



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

April 20, 2018

EA-16-247

Mr. Richard L. Anderson
Site Vice President
Entergy Operations, Inc.
Arkansas Nuclear One
1448 S.R. 333
Russellville, AR 72802-0967

SUBJECT: ARKANSAS NUCLEAR ONE, UNIT 2 – NRC SUPPLEMENTAL INSPECTION
REPORT 05000368/2018040

Dear Mr. Anderson:

On March 15, 2018, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental re-inspection using Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 Inputs," and discussed the results of this inspection with you and other members of your staff. On March 23, 2017, the NRC discussed the implementation of your corrective actions with you and other members of your staff. The results of this inspection are documented in the enclosed report.

The NRC performed this inspection to review your station's actions in response to a White finding in the Mitigating Systems Cornerstone which was documented in NRC Inspection Report 05000368/2016011 on January 19, 2017, (Agencywide Documents Access and Management System (ADAMS) Accession No. ML17019A288), and finalized in NRC Inspection Report 05000368/2017014 on February 27, 2017, (ADAMS Accession No. ML17055A727). This finding involved the failure to provide adequate lubrication to the Unit 2 emergency diesel generator A inboard generator bearing.

Previously in response to this Action Matrix input, on October 6, 2017, the NRC completed a supplemental inspection using Inspection Procedure 95001. However, the NRC concluded that your initial evaluation for the White finding was not of sufficient depth to ensure that the significant performance issues were fully understood, and that the extent of condition and extent of cause reviews did not adequately determine whether vulnerabilities existed in other plant components and other work instructions similar to the deficiency found with the Unit 2 emergency diesel generator A. Because these significant weaknesses were identified during the initial inspection, the NRC concluded that the inspection objectives were not met and the White finding was held open and continued to receive consideration as an Action Matrix input.

On February 20, 2018, you informed the NRC that Arkansas Nuclear One, Unit 2, was ready for the supplemental re-inspection.

The NRC performed this supplemental inspection to determine if: (1) the root and contributing causes of the significant performance issues were understood; (2) the extent of condition and extent of cause for the significant performance issues were identified; (3) the corrective actions taken to address and preclude repetition of significant performance issues were prompt and effective; and (4) the corrective action plans direct prompt actions to effectively address and preclude repetition of significant performance issues.

The NRC noted that your staff's revised evaluation identified that the primary root cause of the White finding was that Production Department leadership did not establish adequate governance to ensure safety-related, noncomplex work order instructions were written to maintain configuration of the 2K-4A emergency diesel generator sight glass scribe mark. Specifically, Production Department leadership did not take the actions necessary to ensure high standards of performance and consistent implementation of quality procedures to ensure nuclear safety is an overriding priority. The NRC determined that your staff identified appropriate corrective actions to revise the work planning governance procedure to support the planning organization in understanding risk and incorporating a level of detail in work instructions that is commensurate with risk and potential consequences, and to revise the emergency diesel generator surveillance procedure to ensure the sight glass is measured properly after maintenance. The NRC also determined that your staff's extent of condition and extent of cause evaluations adequately reviewed whether other safety-related, high risk components were susceptible to inadequate lubrication, and whether other site department's governance procedures impacted the configuration of safety-related and high critical equipment. Based on these determinations, the NRC concluded that all inspection objectives were satisfied.

The NRC inspector did not identify any finding or violation of more than minor significance.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at <http://www.nrc.gov/reading-rm/adams.html> and at the NRC Public Document Room in accordance with 10 CFR 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

/RA/

Neil O'Keefe, Chief
Branch E
Division of Reactor Projects

Docket No. 50-368
License No. NPF-6

Enclosure:
Inspection Report 05000368/2018040
w/ Attachment: Documents Reviewed

**U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report**

Docket Number(s): 50-368

License Number(s): NPF-6

Report Number(s): 05000368/2018040

Enterprise Identifier: I-2018-040-0002

Licensee: Entergy Operations, Inc.

