



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BLVD
ARLINGTON, TEXAS 76011-4511

January 16, 2014

Kevin Mulligan
Vice President Operations
Entergy Operations, Inc.
Grand Gulf Nuclear Station
P.O. Box 756
Port Gibson, MS 39150

SUBJECT: GRAND GULF NUCLEAR STATION – NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000416/2013007

Dear Mr. Mulligan

On December 5, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed a Problem Identification and Resolution Biennial Inspection at Grand Gulf Nuclear Station Unit 1. The enclosed inspection report documents the inspection results discussed on December 5, 2013, with Thomas Coutu, Director, Regulatory Assurance and Performance Improvement, and other members of your staff.

This inspection was an examination of activities conducted under your license as they relate to problem identification and resolution and compliance with the Commission's rules and regulations and the conditions of your license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

Based on the inspection sample, the inspection team concluded that the implementation of the corrective action program and overall performance identifying, evaluating, and resolving problems at Grand Gulf Nuclear Station was generally effective. Licensee identified problems were generally entered into the corrective action program at a low threshold. Problems were generally prioritized and evaluated commensurate with the safety significance of the problems and corrective actions were generally implemented in a timely manner. Lessons learned from industry operating experience were effectively reviewed and applied when appropriate. Audits and self-assessments were effectively used to identified problems and appropriate actions. A safety-conscious work environment has generally been maintained but there are indications of challenges to this environment.

No findings were identified during this inspection.

K. Mulligan

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In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's Agencywide Document Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Ray L. Kellar, P.E., Chief
Technical Support Branch
Division of Reactor Safety

Docket No.: 05000416

License No.: NPF-29

Enclosure: Inspection Report 05000416/2013007

w/Attachments:

1. Supplemental Information
2. Information Request

Electronic Distribution to Grand Gulf Nuclear Station

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SUNSI Rev Compl.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	ADAMS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Reviewer Initials	HAF
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HAFreeman	JRLarsen	BBRice	LRWilloughby	DBAllen	RLKellar
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U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket: 05000416

License: NPF-29

Report: 05000416/2013007

Licensee: Entergy Operations, Inc.

Facility: Grand Gulf Nuclear Station, Unit 1

Location: 7003 Baldhill Road
Port Gibson, MS 39150

Dates: September 23 through December 5, 2013

Team Leader: H. Freeman, Senior Reactor Inspector

Inspectors: J. Larsen, Senior Physical Security Inspector
B. Rice, Resident Inspector
L. Willoughby, Senior Reactor Inspector

Approved By: R. Kellar, P.E., Chief
Technical Support Branch
Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000416/2013007; September 23, 2013 – December 5, 2013; Grand Gulf Nuclear Station
“Biennial Baseline Inspection of the Identification and Resolution of Problems.”

Two regional senior reactor inspectors, one regional senior physical security inspector, and one resident inspector performed this team inspection. No findings of significance were identified during this inspection. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG 1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Identification and Resolution of Problems

The team reviewed approximately 950 condition reports, work orders, engineering evaluations, root and apparent cause evaluations, and other supporting documentation to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team reviewed a sample of system health reports, self-assessments, trending reports and metrics, and various other documents related to the corrective action program. Licensee identified problems were entered into the corrective action program at a low threshold. Problems were generally prioritized and evaluated commensurate with the safety significance of the problems and corrective actions were generally implemented in a timely manner. Corrective actions were generally implemented in a timely manner commensurate with their importance to safety and addressed the identified causes of problems.

The licensee appropriately evaluated industry operating experience for relevance to the facility and had entered applicable items in the corrective action program. The licensee used industry operating experience when performing root cause and apparent cause evaluations. The licensee performed effective quality assurance audits and self-assessments, as demonstrated by self-identification of poor corrective action program performance and identification of ineffective corrective actions.

A. NRC-Identified and Self-Revealing Findings

No findings of significance were identified.

B. Licensee-Identified Violations

None

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (71152)

The team based the following conclusions on the sample of corrective action documents initiated during the assessment period, which ranged from October 21, 2011, to the end of the on-site portion of the inspection on December 5, 2013.

