter of 0350 for non-

reactor facilities, having an analogous programs in that regard?

MR. REYES: I'm going to have Marty address that.

MR. VIRGILIO: Thank you, Marty Virgilio, the EDO's office. We actually did take the 0350 process for Honeywell, and we did modify it and we laid out an action matrix. We did follow that matrix, and we are today still following that matrix in terms of follow-up activities.

You raise a good point. Should we actually create another manual chapter that would parallel 0350? But I'm not sure it is necessary in light of how well this worked in this situation. It was a very useful tool for us and helped guide us through the restart, both headquarters and the region.

MR. REYES: Commissioner, we did that on purpose. We took the 0350 and said, okay, how can we modify it and apply it to, in this case, a conversion facility. And that's what guided us in terms of the recovery activities, and it had the key points of outreach, public meetings, communication, information, all those elements, contacting the state, the other government agencies.

I mean, the checklist was modified to the case in point. Then the question is should we have one generic for that, and let us take that back.

COMMISSIONER MERRIFIELD: Well, it may well be given all of the demands that we placed on staff that it is not worthy of spending resources in order to formalize that. I would think that at a minimum, having gone through it with Honeywell, you would want to be able to capture the lessons learned. So that in the future, if you had to do something similar, you'd at least be aware of the pitfalls, if any, that occurred in the application in this particular example.

I've got to stop. I would want to make one last comment. I haven't heard as much

today, but there is always an issue and a concern regarding how we are consistent in our approach to inspection activities and others. And sometimes this is reflected on the regions and not to take away from the excellent work done in our regions, but we always have that underlying question, “Gee, are we doing things differently Region I and II versus III and IV or some other mix thereof.”

I just wanted to sort of throw out an idea not for you to comment on but to think about. That is, have we thought at all about having some cross-fertilization of our regional inspection teams in order to perhaps have a similar degree of understanding amongst those folks and more regularized and have a greater consistency in terms of our approach?

MR. REYES: We are already do. We’re already conducting inspections at the other regions to try to make sure we are executing things in the same way. But let me go further. The day before the AARM, Sam Collins in his position in the EDO held a meeting with all the four regional administrators, and we had a long discussion about best practices and approaching it in a fleet approach, and trying to help us in addition to the sharing of resources and observing activities, etc., to actually go and come up with best practices and implementing them fleet-wide in all four regions.

It’s a modest effort that we’ve started, and we’re already putting some of those issues together. Region IV is helping us. Region II is taking some. The goal will be to try to make sure we have more than one way to adjust our thresholds in terms of how we do things. There are some activities that go that are not very noticeable outside the agency, but let me give you a couple just to make sure you know we are trying to do just that.

When we do allegation audits, the program office will come to do the audit, and they will have a member from another region. So we participated in the Region III allegation

audit. Region III participated in the Region II allegation audit. The same thing happens with operator licensing. When operator licensing comes in to do an audit, they not only bring the program office but they bring someone from the other region.

We go and give exams in another region, and another region comes and gives exams in Region 2, for example. So, we have a lot of practices that we're trying to make sure we're executing the program the same. Now, it remains a challenge, and I will tell you the reason we're doing this is there's an obvious need. We recognize the needs. Jim and the four regional administrators recognize the need, and we are trying to pursue that.

So we take your comment, and we're already working on it, but we have more thing to do.

MR. DYER: Commissioner, if I can add one other point to it too is, I think Stu talked about it. We dispersed roughly 15 additional FTE for emerging issues, and we dispersed those evenly among the regions with the understanding among the regional administrators that they're responsible for staffing and training those inspectors, but we're going to direct them to the sites that have the problems. We just can't predict two years ahead where those sites are going to be. So it's that understanding. So there is a bit of a modest expected transition, or across the regional boundaries inspections that's actually budgeted now.

DR. MALLETT: Just a couple of comments. As Luis said, I talked to Jeff Grant this morning, and the deputy RAs met yesterday evening to talk about putting together what programs they want to start with to look for best practices. Plus, you mentioned Davis-Besse, we had over 80 different inspectors and contractors from all the regions and headquarters. Now that was driven by the need to have people there, but we had inspectors from everywhere participating in the Davis-Besse oversight, as well as Point

Beach. And when we started doing the round-the- clock coverage, there were 30 different inspectors that came in to help Region III do their round-the-clock coverage.

So we got a lot of folks to not only to do some bench marking, but they got to see, hopefully, the type of facility. That won't happen very often. They got that type of experience. And, I appreciate all the regions and NRR for coordinating and helping out Region III. We couldn't do it by ourselves.

COMMISSIONER MERRIFIELD: Thank you Mr. Chairman.

