UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 E. LAMAR BLVD.
ARLINGTON, TX 76011-4511

August 13, 2015

Mr. Eric W. Olson, Site Vice President
Entergy Operations, Inc.
River Bend Station
5485 US Highway 61N
St. Francisville, LA 70775

SUBJECT: RIVER BEND STATION – NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000458/2015008

Dear Mr. Olson:

On July 2, 2015, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution biennial inspection at the River Bend Station and discussed the results of this inspection with you and members of your staff. The inspection team documented the results of this inspection in the enclosed inspection report.

Based on the inspection sample, the inspection team concluded that River Bend Station's corrective action program, and your staff's implementation of the corrective action program, were adequate to support nuclear safety.

In reviewing your corrective action program, the team assessed how well your staff identified problems at a low threshold, your staff's implementation of the station's process for prioritizing and evaluating these problems, and the effectiveness of corrective actions taken by the station to resolve these problems. The team also evaluated other processes your staff used to identify issues for resolution. These included your use of audits and self-assessments to identify latent problems and your incorporation of lessons learned from industry operating experience into station programs, processes, and procedures. The team determined that your station's performance in each of these areas supported nuclear safety.

However, the team noted that the station did not consistently develop and implement effective corrective actions to address organizational and programmatic contributors to some identified problems. Additionally, the team noted several instances where your staff did not timely initiate condition reports or did not recognize circumstances in which a condition report was required.

Finally, the team did not identify any challenges to your station management's maintenance of a safety-conscious work environment in which your employees are willing to raise nuclear safety concerns through at least one of the several means available.

The NRC inspectors documented four findings of very low safety significance (Green) in this report. Two of these findings involved violations of NRC requirements, both of which are documented as non-cited violations (NCVs) in accordance with Section 2.3.2.a of the NRC Enforcement Policy.

If you contest the violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region IV; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC resident inspector at the River Bend Station. If you disagree with a cross-cutting aspect assignment or a finding not associated with a regulatory requirement in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region IV, and the NRC resident inspector at the River Bend Station.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public Inspections, Exemptions, Requests for Withholding," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents 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/

Thomas R. Farnholtz, Chief
Engineering Branch 1
Division of Reactor Safety

Docket No. 50-458
License No. NPF-47

Enclosure:
Inspection Report 05000458/2015008
w/Attachment: Supplemental Information

cc w/encl: Electronic Distribution

U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket(s):	05000458
License:	NPF-47
Report:	05000458/2015008
Licensee:	Entergy Operations, Inc.
Facility:	River Bend Station
Location:	5485 U.S. Highway 61N St. Francisville, LA 70775
Dates:	June 8 – July 2, 2015
Inspectors:	E. Ruesch, J.D., Team Lead (Acting) (Lead Inspector) C. Alldredge, Project Engineer B. Baca, Project Engineer A. Barrett, Resident Inspector S. Makor, Reactor Inspector
Approved By:	Thomas R. Farnholtz Chief, Engineering Branch 1 Division of Reactor Safety

SUMMARY

IR 05000458/2015008; 06/08/2015 – 07/02/2015; RIVER BEND STATION; Problem Identification and Resolution (Biennial)

The inspection activities described in this report were performed between June 8 and July 2, 2015, by four inspectors from the NRC's Region IV office and the resident inspector at River Bend Station. The report documents four findings of very low safety significance (Green). Two of these findings involved violations of NRC requirements. The significance of inspection findings is indicated by their color (Green, White, Yellow, or Red), which is determined using Inspection Manual Chapter 0609, "Significance Determination Process." Their cross-cutting aspects are determined using Inspection Manual Chapter 0310, "Aspects Within the Cross-Cutting Areas." Violations of NRC requirements are dispositioned in accordance with the NRC Enforcement Policy. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

Assessment of Problem Identification and Resolution

Based on its inspection sample, the team concluded that the licensee maintained a corrective action program in which individuals generally identified issues at an appropriately low threshold. Once entered into the corrective action program, the licensee generally evaluated and addressed these issues appropriately and timely, commensurate with their safety significance. The licensee's corrective actions were generally effective, addressing the causes and extents of condition of problems.

However, the team noted that the station did not consistently develop and implement effective corrective actions to address organizational and programmatic contributors to some identified problems. Additionally, the team noted several instances where licensee personnel did not timely initiate condition reports or did not recognize circumstances in which a condition report was required.

The licensee appropriately evaluated industry operating experience for relevance to the facility and entered applicable items in the corrective action program. The licensee incorporated industry and internal operating experience in its root cause and apparent cause evaluations. The licensee performed effective and self-critical nuclear oversight audits and self-assessments. The licensee maintained an effective process to ensure significant findings from these audits and self-assessments were addressed.

The licensee maintained a safety-conscious work environment in which personnel were willing to raise nuclear safety concerns without fear of retaliation.

Cornerstone: Initiating Events

- Green. The team identified a Green non-cited violation of 10 CFR Part 50 Appendix B Criterion XVI, "Corrective Action," for the licensee's failure to preclude repetition of consequential gaps in operator performance. In August 2013, the licensee identified that gaps in operator fundamentals, a significant condition adverse to quality, had caused or contributed to plant transients earlier that year. The licensee's corrective actions were inadequate to prevent gaps in operator fundamentals from again causing or contributing to plant transients in late 2014.

The failure to correct and preclude repetition of consequential gaps in operator fundamentals, a significant condition adverse to quality, as required by 10 CFR Part 50 Appendix B Criterion XVI, was a performance deficiency. This performance deficiency was more than minor because it affected the human performance attribute of the initiating events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety function. Using Inspection Manual Chapter 0609 Appendix A, the team determined that this finding was of very low safety significance (Green) because it did not involve the loss of mitigation equipment or a support system. This finding has a field presence cross-cutting aspect in the human performance cross-cutting area (H.2) because leaders failed to provide oversight of work activities and to promptly correct deviations from standards and expectations. (Section 4OA2.5.c)

- Green. The team identified a Green non-cited violation of 10 CFR Part 50 Appendix B Criterion XVI, "Corrective Action," for the failure to identify and correct a condition adverse to quality. Specifically, the licensee failed to identify an adverse trend in the performance of post maintenance testing on high critical components. The licensee did not identify a trend or evaluate whether multiple equipment or component failures that in some instances complicated and challenged operators response to a scram was related to maintenance work performed, and if there was an opportunity to identify the issues through post maintenance testing prior to returning equipment to service.

  The licensee's failure to promptly identify and correct a condition adverse to quality, as required by 10 CFR Part 50 Appendix B Criterion XVI, was a performance deficiency. The licensee failed to identify an adverse trend in the performance of post-maintenance testing on high-critical components. The performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the initiating event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the failure to identify a programmatic trend that reduced the reliability of multiple high-critical components whose failure could result in a significant impact to safe and reliable plant operation. Using Inspection Manual Chapter 0609, Appendix A, the team determined that this finding was of very low safety significance (Green) because it did not involve the loss of mitigation equipment or a support system. The finding has a human performance cross-cutting aspect associated with resources, in that the licensee leaders failed to ensure that personnel, equipment, procedures, and resources are available and adequate to support nuclear safety (H.1). Specifically, the licensee failed to evaluate a trend in degraded critical component conditions or malfunctions for multiple high critical components. (Section 4OA2.5.d)

Cornerstone: Mitigating Systems

- Green. The team identified a Green finding for multiple examples of failures to timely document adverse conditions, as defined by corrective action program procedures, in condition reports. The team determined that these multiple failures, which were spread across multiple departments and programs, represented a programmatic deficiency in training of personnel and communication of expectations for compliance with corrective action program requirements.

  The licensee's failure to promptly document multiple adverse conditions in condition reports as required by Procedure EN-LI-102 was a performance deficiency. This performance deficiency was more than minor because if left uncorrected in could lead to a more

significant safety or security concern. Specifically, it could result in the licensee failing to promptly correct an adverse condition, which could lead to more significant consequences. This finding was associated with multiple cornerstones; the team determined that the mitigating systems cornerstone was the most appropriate for screening. Using Inspection Manual Chapter 0609 Appendix A, the team determined that this finding was of very low safety significance (Green) because it did not cause the loss of operability or function of any system or train and did not affect external event mitigation. This finding has a training cross-cutting aspect in the human performance cross-cutting area (H.9) because the licensee failed to ensure that individuals were adequately trained to ensure an understanding of standards. (Section 4OA2.5.b)

Cornerstone: Occupational Radiation Safety

- Green. The team identified a Green finding for a failure to document adverse conditions associated with radiological housekeeping or contamination controls in the corrective action program as required by procedure. The licensee's procedures did not adequately provide examples of deficient radiological practices as adverse conditions.