.1 **Assessment of the Corrective Action Program Effectiveness**

a. Inspection Scope

The team reviewed 950 condition reports, including associated root cause, apparent cause, and direct cause evaluations, from approximately 20,000 that had been issued during the assessment period to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team reviewed a sample of system health reports, operability determinations, self-assessments, trending reports and metrics, and various other documents related to the corrective action program. The team evaluated the licensee's efforts in establishing the scope of problems by reviewing selected logs, work requests, self-assessments results, audits, system health reports, action plans, and results from surveillance tests and preventive maintenance tasks. The team reviewed work requests and attended the licensee's daily condition review group meeting and the management review committee meetings to assess the reporting threshold, prioritization efforts, and significance determination process, as well as observing the interfaces with the operability assessment and work control processes when applicable. The team assessed the timeliness and effectiveness of corrective actions, completed or planned, and looked for additional examples of similar problems.

The team also reviewed corrective action documents that addressed past NRC-identified violations to ensure that the corrective action addressed the issues as described in the inspection reports. The inspectors reviewed a sample of corrective actions closed to other corrective action documents to ensure that corrective actions were still appropriate and timely.

The team considered risk insights from both the NRC's and Grand Gulf Nuclear Station risk assessments to focus the sample selection and plant tours on risk significant systems and components. The team selected the following risk significant systems: Reactor Protection System, Divisions I & II Emergency Diesel Generator. The samples reviewed by the team focused on, but were not limited to, these systems. The team also expanded their review to include five years of evaluations involving these systems to determine whether problems were being effectively addressed. The team conducted a walkdown of the emergency diesel generators to assess whether problems were identified and entered into the corrective action program.

b. Assessments

1. Assessment - Effectiveness of Problem Identification

The team concluded that the licensee generally identified problems at a low threshold and entered them into the corrective action program in accordance with the licensee's corrective action program guidance and the NRC requirements. The licensee had written approximately 20-thousand corrective action documents during the two year period of review, 30 percent of which had been identified by the licensee as conditions adverse to quality. The team noted that the licensee had failed to identify and address four conditions adverse to quality in the corrective action program during the assessment period as documented in the NRC inspection reports that would indicate that additional attention may be warranted in this area.

- Finding 2012003 was issued for failure to ensure material is stored properly in the 500 KV switchyard.
- Non-cited violation 2012008-04, was issued for failure to promptly enter an NRC violation regarding the standby service water system into the corrective action program.
- Non-cited violation 2012301-01, was issued for inadequate procedure for aligning nitrogen backup to automatic deressurization system.
- Non-cited violation 2013002-04, was issued for failure to correct a scaffold affecting fire brigade access.

2. Assessment - Effectiveness of Prioritization and Evaluation of Issues

The team concluded that the licensee was generally effective in performing and/or documenting evaluations of conditions adverse to quality during this assessment period. The team reviewed corrective action documents that involved operability reviews to assess the quality, timeliness, and prioritization of operability assessments. The team concluded that operability assessments were generally completed in an appropriate manner.

The team monitored the licensee's action request review committee and the corrective action review board meetings. The team found that the licensee was effectively reviewing and prioritizing conditions adverse to quality.

The team found that in general, condition reports were appropriately prioritized and evaluated; however, the team noted three examples of ineffective prioritization or evaluation that had been documented during the assessment period.

- Non-cited violation 2012008-02 was issued for failure to establish a testing program for safety-related 125 Vdc circuit breakers. Specifically, the licensee failed to thoroughly evaluate the extent of condition associated with previously identified NRC violation involving the failure to test 480 Vac

molded case circuit breakers that had been identified during the 2009 component design basis inspection.

- Non-cited violation 2012008-05 was issued for failure to follow procedures which resulted in inadequate operability determinations. Specifically, the licensee failed to validate that the operability evaluations associated with an oil leak on the standby liquid control pump B and with degraded bolts on a flanged connection on standby service water B piping completed for prior non-conforming conditions bounded the conditions documented in the new condition.
- Non-cited violation 2012005-02 was issued for failure to make timely corrective actions to repair the degraded auxiliary building water intrusion barrier. This was because the licensee failed to properly classify these conditions as adverse to quality.