Facility: Arkansas Nuclear One, Unit 2

Location: Junction of Highway 64 West and Highway 333 South
Russellville, Arkansas

Inspection Dates: March 12 through March 15, 2018

Inspector: F. Ramírez, Senior Resident Inspector

Approved By: N. O'Keefe, Chief
Branch E
Division of Reactor Projects

Enclosure

SUMMARY

The NRC continued monitoring the licensee's performance by conducting a Supplemental Inspection at Arkansas Nuclear One, Unit 2, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 Inputs," to assess the licensee's evaluation of a White finding associated with the failure to provide adequate lubrication for the inboard bearing of the Unit 2 emergency diesel generator A. As a result, the bearing overheated and caused the emergency diesel generator to fail on September 16, 2016, during a 24-hour endurance test. The licensee's revised root cause evaluation identified that the root cause was that Production Department leadership did not establish adequate governance to ensure that safety-related, noncomplex, work order instructions were written to maintain configuration of the 2K-4A emergency diesel generator sight glass scribe mark. The licensee defined governance as responsible management taking the actions necessary to ensure high standards of performance and consistent implementation of quality procedures to ensure nuclear safety is an overriding priority. The licensee determined that the contributing cause was that Relay craft and supervision demonstrated inadequate maintenance fundamentals of control and knowledge as defined by Procedure EN-MA-100, "Maintenance Fundamentals Program," Revision 3.

The NRC determined that completed or planned corrective actions were sufficient to address the performance issue that led to the White finding previously described and were prioritized commensurate with the safety significance of the issue. In addition, the NRC determined that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem and reached reasonable conclusions as to the root and contributing causes of the event.

After reviewing Arkansas Nuclear One's performance in addressing the White finding subject of this Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 Inputs," the NRC concluded that the actions taken met the objectives of the inspection. Therefore, Notice of Violation 05000368/2016011-01 is closed.

List of Findings and Violations

No findings were identified.

Additional Tracking Items

Type	Issue number	Title	Report Section	Status
NOV	05000368/2016011-01	Failure to Ensure Adequate Lubrication for Emergency Diesel Generator Bearing	95001	Closed

INSPECTION SCOPE

Inspections were conducted using the inspection procedure (IP) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at <http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html>. Documents reviewed by the inspector are listed in the documents reviewed section of this report. The inspector used the Commission's rules and regulations as the criteria for determining compliance along with established licensee standards as the criteria for assessing licensee performance.

The NRC performed this supplemental inspection in accordance with Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 Inputs," to assess the licensee's evaluation of a White finding, which affected the Mitigating Systems Cornerstone in the reactor safety strategic performance area. The inspection objectives were to:

- Objective 1: To assure that the root and contributing causes of significant performance issues were understood;
- Objective 2: To independently assess and assure that the extent of condition and extent of cause of significant performance issues were identified;
- Objective 3: To assure that corrective actions taken to address and preclude repetition of significant performance issues were prompt and effective;
- Objective 4: To assure that corrective action plans directed prompt actions to effectively address and preclude repetition of significant performance issues.

On February 27, 2017, the NRC issued Inspection Report 05000368/2017014 (ADAMS Accession No. ML17055A727), to document the final significance determination for the failure to provide adequate lubrication for emergency diesel generator A in Unit 2. On November 11, 2014, and June 22, 2016, while performing work on the emergency diesel generator A in Unit 2, the licensee failed to provide adequate work instructions for maintenance on the inboard generator bearing such that the minimum bearing oil level was correctly marked and maintained. As a result, the bearing overheated and caused the emergency diesel generator to fail on September 16, 2016, during a 24-hour endurance test. The extent of the damage from the failure led to shutting down Unit 2 to comply with technical specifications. The NRC characterized the finding as having low to moderate (White) safety significance.