  The licensee's failure to document adverse conditions in the corrective actions program as required by procedure was a performance deficiency. This constituted a programmatic weakness in the licensee's corrective action program to document adverse conditions associated with inadequate radiological practices. This performance deficiency is more than minor because it is associated with the program and process attribute (contamination control) of the Occupational Radiation Safety cornerstone and adversely affected the cornerstone objective to ensure adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated August 19, 2008, the inspectors determined the finding to be of very low safety significance because it was not an as low as reasonably achievable (ALARA) issue, there was no overexposure or substantial potential for overexposure, and the licensee's ability to assess dose was not compromised. This finding has a cross-cutting aspect in resources component of the human performance area because the licensee's corrective action procedures were not adequate to include deficient radiological practices as an adverse condition (H.1). (Section 4OA2.5.a)

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (71152)

The team based the following conclusions on a sample of corrective action documents that were open during the assessment period, which ranged from July 12, 2013, to the end of the on-site portion of this inspection on July 2, 2015.

.1 Assessment of the Corrective Action Program Effectiveness

a. Inspection Scope

The team reviewed approximately 275 condition reports (CRs), including associated root cause analyses and apparent cause evaluations, from approximately 14,500 that the licensee had initiated or closed between July 12, 2013, and July 2, 2015. The majority of these (approximately 12,000) were lower-level condition reports that did not require cause evaluations. The inspection sample focused on higher-significance condition reports for which the licensee evaluated and took actions to address the cause of the condition. In performing its review, the team evaluated whether the licensee had properly identified, characterized, and entered issues into the corrective action program, and whether the licensee had appropriately evaluated and resolved the issues in accordance with established programs, processes, and procedures. The team also reviewed these programs, processes, and procedures to determine if any issues existed that may impair their effectiveness.

The team reviewed a sample of performance metrics, system health reports, operability determinations, self-assessments, trending reports and metrics, and various other documents related to the licensee's corrective action program. The team evaluated the licensee's efforts in determining the scope of problems by reviewing selected logs, work orders, self-assessment results, audits, system health reports, recovery plans, and results from surveillance tests and preventive maintenance tasks. The team reviewed daily CRs and attended the licensee's condition review group (CRG), corrective action review board (CARB), and operations focus meetings to assess the reporting threshold and prioritization efforts, and to observe the corrective action program's interfaces with the operability assessment and work control processes. The team's review included an evaluation of whether the licensee considered the full extent of cause and extent of condition for problems, and a review of how the licensee assessed generic implications and previous occurrences of issues. The team assessed the timeliness and effectiveness of corrective actions, completed or planned, and looked for additional examples of problems similar to those the licensee had previously addressed. The team conducted interviews with plant personnel to identify other processes that may exist where problems may be identified and addressed outside the corrective action program.

The team reviewed corrective action documents that addressed past NRC-identified violations to evaluate whether corrective actions addressed the issues described in the inspection reports. The team reviewed a sample of corrective actions closed to other corrective action documents to ensure that the ultimate corrective actions remained appropriate and timely. The team reviewed a sample of condition reports where the licensee had changed the significance level after initial classification to determine

whether the level changes were in accordance with station procedure and that the conditions were appropriately addressed.

The team considered risk insights from both the NRC's and River Bend Station's risk models to focus the sample selection and plant tours on risk-significant systems and components. The team focused a portion of its sample on the residual heat removal systems, which the team selected for a five-year in-depth review. The team conducted walk-downs of this system and other plant areas to assess whether licensee personnel identified problems at a low threshold and entered them into the corrective action program.

b. Assessments

1. Effectiveness of Problem Identification

During the 25-month inspection period, licensee staff generated approximately 14,500 condition reports. The team determined that most conditions that required generation of a condition report by Procedure EN-LI-102, "Corrective Action Program," had been appropriately entered into the corrective action program.

In September 2014, the licensee implemented a major change to its corrective action program. This change provided for the segregation of condition reports documenting "adverse conditions" from those documenting "non-adverse conditions." Adverse conditions include conditions adverse to quality and conditions related to other regulations or regulatory oversight processes. Though both adverse and non-adverse condition reports are handled within the licensee's paperless condition reporting system (PCRS) software, non-adverse condition reports are considered to be outside the corrective action program. Identification of an adverse condition requires prompt initiation of a condition report; condition reports are optional for non-adverse conditions. The team noted several cases where the licensee failed to properly identify and document adverse conditions. These included the failure to recognize conditions involving deficient radiological contamination controls as adverse conditions, and undue delay in documenting adverse conditions related to program implementation. These two examples are discussed in two Green findings in Sections 4OA2.5.a and 4OA2.5.b below.

The team also identified incorrect information in Emergency Operating Procedure EOP-0001, "Reactor Pressure Vessel Control," which had not been identified by licensee staff during revisions of the procedure. Specifically, the team found that the procedure listed incorrect pump flow rates in a table that showed capacity for each pump at listed pressures. The emergency core cooling system line fill pumps, high pressure core spray line fill pump and reactor core isolation cooling fill pump flow rates did not account for the specific system operating curves, and had the potential to mislead operators. Title 10 CFR 50 Appendix B, Criterion V, states in part that, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings." Contrary to this, the emergency operating procedure included operator information that was not appropriate. Failure to use correct pump flow rate information for operators use during an emergency is a performance deficiency. The performance deficiency is minor because it did not impact the station's ability to declare or

upgrade an emergency class. The failure to comply with 10 CFR50 Appendix B, Criterion V, constitutes a minor violation that is not subject to enforcement action in accordance with the NRC's Enforcement Policy. The licensee documented this deficiency in condition report CR-RBS-2015-04730.

Most of the personnel interviewed by the team understood the requirements for condition report initiation; most expressed a willingness to enter newly identified issues into the corrective action program at a very low threshold. However, approximately 29 percent of interviewees expressed negative views when asked how effective the station's corrective action program is at identifying and addressing problems. Several interviewees stated that the corrective action program appeared marginally effective or ineffective at correcting problems unless those problems were either (1) major problems impacting plant operation or (2) very minor problems that could be fixed using minimal resources. As a result, several (approximately 10 percent) expressed reluctance to continue to initiate condition reports for conditions that did not fall into one of these two categories based on a lack of confidence that the problem would be resolved.

Overall, the team concluded that the licensee generally maintained a low threshold for the formal identification of problems and entry into the corrective action program for evaluation. Licensee personnel initiated an average of approximately 600 CRs per month during the inspection period. Most of the personnel interviewed by the team understood the requirements for condition report initiation; most expressed a willingness to enter newly identified issues into the corrective action program at a very low threshold.

2. Effectiveness of Prioritization and Evaluation of Issues

The sample of CRs reviewed by the team focused primarily on issues screened by the licensee as having higher-level significance, including those that received cause evaluations, those classified as significant conditions adverse to quality, and those that required engineering evaluations. The team also reviewed a number of condition reports that included or should have included immediate operability determinations to assess the quality, timeliness, and prioritization of these determinations.

The team reviewed the licensee's evaluation of organizational and programmatic (O&P) causes in 15 root cause evaluations and 20 apparent cause evaluations. In five of the root cause evaluations (33 percent) and seven of the apparent cause evaluations (35 percent), the licensee evaluators determined that managers and other leaders were either not effectively communicating standards or not enforcing compliance with those standards. Three of the root cause evaluations noted an inadequate field presence of supervisors. In each of these instances, corrective actions such as training, increased management observation requirements, or procedure changes were developed. While these corrective actions appeared adequate to correct the issue in each case individually, the licensee failed to develop comprehensive corrective actions to address the trend of leadership-related organizational and programmatic causes.

Additionally, three of the four findings the team documented during this inspection were assigned leadership-related cross-cutting aspects due to licensee

management's failure to provide adequate oversight of some station activities. One of these findings documents a failure to preclude repetition of a significant condition adverse to quality, which recurred—at least in part—due to failures to correct gaps in leadership engagement after these gaps were identified during a September 2013 root cause evaluation. This finding is discussed in Section 4OA2.5.c, below.

The team also identified a deficiency in the licensee's handling of NRC-documented issues. After the September 2014 change to the corrective action program, Procedure EN-LI-102, "Corrective Action Program," required that all findings and violations documented in NRC inspection reports be classified as Category B or higher, requiring at least an apparent cause evaluation. Prior to the September 2014 change, there was only a single very narrow exception allowing such CRs to be classified at a lower level. In reviewing the licensee's follow-up actions to a sample of NRC-documented issues, the team noted that in 10 of 17 cases, the licensee had not performed an apparent cause evaluation. The team noted that the licensee's failure to perform a cause evaluation in these cases resulted in a missed opportunity for the licensee to determine why licensee personnel were not self-identifying issues before they were identified by the NRC. The team determined that this was a minor performance deficiency because it did not adversely affect a cornerstone objective and it was unlikely to lead to a more significant safety concern if uncorrected. The licensee had evaluated all of the mischaracterized issues—albeit at a lower level than required by procedure—prior to the team identifying this issue. The licensee entered this minor performance deficiency into the corrective action program as CR-RBS-2015-04790.

Overall, the team determined that the licensee's process for screening and prioritizing issues that had been entered into the corrective action program supported nuclear safety. The licensee's operability determinations were generally consistent, accurately documented, and completed in accordance with procedures.