3. Assessment – Effectiveness of Corrective Action Program

Overall, the team concluded that the licensee did develop appropriate corrective actions to address problems based on a sample size of 950. The team identified one corrective actions associated with conditions adverse to quality that was not completed in a timely manner (see previous section).

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The team examined the licensee's program for reviewing industry operating experience (OE), including reviewing the governing procedure and self-assessments. A sample of operating experience notifications that had been issued during the assessment period were reviewed to assess whether the licensee had appropriately evaluated the notification for relevance to the facility. The team then examined whether the licensee had entered those items into their corrective action program and assigned actions to address the issues. The team reviewed root cause evaluations and corrective action documents to verify if the licensee had appropriately included industry-operating experience.

b. Assessment

Overall, the team determined that the licensee was adequately evaluating industry operating experience for relevance to the facility. The licensee had entered applicable items in the corrective action program in accordance with station procedures. While the team found that the licensee was generally implementing operating experience into the corrective action program, one example was documented during the assessment associated with the use of operating experience.

- Non-cited violation 2012008-06 was issued for failure to incorporate test and inspection requirements for 4160 Vac Circuit Breakers into Preventive Maintenance Procedures. Specifically, the licensee did not implement and institutionalize vendor information and industry guidance into their maintenance and testing procedure.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The team reviewed a sample size of five licensee self-assessments, surveillances, and audits to assess whether the licensee was regularly identifying performance trends and effectively addressing them. The team reviewed audit reports to assess the effectiveness of assessments in specific areas. The team evaluated the use of self- and third party assessments, the role of the quality assurance department, and the role of the performance improvement group related to licensee performance.

b. Assessment

The team found that the internal self-assessments and audits were generally thorough, detailed, and critical. Corrective actions were initiated and implemented in a timely manner.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The inspection team conducted individual and focus group interviews with over 50 individuals. The interviewees represented various functional organizations and ranged across contractor, staff, and supervisor levels. The team conducted these interviews to assess whether conditions existed that would challenge the establishment of a safety conscious work environment at the Grand Gulf Nuclear Station. The team also reviewed the results of the most recent site-wide safety culture survey taken in February 2012 and aspects of the employee concerns program.

b. Assessment

Overall, the licensee has a safety conscious work environment at the Grand Gulf Nuclear Station. During interviews, personnel indicated they felt free to raise safety issues and enter them in the corrective action program. If not satisfied with the resolution, the majority of the personnel did indicate that they would raise issues beyond their immediate supervisor or would use other avenues such as going to the employee concerns coordinator or the NRC. The majority of the personnel felt they could raise issues without fear of retaliation; however, some indicated that would not raise issues past their immediate supervisor for fear of retaliation. This minority set of personnel did not provide examples but they felt if they went beyond their immediate supervisor, they would be labeled as troublemakers and would receive some form of retaliation. An increase in the number of anonymous condition reports submitted during the period of

January 2008 to November 2013 may be an indicator of this perception. The ongoing “human capital management” efforts by Entergy where many employees were concerned with remaining employed may also have contributed to this perception.

The results of the licensee’s 2012 safety culture survey also indicated that challenges to the safety conscious work environment may exist at the facility. The results placed the Grand Gulf Nuclear Station in the bottom quartile when compared to the nuclear industry and last (eighth out of eight) when compared to the rest of the Entergy fleet. The results also showed a declining trend in all areas as compared to the previous survey taken in 2009.

A high-level review of the employee concerns program revealed a higher number of “harassment, intimidation, retaliation, and discrimination” cases during the two-year period than is typical of most programs. The program had received and addressed eight such cases and substantiated three. The program also had received and addressed four cases involving an adverse safety-conscious work environment and substantiated three. The team noted that all of these cases were associated with the extended power uprated in 2012, and involved contract employees.

