Entergy

Entergy Operations, Inc.
River Bend Station
5485 U.S. Highway 61N
St. Francisville, LA 70775
Tel 225-381-4374

Eric W. Olson
Vice President, Operations
River Bend Station

November 28, 2011

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

RBG-47190

Subject: Additional Information Regarding November 21, 2011, Predecisional Enforcement Conference
River Bend Station – Unit 1
Docket No. 50-458
License No. NPF-47

Reference: 1) NRC Letter EA-11-159, Closed Predecisional Enforcement Conference with River Bend Station, November 2, 2011
2) NRC Confirmatory Order EA-09-060, dated November 10, 2009

During the Predecisional Enforcement Conference (PEC – Reference 1) on November 21, 2011, personnel from Entergy Operations, Inc. (Entergy) discussed actions taken at River Bend Station to prevent reoccurrence of the subject violation. As the Entergy representatives discussed, the immediate cause of the violation was a failure of Entergy licensed operators to exercise individual accountability with regard to strict procedural compliance. However, Entergy has taken a broad set of actions to address such things as safety culture, training, and procedural compliance, as well as personal accountability to lessen the potential for recurrence.

Attachment 1 of this letter describes the actions Entergy has taken to prevent reoccurrence. Some of these actions were taken in direct response to the operators' failures, while others were taken to improve fleet or station performance, or to address other issues. Some, but not all these actions were discussed at the PEC.

This letter contains no new regulatory commitments. Should you have any questions, please contact Mr. Joseph Clark, at (225) 381-4177.

Eric W. Olson

EWO/jac/wjf
Attachment 1, Actions Taken To Prevent Recurrence
Enclosure 1, Training Lesson Plan FSEM-ADM-50.5-50.9 COMPL
Enclosure 2, Training Lesson Plan FCBT-ADM-50.5-50.9 COMPL
Enclosure 3, Root Cause Analysis Report (CR-RBS-2011-03296)
Enclosure 4, Site Procedure ADM-0099
Enclosure 5, Fleet Procedure EN-FAP-OM-001
Enclosure 6, RBS Superviser Training (Nuclear Safety Culture)
Enclosure 7, Fleet Procedure EN-FAP-DC-007

A001
NRR

cc: U.S. Nuclear Regulatory Commission
Region IV
612 East Lamar Blvd., Suite 400
Arlington, TX 76011
Attn: Mark Haire

NRC Resident Inspector
PO Box 1050
St. Francisville, LA 70775

Mr. Alan Wang, Project Manager
U.S. Nuclear Regulatory Commission
MS O-8B1
11555 Rockville Pike
Rockville, MD 20852-2738

RBG-47190

Attachment 1

Actions Taken To Prevent Recurrence

Actions Taken To Prevent Recurrence

Fleet-Wide Training on Completeness and Accuracy of Information and Deliberate Misconduct

Entergy provided fleet-wide training intended to improve human performance and personal accountability. This training is discussed in Sections III and V of Confirmatory Order EA-09-060 (Reference 2). As a central focus, the course highlighted NRC regulatory requirements 10 CFR 50.9 (completeness and accuracy of information) and 10 CFR 50.5 (deliberate misconduct), but also addressed regulatory policy and penalties for noncompliance, Entergy requirements, best practices, fleet and industry operating experience, and among other things, Entergy's Four Platforms of:

- Trust – Honesty – Fairness – Integrity;
- Be Deliberate – Actions Under Control – Follow the Rules;
- Set and Continuously Reinforce High Standards; and
- Do What You Say You Will Do.

Instructor-Based sessions of the 10 CFR 50.5 / 50.9 (FSEM-ADM-50.5-50.9 COMPL – Enclosure 1) training (taught by senior management personnel) was provided in the June-October, 2010 time frame to:

- Supervisors and above, including SROs
- Engineering Support
- Project Management
- Licensing Department

Computer based training sessions of 10 CFR 50.5 / 50.9 (FCBT-ADM-50.5-50.9 COMPL – Enclosure 2) was provided to the remaining population in the July-October, 2010 time frame.

Actions Arising From a Root-Cause Evaluation of an Adverse Trend at River Bend Station

As a result of the findings of the At-The-Controls (ATC) operator internet investigation and other incidents and issues across the organization, RBS senior management recognized the existence of an adverse trend in the RBS nuclear safety culture. On April 4, 2011, the station initiated rollup Condition Report CR-RBS-2011-03296 to address the adverse trend. A Root Cause Analysis (Enclosure 3) was performed and actions were initiated to address this trend at a site level rather than just the Operations department.

The following summarizes actions taken as a result of the Root Cause Evaluation that addresses potential behavior issues such as those related to ATC Operator internet usage.

1. The station conducted all-employee meetings to inform the organization of the issue and provide a brief discussion of each contributing event, the safety culture implications, and the actions the organization would take to improve the site's commitment to a safety conscious work environment. In these meetings the site vice president discussed expectations for procedure compliance and emphasized that situation standards would not be tolerated.

2. Established a structure for continued self-assessment of department performance/behaviors against established standards / fundamentals using cross discipline team members (e.g., Focused Crew Observations). By performing these observations, the station can improve performance across the site by being engaged and intrusive. The insight from these observations will help each department to identify and correct weaknesses and gaps. In addition, performance gaps are also documented and analyzed in Department/Crew Level Performance Improvement Notebooks. The Notebooks are an all inclusive look at department and/or crew level performance and gives the senior leadership team a "real-time" look at how well each leader is driving performance in their respective area. Periodic reviews of the Notebooks by the senior leadership team are conducted to ensure that weaknesses are being identified and addresses appropriately and that each responsible leader is being engaged and intrusive and is driving performance by changing worker behaviors. Site administrative procedure ADM-0099, River Bend Continuous Improvement Process, (Enclosure 4) along with fleet administrative procedure EN-FAP-OM-001, Leadership Forums for Continuous Improvement, (Enclosure 5) institutionalize this process.

   Operations conducts these focused observations three times a month and includes both Control Room and field observations. Other selected departments (Maintenance, Radiation Protection, Chemistry, and Security) perform them at a similar frequency. Engineering also performs focused crew assessments per fleet administrative procedure EN-FAP-DC-007, Engineering Focused Crew Assessments, (Enclosure 7).

3. Developed and implemented a comprehensive program to establish nuclear safety culture as the overriding station priority. This program includes the following:

   - A Nuclear Safety Culture Committee with the purpose of creating a safety-conscious work environment that internalizes and promotes the concept of safety culture as it applies to every employee from the board of directors to the individual contributor. The committee is comprised of both supervisory and worker level individuals. The committee reviews condition reports, observes work, conducts surveys, and reviews observations to look for trends.
   - Monitoring
   - Evaluation
   - Communication

4. Providing Nuclear Safety Culture training to RBS Supervisors, Superintendants, and Managers (Enclosure 6). The training used various case studies to illustrate how degradation of management standards can lead to station events.

5. Implemented a process to provide meeting notes of the periodic Leadership & Alignment meeting to supervisors to review with their direct reports. This action ensures that information from the meetings is delivered to the workers. The station conducts Leadership and Alignment Meetings each week for supervisors and above that focus on both department and site performance and trends.

6. Communicated the results of the root cause to personnel across the station.

RBG-47190

Enclosure 1

Training Lesson Plan FSEM-ADM-50.5-50.9 COMPL

[redacted]

[redacted]

This form is used to approve fleet training materials that do not have a review/approval block.

*TRAINING MATERIAL NUMBER:

FSEM-ADM-50.5-50.9 COMPL Rev 2

*TRAINING MATERIAL TITLE:

Completeness and Accuracy of Information and Deliberate Misconduct Training

☐ Handout ☒ Qualification Card / Familiarization Guide ☐ Lab Guide ☐ Simulator Guide

☐ CMI Course ☐ Electronic Document ☒ Other Lesson Plan

☐ New Material ☒ Minor Revision ☐ Major Revision ☐ Cancellation

REASON FOR REVISION:
Revised for comments after train the trainer sessions.

REVIEW / APPROVAL: ☐ Electronic Approval (TEAR _____)

Prepared By:	Morgan and Lewis - Vendor Preparer	7/2/2010 Date
Reviewed By:	Dave Marinal Technical Reviewer (e.g., SME, line management)	7/5/2010 Date
Instructional Adequacy Determined By:	Shawn Tanner Qualified Instructor	5/26/2010 Date
Approved By:	Kelly Robinson Responsible Fleet Training Manager	7/6/2010 Date
*Approval Date	7/7/2010	

FLEET PROGRAM REVIEW: ☒ Not Applicable

ANO		NP	
BRP		PLP	
CNS		PNPS	
GGNS		RBS	
HQN		VY	
IPEC		W3	
JAF			

* Indexing Information Class Code: _____

ENTERGY NUCLEAR		Page 1 of 1
E-DOC TITLE:	E-DOC NO.	REVISION NO.
FLEET TRAINING MATERIAL APPROVAL	TQF-201-DD09	1

Entergy.
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Completeness and Accuracy of Information and Deliberate Misconduct Training

FSEM-ADM-50.5-50.9 COMPL

Agenda

- Objectives
- Regulations, Procedures, and Policies
- Quiz Review
- Best Practices
- Case Studies

Terminal Objective

When interacting with the NRC, communicate effectively, and completely and accurately, in accordance with NRC requirements (e.g., 10 CFR §§ 50.5 and 50.9) and Entergy policies and procedures

Enabling Objectives

- Outline applicable regulatory and procedural requirements and the policies underlying them
- Describe the importance of providing complete and accurate information to the NRC
- Paraphrase the penalties associated with not following applicable requirements
- Discuss Best Practices associated with communicating with the NRC
- Given a relevant case study, identify the Best Practices for meeting the applicable requirements

Operating Fundamentals

Confirmatory Order

"Entergy shall provide training to Entergy's workforce on the sensitivity and importance of providing complete and accurate information to the NRC. This training shall be completed at all of Entergy's licensed facilities."