COMMISSIONER MCGAFFIGAN: Mr. Chairman, could I make one suggestion might help you at an upcoming hearing. Listening to the staff today, when our budget for fiscal year 2004 came out in January or February of 2003, I remember we had some criticism about not having enough inspection resources. It strikes me that the budget you're executing today for fiscal year 2004, including the sum total of inspection resources is significantly higher than what we predicted it would be. Documenting that might be very useful for next time we have a Congressional hearing.

You just mentioned 15 FTE and training and various regions that have been assigned. I don't think those are budgeted in January or February of 2003. I think that's been a reaction to the problems we had staffing in 2002, 2003, the inspection program, and you guys have made appropriate changes. So we have a lot more inspection resources today than we planned on having, and it is a good news story, I suspect.

CHAIRMAN DIAZ: Thank you very much. Let me just say that I am not ready to retire Hub Miller yet. He and I have still some work to do. It's coming right around the corner. So don't get comfortable on me all right.

I also like to recognize though that we have some wisdom in here occasionally. Last week, I had the pleasure of going with Hub Miller and Sam Collins to see them receive their

Presidential Rank Awards, which were very well deserved and, of course, Sam will eventually take Hub's place and that certainly seems like a fitting thing that both Presidential Rank Awards are changing places.

With that note, let me turn onto something that I picked up as the meeting was going and it is the issues of determination of thresholds. What do you do when something happens? And a couple of times human performance came about, and it's always one of those issues that gets buried. And like Commissioner Merrifield said, sometimes we call it safety culture, safety SWCE. Sometimes we call it -- I've been calling it safety management.

Are we having problems or are we getting better at looking at human performance issues and put them in the right perspective? Is that something that's true, we're not completely there, but is it getting better?

MR. DYER: Everybody's looking at me.

CHAIRMAN DIAZ; I can look at Jim.

MR. DYER: Okay. I'll start, Chairman from my perspective in looking at it. I looked at it as broader as across all the cross-cutting issues. It is some times when you look at the examples and the justification that the regions use to identify the substantive cross-cutting issues -- there is overlap. And that's the area that I see the greatest struggle in is if this is an issue that may have two or three attributes, does it get binned? Do they put it in all? Does it get diluted and fuzzied up so we don't do a good job of assessing it?

When we talk about thresholds and criteria, I think that's one of the issues that I wanted to bring forward is for the cross-cutting issues more clearly defined and articulate what they are. So we can actually bin them and define what they are.

MR. MILLER I think in broad terms, the industry has a tremendous focus on human

performance, through INPO and the INPO methods and methodologies and guidelines. They're very good, and most licensees are focused on it. What you're referring to are the cross-cutting issues. We've had a few in our region. We just closed one out on Indian Point.

In some respects, you could say almost any issue that arises at a plant is a human performance issue. We tend to focus on them, however, when there was a rash, as there was at Indian Point earlier in the year, in both the Unit 2 and Unit 3 outages, of a large number of personnel errors. But they were able to address those, and they were able to prove to us for the rest of year that they could make progress. I'm not sure if this is helpful to you.

I think one thing to keep in mind on these cross-cutting issues is that the requirement is that there is a performance theme that cuts across a couple of areas. And it's got to be documented, and it has to be documented in findings. Some of the themes are this wide and others are much wider. And so I know there's the appearance to some in looking at the cross-cutting issues that if you identify a trend in performance, in human performance or PINR that there's necessarily something quite serious. And that's not the case in all cases. It is what it is. It's what the region documents.

When we document, one of the requirements, for example on human performance, is to point out the specific examples to give a sense of how wide or broad that theme is. But to answer your broad question, I think that my experience is that these cross-cutting issues as we identify them, do serve to raise the issues. And one case I can think of recently where we have identified a human performance trend, we promptly took action and there was improvement, and we recognized it.

CHAIRMAN DIAZ: Maybe all regional administrators should answer this because

this is a cross-cutting issue.

DR. MALLETT: I wanted to add on to what Hub was saying. I think you hit it right on the head when you said, Chairman, are we getting better and are we putting it in the right perspective? I am very pleased that we have a low threshold for looking for human performance issues. I think that's how you detect problems early.

When you study Indian Point 2, Point Beach, Cooper, and other places, you will find that as a factor. So I think it's an early indicator and we need to keep that as a low threshold for looking. Where the issue where we struggle in my view is discerning when that becomes a programmatic issue across the plant.

And that speaks to your issue, are we putting it in the right perspective? I think what the program office has done in prescribing what the human performance means as a cross-cutting issue and the basis for that in the manual chapter is a good start at that. So I think it's good to keep a low threshold to pick up is there a problem. I also think it is good to look for the root cause.