3. Effectiveness of Corrective Actions

In general, the corrective actions identified by the licensee to address adverse conditions were effective when the adverse conditions were equipment related. However, the team noted that the licensee did not always develop and implement effective corrective actions for organizational and programmatic issues.

As discussed in the Prioritization and Evaluation section above, the licensee often identified organizational and programmatic causes during root and apparent cause evaluations. However, the licensee did not develop and implement comprehensive corrective actions for these programmatic causes, especially when the causes were related to leadership behaviors.

Further, the team identified that the licensee had repeatedly identified gaps in operator performance related to operator fundamentals. These gaps resulted in plant transients such as run-backs and scrams, loss of configuration control events such as component mispositionings, and errors associated with clearance tags. Corrective actions developed and implemented after these adverse trends were identified repeatedly failed to provide sustainable improvement to prevent future events due to the same or similar causes. This performance deficiency is further discussed as a finding in section 4OA2.5.c below.

Overall, despite these gaps, the team concluded that the licensee generally identified effective corrective actions for the problems evaluated in the corrective action program. The licensee generally implemented these corrective actions in a timely manner, commensurate with their safety significance, and reviewed the effectiveness of the corrective actions appropriately.

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The team examined the licensee's program for reviewing industry operating experience, including reviewing the governing procedures. The team reviewed a sample of 25 industry operating experience communications and the associated site evaluations to assess whether the licensee had appropriately assessed the communications for relevance to the facility. The team reviewed assigned actions to address these communications to determine whether they were appropriate. The inspectors also reviewed a sample of ten fleet corrective actions for assessment and communication to site workers.

b. Assessment

Overall, the team determined that the licensee appropriately evaluated industry operating experience for its relevance to the facility. Operating experience information was incorporated into plant procedures and processes as appropriate. The team determined that the licensee appropriately evaluated industry operating experience when performing root cause analyses and apparent cause evaluations.

The licensee incorporated both internal and external operating experience into lessons learned for training and pre-job briefs. However, the inspectors identified a weakness in which only significant operating experience was reviewed during work planning and problem resolution while lower-level operating experience was reviewed during root cause analysis and apparent cause evaluations. This weakness lead to an untimely assessment of an adverse trend with post-maintenance testing of critical components, as documented in Section 4OA2.5.d below.

Procedure EN-OE-100, "Operating Experience Program," provides a process by which industry operating experience is evaluated and disseminated at the facility. The licensee receives industry operating experience data packages with selected information flagged as "significant." The significant operating events are evaluated, addressed, and placed into the corrective action program. The less significant events are reviewed and, if not elevated for additional evaluation, are entered into PCRS for future data mining. The team determined that the licensee was not effectively evaluating and incorporating potential lessons learned using the lower-level operating experience trends to prevent events at River Bend. The team noted multiple examples where, following an event or the identification of a condition requiring a cause evaluation, the licensee's cause evaluators identified a several similar events or events with similar causes at other Entergy facilities. Had the licensee proactively identified these similar events through its operating experience program or while incorporating lessons learned into work packages, the station may have been able to develop improvements to programs,

processes, or procedures that may have precluded the event from occurring at River Bend.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The team reviewed a sample of licensee self-assessments and audits to assess whether the licensee was regularly identifying performance trends and effectively addressing them. The team also reviewed audit reports to assess the effectiveness of assessments in specific areas. The specific self-assessment documents and audits reviewed are listed in Attachment 1.

b. Assessment

Overall, the team concluded that the licensee had an effective self-assessment and audit process. The team determined that self-assessments were self-critical and thorough enough to identify deficiencies.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The team interviewed 39 individuals in five focus groups. The purpose of these interviews was (1) to evaluate the willingness of licensee staff to raise nuclear safety issues, either by initiating a condition report or by another method, (2) to evaluate the perceived effectiveness of the corrective action program at resolving identified problems, and (3) to evaluate the licensee's safety-conscious work environment (SCWE). The focus group participants included personnel from security, radiation protection, chemistry, engineering (design and systems), operations, production, and maintenance. At the team's request, the licensee's regulatory affairs staff selected the participants blindly from these work groups, based partially on availability. To supplement these focus group discussions, the team interviewed the employee concerns program coordinator to assess her perception of the site employees' willingness to raise nuclear safety concerns. The team reviewed the employee concerns program case log and select case files. The team also reviewed the minutes from the licensee's most recent safety culture monitoring panel meetings.

b. Assessment

1. Willingness to Raise Nuclear Safety Issues

All individuals interviewed indicated that they would raise nuclear safety concerns. All felt that their management was receptive to nuclear safety concerns and was willing to address them promptly. All of the interviewees further stated that if they were not satisfied with the response from their immediate supervisor, they had the ability to escalate the concern to a higher organizational level. Most expressed positive experiences after raising issues to their supervisors. All expressed positive experiences documenting most issues in condition reports.

2. Employee Concerns Program

All interviewees were aware of the employee concerns program. Most explained that they had heard about the program through various means, such as posters and training. With the exception of one group, all interviewees stated that they would use employee concerns if they felt it was necessary. All except for that same group expressed confidence that their confidentiality would be maintained if they brought issues to employee concerns.

3. Preventing or Mitigating Perceptions of Retaliation

When asked if there have been any instances where individuals experienced retaliation or other negative reaction for raising issues, all individuals interviewed stated that they had neither experienced nor heard of an instance of retaliation, harassment, intimidation or discrimination at the site.

.5 Findings

a. Failure to recognize violations of contamination control requirements as adverse conditions

Introduction. The team identified a Green finding for a failure to document adverse conditions associated with radiological housekeeping or contamination controls in the corrective action program as required by procedure. The licensee's procedures did not adequately provide examples of deficient radiological practices as adverse conditions.

Description. On multiple inspector facility tours from May 27 through June 11, 2015, the inspectors identified poor radiological housekeeping practices in which contaminated materials were not appropriately controlled within contaminated areas. For example, contaminated material was observed spilling out of a radiological trash bag over grated flooring, miscellaneous tools were observed crossing posted contaminated areas, and unsecured ropes and hoses were noted crossing the posted boundaries.

In Procedure EN-LI-102 Attachment 9.2, the licensee identifies as adverse conditions items which are "violations of procedures or regulations that are intended to satisfy 10CFR19, 10CFR20, or other applicable federal regulation." Radiological housekeeping deficiencies are violations of procedures intended to satisfy 10 CFR Part 20, which are also required by Technical Specification 5.4.1(a).

Technical Specification 5.4.1(a) requires the implementation of procedures listed in Appendix A to Regulatory Guide 1.33, Revision 2. These include radiation protection procedures for contamination control. The licensee implements this requirement with Procedure EN-RP-100, "Radiation Worker Expectations." Sections 5.6[1](l, n, and o) of Revision 9 of this procedure require radiation workers to keep work areas neat and orderly during work, to ensure work areas are cleaned up after job completion, to contact Radiation Protection prior to placing anything across a contamination area boundary, and to secure all cords, hoses, wires, etc. that cross contamination area boundaries. Further, Section 5.6[2](o) requires employees to "Maintain neat and orderly work areas to prevent contamination spread within Contamination Areas and across Contamination Area boundaries." The team determined that because the radiological housekeeping deficiencies constituted violations of procedures both required by the station's license

and intended to implement requirements of 10 CFR Part 20, these were adverse conditions which required initiation of a condition report.

During discussions of the licensee's procedural definition of adverse conditions, the inspectors identified that either the corrective action program did not provide adequate guidance regarding deficient radiological practices, or station personnel did not understand the guidance provided. The adverse conditions were subsequently documented in the corrective action program as CR-RBS-2015-03877, -04265, and -04298. While each individual violation of EN-RP-100 was a minor performance deficiency in itself, the programmatic failure to recognize and document these violations as adverse conditions was a separate and more significant performance deficiency.

Analysis. The licensee's failure to document adverse conditions in the corrective actions program as required by procedure was a performance deficiency. This constituted a programmatic weakness in the licensee's corrective action program to document adverse conditions associated with inadequate radiological practices. This performance deficiency is more than minor because it is associated with the program and process attribute (contamination control) of the occupational radiation safety cornerstone and adversely affected the cornerstone objective to ensure adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated August 19, 2008, the inspectors determined the finding to be of very low safety significance because it was not an as low as reasonably achievable (ALARA) issue, there was no overexposure or substantial potential for overexposure, and the licensee's ability to assess dose was not compromised. This finding has a cross-cutting aspect in resources component of the human performance area because the licensee's corrective action procedures were not adequate to include deficient radiological practices as an adverse condition (H.1).

Enforcement. This finding does not involve enforcement action because no violation of a regulatory requirement was identified. The licensee documented the finding in the corrective action program as CR-2015-04791. Because the finding does not involve a violation and is of very low safety significance (Green), it is being characterized as a finding: FIN 05000485/2015008-01, "Failure to Recognize Violations of Contamination Control Requirements as Adverse Conditions."

b. Failure to promptly document adverse conditions in the corrective action program

Introduction. The team identified a Green finding for multiple examples of failures to timely document adverse conditions, as defined by its corrective action program procedures, in condition reports. The team determined that these multiple failures, which were spread across multiple departments and programs, represented a programmatic deficiency in training of personnel and communication of expectations for compliance with corrective action program requirements.