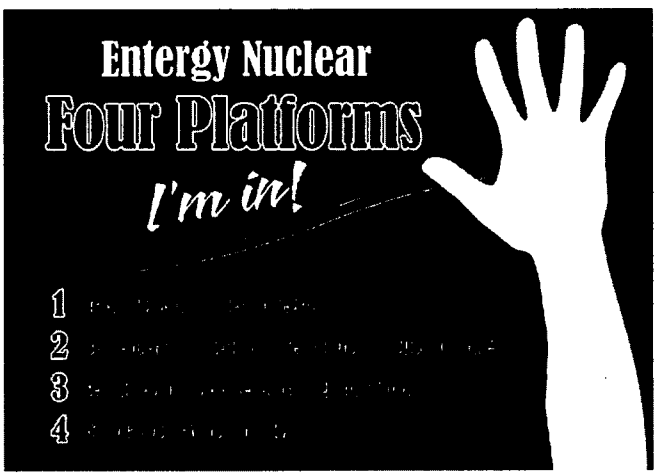
Entergy Nuclear Operations, Inc., (Palisades Nuclear Plant), EA-09-060, 74 Fed. Reg. 59,995, 59,995 (Nov. 10, 2009) (Confirmatory Order)

Recent Events Among the Fleet

- Inaccurate information regarding underground cables in response to Generic Letter 2007-01 (ANO)
- Inaccurate information regarding manual reactor trip / control rod insertion in 10 CFR § 50.72 report (ANO)
- Inaccurate licensed operator medical information in NRC Form 396s (Indian Point and Pilgrim)
- Incomplete individual monitoring information in NRC Form 5s (Palisades)
- Incomplete Occupational Exposure Control Effectiveness Performance Indicator data (Palisades)

The Four Platforms

- Trust – Honesty – Fairness – Integrity
- Be Deliberate – Actions Under Control – Follow the Rules
- Set and Continuously Reinforce High Standards
- Do What You Say You Will Do



Regulatory Trends

- Increase in the amounts and types of information requested (e.g., Requests for Information, supporting documentation, etc.)
- Increase in the rigor of review of information provided (e.g., pre-docketing questions regarding applications, etc.)
- Entergy found that in 2008, there were 5 inspection findings industry wide with a 10 CFR § 50.9 finding, versus 19 in 2009

Notable Industry Events

- Davis-Besse – Incomplete/inaccurate reactor vessel inspection information
- Millstone – Incomplete/inaccurate Reactor Operator qualification information

Statutory Requirements

Various federal statutes, including the Atomic Energy Act of 1954, 42 U.S.C. § 2236, and other non-energy specific statutes, 18 U.S.C. § 1001, prohibit providing incomplete or inaccurate information and/or maintaining incomplete or inaccurate records

NRC Regulations

10 CFR § 50.9

Requires that all material information:

1. Provided to the NRC (orally or in writing) or
2. Maintained pursuant to NRC requirements

be complete and accurate

NRC Regulations

10 CFR § 50.5

Prohibits deliberate misconduct, which includes:

1. Deliberately submitting incomplete or inaccurate information and
2. Deliberately causing a violation of a requirement

NRC Regulations

Other NRC regulations impose the same requirements on other licensees/license applicants and workers:

- 10 CFR §§ 72.11 and 72.12 (Independent Spent Fuel Storage Installations)
- 10 CFR §§ 52.4 and 52.6 (Construction Permit and Operating License Applicants)

Regulatory Policies

Compliance is critical to the NRC as a regulator because:

The NRC relies on information provided by licensees, license applicants, and their representatives

Complete and accurate information is needed to protect public health and safety

It reflects the integrity and trustworthiness of licensees, license applicants, and their representatives

Regulatory Policies

The NRC is NOT the only regulatory body that expects complete and accurate information:

State and local agencies also expect information to be complete and accurate and you must act accordingly

10 CFR § 50.9: Scope

What is the scope of 10 CFR § 50.9?

- All communications to the NRC fall within the scope of the rule, including written and oral communications (e.g., answers to Requests for Information, Performance Indicator data, etc.)
- All information required to be maintained by NRC rule, regulation, order, or technical specifications (e.g., Fire Watch logs, Condition Reports, Test data, etc.)

10 CFR § 50.9: Scope

- Violations may include:
  - Acts of commission (i.e., providing inaccurate information)
  - Acts of omission (i.e., not providing information)
- Intent is NOT a requirement:
  - Honest mistakes result in violations
  - Intent influences the nature and size of the penalty

10 CFR § 50.9: Materiality

- What does "in all material respects" mean?
  - "Has the ability to influence the agency in the conduct of its regulatory responsibilities"
- Actual NRC reliance is NOT a prerequisite
- Safety significance is NOT a prerequisite

10 CFR § 50.9: Materiality

What types of information could the NRC consider "material"?

- Information related to design or testing of safety-related components
- Information related to compliance with NRC regulations or guidance
- Information related to assessing effectiveness of corrective actions

Signatures and Initials

Signatures and initials are significant because they:

- Attest that a step or job has been performed/completed
- Identify the source of (i.e., person responsible for) information contained in the document
- Affirm the completeness and accuracy of information to the best of the person's knowledge, information, and belief

Oral Communications

Oral communications also must be complete and accurate because:

- The NRC and others, including Entergy, rely on your oral communications
- Oral communications can have the same significance as a signature or initial

Entergy Procedures

- EN-LI-106, "NRC Correspondence"
- EN-LI-108, "Event Notification and Reporting"
- EN-LI-114, "Performance Indicator Process"
- EN-LI-123, "NRC Inspection Support"

Entergy "Philosophy Statement"

"It is the policy of Entergy that all communication with any regulatory agency be true, accurate, and complete"

EN-LI-106, "NRC Correspondence," Rev. 6 (§ 5.3 and Attachment 9.1)

EN-LI-106, "NRC Correspondence"

- Covers processing written correspondence that the NRC will rely upon to make a regulatory decision (§ 1.0)
- Requires "certification" of "material" information (i.e., information that the NRC may rely upon "as a basis for a decision") (Attachment 9.1)
- "Certification" is the process of attesting to, with reasonable assurance, the accuracy of "material" statements (§ 3.0)

EN-LI-106, "NRC Correspondence"

Challenges associated with information covered by this procedure:

- Difficult to know everything that the NRC might use
- Information is often collected from multiple sources and sources not originally created for the purpose of certification
- Written correspondence is often revised many times
- Signators, Correspondence Preparers, and Individuals Responsible for Certifying Statements often are not the same

EN-LI-108, "Event Notification and Reporting"

- Covers process for the identification and development of reports required by federal rules and regulations (§ 1.0)
- Reporting may be written or oral and includes (1) periodic, (2) condition-related, (3) process driven, and (4) 10 CFR Part 21 reports (§ 3.0)
- Provides that written correspondence to the NRC should be prepared, reviewed, and submitted in accordance with EN-LI-106 (§ 5.0)

EN-LI-108, "Event Notification and Reporting"

Challenges associated with information covered by this procedure:

- Same as for EN-LI-106, "NRC Correspondence"
- Reporting information orally presents unique challenges
- Available information may be limited
- There may be a greater sense of urgency or stress

EN-LI-114, "Performance Indicator Process"

- Covers responsibilities and expectations for collecting, compiling, reporting, and analyzing plant performance indicator (PI) data (§ 1.0)
- PI data sent quarterly to the NRC is certifiable as defined by EN-LI-106, "NRC Correspondence" (§ 5.6)
- Data submitted is certified to be complete and accurate in all material respects by (1) Data Provider and (2) Data Verifier (§ 5.6)

EN-LI-114, Performance Indicator Process

Challenges associated with information covered by this procedure:

- Same as for EN-LI-106, "NRC Correspondence"
- Possible large number of sources of data
- PI data may only be as complete as the other sources of information on which the PI Process depends
- Complacency due to repetitiveness

EN-LI-123, "NRC Inspection Support"

- Covers preparation for and facilitation of NRC inspections (e.g., baseline, supplemental and team) (§ 1.0)
- Requires a process to review responses to inspection questions to ensure that they are complete, accurate, and timely (§ 5.3)

EN-LI-123, "NRC Inspection Support"

Challenges associated with information covered by this procedure:

- Same as for EN-LI-108, "Event Notification and Reporting"
- Questions asked by inspectors could vary widely
- Individuals interfacing with inspectors could vary widely
- Questions and answers in "real time" are difficult to track

10 CFR § 50.5: Scope

- 10 CFR § 50.5 prohibits:
  1. Deliberately submitting incomplete or inaccurate information (§ 50.5(a)(2))
  2. Deliberately causing a violation of any other NRC requirement (§ 50.5(a)(1))
- Applies to licensed and non-licensed individuals:
  - Employees of a licensee or license applicant
  - Contractors of a licensee or license applicant
  - Employees of a contractor
  - Applicants for unescorted plant access

10 CFR § 50.5: Deliberate Misconduct

Deliberate misconduct requires the individual to have:

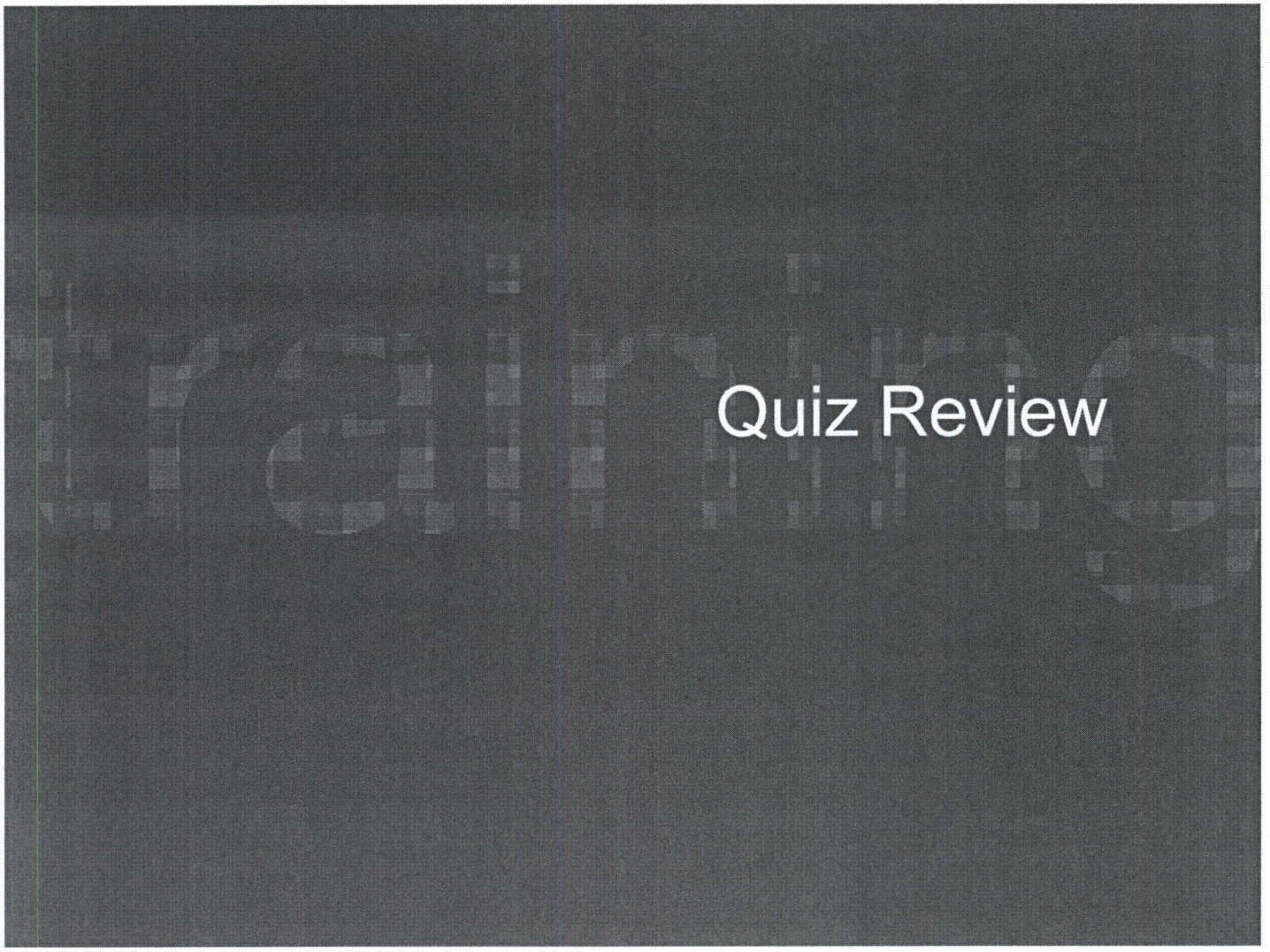
- Acted voluntarily as opposed to inadvertently
- Known a requirement existed
- Understood the requirement
- Known that the requirement was applicable
- Known that his or her actions were contrary to the requirement

NRC Enforcement: Sanctions

- Notices of violation
- Civil penalties
- Orders modifying, revoking, or suspending licenses
- Letters of reprimand
- Orders prohibiting involvement in licensed activities
- Criminal prosecution

NRC Enforcement: Considerations

- Level of responsibility
- Knowledge of inaccurate or incomplete information
- Opportunity to correct
- Intent or negligence involved
- Formality of the communication
- Significance of the communication
- Reasonableness of the reason


Quiz Review

Best Practices

- Use a rigorous approach to all communications with the NRC
- Assume information could be used/relied upon by the NRC
- Adjust your communication technique depending on the interaction
- NEVER assume completeness and accuracy—verify and satisfy yourself

Best Practices

Regarding written materials:

- Reviewing the document as though you are the last line of defense
- Avoiding passing off your responsibility to others or assume they will verify the information
- When resolving comments, subject changes to the same rigor as the original
- Maintaining a questioning attitude

Best Practices

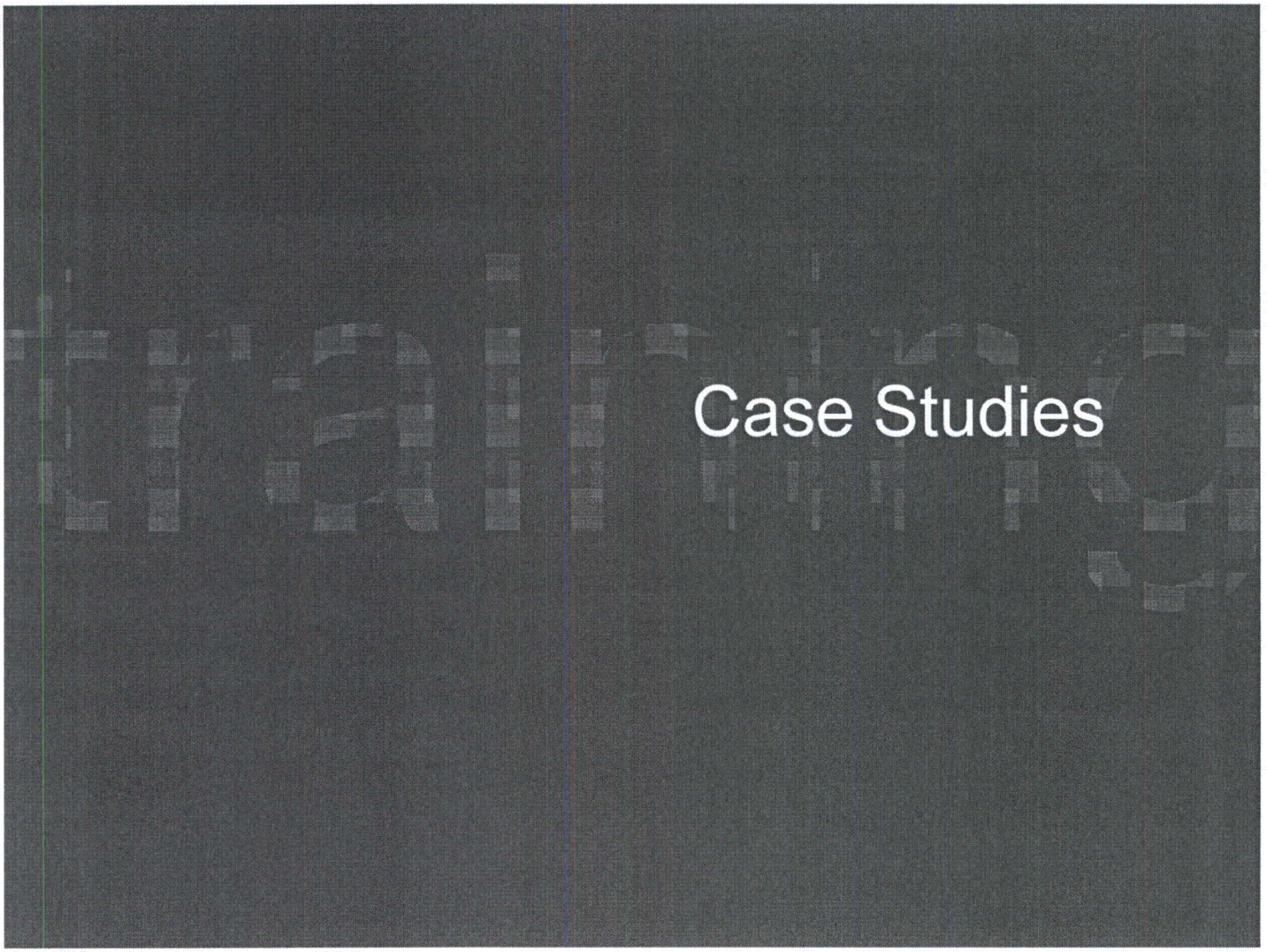
Regarding oral communications:

- Distinguishing fact from assumption or opinion and clearly identify opinions as such
- Being open and forthcoming with the NRC at all times
- Identifying preliminary versus final information provided to the NRC
- Avoiding rushing to an answer when a question is time sensitive or you feel pressured in some other way
- Resisting the urge to tell the NRC what you think it wants to hear

Best Practices

If you are not satisfied:

- ***Investigate*** any reasonable doubt regarding completeness or accuracy of information
- ***Raise concerns*** by alternative mechanisms (e.g., Senior Management, Corrective Action Process, Employee Concerns Program) if:
  - *Unsatisfactory response*
  - *Uncomfortable going to supervision*


Case Studies

Case Study 1

Bill is a Shift Technical Advisor. He makes a required 10 CFR § 50.72 report over the telephone after a site fire prompts a manual reactor trip. He states that the fire has been extinguished. Before calling the NRC, Bill telephoned the control room and checked the status of the fire. Bill spoke with a Reactor Operator (RO), who told Bill that the fire had been extinguished. Nonetheless, the RO only assumed the fire had been extinguished based on his knowledge of certain control room instrument readings and the fire suppression systems involved. Hours later, Bill learns the fire was extinguished 2 minutes after he called the NRC, and that it lasted about 5 minutes.

Is there a 10 CFR § 50.9 violation? Did anyone (Bill or the RO) violate 10 CFR § 50.5?

What procedure governs this interaction with the NRC?

What should Bill do? What should he have done?

What should the RO have done to avoid the communication of erroneous information?

Does it matter that the NRC did not specifically ask Bill if the fire had been extinguished?