A 95001 supplemental inspection was completed on October 6, 2017, and documented in Inspection Report 05000368/2017016 (ADAMS Accession No. ML17311A115). The NRC concluded that a significant weakness existed because the evaluation was not of sufficient depth to ensure that the significant performance issues were fully understood as described in Objective 1 of Inspection Procedure 95001. The NRC also identified significant weaknesses associated with the extent of condition and extent of cause reviews, as described in Objective 2, because the licensee's evaluation did not adequately determine whether vulnerabilities existed in other plant components and other work instructions similar to the deficiency found with the Unit 2 emergency diesel generator A. As a result of these significant weaknesses, the NRC determined that all of the inspection objectives were not met and the White finding was held open and continued to receive consideration as an Action Matrix input.

In response to the 95001 supplemental inspection results, the licensee re-performed the root cause evaluation under Condition Report CR-ANO-2-2016-03307. On February 20, 2018, the licensee informed the NRC that they were ready for the supplemental re-inspection. In preparation for the re-inspection, the licensee provided Revision 2 of the Root Cause Evaluation Report, "2K-4A EDG Inboard Bearing Failure," dated February 14, 2018, to the inspector for review.

The inspector reviewed the licensee's revised root cause evaluation and supplemental information that the licensee provided during the inspection period. The inspector held discussions with licensee personnel to determine if the root cause, contributing cause, and the contribution of safety culture components of the issue were understood, and that corrective actions taken or planned were appropriate to address the causes and preclude repetition. The highlights of the performance review and NRC's assessment are documented below.

REACTOR SAFETY

OTHER ACTIVITIES – TEMPORARY INSTRUCTIONS, INFREQUENT AND ABNORMAL

95001 - Supplemental Inspection Response to Action Matrix Column 2 Inputs

(1) Problem Identification and Root Cause Evaluation (Objective 1)

a. Scope

The inspector verified that the evaluation documented who identified the issue, which was self-revealed, and under what conditions the issue was identified. The inspector determined that the evaluation documented how long the issue existed and prior opportunities for identification. The inspector also determined that the evaluation documented significant plant-specific consequences and compliance concerns associated with the issue.

The inspector verified that the significant performance issues were evaluated using a systematic methodology. The inspectors evaluated whether the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem, and whether it included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

b. Assessment

The licensee re-evaluated the Unit 2 emergency diesel generator A (2K-4A) inboard bearing failure and identified one root and one contributing cause for this event. Specifically, the licensee's evaluation determined that the root cause of this event was that Production Department leadership did not establish adequate governance to ensure that safety-related, noncomplex, work order instructions were written to maintain configuration of the 2K-4A emergency diesel generator sight glass scribe mark. The licensee defined governance as responsible management taking the actions necessary to ensure high standards of performance and consistent implementation of quality procedures to ensure nuclear safety is an overriding priority. The licensee determined that the contributing cause was that Relay craft personnel and supervision demonstrated inadequate maintenance fundamentals of control and knowledge as defined by Procedure EN-MA-100, "Maintenance Fundamentals Program," Revision 3.

During the previous 95001 supplemental inspection, Significant Weakness 1 documented the NRC's conclusion that even though the licensee identified that the work planning function contributed to the inboard bearing failure, and that the potential risk associated with the intended work was not understood, the causes for these items were not identified. In addition, the inspectors noted that the process for ensuring that work instruction details are appropriate for the skill of the craft who would perform the work had not been evaluated.

After re-performing the root cause evaluation, as documented in Revision 2 of Condition Report CR-ANO-2-2016-03307, the licensee concluded that planning personnel often viewed risk as the probability of a failure without considering the potential consequence of a failure. When planning personnel prepared work instructions for tasks that they considered simple, such as fixing a small leak in a sight glass, they did not fully consider the potential consequences to nuclear safety associated with errors that might occur during the work. The licensee's root cause evaluation also concluded that a lack of guidance for work planning personnel resulted in them applying their own standards of risk and the level of work instruction detail needed for the tasks being planned. As a result, the licensee identified and addressed weaknesses in the process of planning work on safety-related and high critical equipment, such as the definition and understanding of "risk" and "critical dimensions", the use of available resources to get an understanding of equipment safety function and critical dimensions, the incorporation of vendor manual information into work instructions, and incorporating the proper level of detail into work packages. The licensee's corrective actions to address these weaknesses are discussed in Objective 3 below.