Description. The licensee's corrective action program is described in Procedure EN-LI-102, "Corrective Action Program." This procedure defines an adverse condition as:

> A general term which [sic] includes Conditions Adverse to Quality plus conditions related to the following: . . . (a) Design basis (b) Licensing basis (c) NRC regulations and commitments (d) State and federal regulations other than NRC . . . (e) Key elements of reactor oversight process (ROP) (f) Equipment required to support safety related equipment as defined by the functionality assessment process.

Section 5.2[1](b) requires all employees and contractors to initiate condition reports for adverse conditions, and encourages them to initiate CRs for other issues that do not meet the definition of adverse condition. Section 5.2[1](d) requires any individual discovering an adverse condition "to ensure . . . The condition is promptly documented in a Condition Report."

The team identified multiple examples in which licensee personnel failed to promptly initiate a condition report following discovery of an adverse condition:

- On June 10, 2015, during a discussion with the team, a licensee manager stated that an adverse trend in housekeeping, including radiological housekeeping, had been identified on June 4. After the team requested the condition report documenting the adverse trend, the manager generated the condition report on June 11.

- Condition report CR-RBS-2015-04071 was generated following a failed effectiveness review of a corrective action to preclude repetition of gaps in operator fundamentals (CR-RBS-2014-05022; see discussion in Section 4OA2.5.c below). The licensee's condition review group (CRG) processed this condition report on June 9, 2015, assigning category D and closing it to actions being taken under another condition report; however, this other condition report did not address the causes of the failed effectiveness review. After identification by the team on June 12, CR-RBS-2015-04071 was upgraded to category C at CRG on June 22. No new condition report was initiated to document the inappropriate initial screening.

- On June 30, 2015, NRC inspectors performing another inspection activity identified an adverse condition related to cybersecurity. Licensee security personnel immediately corrected the condition, but failed to initiate a condition report until prompted by the NRC senior resident inspector the following morning.

- While performing reviews of corrective actions for a degrading emergency core cooling system line fill pump, the inspectors identified incorrect flow rates used by operators to estimate coolant flow to the reactor core during accident conditions. The emergency operating procedure did not list pump flow rates using the specific system operating curves, which may have misled operators during an event. The inspectors brought these concerns to the plant staff during the first week of the inspection (June 8-12, 2015), however no condition report was written until questioned by the inspectors three weeks later on July 1.

Analysis. The licensee's failure to promptly document multiple adverse conditions in condition reports as required by Procedure EN-LI-102 was a performance deficiency. This performance deficiency was more than minor because if left uncorrected in could lead to a more significant safety or security concern. Specifically, it could result in the licensee failing to promptly correct an adverse condition, which could lead to more significant consequences. This finding was associated with multiple cornerstones; the team determined that the mitigating systems cornerstone was the most appropriate for screening. Using Inspection Manual Chapter 0609 Appendix A, the team determined that this finding was of very low safety significance (Green) because it did not cause the loss of operability or function of any system or train and did not affect external event mitigation. This finding has a training cross-cutting aspect in the human performance cross-cutting area (H.9) because the licensee failed to ensure that individuals were adequately trained to ensure an understanding of standards.

Enforcement. This finding does not involve enforcement action because no violation of a regulatory requirement was identified. Because this finding does not involve a violation and is of very low safety significance, it is identified as FIN 05000458/2015008-02, "Failure to Promptly Document Adverse Conditions in the Corrective Action Program."

c. Failure to preclude repetition of consequential gaps in operator performance

Introduction. The team identified a Green non-cited violation of 10 CFR Part 50 Appendix B Criterion XVI for the licensee's failure to preclude repetition of consequential gaps in operator performance. In August 2013, the licensee identified that gaps in operator fundamentals, a significant condition adverse to quality, had caused or contributed to plant transients earlier that year. The licensee's corrective actions were inadequate to prevent gaps in operator fundamentals from again causing or contributing to plant transients in late 2014.

Description. On August 1, 2013, the licensee initiated condition report CR-RBS-2013-05180 "to document areas of declining performance within the Operations Department." One of the areas identified in which performance declining was "operator fundamentals." The condition report noted that "weaknesses in application" of operator fundamentals had resulted in several operational events including a flow-control valve runback and component mispositionings. The licensee evaluated this as a significant condition adverse to quality and initiated a root cause evaluation.

The licensee's root cause evaluators determined that root cause of the decline in operator performance was that "operations department workers and leaders do not consistently demonstrate high standards in all activities." The root cause evaluators recommended two corrective actions to preclude repetition of this significant condition adverse to quality by eliminating the root cause. First, develop and implement guidance to provide for additional shift manager oversight in the control room during high activity periods; and second, develop and implement guidance to require that one field observation per shift be observed and critiqued against the operator fundamentals. After incorporating comments made by the corrective action review board—the station's leadership oversight of the corrective action process for significant issues—the root cause was changed to state, "Crew performance monitoring following the departmental

realignments after RF-17 was insufficient in identifying gaps in operator fundamentals." The corrective action to preclude repetition of this condition was revised as follows:

> Develop and implement a protocol to cause additional monitoring of crew performance. This protocol will include event and condition based triggers to prompt the additional monitoring and guidance on how the monitoring will be documented. . . . Include this material in OSP-0222, "Operations General Administrative Guidelines."

To implement this corrective action, rather than revising the controlled OSP-0222 procedure as directed by the CARB, operations staff instead added guidance to the Operations Standards and Expectations. The Operations Standards and Expectations is an uncontrolled "guideline"; it had been revised 34 times in the 18-month period between September 2013 and March 2015. This change to the corrective action to preclude repetition (CAPR) was approved by the operations manager with no oversight by the CARB, contrary to the direction of Procedure EN-LI-102, revision 21, steps 4.0[9](f) and 5.7[8], which required CARB review and approval for the replacement of CAPRs. Also contrary to the requirements of Procedure EN-LI-102,[1] there is no indication that these added guidelines, currently contained on page 78 of the 103-page document, are intended to implement a CAPR. Additionally, EN-LI-118, "Root Cause Evaluation Process," includes guidance that neither "training" nor "reinforcing or clarifying expectations" are appropriate actions for CAPRs "unless done systematically."[2] The same section of EN-LI-118 required that CAPRs be "sustainable" actions that would "clearly result in long-term correction." The actions implemented by the licensee failed to meet these corrective action program requirements.

The licensee's root cause evaluators also determined that one of the contributing causes of declining performance was that "operations leaders failed to detect and correct low level behavioral issues." The root cause evaluators recommended seven corrective actions to address this contributing cause. These included the addition of specific requirements for shift managers to perform formal observations of crew performance and report observations to the leadership team, the addition of specific requirements for other management observation of crew performance, and several actions to formalize the reporting process of these observations. Following review of the root cause evaluation by the CARB, this contributing cause was removed and all of these corrective actions were deleted. The team noted that several of these canceled actions would have enhanced monitoring by leadership and would have met the procedural requirements for CAPRs.

In April 2014, the licensee performed an effectiveness review of the CAPR under LO-RLO-2013-00107, which determined that the CAPR had been effective. The effectiveness review documented that the guidance had been added to the Operations

[1] Step 5.9[1](d) of revisions 21 and 22, which were in effect when the CAPR was initiated (9/13/13) and implemented (11/18/13), states, "For CAPRs that are credited as being implemented by procedure actions or requirements the applicable steps in the associated procedure should be annotated or flagged as commitments in accordance with EN-AD-101 and applicable site procedures." Revision 24, which was in effect at the time of the inspection, contains the same requirement at step 5.6[1](c).

[2] This guidance was in Attachment 9.9 § A.3 of revision 18, which was in effect when the CAPR was initiated, and step 5.12[10](e) of revision 19, which was in effect when the CAPR was implemented and when the effectiveness review was performed.

Standards and Expectations rather than OSP-0022, but did not document this as a deficiency. The team noted that after an assistant operations manager had initially changed the CAPR without CARB approval, this change had been reviewed by the operations manager to approve completion of the action, the corrective action program manager to approve closure of the condition report, and again by the operations department during its effectiveness review. None of these reviews identified that the CAPR had been inappropriately changed.

In October 2014, the licensee's operations department documented in CR-RBS-2014-05022 an adverse trend in operations department performance, which included several errors "tied to operator fundamentals." The licensee determined that one of the apparent causes for this decline in performance was "a deficiency in the Operations Fundamental of Control." Corrective actions for this apparent cause again involved several revisions to the Operations Standards and Expectations. In the apparent cause evaluation, the licensee identified that the effectiveness measures used to evaluate the CAPR from the August 2013 root cause evaluation had been inappropriate: "Absence of events does not equate to better performance." The apparent cause evaluators documented that for the August 2013 root cause, "More appropriate actions may have been to require managers to perform a certain number of observations on fundamentals, structure the observations so that they are critical, development of [sic] a matrix to track those observations, analysis of [sic] the data to identify weaknesses, then to adjust as necessary going forward so that the observation program is being effectively used." The inspectors noted that these actions suggested by the apparent cause evaluators were very similar to the proposed actions that the CARB had rejected. The corrective actions for the apparent cause evaluation included the implementation of several of these "more appropriate actions."