Case Study 2

Pat is the Maintenance Supervisor and oversees personnel who perform hourly fire watch rounds. She knows personnel sometimes pre-sign their rounds logs to ensure the documentation is completed before the end of their shifts. She also knows that the purpose of the rounds logs is to document the completion of rounds in accordance with a NRC-required Fire Protection Program and a related procedure. Pat believes that personnel are performing their rounds and that, in the end, the documents are, therefore, complete and accurate. She reviews the rounds logs and finds no evidence of rounds being missed.

Is there a 10 CFR § 50.9 violation? Did anyone (Pat or personnel) violate 10 CFR § 50.5?

What are the risks associated with pre-signing a document?

What if, unbeknownst to Pat, personnel signed their rounds logs in advance so they could leave work early while creating the appearance that they were at work and performed their rounds?

Case Study 3

Tony is the Operations Manager. During an inspection, the NRC resident inspector asks him about the results of surveillance tests performed that day. Tony does not want to make the inspector wait for the information because the inspector complained about waiting for similar information in the past. To be responsive, Tony forwards an email from one of the engineers who performed the tests. The engineer's email notes that the results are "preliminary." Tony forwards the email and writes, "Here are the test results you requested." Tony later finds that the engineer's email contains an error about whether a technical specification was exceeded.

Is there a 10 CFR § 50.9 violation? Did anyone (Tony or the engineer) violate 10 CFR § 50.5?

What procedure governs this interaction with the NRC?

What should Tony have done?

What should Tony have done upon learning of the error?

Case Study 4

Joe is a radwaste manager. While preparing a shipment of low level radwaste, he asks a subordinate supervisor to perform a visual inspection of the radwaste liner before its placement inside a shipping cask for transport. Joe does not check a box in the loading report, which is part of the loading procedure, indicating whether a visual inspection has been performed. Knowing that an inspection has not been performed, he also leaves the space for the time of the inspection blank. Moments later, Joe and this supervisor are called into a series of meetings to discuss an emerging issue. When the meetings end, no one remembers that the visual inspection still needs to be performed. The radwaste is shipped and the loading report placed in the files.

Is there a 10 CFR § 50.9 violation? Did anyone (Joe or the supervisor) violate 10 CFR § 50.5?

What should Joe and the supervisor have done to prevent this error?

What if Joe checked the box, but left the time blank for the supervisor to fill in once the inspection was performed?

Case Study 5

Brian is an Instrument and Control Technician. Upon reviewing a preventive maintenance work order, he notices it does not include what he believes to be a required thermocouple test. It is a test he had previously performed as part of similar work order a few years ago. Brian also does not like the individual who prepared the work order. Brian writes a condition report stating that "the work order may be deficient" because it does not include the thermocouple test. Unbeknownst to Brian, the testing is no longer required. In fact, the Maintenance Department recently informed the NRC that it planned on ending the testing and the NRC approved the plan. Also, the NRC routinely reviews condition reports.

- Is there a 10 CFR § 50.9 violation? Did anyone (Brian) violate 10 CFR § 50.5?
- What should Brian have done?

Case Study 6

Tim works in the Licensing Department and supports the Performance Indicator (PI) Process as a Data Provider. In this role, he gathers evidence to support the quarterly PI data compiled by the department for submittal to the NRC. Someone other than the Data Provider, a Data Verifier, is required by procedure to perform an independent review of the evidence Tim collects. Tim knows that the extra step of verifying the evidence is a procedural requirement but thinks it is a waste of time. Contrary to the procedure, Tim does not use a Data Verifier and when he completes the required paperwork, he writes a note saying so. To date, none of the PI data Tim has provided has been found to contain any inaccuracies.

Is there a 10 CFR § 50.9 violation? Did anyone (Tim) violate 10 CFR § 50.5?

What procedure governs this interaction with the NRC?

What should Tim have done about his views on data verification?

Can Tim not follow procedures as long as he documents it?

Does it matter that no inaccurate information was found?

Case Study 7

Susan is a station manager. She and her staff are tasked with investigating a Request for Information (RFI) from the NRC. The RFI contains an allegation that Senior Reactor Operators (SROs) have not completed the requisite training for requalification. Susan and her staff review the most recent NRC Form 398s for each SRO, which indicate that each SRO has completed the requisite training. Based on this review, Susan concludes that the allegation is not substantiated and presents her findings to the Site Vice President, who in turn has the Licensing Department summarize the results of Susan's investigation in a letter to the NRC, which the Site Vice President signs. In the drafting process, the Licensing Department "certifies" Susan's conclusion based on their own review the NRC Form 398s. The NRC then asks for a sample of the SROs' training records, which demonstrate that some of the SROs did not complete all required training.

Is there a 10 CFR § 50.9 violation? Did anyone (Susan and her staff, the Licensing Department, or the Site Vice President) violate 10 CFR § 50.5?

What procedure governs this interaction with the NRC?

What should Susan and her staff have done?

What should the Licensing Department have done?

What should be done about the NRC Form 398s?

Case Study 8

Paul is a supervisor in the Maintenance Department. He is tasked with closing a condition report and the following corrective action: "Maintenance to perform an assessment of the condition of the doors in the Reactor Auxiliary Building." The corrective action response provides: "Assigned the assessment to a qualified technician to complete by the assigned due date." The due date assigned to the corrective action precedes a due date agreed to by the site and the NRC. On the basis of the corrective action response (i.e., that the corrective action has been assigned), Paul closes the corrective action before the assessment is performed. His close-out entry provides: "Assessment to be performed, as stated." Due to unrelated emerging issues, however, the assessment is not performed until after the site's internal due date and the NRC commitment date. No other entries or changes are made to the corrective action or the parent condition report. Paul does not discover that the assessment has not been performed until a few weeks later.

Is there a 10 CFR § 50.9 violation? Did anyone (Paul or the technician) violate 10 CFR § 50.5?

What should Paul have done?

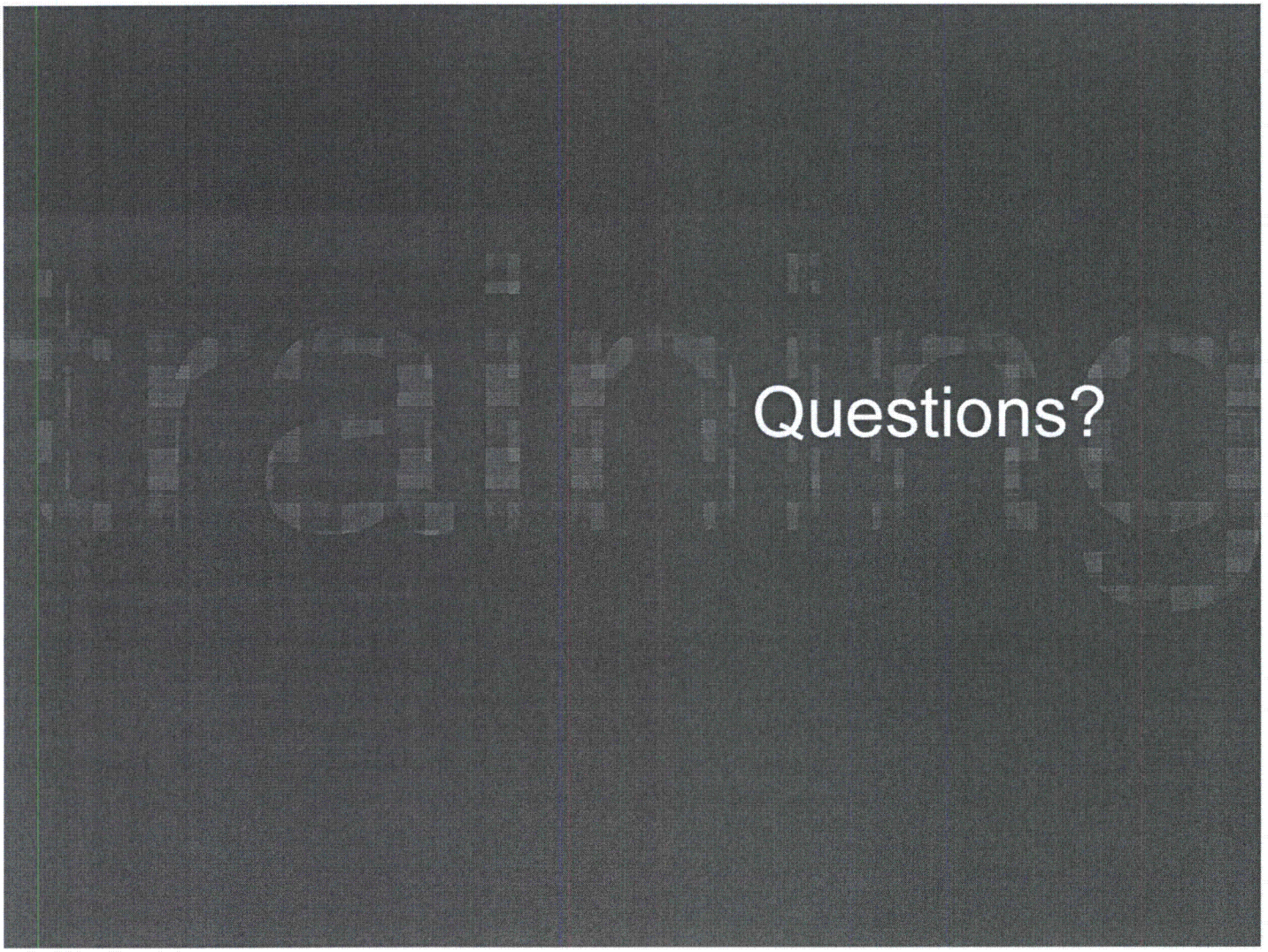
What should Paul do upon discovering his mistake?