The inspector determined that the licensee's evaluation adequately addressed Significant Weakness 1 previously identified after evaluating the planning department's contribution to the Unit 2 emergency diesel generator A bearing failure. The inspector also concluded that the root and contributing causes of the significant performance issue were understood. As a result, Inspection Objective 1 is met.

(2) Extent-of-Condition, and Extent-of-Cause Evaluation (Objective 2)

a. Scope

The inspector verified that the significant performance issues were evaluated using a systematic methodology. The inspector evaluated whether the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem, and that it included a consideration of prior occurrences of the problem and knowledge of prior operating experience. Additionally, the inspector assessed whether the root cause evaluation addressed the extent of condition and the extent of cause associated with the significant performance issues, and assessed whether the licensee appropriately considered safety culture traits in NUREG-2165, "Safety Culture Common Language," referenced in Inspection Manual Chapter 0310, "Aspects within Cross-Cutting Areas," dated December 4, 2014. The licensee did not perform a common cause analyses for potential programmatic weaknesses in performance since only one White finding currently exists in the affected cornerstone.

b. Assessment

The inspector determined that the licensee re-performed the root cause evaluation using systematic methodologies and was conducted to a level of detail commensurate with the significance of the problem. The identified causes, discussed in the previous section of this inspection report, are the result of an aggregate review using multiple analytical techniques. The inspector also determined that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

As documented in NRC Inspection Report 05000368/2017016, Significant Weakness 2 documented the NRC's conclusion that the licensee's initial extent of condition review did not cover an adequate population of risk-significant equipment where adequate lubrication is necessary to support the function and mission time of safety-significant equipment. After re-performing the root cause evaluation, as documented in Revision 2 of CR-ANO-2-2016-03307, the licensee's extent of condition review was expanded to include a significant number of components. The extent of condition review included Unit 1 emergency diesel generators, and all other safety-related, critical or high probabilistic risk assessment (PRA) risk equipment in both units which require any type of lubrication, and could be susceptible to improper configuration or lack of monitoring. Specifically, the extent of condition review included a risk-based review and evaluation of lubricated safety-related rotating equipment with oil lubricated bearings (including sight glasses and bullseyes), critical rotating equipment (including grease and oil lubrication), and risk significant PRA components (including pump couplings, electrical equipment, valve operators, and rotating equipment not previously identified in Revision 1 of the root cause evaluation). The licensee's extended review identified some issues including the need for better methods of marking some sight glasses, and a level discrepancy on a safety-related pump that did not affect operability. The licensee entered these issues into the correction action program and corrected them as they were identified.

In NRC Inspection Report 05000368/2017016, Significant Weakness 3 documented the NRC's conclusion that the licensee's original extent of cause review did not consider whether a lack of technical detail and vendor information existed for procedures and work orders for components without sight glasses. However, when the licensee re-performed the root cause evaluation, it resulted in the identification of a new root cause as documented in Revision 2 of CR-ANO-2-2016-03307. In the new root cause evaluation, the licensee extended the root cause, which focused on Production Department leadership, to other departments that could potentially impact the configuration of safety-related and high critical equipment. Specifically, the licensee evaluated leadership and governance (site and fleet procedure) in Work Management, Fix-It-Now Team, Maintenance Support and Projects, Engineering, Operations, and Maintenance to evaluate if they impacted the operability of safety-related and high critical components.

The revised root cause evaluation also extended the contributing cause, which did not change from the original root cause evaluation. Since the contributing cause focused on technicians and supervisors demonstrating inadequate maintenance fundamentals, the extent of contributing cause reviewed site organizations to identify gaps in their respective fundamentals. The organizations reviewed included Operations, Chemistry, Radiation Protection, Maintenance, and Maintenance Support and Projects.