We do struggle a bit in my view with where do we draw the line and say it's a cross the plant issue.

MR. CALDWELL: Well, you mentioned and Jim Dyer discussed the fact that a lot of the issues can end up in any of the three safety culture or safety conscious work environment, human performance, or corrective action program. But since I brought this up at Point Beach, maybe I was the initiator of it, I looked at some of the human performance issues that resulted in that cross-cutting issue, and you could make them corrective action or safety culture, but they were clearly human performance problems.

The operator started an RHR pump without opening the suction valve. They closed the reactor trip breakers with the feed wire control system in automatic. It's supposed to be

a manual. When they did that, they got a significant cool down, and the reactor tripped.

Most recently, they were putting in their -- the dams, inside the loops, the hot leg. The procedure required you to have a vent path. This goes all the way back to 1988, I believe it was, generic letter for making sure you have a proper vent path. They couldn't get the pressurized man-way off.

So they made a decision among all themselves that they would establish a different vent path and go ahead and put the nozzle dam in. It didn't meet the criteria. Again, it was a human performance error. So I think we're pretty good at identifying what those are, but you're right, they can fit. What you try to do is figure out the message you're trying to send and what you want the licensee to fix. That's how you try to put it in that bin so that they'll focus in that area. It is pretty clear to them that they have a human performance problem at Point Beach, as well as part of their excellent plan when they established it.

I think we are good at it. They get fuzzy at times like Jim said, but you try to put it where you think you'll get the best fix for the problem.

CHAIRMAN DIAZ: And I'll give Mr. Reyes the last word as Region II Administrator and as upcoming EDO.

MR. REYES: Okay. I think it's getting better. I go with what the other speakers have said because the licensees are putting attention to it, and we are putting attention to it. So it gets dealt with and lot of the success stories are not discussed because when you find human performance issues early on, whether it's a licensee or us, and you start the dialogue right away, you're affecting that. And the fact that we can have a dialogue with the licensee about human performance and what they are doing about it, right away generates action from their part and our part.

Where we have a little more difficulty is that if in fact we see the incidence to be little

bit higher. Then, you're trying to find out why and to what extent. Is it horizontal? Is it vertical? And we do wrestle with that. But I think there's a good story in it because we engage the licensee on it. I mean, we don't just go into a room and talk among ourselves. You do talk with the licensee about it.

And whether they call it one way and we call it the other, at the end of the day, is are you fixing the problem and is safety being taken care of? So I think there is a success here, but we do have to deal with the labels and processes on how to engage from an agency point of view.

CHAIRMAN DIAZ: Well, I think this has been a great meeting. I think we had a tremendous amount of good dialogue between the senior managers and the Commission. I'm really pleased we get to this point. I keep remembering when I got to the agency, there was a different process. And I think that we all realize and I hope my fellow commissioners agree, that this process has given us more predictability.

I think it's a process that is most fair and equitable that is also an open process, provides many opportunities for those who want to be engaged that are stakeholders. It provides both our licensees and our staff opportunities to see what is happening and to take actions when we need to do in an early fashion.

I think what we have seen is that no process is perfect. And that we cannot predict many of the things always in the right matter. And, therefore, we have to have, you might want to call it flexibility or the ability to intervene. I think President Regan called it trust and verify. And I think with that note, I would like to close the meeting unless my fellow commissioners have --

COMMISSIONER MCGAFFIGAN: Well, Mr. Chairman, I'll just echo what you said. I'm very proud of the reactor oversight process. I'm of proud today. It was, as you said, an

excellent meeting. We discussed important issues in public. I think we're unique among the regulatory agencies of the Federal Government. And at least for the 64 sites, where we have power reactors and I think it is true more broadly for Honeywell and others, any member of the public can click on our web page, look at all our recent inspection findings, look at all of our performance indicators, and look at additional information, like deviation from action matrix letters, or whatever. They're all very available, and very much out there for them to analyze.

And as I say, I think we have among regulatory agencies of the Federal Government, I think we have an unmatched process. Is it perfect? No. Can it be improved? Yes. And are we dedicated to improving it? Of course. But I echo what you said.

COMMISSIONER MERRIFIELD: Mr. Chairman, so there's a degree of unanimity on this side of the table, I would want to provide a further echo of both the Chairman and Commissioner McGaffigan. I think we have a very good program, and I think the nature of the comments that we made on this side of the table today, and our questioning, and certainly the responses from our senior managers are indicative of an agency dedicated to taking a very good program and making it even better.

And that's certainly an ongoing part of our very deliberate and important mission in meeting the public's expectations of health and safety at these units. And it's the right thing to do.

CHAIRMAN DIAZ: Thank you very much, and with that, we are adjourned.