Case Study 9

George and Al are operators. They often perform surveillance tests on the site fire hydrants to verify that the hydrant valves fully close and re-open within the allowable number of turns. The valves typically (but not necessarily) close and re-open in four turns (two turns to close and two to re-open), which is within allowable limits and why George and Al jokingly call the test, "The Four Turn Test." After testing, valves are required to be left open, which can be visually confirmed by looking at an indicator on the valve. Two operators perform the test so that it can be concurrently verified that the valve is left in the open position after testing. The last time George and Al tested a valve, Al turned it four times (twice in both directions), which George observed, and both recorded. Al and George then recorded that the valve was left in the open position, when in fact, it was not. They forgot to look at the indicator. One day later, another operator, Dave, performed an independent inspection of the valve to verify that it was open. He had performed this inspection several times before and had never come across a valve that was closed when it should have been open. When he looked at the indicator, however, he misread it and, like George and Al, incorrectly recorded that it was open. Later that same day, the closed valve was discovered, after it failed a flow test due to low flow.

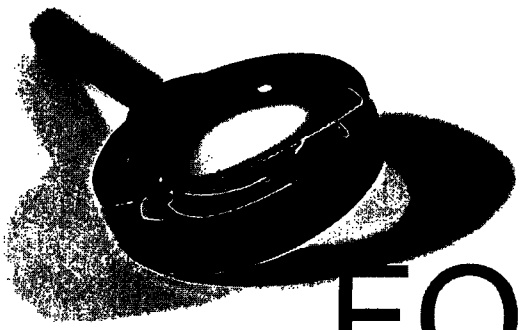
Is there a 10 CFR § 50.9 violation? Did anyone (George, Al, or Dave) violate 10 CFR § 50.5?

What should George, Al, and Dave have done?


Questions?

Summary

- This training is warranted based on, among other things, events among the Entergy fleet
- Information submitted to regulators, or required to be maintained, must be complete/accurate
- "Best Practices" go beyond meeting basic requirements
- Conduct and communications must be transparent both internally and externally



FOCUS

RBG-47190

Enclosure 2

Training Lesson Plan FCBT-ADM-50.5-50.9 COMPL

This form is used to approve fleet training materials that do not have a review/approval block.

*TRAINING MATERIAL NUMBER:

FCBT-ADM-50.5-50.9 COMPL Rev 0

*TRAINING MATERIAL TITLE:

Completeness and Accuracy of Information and Deliberate Misconduct Training

☐ Handout ☒ Qualification Card / Familiarization Guide ☐ Lab Guide ☐ Simulator Guide

☐ CMI Course ☐ Electronic Document ☒ Other Lesson Plan

☒ New Material ☐ Minor Revision ☐ Major Revision ☐ Cancellation

REASON FOR REVISION:
New material for NRC Confirmatory Order

REVIEW / APPROVAL: ☐ Electronic Approval (TEAR _____)

Prepared By:	Morgan and Lewis - Vendor / Bonnie Scott Preparer	6/10/2010 Date
Reviewed By:	Dave Mannai Technical Reviewer (e.g., SME, line management)	7/5/2010 Date
Instructional Adequacy Determined By:	Shawn Tanner Qualified Instructor	6/11/2010 Date
Approved By:	Kelly Robinson Responsible Fleet Training Manager	7/6/2010 Date
*Approval Date	7/12/2010	

FLEET PROGRAM REVIEW: ☐ Not Applicable

ANO	Bice	NP	n/a
BRP	n/a	PLP	Anderson
CNS	n/a	PNPS	Lynch
GGNS	Perino	RBS	Lorfing
HQN	Kingsley	VY	Devincentis
IPEC	Buchanon	W3	Steelman
JAF	Pechacek		

* Indexing Information Class Code: _____

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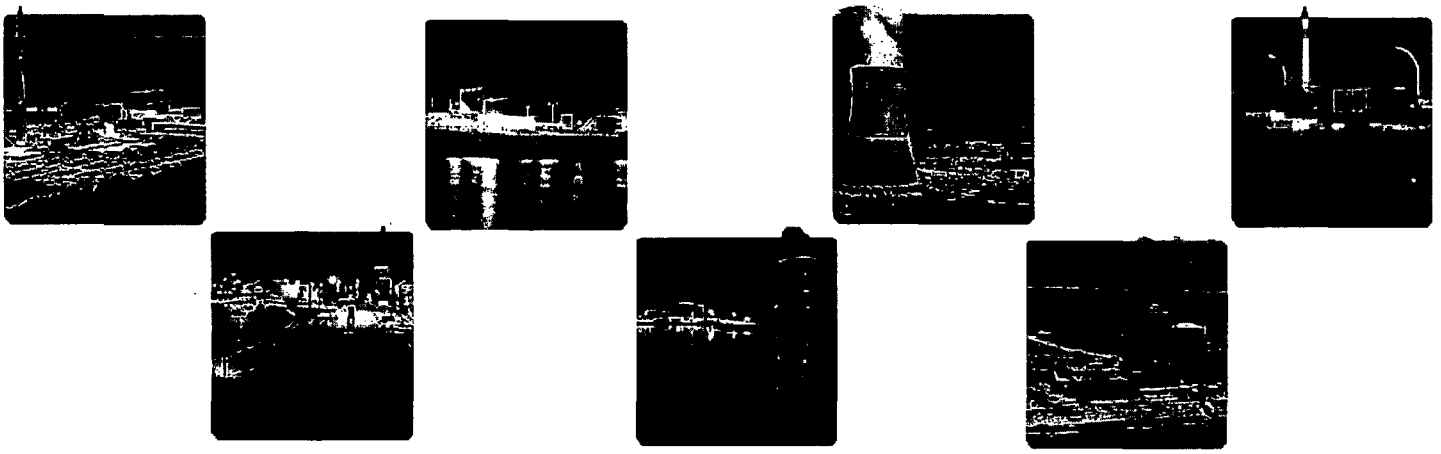
Completeness and Accuracy of Information and Deliberate Misconduct

FCBT-ADM-50.5-50.9 COMPL



Agenda

- Objectives and Background
- Completeness and Accuracy of Information
- Deliberate Misconduct
- Quizzes
- Best Practices
- Drills

Objectives and Background

Terminal Objective

Your terminal objective is to:

Communicate with the NRC completely and accurately—in accordance with NRC requirements (10 CFR §§ 50.5 and 50.9) and Entergy policies and procedures

Enabling Objectives

You will need to meet the following enabling objectives to meet your terminal objective:

- Outline applicable regulatory and procedural requirements
- Describe the importance of providing complete and accurate information to the NRC
- Recognize the penalties associated with not following applicable requirements
- State the Best Practices associated with communicating with the NRC
- Given a relevant drill question, identify the Best Practices for meeting the applicable requirements

Operating Fundamentals

- **Our primary mission, and core business, is to operate our nuclear assets safely and reliably**
- **To do this, we must be deliberate, use conservative decision-making, be precise, knowledgeable, and work as a team**
- **We must be accurate, thorough, and truthful--our integrity has to be beyond reproach**
- **When we fall short, our attention gets diverted from the safe, efficient operations of our facilities**
- **Remember – Platform 1 – "Integrity," which means our word is good, and Platform 4 – we did what we said we would do.**

Important Training

This training is required by a NRC Confirmatory Order:

- The Confirmatory Order requires Entergy to provide training to the workforce on the sensitivity and importance of providing complete and accurate information to the NRC
- A Confirmatory Order is a type of administrative action that the NRC takes to confirm a licensee's agreement to take certain actions to address significant concerns
- The NRC issued the Confirmatory Order after concluding that it received incomplete and inaccurate information regarding a condition involving a potential security vulnerability at Palisades
- The information at issue was contained in two related condition reports and was provided to the NRC verbally during an unscheduled, informal telephone conversation

Timely Training

The NRC also has found that it received incomplete and inaccurate information from Entergy on other occasions—further demonstrating the importance of this training:

- Information regarding underground cables in response to GL 2007-01 (Inaccessible or Underground Power Cable Failures)
- Information regarding manual reactor trip / control rod insertion in 10 CFR § 50.72 report (Immediate Notification Requirements)
- Inaccurate licensed operator medical examination information in NRC Form 396s (Certification of Medical Examination)
- Incomplete individual monitoring information in NRC Form 5s (Occupational Dose Record for a Monitoring Period)

Open Communications

Entergy encourages its employees to communicate openly and freely

with the NRC

This training is intended to improve the quality of your communications with the NRC

NRC Requirements

NRC regulations for nuclear power plant licensees and workers:

1. 10 CFR § 50.5 - Prohibits deliberate misconduct, i.e., intentional violations of known requirements
2. 10 CFR § 50.9 - Requires material information to be complete and accurate

NRC Requirements

Other NRC regulations impose the same requirements on other licensees and workers:

- 10 CFR §§ 72.11 and 72.12 (Independent Spent Fuel Storage Installations)
- 10 CFR §§ 52.4 and 52.6 (Construction Permit and Operating License Applicants)

Purpose of Requirements

Why is compliance with 10 CFR §§ 50.5 and 50.9 so critical to the NRC as a regulator?