Senior licensee management acknowledged the less than favorable results from the 2012 safety culture survey and the employee concerns program cases. Management described the actions that had been taken or that were in progress to improve the environment. These actions included forming employee-working groups to address potential causes, focusing on long-standing equipment issues, and leadership changes. However, while employees interviewed by the NRC were aware of the 2012 safety culture results and knew of management’s initial actions to address them, they were not aware of any ongoing efforts to improve the environment.

The team concluded that while a work environment where employees feel free to raise safety concerns without fear of retaliation generally exists at the Grand Gulf Nuclear Station; there are indications of challenges to this environment based on the licensee’s safety culture assessment and NRC interviews.

4OA5 Other Activities

(Closed) Followup of Corrective Actions for Violation 05000416/2011006-04 “Inadequate Corrective Action for a Leak on the Division II Emergency Diesel Generator Lube Oil Sump”

The team reviewed the status of the corrective actions to address a violation cited in January 2012, for failure to implement adequate corrective actions to address an oil leak on the Division II emergency diesel generator lube oil sump. The condition had been discovered and documented by the licensee in 2004, and was initially determined by the NRC to be a minor violation in 2009. However, by late 2011, the licensee had still not taken actions to correct the condition or characterize the flaw. In response, the NRC concluded the finding more than minor because if left uncorrected, the failure to restore the lube oil sump to design conditions had the potential to lead to a more significant safety concern, specifically, the leak could worsen and potentially affect operability of the emergency diesel generator.

The team found that the licensee has made progress in addressing the leak. The licensee had entered the condition into their corrective action program and assigned an appropriate priority. The licensee initiated a method to evaluate the leak rate and was able to determine that it did not affect the operability of the diesel and was not increasing. Because the leak was in a location not easily accessible, they have not been able to pinpoint the source of the leak and fully characterize the flaw but they do believe that the leak is likely to be from a bolted flange on the side of the tank. The licensee has a work order planned to replace the gasket in the bolted connection and to verify the integrity of the welded connections during the next available diesel outage.

The team concluded that while the licensee has yet to correct this condition, their efforts to locate, and characterize the flaw and to monitor the leak rate provided reasonable assurance that the condition did not affect the operability of the diesel generator and would not degrade without notice. Additionally, the team concluded that the amount of time that has elapsed since being cited for this violation was not unreasonable given the few available opportunities that have occurred and was in line with the low safety significance of the condition. This open action item is being closed based upon the condition being in the licensee's corrective action program, and based upon actions already taken and planned to address the condition.

40A6 Meetings

Exit Meeting Summary

On December 5, 2013, the team presented the inspection results to Thomas Coutu, Director, Regulatory Assurance and Performance Improvement, and other members of the licensee staff. The licensee acknowledged the issues presented. The licensee advised that no materials examined during the inspection were considered to be proprietary.

40A7 Licensee-Identified Violations

None

ATTACHMENTS:

1. Supplemental Information
2. Information Request

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

Richard Scarborough	Licensing Specialist
Kevin Christian	Production Manager
Paul Salgado	Production Outage Manager
Jeff Gerard	Operations Manager
Roy Miller	Radiation Protection Manager
Michael Milly	Maintenance Manager
James Nadeau	Corrective Actions and Assessment Manager
Gerald Giles	Training Manager
Thomas Coutu	Director, Regulatory Assurance and Performance Improvement
Dennis Wiles	Director, Engineering
Thomas Thornton	Manager, Design Engineering
Jeff Seiter	Acting Manager, Licensing
James Owen	Coordinator, Employee Concerns Program

NRC personnel

Richard Smith	Senior Resident Inspector
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LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Closed

05000416/2011006-04 VIO Inadequate Corrective Action for a Leak on the Division II
Emergency Diesel Generator Lube Oil Sump