In January 2015, the licensee's performance improvement department initiated CR-RBS-2015-00153, which again documented an adverse trend in operations performance. This condition report identified the adverse trend as a result of several station events that occurred in the third quarter of 2014, including two reactor scrams and a reactor recirculation flow-control valve run-back. The licensee performed an apparent cause evaluation and a common cause analysis to evaluate this adverse trend. The cause evaluators identified four apparent causes for this adverse trend. Among these were (1) leaders and managers were not reinforcing standards or holding themselves accountable to those standards, and (2) leaders, managers, and workers were not rigorously applying sound fundamentals to everyday work preparation and execution. To correct the adverse trend and its apparent causes, the licensee developed and began implementing a comprehensive station recovery plan, which was issued on May 6, 2015, and is being implemented in accordance with Fleet Procedure EN-FAP-OM-020, "Comprehensive Recovery Plans."

The team noted that the licensee now appears to have identified appropriate causes for the continued challenges to operations performance. The licensee's recovery plan contains actions to correct these causes that appear to be comprehensive, with success criteria that appear measurable and appropriate. However, this finding is NRC identified because the licensee failed to address the repeated unsuccessful corrective actions, the failures to follow corrective action program procedures, or the evidence of potential inappropriate CARB direction regarding determination of causes and development of corrective actions following initial identification of the issue.

Analysis. The failure to correct and preclude repetition of consequential gaps in operator fundamentals, a significant condition adverse to quality, as required by 10 CFR 50 Appendix B Criterion XVI, was a performance deficiency. This performance deficiency was more than minor because it affected the human performance attribute of the initiating events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety function. Using Inspection Manual Chapter 0609 Appendix A, the team determined that this finding was of very low safety significance (Green) because it did not involve the loss of mitigation equipment or a support system. This finding has a field presence cross-cutting aspect in the human performance cross-cutting area (H.2) because leaders failed to provide oversight of work activities and to promptly correct deviations from standards and expectations.

Enforcement. Title 10 of the *Code of Federal Regulations*, Part 50, Appendix B, Criterion XVI requires that for significant conditions adverse to quality, the licensee establish measures that assure that the cause of the condition is determined and corrective action taken to preclude repetition. Contrary to this requirement, from August 2013 through January 2015, the licensee failed to establish measures that assured that the cause of a significant condition adverse to quality was determined and that corrective actions were taken to preclude repetition. Specifically, in August 2013, the licensee identified that gaps in operator fundamentals had led to plant transients, which was a significant condition adverse to quality. The licensee's corrective actions did not ensure that these gaps did not recur; in January 2015, the licensee identified that the recurrence of these gaps had led to additional plant transients in late 2014. At the conclusion of this inspection, the licensee was developing and implementing actions to provide oversight from station leadership that would communicate and reinforce operations standards and expectations; the licensee intends to establish measures to ensure improvements resulting from these actions are sustainable. Because this violation was of very low safety significance and was entered into the licensee's corrective action program as CR-RBS-2015-04794, it is being treated as a non-cited violation in accordance with Section 2.3.2 of the NRC Enforcement Policy: NCV 05000458/2015008-03, Failure to Preclude Repetition of Consequential Gaps in Operator Performance.

d. Failure to identify an adverse trend in the performance of post-maintenance testing

Introduction. The team identified a Green non-cited violation of 10 CFR Part 50 Appendix B Criterion XVI, "Corrective Action," for the licensee's failure to identify and correct a condition adverse to quality. Specifically, the licensee failed to identify an adverse trend in the performance of post maintenance testing on high-critical components. The licensee did not identify a trend or evaluate whether multiple equipment or component failures that in some instances complicated and challenged operators response to a scram were related to maintenance, or if there had been an opportunity to identify the issues through post-maintenance testing prior to returning equipment to service.

Description. During the problem identification and resolution inspection, the team identified five examples of high-critical components that failed to meet their function following maintenance, and in some cases complicated recovery following a scram. The licensee had failed to identify these multiple failures as an adverse trend:

- In May and June 2014, EC50035 implemented a chiller heater control circuit modification, and three chiller ECs (50103, 50104, and 50105) that modified the oil heater for HVK-CH21A, B, and C by disabling its operation while chiller is running. Following this design change, A and B oil heater logic contained an error that prevented the chiller oil heater from energizing while the chiller was in standby. The licensee determined that the post-modification plan had been inadequate because when B was returned to service, all required functions of the chiller and oil heater had not been verified to be functioning properly. (CR-RCS-2015-02660)

- From December 12–31, 2014, reactor feedwater pumps failed to start on five different occasions due to their breakers failing to close. The licensee experienced ten failures to close when required in the last five years, with eight of these failures being associated with the supply breaker (NPS-SWG1B-ACB28) for reactor feedwater pump 1B (FWS-P1B). This also contributed to complicating the December 25, 2014, scram recovery. The licensee modified maintenance procedures to correct this condition. The licensee documented this issue in CR-RBS-2015-06696.

- On January 9, 2013, the main control room received two alarms after the relay calibration of C33A-K10, which was part of the low-level setpoint setdown circuitry, due to inadequate post-maintenance testing. The licensee documented this condition CR-RBS-2013-07482.

- On December 6, 2014, the Division 2 reactor protection system (RPS) bus de-energized unexpectedly. This event involved the loss of RPS B bus voltage due to a loss of the B RPS motor-generator set when the Electrical Protection Assembly (EPA) breakers 3B/3D and the generator output breaker for RPS B were found tripped. The event occurred approximately 25 hours after the Division 2 RPS motor-generator had been aligned to the bus following voltage regulator replacement. The loss of RPS Bus B caused a Division 2 scram. The licensee addressed this issue in CR-RBS-2014-06233.

- In October 2014, the license replaced the startup feed regulating valve controller, but failed to perform adequate post-maintenance. As a result, an unidentified latent condition caused a failure of the controller, which resulted in complicating operators' recovery from a plant scram on December 25, 2014. In CR-RBS-2015-02812, the licensee identified that work order WO 52571888 had been issued to replace the valve during refueling outage RF-18, but had not been completed. Specifically, a task within the work order to perform online tuning had not been performed and the tuning following the card replacement could not be verified.

The team found that the failure to identify a programmatic trend reduced the reliability of multiple high-critical components whose failure could result in a significant impact to safe and reliable plant operation.

Analysis. The licensee's failure to promptly identify and correct a condition adverse to quality, as required by 10 CFR Part 50 Appendix B Criterion XVI, was a performance deficiency. The licensee failed to identify an adverse trend in the performance of post

maintenance testing on high-critical components. The performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the initiating event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the failure to identify a programmatic trend that reduced the reliability of multiple high-critical components whose failure could result in a significant impact to safe and reliable plant operation. Using Inspection Manual Chapter 0609, Appendix A, the team determined that this finding was of very low safety significance (Green) because it did not involve the loss of mitigation equipment or a support system. The finding has a human performance cross-cutting aspect associated with resources, in that the licensee leaders failed to ensure that personnel, equipment, procedures, and resources are available and adequate to support nuclear safety (H.1). Specifically, the licensee failed to evaluate a trend in degraded critical component conditions or malfunctions for multiple high critical components.

Enforcement. Title 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," states, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to the above, the licensee failed to establish measures to assure that a condition adverse to quality was promptly identified and corrected. Specifically, the licensee failed to identify and correct an adverse trend in the performance of post-maintenance testing on high-critical components. The licensee addressed this deficiency by entering this condition into this corrective action program. Because this violation is of very low significance (Green) and was entered into the licensee's corrective action program as CR-RBS-2015-04795, this violation is being treated as a non-cited violation (NCV), consistent with Section 2.3.2 of the Enforcement Policy: NCV 05000458/2015008-04, "Failure to Identify an Adverse Trend in the Performance of Post Maintenance Testing on High Critical Components."

.6 Review of Open Items

(Closed) Licensee Event Report (LER) 05000458/2014-006-00, Automatic Reactor Scram and Primary Containment Isolation Due to Loss of Power on the Division II Reactor Protection System with a Concurrent Division I Half-Scram

The licensee event report described a reactor scram that occurred on December 25, 2014, while the plant was operating at approximately 85 percent power. This event resulted from the loss of power on the Division II reactor protection system bus in conjunction with a pre-existing half scram on Division I. Four minutes after the scram, reactor water level increased to the Level 8 setpoint, causing the running main feedwater pump to trip. Operators attempted to re-start main feedwater pump C, but its supply breaker failed to close. The station started main feedwater pump A. The startup feedwater regulating valve should have opened to establish control, but the valve failed to open, and reactor pressure vessel level decreased slightly below the level 3 setpoint, resulting in a second scram signal. The station placed C feedwater regulating valve in service, and restored feed, and raised reactor pressure vessel water level above the Level 3 setpoint, and maintained vessel level in a normal shutdown band.