- Because the NRC relies on information provided by licensees, license applicants, etc.
- Because complete and accurate information is essential to protect public health and safety
- Because compliance is consistent with our standards for integrity and trustworthiness

Entergy "Philosophy Statement"

In addition:

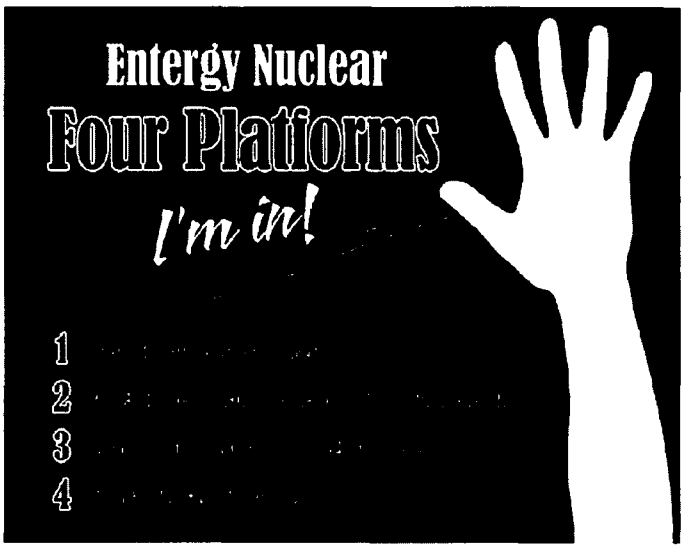
"It is the policy of Entergy that all communication with any regulatory agency be true, accurate, and complete"

- EN-LI-106, "NRC Correspondence" (Attachment 9.1)

The Four Platforms

Providing and maintaining complete and accurate information and complying with all other requirements also fit within the Four Platforms:

- Trust – Honesty – Fairness – Integrity
- Be Deliberate – Actions Under Control – Follow the Rules
- Set and Continuously Reinforce High Standards
- Do What You Say You Will Do



Completeness and Accuracy of Information: 10 CFR § 50.9

10 CFR § 50.9

Requires that all material information:

1. Provided to the NRC (orally or in writing) or
2. Maintained pursuant to NRC requirements

be complete and accurate

10 CFR § 50.9: Scope

10 CFR § 50.9 broadly covers *written* and *oral* information provided to the NRC

- **There is no communication that is not covered because it is "off-the-record" or "informal"**
- **It does not matter if the information provided was not intended to be provided when it was created**

10 CFR § 50.9: Scope

10 CFR § 50.9 also covers information maintained pursuant to NRC rule, regulation, order, or technical specification

- **It does not matter if the NRC has not yet requested, reviewed, or relied upon it**
- **It only matters that the information is required to be maintained and the NRC may rely on it**

10 CFR § 50.9: Materiality

10 CFR § 50.9 applies to "material" information, which is information that:

"Has the ability to influence the [NRC] in the conduct of its regulatory responsibilities"

- Final Rule and Statement of Policy, 52 Fed. Reg. 49,362, 49,366 (Dec. 31, 1987)

10 CFR § 50.9: Materiality

Information that could influence how the NRC performs its duties (i.e., "material" information) is information that could cause the NRC to:

- **Take a different action**
- **Take an enforcement action**
- **Perform an additional inspection, review, or evaluation**

10 CFR § 50.9: Materiality

As shown, the definition of "material" information is quite broad:

- Actual NRC reliance is NOT required
- Safety significance is NOT required

10 CFR § 50.9: Materiality

- Examples of documents containing information that the NRC may consider "material":
  - Condition Reports and Responses/Corrective Actions
  - Work Packages and Procedures
  - Rounds Logs
  - Timesheets
- You provide and/or sign-off on the information contained in these documents

10 CFR § 50.9: Violations

- Violations of 10 CFR § 50.9 include:
  - Acts of commission (i.e., providing inaccurate information)
  - Acts of omission (i.e., not including certain information)
- Intent is NOT a requirement:
  - Honest mistakes result in violations
  - Intent only impacts the nature and size of the penalty

10 CFR § 50.9: Violations

- If you identify an error, take action to ensure it is corrected and reported promptly:
  - Notify supervision
  - Write a Condition Report
- The failure to correct a known error may increase the severity of a violation

Signatures and Initials

Signatures and initials are significant because they:

- Attest that a step or job has been performed/completed
- Identify the source of (i.e., person responsible for) information contained in the document
- Affirm the completeness and accuracy of information to the best of the person's knowledge, information, and belief

Oral Communications

Oral communications also must be complete and accurate because:

- The NRC and others, including Entergy, rely on your oral communications
- Oral communications can have the same significance as a signature or initial

Entergy Procedures

Various Entergy procedures cover communications with the NRC:

- EN-LI-106, "NRC Correspondence"
- EN-LI-108, "Event Notification and Reporting"
- EN-LI-114, "Performance Indicator Process"
- EN-LI-123, "NRC Inspection Support"

EN-LI-106, "NRC Correspondence"

- Covers processing written correspondence that the NRC will rely upon to make a regulatory decision (§ 1.0)
- Requires "certification" of material information (i.e., information that the NRC may rely upon "as a basis for a decision") (Attachment 9.1)
- "Certification" is the process of attesting to, with reasonable assurance, the accuracy of "material" statements (§ 3.0)

EN-LI-108, "Event Notification and Reporting"

- Covers the process for identifying and developing reports required by federal rules and regulations (§ 1.0)
- Reporting may be written or oral and includes (1) periodic, (2) condition-related, (3) process driven, and (4) 10 CFR Part 21 reports (§ 3.0)
- Provides that written correspondence to the NRC should be prepared, reviewed, and submitted in accordance with EN-LI-106 (§ 5.0)

EN-LI-114, "Performance Indicator Process"

- Covers responsibilities and expectations for collecting, compiling, reporting, and analyzing plant performance indicator (PI) data (§ 1.0)
- PI data sent quarterly to the NRC must be "certified," as defined by EN-LI-106, "NRC Correspondence" (§ 5.6)
- Data submitted is certified to be complete and accurate in all material respects by: (1) a Data Provider; and (2) a Data Verifier (§ 5.6)

EN-LI-123, "NRC Inspection Support"

- Covers preparation for and facilitation of NRC inspections (e.g., baseline, supplemental, and team inspections) (§ 1.0)
- Calls for the review of responses to inspection questions to ensure that responses are complete, accurate, and timely (§ 5.3)

Quiz

Question 1

10 CFR § 50.9 requires that written materials submitted to the NRC be:

(a) Signed by a company official

(b) Complete to the best of one's knowledge

(c) Complete and accurate in all material respects

(d) Accurate based on a reasonable belief

Question 2

True or False? 10 CFR § 50.9 only covers information that is provided to the NRC.

(a) True

(b) False

Question 3

In order to be "material," information must be:

(a) Safety-significant

(b) Relied upon by the NRC

(c) Able to influence how the NRC performs its duties

(d) Able to change the outcome of a NRC proceeding

Question 4

True or False? A good-faith, inadvertent omission of material information from a document submitted to the NRC is not subject to 10 CFR § 50.9.

(a) True

(b) False

Question 5

Which of the following communications is not covered by 10 CFR § 50.9?

(a) An informal conversation in the hallway with a NRC resident inspector

(b) Formal correspondence to the Nuclear Energy Institute

(c) An unscheduled telephone conversation with NRC staff that is not recorded or transcribed

(d) A PowerPoint presentation shown to a NRC inspection team

Question 6

True or False? Entergy procedure EN-LI-106, "NRC Correspondence," requires the certification of material statements made in written correspondence to the NRC.

(a) True

(b) False

Question 7

If you discover that incomplete or inaccurate information has been provided to the NRC, what should you do?

(a) Assess whether the information is material

(b) Determine whether the information relates to nuclear safety

(c) Ensure the error is corrected and reported promptly

(d) Propose a correction

Deliberate Misconduct: 10 CFR § 50.5

10 CFR § 50.5

Prohibits deliberate misconduct, which includes:

1. Deliberately submitting incomplete or inaccurate information (e.g., to the NRC, a licensee or license applicant, a contractor, etc.)

2. Deliberately causing a violation of a requirement (e.g., a NRC regulation, a license condition, a station procedure, etc.)

10 CFR § 50.5: Scope

The prohibition against deliberately submitting incomplete or inaccurate information includes information that is submitted to:

- The NRC
- A licensee
- A license applicant
- A licensee's or license applicant's contractor

10 CFR § 50.5: Scope

The prohibition against deliberately causing a violation includes violations of:

- NRC rules, regulations, and orders
- Terms and conditions of a NRC license
- Procedural requirements

10 CFR § 50.5: Scope

10 CFR § 50.5 applies to the following licensed and non-licensed individuals:

- Employees of a licensee or license applicant
- Contractors of a licensee or license applicant
- Employees of a contractor
- Applicants for unescorted plant access

10 CFR § 50.5: Deliberate

A violation is deliberate when an individual:

- Knows that a requirement exists
- Understands the requirement
- Knows that the requirement is applicable
- Knows that his/her actions are contrary to the requirement
- Acts voluntarily (as opposed to inadvertently)

- NRC Enforcement Manual, Section 6.1.c (Dec. 22, 2008)

10 CFR § 50.5: Careless Disregard

An act of careless disregard occurs when:

- A requirement exists
- A violation of the requirement occurs
- The violation is the result of a voluntary act
- The individual causing the violation acted with indifference to:
  - *The existence of the requirement*
  - *The meaning of the requirement*
  - *Whether his/her conduct conformed to the requirement*

- NRC Enforcement Manual, Section 6.1.d (Dec. 22, 2008)

10 CFR § 50.5: Careless Disregard

- Acts of careless disregard do not violate 10 CFR § 50.5, though they can violate other requirements
- Enforcement action will not be taken against a non-licensed individual who acts with careless disregard, but Entergy can take personnel action
- Acts of careless disregard are considered "willful" and willful acts can result in enforcement action against a licensee or license applicant

NRC Enforcement: Sanctions

- The types of penalties that could result from a violation of 10 CFR §§ 50.5 or 50.9 include:
  - Notices of violation
  - Civil penalties
  - Orders modifying, revoking, or suspending licenses
  - Letters of reprimand
  - Orders prohibiting involvement in licensed activities
  - Criminal prosecution
- Note that apparent violations typically result in investigations by the NRC's Office of Investigations

Enforcement Action: Penalties at Davis-Besse

The NRC's findings of violations regarding reactor vessel head inspections at Davis-Besse resulted in:

- Criminal indictments against two employees and contractor
- Employees and contractor banned from NRC-regulated activities
- $28,000,000 in exchange for deferred criminal prosecution of the licensee
- $230,000 in civil penalties for incomplete and inaccurate information

Quiz

Question 1

An individual who commits a deliberate violation (i.e., engages in deliberate misconduct)

(a) Knows a requirement exists and understands the requirement

(b) Knows the requirement is applicable at the time

(c) Acts voluntarily and in a way the individual knows is contrary to the requirement

(d) All of the above

Question 2

True or False? An inadvertent omission of material information from a document submitted to the NRC is not subject to 10 CFR § 50.5.