LIST OF DOCUMENTS REVIEWED

Procedures

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
01-S-02-3	Main Steam Safety/Relief Valves Removal and Installation	17
05-1-02-I-1	Off-Normal Event Procedure – Reactor Scram	120
07-S-12-40	General Cleaning and Inspection of Rotating Electrical Equipment	2
EN-AD-101-01	NMM Procedure Writer Manual	12
EN-EC-100	Guidelines for Implementation of the Employee Concerns Program	6
EN-LI-102	Corrective Action Process	21
EN-LI-102-01	Prompt Investigations	0
EN-LI-102-02	CR Closure Quality	7
EN-LI-104	Self-Assessment and Benchmark Process	9
EN-LI-118	Root Cause Evaluation Process	18
EN-LI-119	Apparent Cause Evaluation (ACE) Process	16
EN-LI-121	Entergy Trending Process	12
EN-MA-119	Material Handling Program	16
EN-MA-119	Material Handling Program	17

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
EN-MA-126	Control of Supplemental Personnel	16
EN-MA-126	Control of Supplemental Personnel	11
EN-OE-100	Operating Experience Program	19
EN-OP-104	Operability Determination Process	6
EN-OP-111	Operational Decision-Making Issue (ODMI) Process	11
EN-WM-100	Work Request (WR Generation, Screening and Classification	8

Condition Reports

CR GGN-2012-07031	CR-GGN-2001-01712	CR-GGN-2001-01999	CR-GGN-2002-00054
CR-GGN-2002-00297	CR-GGN-2002-00485	CR-GGN-2002-01116	CR-GGN-2002-01124
CR-GGN-2003-00899	CR-GGN-2003-02072	CR-GGN-2003-02402	CR-GGN-2004-03904
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Condition Reports

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CR-GGN-2013-07419	CR-HQN-2013-00877		

Engineering Documents

<u>Number</u>	<u>Title</u>	<u>Revision/Date</u>
EC-GGN-0000042687	Establish Table for Operability Surveillance of SSW Siphon Line	0
EC-GGN-0000046029	Evaluate CR-GGN-2013-4506 Concerns – Update FSAR Section 5.2.5.2B	0
GGNS-CS-20	Standard for Heavy Loads	0
SDC-C71	Reactor Protection System	0
EC-GGN-0000023925	GGN EPU – Reactor Protection System Setpoint Changes	0
EC-GGN-0000031752	Update UFSAR 8.3.1.1.5.4 to Allow Limited Connection of RPS A and B to Their Alternate Power Supplies to Support Emergent Plant Situations	0
EC-GGN-0000034921	GGNS EPU – SCRAM Bypass Setpoint (C71 RPS) CLTP OPS with New HPT	0
EC-GGN-0000042199	Modify Field Flash Circuit For RPS MG Set 1C71S001B	0
EC-GGN-0000043454	Acceptance of Resistor 9R Value Installed For RPS MG Set Field Flash Kit	

Miscellaneous

<u>Number</u>	<u>Title</u>	<u>Revision/Date</u>
TEAR GGNS-2013-152	-	May 3, 2013
WT-WTGGN-2012-00283	-	November 11, 2012
LBDCR-2012-049	Add SR TRM 3.7.1.1 to Technical Requirements Manual	October 31, 2012
FLP-MTHL-MOBILE-CRANE	Mobile Crane Classroom	01
WO-GGN-52323390	Motor OOSVC Inspect and Test for C71S001B	March 27, 2013
VM460000046	Motor Generator Package Set	June 28, 2006

Miscellaneous

Security Incident Report Forms (SIR) 2013-0211, 2013-0067, 2013-0077, 2013-0156, 2013-0162
Online Corrective Maintenance Backlog
November 2013 Update on the Division II Standby Diesel Generator lube oil leak
Maintenance Rule Functions for Standby Diesel Generator System (P75) and High Pressure Core Spray Diesel Generator System (P81)
EC 0000031442, "Long Term Scaffolding Request For Auxiliary, Containment, Diesel, Radwaste And Turbine Buildings," Revision 000
Grand Gulf Nuclear Station Technical Specifications
Grand Gulf Nuclear Station Technical Requirements Manual
Grand Gulf Nuclear Station Technical Specification Bases
Grand Gulf Nuclear Station Technical Requirements Manual Bases
Training Material GLP-OPS-P7500, "Standby Diesel Generator System – P75," Revision 24
Training Material GLP-OPS-P8100, "High Pressure Core Spray (HPCS) Diesel Generator System – P81," Revision 16
Training Material GLP-OPS-X4600, "EOF and Telecom Diesel Generator," Revision 5