The resident inspectors responded to the site, interviewed plant personnel, and reviewed plant parameters and conditions. One of two special inspection teams was chartered to investigate the particulars of this scram and began inspection activities onsite on

January 26, 2015. The site performed an apparent cause evaluation (CR-RBS-2014-06602) that was rejected by the CARB based on the quality and facts associated with the investigation, which did not fully address the condition identified during the reactor scram (CR-RBS-2015-01615). Condition Report CR-RBS-2015-02812 documents that Work Order WO 52571888 to replace the Start-up Feedwater Regulating Valve, which was performed in refueling outage RF-18, was closed, but had not been completed. Task 03 to perform online tuning had not been performed, and the tuning following the card replacement could not be verified. The problem identification and resolution team reviewed the licensee's design control, post-maintenance testing, and the overall replacement of the controller for the startup feed regulating valve. The performance deficiencies and other significance and enforcement aspects of the issues related to this event are discussed in Special Inspection Report 05000458/2015008 and in Section 4OA2.5.d above. [Licensee Even Report (LER) 05000458/2014-006-00 is closed.]

4OA6 Meetings, Including Exit

Exit Meeting Summary

On July 2, 2015, the inspectors presented the inspection results to Mr. Eric Olson, Site Vice President, and other members of the licensee staff. The licensee acknowledged the issues presented. The licensee confirmed that any proprietary information reviewed by the inspectors had been returned or destroyed.

ATTACHMENTS:
1. Supplemental Information
2. Information Request

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

C. Blankenship, Sr. HP/Chemistry Specialist
T. Brumfield, Director, Regulatory and Performance Improvement
P. Chapman, ILD Power, Inc.
L. Creekbaum, ECP Coordinator
K. Crissman, Sr. Manager, Maintenance
M. Freeman, Sr. CAA Specialist
R. Horn, Radiation Protection Technician
K. Huffstatler, Sr. Licensing Specialist
K. Klamert, Sr. Engineer
R. Leasure, Manager (Acting), Radiation Protection
P. Lucky, Manager, Performance Improvement
R. Mayeux, ILD Power, Inc.
J. Reynolds, Sr. Manager, Operations
E. Roan, Sr. Staff Engineer
G. Wascom, Sr. CAA Specialist

NRC Personnel

J. Sowa, Senior Resident Inspector, River Bend Station

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000485/2015008-01	FIN	Failure to Recognize Violations of Contamination Control Requirements as Adverse Conditions (Section 4OA2.5.a)
05000458/2015008-02	FIN	Failure to Promptly Document Adverse Conditions in the Corrective Action Program (Section 4OA2.5.b)
05000458/2015008-03	NCV	Failure to Preclude Repetition of Consequential Gaps in Operator Performance (Section 4OA2.5.c)
05000458/2015008-04	NCV	Failure to Identify an Adverse Trend in the Performance of Post Maintenance Testing on High Critical Components (Section 4OA2.5d)

Closed

05000458/2014-006-00	LER	Automatic Reactor Scram and Primary Containment Isolation Due to Loss of Power on the Division II Reactor Protection System with a Concurrent Division I Half-Scram (Section 4OA2.6.b)

Discussed

05000458/2013007-01	VIO	Failure to Resolve Noncompliance Associated with Multiple Spurious Operations in a Timely Manner (Section 4OA2.6.a)

LIST OF DOCUMENTS REVIEWED

Procedures

Number	Title	Revision
EIP-2-001	Classification of Emergencies	25
EN-DC-117	Post Modification Testing and Special Instructions	7
EN-DC-203	Maintenance Rule Program	3
EN-DC-204	Maintenance Rule Scope and Basis	3
EN-DC-205	Maintenance Rule Monitoring	5
EN-DC-206	Maintenance Rule (a)(1) Process	3
EN-DC-345	Critical Component Failure Determination	3
EN-FAP-LI-001	Condition Review Group (CRG)	5
EN-FAP-LI-003	Corrective Action Review Board (CARB) Process	16
EN-FAP-LR-007	Evaluation of Aging Management Programs	6
EN-FAP-OP-006	Operator Aggregate Impact Index Performance Indicator	2
EN-FAP-WM-011	Work Planning Standard	3
EN-HU-101	Human Performance Program	15
EN-HU-102	Human Performance Traps and Tools	13
EN-HU-105	Human Performance – Managed Defenses	15
EN-LI-102	Corrective Action Program	21-24
EN-LI-102-02	CR Closeout Review	9
EN-LI-104	Self-Assessment and Benchmark Process	11
EN-LI-118	Cause Evaluation Process	18-21
EN-LI-118-03	Barrier Analysis	1
EN-LI-118-11	Why Staircase	0
EN-OE-100	Operating Experience Program	23
EN-OE-100-01	IER Level 1 and Level 2 Evaluations and Effectiveness Reviews	1
EN-OE-100-02	Operating Experience Evaluations	1
EN-OP-115	Conduct of Operations	15
EN-RP-100	Radiation Worker Expectations	9
EN-RP-102	Radiological Controls	4
EN-RP-108	Radiation Protection Posting	15

Procedures

Number	Title	Revision
EN-RP-121	Radioactive Material Control	10
EN-WM-100	Work Request (WR) Generation, Screening and Classification	10
EN-WM-102	Work Implementation and Closeout	9
EN-WM-105	Planning	15
EN-WM-107	Post Maintenance Testing	4
EOP-0001	Emergency Operating Procedure – RPV Control	026
OSP-0022	Operations General Administrative Guidelines	77, 78, 82
RBNP-097	Control and Use Of Temporary Hoses	8
RPP-0005	Radiological Postings	29
RSP-0008	Offsite Dose Calculation Manual (ODCM)	14
STP-000-6606	Section XI Safety and Relief Valve Testing	025
STP-204-6301	DIV I LPCI (RHR) Pump and Valve Operability Test	026
STP-204-6302	DIV II LPCI (RHR) Pump and Valve Operability Test	029
STP-204-6303	DIV I RHR Quarterly Valve Operability Test	021
STP-204-6304	DIV II RHR Quarterly Valve Operability Test	022
STP-204-6501	DIV I ECCS Check Valve Operability Test	002
STP-204-6502	DIV II ECCS Check Valve Operability Test	002
STP-204-6603	RHR System Refuel Pressure Isolation Valve Test	006
STP-204-6604	RHR System Refuel Valve Operability Test	301
STP-204-6801	DIV I ECCS Cold Shutdown Valve Operability Test	012
STP-204-6802	DIV II ECCS Cold Shutdown Valve Operability Test	010
TSP-0018	Loop C RHR System Leak Test	5B

Training Documents

Number	Title	Revision
RLP-STM-0204	Operations Training – Residual Heat Removal (RHR) System	2
RPPT-STM-0204-ILO	RHR System	0

Training Documents

Number	Title	Revision
RPPT-STM-0204-LOR	Residual Heat Removal	0
RSMS-OPS-314	Simulator Training – Saboteur Loss of Inventory with SDC in Service	02
RSMS-OPS-0321	Simulator Training – RPV Head Off – Refueling – LOP – Fuel Bundle in IFTS – Loss of SDC	4

Other Documents

Number	Title	Revision/Date
	Entergy Quality Assurance Program Manual	29
	On-Line Operations Aggregate Index (OAI)	April 30, 2015
	On-Line Operations Aggregate Index (OAI)	May 31, 2015
	On-Line Operations Aggregate Index (OAI)	June 30, 2014
	On-Line Operations Aggregate Index (OAI)	August 27, 2014
	On-Line Operations Aggregate Index (OAI)	September 30, 2014
	On-Line Operations Aggregate Index (OAI)	October 31, 2014
	On-Line Operations Aggregate Index (OAI)	November 30, 2014
	On-Line Operations Aggregate Index (OAI)	November 30,2014
	On-Line Operations Aggregate Index (OAI)	December 3, 2014
	River Bend Recovery Plan	00
	River Bend Station Operations Standards and Expectations	53, 87
	System 410 and 200 (a)(1) History Summary	July 1, 2015
	Total Operations Aggregate Index (OAI)	July 31, 2015
	Total Operations Aggregate Index (OAI)	February 28, 2015
	Total Operations Aggregate Index (OAI)	March 31, 2015
	Total Operations Aggregate Index (OAI)	July 31, 2014
	Total Operations Aggregate Index (OAI)	July 29, 2014
	Total Operations Aggregate Index (OAI)	August 31, 2014
	Total Operations Aggregate Index (OAI)	September 24, 2014
	Total Operations Aggregate Index (OAI)	December 31, 2014
	Total Operations Aggregate Index (OAI)	August 20, 2014