(a) True

(b) False

Question 3

Which individuals are subject to 10 CFR § 50.5?

(a) Licensed and non-licensed individuals working for a NRC licensee or license applicant

(b) Licensed and non-licensed individuals working for a contractor of a NRC licensee or license applicant

(c) Licensed individuals only

(d) A and B

Question 4

Which types of violations are prohibited by 10 CFR § 50.5?

(a) Violations of NRC regulations

(b) Violations of the terms and conditions of a NRC license

(c) Violations of a licensee's procedures

(d) All of the above

Question 5

True or False? 10 CFR § 50.5 prohibits individuals from deliberately withholding material information from a licensee.

(a) True

(b) False

Question 6

10 CFR § 50.5 prohibits individuals from providing incomplete or inaccurate information to which of the following?

(a) The NRC and any other government agency

(b) The NRC only

(c) The NRC, licensees, license applicants, and contractors of licensees and license applicants

(d) The NRC, licensees and license applicants only

Question 7

An individual who violates 10 CFR § 50.5 may be subject to:

(a) A civil penalty

(b) Letter of reprimand

(c) Criminal prosecution

(d) All of the above

Question 8

Which of the following statements about acts of careless disregard is true?

(a) Acts of careless disregard do not violate 10 CFR § 50.5

(b) A non-licensed individual who acts with careless disregard can be subject to personnel action by the licensee

(c) A non-licensed individual who acts with careless disregard can subject the licensee to enforcement action

(d) All of the above

Best Practices

Best Practices

- Use a rigorous approach to all communications with the NRC and others (internal and external)
- Assume information could be used/relied upon by the NRC and/or others
- NEVER assume that information is complete or accurate—verify and satisfy yourself

Best Practices

Some Best Practices with respect to written materials (whether you prepare, contribute to, or are asked to review them) include:

- Review the materials as though you were the last line of defense
- Do not pass off your responsibility to others or assume they will verify
- Subject changes/revisions you make in resolving comments to the same rigor as the original version
- Do not approve, sign, initial, or transmit the materials if you are not satisfied that information is complete and accurate
- Keep a questioning attitude

Best Practices

Some specific Best Practices with respect to oral communications (whether in-person, over the telephone, or under any other circumstances) include:

- Distinguish fact from assumption or opinion and clearly identify opinions as such
- Be open and forthcoming with the NRC at all times
- Identify preliminary versus final information provided to the NRC
- Avoid rushing to an answer when a question is time sensitive or you feel pressured in some other way
- Resist the urge to tell the NRC what you think they want to hear
- Review applicable documents if you are unsure of the contents

Best Practices

If you are not satisfied that information is complete and accurate:

- Investigate – Any reasonable doubt about the completeness or accuracy of information should be investigated (e.g., follow-up with someone who has first-hand knowledge and/or your supervisor)
- Use Alternative Mechanisms – Use other mechanisms (e.g., Senior Management, Corrective Action Process, or Employee Concerns Program) if you are not satisfied with the response or uncomfortable going to your supervisor

Drills

Drill 1

Situation: Bill, the STA, is preparing to make an immediate report to the NRC via telephone regarding the status of recent fire on site.

- Bill calls the control room to check the status of the fire.
- Bill speaks with a Reactor Operator (RO).
- The RO tells Bill that the fire has been extinguished.

Drill 1

What should Bill do?

1. Telephone the NRC—he has all the information he needs to make the report.
2. Confirm that the RO's training and other qualifications are up to date.
3. Ask the RO to identify his or her bases for concluding that the fire has been extinguished.

Drill 1

Bill should ask the RO to identify his or her bases for concluding that the fire has been extinguished.

- Without asking the RO his or her bases, Bill does not know if the RO's conclusion is fact, opinion, or preliminary.
- Depending on the RO's response, Bill may need to speak with someone else about the status of the fire.
- Bill must avoid rushing to an answer merely because the circumstances call for an immediate report.

Drill 2

Situation: Tony, the Operations Manager, is approached by the NRC Resident Inspector who asks about the results of some surveillance tests performed earlier that day.

- Testing will not be completed, and the results will not be confirmed, for three more days.
- Tony has a copy of the preliminary results at his desk and no technical specifications appear to have been exceeded.
- The NRC Resident Inspector tells Tony that he or she wants an answer before the end of the day.

Drill 2

What should Tony do?

1. Tell the NRC Resident Inspector that he or she has to wait until the testing is completed and the results are confirmed.
2. Tell the NRC Resident Inspector that (so far) no technical specifications have been exceeded.
3. Share the preliminary test results with the NRC Resident Inspector, but tell him or her that they are only preliminary.

Drill 2

Tony should share the preliminary test results with the NRC Resident Inspector, but tell him or her that they are preliminary.

- Tony should be cooperative and do his best to accommodate the NRC Resident Inspector's request.
- Tony cannot say that no technical specifications have been exceeded because the test results are unconfirmed.
- Tony can be accommodating, without misleading the inspector, by stating that the test results are preliminary.

Drill 3

Situation: Brian, a Technician, joins a conference call with a NRC reviewer regarding some upcoming maintenance.

- Brian tells the NRC reviewer that the maintenance will include some thermocouple testing.
- The reviewer does not seem to care about the testing, asks no questions about it, and (instead) asks about the flow rate of an auxiliary feedwater pump—a topic unrelated to the testing.
- Brian realizes after the conference call that the thermocouple testing will not be conducted.

Drill 3

What should Brian do?

1. Nothing—the NRC reviewer did not appear to be interested in the thermocouple testing.
2. Document that thermocouple testing was not performed upon completion of the scheduled maintenance.
3. Promptly notify supervision of the error and follow-up to ensure that the NRC is informed of the error.

Drill 3

Brian should promptly notify supervision of the error and follow-up to ensure that the NRC is informed of the error.

- Regardless of whether the NRC reviewer appeared interested, the NRC could treat the information as material.
- Documenting that the testing was not performed will not ensure that the NRC receives the correct information in a timely manner.
- The failure to correct a known error could increase the severity of a violation and credit will be given if an error is corrected before it is relied upon.

Drill 4

Situation: Susan works in the Licensing Department and is asked by her supervisor to review a draft NRC Request for Information (RFI) response, but is told that someone else is certifying material statements.

- The RFI contains an allegation that the Senior Reactor Operators (SROs) did not complete required training.
- The draft response states that the SROs completed the training and that the allegation could not be substantiated.
- The draft response does not contain any information that supports the conclusion that the SROs completed training.

Drill 4

What should Susan do?

1. Not worry about whether the SROs completed training—that is a certification issue, which is not her responsibility.
2. Postpone her review of the draft until the certification process is completed.
3. Speak with her supervisor and/or the individual responsible for certification about the apparent omission.

Drill 4

Susan should speak with her supervisor and/or the individual responsible for certification about the omission.

- Susan should not assume that the individual responsible for certification will identify the issue.
- Waiting to raise the issue until after the certification process only wastes time.
- Susan should keep a questioning attitude and review the draft as though she is the last line of defense.

Drill 5

Situation: Paul is a Work Planner and is gathering documents for members of a NRC Special Inspection Team.

- One of the inspectors asks Paul a question about a work order that Paul has never seen before and that is outside Paul's area of expertise.
- The inspector tells Paul, "I am almost positive I know the answer, but I want to confirm it with you, Paul."
- Paul is embarrassed that he is not sure of the answer and wants to be helpful.

Drill 5

What should Paul do?

1. Review the work order and do his best to answer the question.
2. Agree with whatever the NRC inspector believes the answer is—after all, the inspector already told Paul that "I am almost positive I know the answer."
3. Inform the NRC inspector that he is not sure of the answer but that he will find someone who is.

Drill 5

Paul should inform the NRC inspector that he is not sure of the answer but that he will find someone who is.

- The work order is outside Paul's area of expertise, so it will not help to review the order to try to answer the question.
- Paul should resist the urge to tell the inspector what he thinks the inspector wants to hear (i.e., by simply agreeing with the inspector).
- It is okay if Paul does not know the answer and perfectly appropriate for him to find someone more knowledgeable.

Summary

- This training is warranted based on, among other things, events among the Entergy fleet
- Information submitted to regulators, or required to be maintained, must be complete/accurate
- "Best Practices" go beyond meeting basic requirements
- Conduct and communications must be transparent both internally and externally

Focus

- **Remember that to be successful, we must focus on the fundamentals of operations and avoid making errors that divert our attention**

- **Our primary mission, and core business, is to operate our nuclear assets safely and reliably—our integrity has to be beyond reproach**

- **Remember – Platform 1 – "Integrity," which means our word is good, and Platform 4 – we did what we said we would do.**

Questions?

If you have any questions about this training, you can contact your:

- ***Supervisor***
- ***Licensing department***
- ***NSA Director***

RBG-47190

Enclosure 3

Root Cause Analysis Report (CR-RBS-2011-03296)

Root Cause Evaluation Report

Adverse Trend in Nuclear Safety Culture

CR-RBS-2011-3296; Event Date: 04-04-2011

REPORT DATE: 05-10-2011, Rev 1

Position	Name	Date
Evaluator	**Jennifer Seymour**	**5/10/2011**
Reviewer	**Emily Robertson**	**5/10/2011**
Responsible Manager	**Jerry Roberts**	**5/10/2011**
CARB Chairperson	**Gene Bush**	**5/10/2011**

Problem Statement

An adverse trend in Nuclear Safety Culture has resulted in declined personnel performance and equipment challenges.