The licensee's root cause evaluation included a review of whether weaknesses in any safety culture aspect contributed to the significant performance issue. The revised root cause evaluation identified nine safety culture aspects that were related to the identified root and contributing causes. Within the area of human performance, weaknesses in the aspects of resources (H.1), work management (H.5), design margins (H.6), documentation (H.7), training (H.9), and avoid complacency (H.12) were identified. Within the area of supplemental cross-cutting aspects, weaknesses in the areas of leader behaviors (X.5), standards (X.6), and job ownership (X.7) were identified. The organization did not ensure that procedures were in place to maintain the configuration of the emergency diesel generator sight glass, and it did not plan, control, and execute work activities on the emergency diesel generator sight glass commensurate with risk.

The inspector determined that the licensee's evaluation adequately addressed Significant Weaknesses 2 and 3, and that the extent of condition and extent of cause of the significant performance issues were adequately identified. The reviews performed for the new root cause were also adequate. As a result, Inspection Objective 2 is met.

(3) Corrective Actions Taken (Objective 3)

a. Scope

The inspector reviewed the licensee's revised cause evaluation to assess whether appropriate corrective actions were specified for the revised root and contributing causes or that the licensee had an adequate evaluation for why no corrective actions were necessary. The inspector also assessed whether the corrective actions had been prioritized with consideration of the significance and regulatory compliance. The inspector evaluated whether the corrective actions taken to address and preclude repetition of significant performance issues were prompt and effective, and whether the Notice of Violation related to the supplemental inspection was adequately addressed.

b. Assessment

The licensee's revised root cause evaluation identified and completed corrective actions in addition to the ones that were inspected and documented in NRC Inspection Report 05000368/2017016. Revision 20 to Procedure EN-WM-105, "Planning," was implemented to define "risk" in relationship to probability of occurrence and potential consequence, to remove a statement that allowed planners to not include detailed instructions in work packages, and to add the requirement that work packages be planned to include the level of detail needed to support having a minimum qualified worker successfully perform the work.

Additional revisions to Procedure EN-WM-105 included defining "critical dimensions" to ensure a component is returned to its design configuration following work activities; adding a requirement for planners to get an understanding of the equipment, its safety function, operational characteristics, critical dimensions, and acceptance criteria to incorporate critical dimensions and acceptance criteria in detailed work instructions; adding a requirement for planners to review vendor manuals when developing work instructions to incorporate critical dimension in detailed work instructions; and adding review of vendor recommendations and critical dimensions and acceptance criteria requirements to the work package quality checklist.

The inspector reviewed the implementation of these new corrective actions (Condition Report CR-ANO-2-2016-03307, Corrective Action Nos. 74 and 83) and concluded that they were adequate to address the root cause of the significant performance issue which was associated with Production Department leadership not establishing adequate governance to ensure that safety-related, noncomplex, work order instructions were written to maintain configuration of the 2K-4A emergency diesel generator sight glass scribe mark. The inspector also determined that the new corrective actions taken had been prioritized and completed with consideration of the significance and regulatory compliance.

The inspector concluded that by completing the corrective actions to prevent recurrence inspected in NRC Inspection Report 05000368/2017016, and the ones listed above, the licensee restored compliance from the NRC Notice of Violation issued on February 27, 2017, for the failure to ensure adequate lubrication to the inboard generator bearing. The Notice of Violation was documented in NRC Inspection Report 05000368/2017014. As a result, Inspection Objective 3 is met.

(4) Corrective Actions Planned (Objective 4)

a. Scope

The inspector reviewed the licensee's root cause evaluation to assess whether appropriate corrective action plans were specified for each root and contributing cause or that the licensee had an adequate evaluation for why no corrective actions are necessary. The inspector also assessed whether the corrective actions had been prioritized with consideration of the significance and regulatory compliance. The inspector evaluated whether the corrective action plans to address and preclude repetition of significant performance issues were prompt and effective, and that appropriate quantitative or qualitative measures of success have been developed for determining the effectiveness of planned corrective actions.

b. Assessment

The licensee's revised root cause evaluation identified and planned corrective actions in addition to the ones that were inspected and documented in NRC Inspection Report 05000368/2017016. Some of the corrective action plans include reviewing safety-related and high critical work orders, Fix-It-Now work orders, and corrective maintenance and preventive maintenance work orders to ensure the newly-established planning requirements are met; reviewing governance procedures for maintenance and engineering to identify gaps in maintaining critical dimensions in plant equipment; developing a training plan in accordance with Procedure EN-TQ-129, "Planner Training Program;" and performing an analysis for Chemistry, Radiation Protection, and Operations to identify gaps in each department's fundamentals. The licensee documented these planned actions in Condition Report CR-ANO-2-2016-03307, Corrective Actions Nos. 75, 77, 78, 80 through 82, and 84 through 86.