Other Documents

Number	Title	Revision/Date
	Total Operations Aggregate Index (OAI)	September 17, 2014
	Total Operations Aggregate Index (OAI)	December 10, 2014
00108828	Procurement Engineering Evaluation for Manual Control Unit Feedwater System (C33-R602-2/Manual)	July 16, 2012
00108829	Procurement Engineering Evaluation for Unit, Logic (C33-R602-3/Logic)	July 16, 2012
00108834	Procurement Engineering Evaluation for Control Unit (C33-R602-1/Auto)	July 16, 2012
G13.18.2.6*183	Subsystem Fill Pumps Calculation of TDH, NPSH, and Heat Dissipation Capabilities	3
LO-RLO-2013-00104	Operating Experience Program Assessment	January 17, 2014
LO-RLO-2014-00103	Radioactive Shipping Documentation	April 15, 2015
WTRBS-2015-0213	Radiation Protection Recover Plan	May 6, 2015

Operating Experience Documents

Number	Title
CR-ANO-C-2013-3001	2013 INPO Evaluation Area for Improvement (OP.1-1) During simulated events, operators and supervisors are not proficient in the implementation of some Emergency Operating Procedure (EOP) strategies
CR-ANO-C-2014-0022	INPO AFI on Operation's Errors During Plant Configuration Changes
CR-CNS-2014-03926	Operator knowledge gaps
CR-IP2-2014-02351	INPO 2103 E&A Performance Deficiency: RP
CR-JAF-2014-1990	2014 WANO AFI (LF.1-2): In a few cases, managers and supervisors are not reinforcing standards and expectations to improve behaviors necessary to accelerate station improvement
CR-PNP-2014-1080	Unexpected Voltage in Fuse Block Holder
EPRI-21-TIN-2014-01	Performance Predictive Methodology (PPM) Motor Operated Valve (MOV) Software (versions 1.0 through 3.5)
GE-TIL-1920	Recommendations for NDT and Evaluation of Generator Fields

Number	Title
ICES-305245-20130928-(6)	ANO-1 Generator Stator Temporary Lifts Assembly Collapse While Removing the Original Stator from the Turbine Building Causing a Fatality and Extensive Damage to Turbine Building and Non Vital Electrical Distribution System
ICES-305633-20130817-(4)	Unusual Event - Inability to Confirm Fire in Protected Area
ICES-306442-20130803-(3)	Leakage Through Turbine/Condenser Expansion Joint (Dogbone) Results in Plant Shutdown
ICES-310444-20140503-(1)	Common Cause Evaluation NRC 95-002 White Finding Events
ICES-313638-20141122-(1)	Reactor Makeup Water Tank Contamination Caused By Internals Coating
INPO-IER-L2-14-26	Temporary Lift Assembly Failure Results in a Fatality, Loss of Off-site Power, Scram and Equipment Damage
INPO-IER-L3-13-30	Automatic Reactor Scram Following a 500-kV Insulator Flashover
INPO-IER-L3-13-33	Automatic Scram Following Closure of a Main Steam Isolation Valve
INPO-IER-L3-13-38	Reactor Scram Caused by Debris in Feedwater Regulator Control Valve
INPO-IER-L3-13-44	Manual Reactor Scram Resulting From Loss of Feedwater Control
INPO-IER-L3-13-51	Long-Standing Equipment Problems Complicate Scram Response
INPO-IER-L3-14-1	Improper Setpoints Lead to Generator Trip and Reactor Scram
INPO-IER-L3-14-11	Inadequate Communications Resulted in Cable Support Structure Damage
INPO-IER-L3-14-16	Delayed Dose Survey Led to Unplanned Worker Dose
NRC-21-EVENT-49370	Part 21 Issue On Rosemount Model 710DU Trip Units
NRC-21-EVENT-49809	Part 21 Interim Reporting Regarding Tricentric Triple Offset Butterfly Valves
NRC-21-SC-13-13	Rosemount 710 Trip Unit Radiological Qualification Concern
NRC-IN-2013-13	Deficiencies with Effluent Radiation Monitoring System Instrumentation
NRC-IN-2013-14	Potential Design Deficiency in Motor-Operated Valve Control Circuitry

Number	Title
NRC-IN-2013-15	Willful Misconduct/Record Falsification and Nuclear Safety Culture
NRC-IN-2013-18	Refueling Water Storage Tank Degradation
NRC-IN-2014-15	Inadequate Controls of Respiratory Protection Accessibility, Training, and Maintenance
NRC-RIS-2012-08-REV1	Developing Inservice Testing And Inservice Inspection Programs Under 10 CFR Part 52

Condition Reports (CRs) (CR-RBS-)

2008-02376	2012-02211	2013-03273	2013-07368	2014-01834	2014-04212	2015-00182
2008-05615	2012-02213	2013-03465	2013-07414	2014-01863	2014-04277	2015-00213
2009-02377	2012-02340	2013-03630	2013-07417	2014-01865	2014-04306	2015-00272
2010-00790	2012-02347	2013-03661	2013-07482	2014-01952	2014-04307	2015-00280
2010-02481	2012-02480	2013-04049	2013-07690	2014-01955	2014-04332	2015-00287
2010-03311	2012-03192	2013-04083	2014-00072	2014-02040	2014-04467	2015-00450
2010-03361	2012-03252	2013-04191	2014-00106	2014-02085	2014-04585	2015-00484
2010-03404	2012-03307	2013-04228	2014-00119	2014-02115	2014-04596	2015-00626
2010-03499	2012-03310	2013-04291	2014-00186	2014-02200	2014-04624	2015-00667
2010-03648	2012-03351	2013-04295	2014-00237	2014-02454	2014-04637	2015-01096
2010-03936	2012-03395	2013-04369	2014-00413	2014-02456	2014-04802	2015-01134
2010-04538	2012-03658	2013-04402	2014-00541	2014-02480	2014-05022	2015-01160
2010-05979	2012-03685	2013-04419	2014-00627	2014-02489	2014-05074	2015-01216
2010-06834	2012-03742	2013-04428	2014-00720	2014-02513	2014-05098	2015-01260
2011-00331	2012-04058	2013-04431	2014-00832	2014-02559	2014-05162	2015-01370
2011-00363	2012-04063	2013-04780	2014-00926	2014-02803	2014-05209	2015-01379
2011-00834	2012-05869	2013-05180	2014-00951	2014-02815	2014-05253	2015-01474
2011-01197	2012-06329	2013-05649	2014-00966	2014-02849	2014-05254	2015-01476
2011-01285	2012-06472	2013-06073	2014-01029	2014-02850	2014-05314	2015-01487
2011-01540	2012-07040	2013-06309	2014-01030	2014-02940	2014-05466	2015-01494
2011-01863	2012-07077	2013-06358	2014-01168	2014-03006	2014-05894	2015-01495
2011-01902	2013-00515	2013-06471	2014-01218	2014-03057	2014-05974	2015-01595
2011-02933	2013-00971	2013-06729	2014-01220	2014-03212	2014-06135	2015-01605
2011-03117	2013-01326	2013-06743	2014-01221	2014-03408	2014-06218	2015-01615
2011-03531	2013-01389	2013-06744	2014-01307	2014-03409	2014-06233	2015-01698
2011-03813	2013-01475	2013-06750	2014-01309	2014-03543	2014-06350	2015-01714
2011-04665	2013-01691	2013-06755	2014-01390	2014-03545	2014-06357	2015-01772
2011-05642	2013-01742	2013-06789	2014-01394	2014-03576	2014-06601	2015-01783
2011-05801	2013-01806	2013-06824	2014-01465	2014-03641	2014-06605	2015-01824
2011-06147	2013-01836	2013-06855	2014-01475	2014-03778	2014-06649	2015-02123
2011-07674	2013-01987	2013-06860	2014-01500	2014-03977	2014-06653	2015-02245
2011-09030	2013-02096	2013-06877	2014-01540	2014-04049	2014-06685	2015-02260
2011-09171	2013-02345	2013-07105	2014-01678	2014-04084	2014-06691	2015-02264
2011-09173	2013-02427	2013-07133	2014-01681	2014-04086	2014-06696	2015-02322
2012-00183	2013-02442	2013-07222	2014-01746	2014-04104	2015-00038	2015-02335
2012-01541	2013-03098	2013-07265	2014-01763	2014-04106	2015-00112	2015-02354
2012-01652	2013-03118	2013-07316	2014-01764	2014-04108	2015-00153	2015-02496

2015-02635 2015-02810 2015-02949 2015-03019 2015-03197 2015-03532 2015-03951
2015-02660 2015-02812 2015-02953 2015-03024 2015-03428 2015-03696 2015-04071

Work Orders

00257122 00304959 00323679 00327687 00360451 00398658 50688170
50986092 51038080 51514125 52251008 52331679 52341561 52428117
52456572