Information Request
July 30, 2013
Biennial Problem Identification and Resolution Inspection –
Grand Gulf Nuclear Station
Inspection Report Number 05000416/2013007

This inspection will cover the period from October 21, 2011, through the end of the inspection on October 11, 2013. All requested information should be limited to this period up to the day provided unless otherwise specified. To the extent possible, the requested information should be provided electronically in Microsoft Office format. Lists of documents should be provided in Microsoft Excel or a similar sort-able format. Please provide the information on a compact disc (one for each team member), if possible. This information may also be uploaded on the Certrec IMS website if so desired.

Please provide the following no later than August 30, 2013:

1. Copies of the corporate and site level procedures and sub-tier procedures associated with the corrective action program. This should include procedures related to:
 - a. Corrective action process;
 - b. Operating experience program;
 - c. Employee concerns program;
 - d. Self-assessment program;
 - e. Maintenance rule program and implementing procedures;
 - f. Operability determination process;
 - g. Degraded/non-conforming condition process (e.g., RIS 2005-20);
 - h. System Health process or equivalent equipment reliability improvement programs;
 - i. Operational Decision Making (ODMI) process.
2. Scheduled date/time/location of all meetings associated with implementation of the corrective action program, such as screening meetings, corrective action review board meetings, etc.
3. List of all condition reports generated sorted by priority, with the following information: number; priority; system/component affected; title/description; date initiated; and status (open or closed). The condition reports should be grouped by the responsible department (operations, maintenance, engineering, radiation protection, emergency preparedness, and security).
4. Listing of the total number of condition reports generated annually, sorted by the above departments.
5. A copy of all root, apparent, and common cause evaluations.
6. A list of condition reports generated as a result of identified trends. The list should be sorted by priority and have the following information: number, title/description, date initiated, status and initiating department.
7. A list of outstanding corrective actions, sorted by priority, with the following information: number; priority; system/component affected, initiating date and due date. Please also identify and list any associated due date extensions.

8. List of control room deficiencies and operator work-arounds, sorted by priority, with a brief description and corresponding condition report number and/or work order number, and initiation date.
9. A chronological list of all nuclear Quality Assurance/Nuclear Oversight audits and department/station self-assessments including their reference number.
10. A list of all system health reports.
11. All copy of assessments or evaluations (internal or external) regarding station or department safety-culture.
12. A list of all operability determinations and ODMIs performed with the following information: date initiated, initiating CR and status (open or closed).
13. A list of maintenance preventable functional failures (MPFFs) of risk-significant systems (include actions completed and current status). A list of current Maintenance Rule a(1) systems and a list of those systems that entered a(1) within the last two years, but which were returned to a(2) status. Include a copy of the current system health report for those systems now in a(1).
14. Copy of the latest corrective action program statistics such as the number initiated by department, human performance errors by department, backlog, corrective action timeliness and others as may be available.
15. Any performance indicators associated with backlog of corrective maintenance items.
16. List of industry operating experience evaluated by the site and associated condition report number if applicable. Additionally, list of all NRC generic communications (information notices, generic letters, etc.) evaluated by the site for applicability to the station regardless of the determination of applicability.
17. A list of condition reports where the NRC was the identifying organization. This list should include non-cited and minor violations, and findings, regardless of whether there was an associated violation. Please provide the IR number, title, date initiated and status.
18. A chronological list of all Licensee Event Reports, with a brief description of the affected components or systems.
19. A listing of the top 10 risk-significant systems, components, and/or operator manual actions as appropriate.

Please provided on CDs and/or DVDs sent via overnight carrier to:

U.S. NRC Region IV
1600 E. Lamar Blvd.
Arlington, TX 76011-4511
Attention: Harry Freeman

Please note that the NRC is not currently able to accept electronic documents on thumb drives or other similar digital media.