The inspector reviewed the planned corrective actions and determined that they have been prioritized to be completed with consideration of the significance and regulatory compliance and were adequate to address the causes identified. The inspector also determined that the licensee had developed effectiveness review plans for the corrective actions to prevent recurrence. As a result, Inspection Objective 4 is met.

(5) Evaluation of IMC 0305 Criteria for Treatment of Old Design Issues

The licensee did not request credit for self-identification of an old design issue; therefore, the risk-significant issue was not evaluated against the Inspection Manual Chapter 0305, "Operating Reactor Assessment Program," dated November 17, 2016, criteria for treatment of an old design issue.

(6) Assessment of Licensee's Evaluation and Corrective Actions

The inspector determined that completed and planned corrective actions were sufficient to address the performance issue that led to the White finding and were prioritized commensurate with the safety significance of the issue. In addition, the inspector determined that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem and reached reasonable conclusions as to the root and contributing causes of the event.

After reviewing the licensee's performance in addressing the White finding subject of this Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 Inputs," the inspector determined that all four inspection objectives were met and the three significant weaknesses identified in the previous inspection were adequately addressed. Therefore, this finding and associated Notice of Violation are closed. (NOV 05000368/2016011-01, "Failure to Ensure Adequate Lubrication for Emergency Diesel Generator Bearing").

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

On March 15, 2018, the inspector conducted an exit meeting with the supplemental inspection results to Mr. R. Anderson, Site Vice President, and other members of the licensee staff.

DOCUMENTS REVIEWED

95001 - Supplemental Inspection Response to Action Matrix Column 2 Inputs

Miscellaneous Documents

<u>Number</u>	<u>Title</u>	<u>Revision/Date</u>
	ANO System High Risk Rankings	March 8, 2018
	Matrix of NRC 95001 Inspection Report (11-07-2017) to RCE [Root Cause Evaluation] EDG [Emergency Diesel Generator] RCE (Revision 2)	February 21, 2018
	Matrix: NRC 95001 Inspection Report (11-07-2017) to EDG RCE Revision 2 (02-14-2018)	February 25, 2018
	T+1 Meeting Week Critique for 3-5-18	March 14, 2018
	Unit 1 High Safety Significance List	March 13, 2018
	Unit 2 High Safety Significance List	March 13, 2018
EC 74158	Oil Level Verification Information for ANO Safety Related Pumps Extent of Condition Oil Level Verifications for CR-ANO-2-2016-03307 – Revision 2	0
PQRT	Planning Quality Review Team – PQRT Monthly Rollup	December 18, 2017
PQRT	Planning Quality Review Team – PQRT Monthly Rollup	January 30, 2018
PQRT	Planning Quality Review Team – PQRT Monthly Rollup	February 20, 2018

Procedures

<u>Number</u>	<u>Title</u>	<u>Revision</u>
EN-MA-100	Maintenance Fundamentals Program	3
EN-MA-101	Conduct of Maintenance	25
EN-MA-105	Control of Measuring and Test Equipment	13
EN-MA-125	Troubleshooting and Control of Maintenance	22
EN-MA-145	Maintenance Standard for Torque Applications	9
EN-WM-105	Planning	20
EN-WM-100	Work Request Generation, Screening and Classification	13

Condition Reports (CR-ANO-)

2-2016-03307	C-2017-03618	C-2017-03619	C-2017-03620
C-2017-03672	C-2017-05068	C-2017-05087	C-2017-05225
LO-ALO-2018-00039			

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