Self-Assessments

LO-RLO-2013-00107	
LO-RLO-2013-0028	Conduct of Operations
LO-RLO-2013-0063	SE EPRI Diesel Generator Reliability Tech Advisory Meeting
LO-RLO-2014-00145,	RBS Pre-Nuclear Industry Evaluation Program (NIEP), October 8, 2014
LO-RLO-2014-00175	
LO-RLO-2014-0026	Snubber Program Compliance with 10CFR503.55a
LO-RLO-2014-0078	Control of Supplemental Personnel BM
LO-RLO-2014-0098	Troubleshooting
LO-RLO-2014-0103	Radwaste Shipping
LO-RLO-2014-0104	Foreign Material Exclusion Snapshot Assessment
LO-RLO-2015-0010	Snapshot Assessment of NERC Standard PRC-005 Program
LO-RLO-2015-0012	Operator Aggregate Assessment of Plant Deficiencies
LO-RLO-2015-0059	Annual Snapshot Assessment of Selected Elements of EN-NS-2014
LO-RLO-2015-0104	Maintenance Fundamentals Incorporation in Training
LO-RLO-2015-0115	Loss of Shutdown Cooling
LO-RLO-2015-0121	Loss of Control Building Ventilation RF-18
OE-NOE-2014-00020	
QS-2013-RBS-015	
QS-2013-RBS-016	
QS-2013-RBS-018	
QS-2013-RBS-019	
QS-2013-RBS-020	
QS-2013-RBS-021	
QS-2013-RBS-022	
QS-2013-RBS-024	
QS-2013-RBS-026	
QS-2013-RBS-028	
QS-2013-RBS-029	
QS-2013-RBS-030	
QS-2013-RBS-031	
QS-2013-RBS-032	
QS-2013-RBS-033	
QS-2013-RBS-034	
QS-2013-RBS-035	
QS-2013-RBS-036	
QS-2013-RBS-037	
QS-2013-RBS-038	

Information Request
Biennial Problem Identification and Resolution Inspection
River Bend Station
April 20, 2015

Inspection Report: **50-458/2015008**
On-site Inspection Dates: **June 8–12 and June 29–July 2, 2015**

This inspection will cover the period from July 12, 2013, through July 2, 2015. All requested information is limited to this period or to the date of this request unless otherwise specified. To the extent possible, the requested information should be provided electronically in word-searchable Adobe PDF (preferred) or Microsoft Office format. Any sensitive information should be provided in hard copy during the team's first week on site; do not provide any sensitive or proprietary information electronically.

Lists of documents ("summary lists") should be provided in Microsoft Excel or a similar sortable format. Please be prepared to provide any significant updates to this information during the team's first week of on-site inspection. As used in this request, "corrective action documents" refers to condition reports, notifications, action requests, cause evaluations, and/or other similar documents, as applicable to River Bend Station.

Please provide the following information no later than May 26, 2015:

1. Document Lists
   Note: For these summary lists, please include the document/reference number, the document title, initiation date, current status, and long-text description of the issue.

   a. Summary list of all corrective action documents related to significant conditions adverse to quality that were opened, closed, or evaluated during the period

   b. Summary list of all corrective action documents related to conditions adverse to quality that were opened or closed during the period

   c. Summary lists of all corrective action documents that were upgraded or downgraded in priority/significance during the period (these may be limited to those downgraded from, or upgraded to, apparent-cause level or higher)

   d. Summary list of all corrective action documents initiated during the period that "roll up" multiple similar or related issues, or that identify a trend

   e. Summary lists of operator workarounds, operator burdens, temporary modifications, and control room deficiencies (1) currently open and (2) that were evaluated and/or closed during the period

   f. Summary list of safety system deficiencies that required prompt operability determinations (or other engineering evaluations) to provide reasonable assurance of operability

   g. Summary list of plant safety issues raised or addressed by the Employee Concerns Program (or equivalent) (sensitive information should be made available during the team's first week on site—do not provide electronically)

h. Summary list of all Apparent Cause Evaluations completed during the period

2. Full Documents with Attachments

a. Root Cause Evaluations completed during the period; include a list of any planned or in progress

b. Quality Assurance audits performed during the period

c. Audits/surveillances performed during the period on the Corrective Action Program, of individual corrective actions, or of cause evaluations

d. Functional area self-assessments and non-NRC third-party assessments (e.g., peer assessments performed as part of routine or focused station self- and independent assessment activities; do not include INPO assessments) that were performed or completed during the period; include a list of those that are currently in progress

e. Any assessments of the safety-conscious work environment at River Bend Station

f. Corrective action documents generated during the period associated with the following:

i. NRC findings and/or violations issued to River Bend Station

ii. Licensee Event Reports issued by River Bend Station

g. Corrective action documents generated for the following, if they were determined to be applicable to River Bend Station (for those that were evaluated but determined not to be applicable, provide a summary list):

i. NRC Information Notices, Bulletins, and Generic Letters issued or evaluated during the period

ii. Part 21 reports issued or evaluated during the period

iii. Vendor safety information letters (or equivalent) issued or evaluated during the period

iv. Other external events and/or Operating Experience evaluated for applicability during the period

h. Corrective action documents generated for the following:

i. Emergency planning drills and tabletop exercises performed during the period

ii. Maintenance preventable functional failures which occurred or were evaluated during the period

iii. Adverse trends in equipment, processes, procedures, or programs that were evaluated during the period

iv. Action items generated or addressed by offsite review committees during the period

3. Logs and Reports

a. Corrective action performance trending/tracking information generated during the period and broken down by functional organization (if this information is fully included in item 3.c, it need not be provided separately)

b. Corrective action effectiveness review reports generated during the period

c. Current system health reports, Management Review Meeting package, or similar information; provide past reports as necessary to include ≥12 months of metric/trending data

d. Radiation protection event logs during the period

e. Security event logs and security incidents during the period (sensitive information should be made available during the team's first week on site—do not provide electronically)

f. Employee Concern Program (or equivalent) logs (sensitive information should be made available during the team's first week on site—do not provide electronically)

g. List of training deficiencies, requests for training improvements, and simulator deficiencies for the period

Note: For items 3.d–3.g, if there is no log or report maintained separate from the corrective action program, please provide a summary list of corrective action program items for the category described.

4. Procedures
Note: For these procedures, please include all revisions that were in effect at any time during the period.

a. Corrective action program procedures, to include initiation and evaluation procedures, operability determination procedures, apparent and root cause evaluation/determination procedures, and any other procedures that implement the corrective action program at River Bend Station

b. Quality Assurance program procedures (specific audit procedures are not necessary)

c. Employee Concerns Program (or equivalent) procedures

d. Procedures which implement/maintain a Safety Conscious Work Environment

5. Other

a. List of risk-significant components and systems, ranked by risk worth

b. Organization charts for plant staff and long-term/permanent contractors

c. Electronic copies of the UFSAR (or equivalent), technical specifications, and technical specification bases, if available

d. For each day the team is on site,

i. Planned work/maintenance schedule for the station

ii. Schedule of management or corrective action review meetings (e.g. operations focus meetings, condition report screening meetings, CARBs, MRMs, challenge meetings for cause evaluations, etc.)

iii. Agendas for these meetings

Note: The items listed in 5.d may be provided on a weekly or daily basis after the team arrives on site.

All requested documents should be provided electronically where possible. Regardless of whether they are uploaded to an internet-based file library (e.g., Certrec's IMS), please provide copies on CD or DVD. One copy of the CD or DVD should be provided to the resident inspector at River Bend Station; three additional copies should be provided to the team lead, to arrive no later than May 26, 2014:

Eric A. Ruesch
U.S. NRC Region IV
1600 East Lamar Blvd.
Arlington, TX 76011-4511

PAPERWORK REDUCTION ACT STATEMENT

This request does not contain new or amended information collection requirements subject to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.). Existing information collection requirements were approved by the Office of Management and Budget, control number 3150-0011.

If you contest the violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region IV; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC resident inspector at the River Bend Station. If you disagree with a cross-cutting aspect assignment or a finding not associated with a regulatory requirement in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region IV, and the NRC resident inspector at the River Bend Station.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public Inspections, Exemptions, Requests for Withholding," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents 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/

Thomas R. Farnholtz, Chief
Engineering Branch 1
Division of Reactor Safety

Docket No. 50-458
License No. NPF-47

Enclosure:
Inspection Report 05000458/2015008
w/Attachment: Supplemental Information

cc w/encl: Electronic Distribution

Distribution
See next page

ADAMS ACCESSION NUMBER: ML15229A163

☒ SUNSI Review by: EAR	ADAMS: ☒ Yes ☐ No	☒ Non-Sensitive ☐ Sensitive	☒ Publicly Available ☐ Non-Publicly Available	Keyword: NRC-002

OFFICE	PE/DRS	PE/DRS	RI/DRP	RI/DRS	C:/DRP/PBC	SRI/DRS	C:EB1
NAME	CAlldredge:DCH	BBaca	ABarrett	SMakor	GWarnick	ERuesch	TFarnholtz
SIGNATURE	/RA/	/RA/-email	/RA/-email	/RA/	/RA/	/RA/	/RA/
DATE	8/6/15	8/7/15	8/11/15	8/6/15	8/10/15	8/12/15	8/13/15

OFFICIAL RECORD COPY

Letter to Eric W. Olson from Thomas R. Farnholtz, dated August 13, 2015

SUBJECT: RIVER BEND STATION – NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000458/2015008

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