Event Narrative

EVENT SUMMARY

Safety Culture is defined as an organization's values and behaviors which are modeled by its leaders and internalized by its members that serve to make nuclear safety the over-riding priority.

On 4/4/2011, the Vice President Nuclear Operations for River Bend Station initiated condition report CR-RBS-2011-03296. The condition report description states "There is an adverse trend in Nuclear Safety Culture at River Bend Station". The below listed examples indicate weaknesses with Principles of a Strong Nuclear Safety Culture.

Operators in the Control Room on the Internet	**CR-RBS-2010-02953**
Maintenance AFI from INPO Evaluation	**CR-RBS-2010-05456**
"B" Recirculation Pump Trip	**CR-RBS-2010-06059**
Misplaced Bundle in the Spent Fuel Pool	**CR-RBS-2011-00886**
Bent Mast during Refueling	**CR-RBS-2011-00899**
Misplaced Bundle in the Core	**CR-RBS-2011-01850**

On 6/29/2010, a condition report (CR-RBS-2010-2953) was initiated to identify that the computer located in the Main Control Room (MCR) At-The-Controls (ATC) Operator desk was found to allow access to external internet sites. This was not in accordance with the Operations Manager's understanding and expectations that this machine was blocked from all external access. As a result, operators had access to non-work related sites in violation of procedures and causing distraction to the Operators. Further investigation revealed that some Operators had accessed the internet while on watch as the ATC Operator. This action is contrary to the requirements that potentially distracting activities in the control room and other watch stations are prohibited.

During the 2010 INPO Evaluation, an AFI (CR-RBS-2010-5456) was identified for Maintenance workers and supervisors not consistently following procedures and work instructions as written. It was determined that workers are not consistently following the rules or holding each other accountable for following the rules because the rules are not well defined and known. Principle 1 of principles for a Strong Nuclear Safety Culture addresses the need for everyone to be responsible for nuclear safety. Specifically that all personnel understand the importance of adherence to nuclear safety standards and that leaders exercise healthy accountability for shortfalls in meeting standards. There is evidence that all disciplines and all levels of maintenance, including maintenance management, have differing interpretations of the procedure requirements and management expectations for procedure and work order use and adherence.

On 11/20/10, the Reactor Recirculation Pump 'B' tripped off, unexpectedly (CR-RBS-2010-6059). The root cause of this event is a seven second loss of dc control power and the failure mode is indeterminate. Equipment troubleshooting did not reveal any failed components and interviews did not identify any human actions which would have resulted in the failure of this breaker.

On 1/21/11, a fuel assembly was mispositioned in the Spent Fuel Pool, while executing fuel movement plan STS-COR-16-01 (CR-RBS-2011-886). The Spotter misidentified a step to be performed and

presented the step to the driver who then performed the step as written. Step 585 was performed instead of step 552. This resulted in assembly NAN815 being placed in the location designated for assembly NAN799. After the bundle was un-grappled and the mast was restored to its normal up position, the spotter realized he had inadvertently flipped over an extra page and that they had placed the bundle in the wrong location. The root cause determined that self checking was not applied to ensure the correct component.

On 1/21/11, a fuel assembly was only withdrawn ~10" from the core when the Bridge was moved (CR-RBS-2011-899). This resulted in damage to the refueling bridge mast and potential damage to the fuel assembly. Furthermore, it was determined to continue with fuel movement activities even after it was identified that the bridge had been moved. The evaluation revealed that the Driver failed to refocus and self check after reviewing the move sheet resulting in the bridge being moved with a fuel bundle grappled and only partially withdrawn from the core. The Spotter and ROV Operator failed to perform their required duties for fuel movement activities as delineated in REP-0029, FHP-0002, & FHP-0003. The SRO failed to provide management oversight and incorrectly determined that it was acceptable for the crew to continue with move 553 after identifying that the bridge was moved with a fuel bundle grappled but not fully withdrawn from the core.

During core alterations on 2/4/2011, fuel assembly QGE667 was erroneously placed in Core location 40-49 at Step 757 of STS-COR-16-02A at about 2330 (CR-RBS-2011-1850). The root cause evaluation determined that self checking was not applied by the Bridge Driver, SRO, Spotter, and the ROV Operator to ensure the correct component. All three individuals involved failed to adequately perform their roles and responsibilities in accordance with FHP-0003, *Fuel Handling Platform Operation,* and REP-0029, *Fuel Movement.* Additional causes included insufficient procedural guidance and unexpected equipment failure.

A team was formed to evaluate a potential trend in Nuclear Safety Culture using a common cause analysis (Reference Attachment 1). The team was comprised of members from Operations, Engineering, Training, Licensing, Chemistry, Radiation Protection, HU/ECI, Security, and Maintenance. In addition to the above referenced condition reports, the team reviewed condition reports generated from 4/1/2010 – 4/14/2011, LEL entries, Human Performance Error Reviews (HPERs), conducted interviews, and initiated a site safety culture survey. The results of the data gathered were used in determining the root and contributing causes.

CR-RBS-2011-3742 was closed to this condition report. Plant housekeeping during and post RF-16 was not maintained in accordance with Management standards. The behaviors identified in CR-RBS-2011-3742 are addressed in the corrective actions and causes identified in this evaluation.

ANALYSIS SUMMARY

In accordance with EN-LI-118-06, a common cause analysis was performed. The team reviewed multiple data inputs including Condition Reports, Leadership Effectiveness Log (LEL) entries, and Human Performance Error Review (HPER) results. Additionally, the team collected inputs via a web based survey, and conducted interviews with personnel from multiple levels of the organization. Team members provided additional insights based on the cause evaluations for the condition report examples sited in the condition report description, and new condition reports initiated during the team evaluation period.

Three major areas were identified for evaluation. The three major areas were Outage and Time Pressured Situations, Communications, Ownership.

The area of Outage and Time Pressured Situations was identified primarily from interview results. Employees stated that site management has adopted the safety culture principles, but in time periods of high work load such as outages, the right behaviors are not occurring, due to a lack of individual ownership and a lapse in the reinforcement of standards. When a challenge is present, the site may not make a positive nuclear safety choice.

Communication issues were noted in multiple areas such as: lack of feedback from processes including the corrective action process, limited coaching on Nuclear Safety Principles, and lack of cross-department feedback concerning current issues. The lack of communication contributes to the station overall safety culture as related to being a learning organization (Principle 7) and organizational trust (Principle 3). Additionally, as already noted, lack of communication of coaching on the safety principles misses an opportunity for communication of standards and making ties between day to day activities and the principles. This contributes to the lapse in standards.

Ownership issues appear to be in the implementation of responsibilities and in the identification of an overall program owner. These issues are behavioral and lack accountability in some cases. These ownership issues are contributing to station inability to achieve desired standards in some areas. In a program with multiple element owners, it is difficult to determine consistent standards to apply. In a program with no clearly defined owner, standards are not consistently implemented.

The results of the Safety Culture Evaluation identified the following areas that require additional focus and have been incorporated into the causes to be addressed by the initiated corrective actions:

- RC_1 – Leaders' ineffective modeling of nuclear safety culture values and behaviors
- RC_1 – Situational standards
- CC_1 – Work practices
- CC_2 – Inadequate communication
- CC_3 – Lowered acceptance standards

Root Cause Evaluation

A. ROOT CAUSE(S)

1. **RC_1 OP5AE** - The values and behaviors that comprise a strong nuclear safety culture are not effectively and consistently modeled by some station leaders.

Middle management, defined as responsible managers, superintendants, and supervisors, demonstrate situational standards regarding nuclear safety culture. Their actions convey to the workforce that nuclear safety is not always the station's overriding concern. The "lead by example" element that must be prevalent in site leadership is inconsistent resulting in the workforce on site not making positive nuclear safety choices when faced with a challenge. Their behavior also enables some workers to lower their standards. Data has revealed this weakness is compounded during increased workloads such as outages.

B. CONTRIBUTING CAUSE(S)

1. **CC_1 OP5E** – Inadequate work practices and decision making.

Individuals are not consistently practicing nuclear safety culture principles to ensure that it is always the overriding priority. Additionally, individuals are not challenging the organization vertically and horizontally to uphold the highest nuclear safety standards. At times, workers have lowered their standards which have contributed to site challenges such as fuel handling errors, housekeeping deficiencies, and inappropriate internet usage.

2. **CC_2 OP5D** - Inadequate communication within the organization.

The organization is not effectively communicating the values and behaviors required to make nuclear safety the overriding priority. Leaders do not always communicate important decisions and their bases to the workforce in such a way to build trust and reinforce a healthy safety culture.

3. **CC_3 OP2D** - Lack of organization authority for program implementation.

Lack of program ownership has resulted in gaps in the implementation of some key station programs and processes (i.e. Fuel Handling & Housekeeping). Continued acceptance of these conditions has eroded the station's nuclear safety culture.

The behaviors that led to this contributing cause are symptomatic of RC_1.

C. ORGANIZATIONAL AND PROGRAMMATIC WEAKNESS EVALUATION:

The root and contributing causes were evaluated in accordance with EN-LI-118 Attachment 9.5 to determine any Organizational and Programmatic causal factors that are applicable. This root cause evaluated the site safety culture through common cause methodology. The causes, as determined through analysis, are inherently organizational issues based on the nature of the issue. The causal factors listed in EN-LI-118 were screened for applicability to the causes. There results of that screening revealed two areas of Organizational and Programmatic weaknesses. The areas where weakness was most prevalent were Organizational to Programmatic – OP2X and Organizational – OP5X. The following causal factors relate the Organizational and Programmatic weakness to the resulting causes.

1. **OP5AE** – Personnel exhibited insufficient awareness of the impact of actions on safety.

Management failed to provide positive reinforcement and practical application to personnel concerning nuclear safety principles.

2. **OP5E** – Inadequate work practices and decision making.

Individuals are not consistently practicing nuclear safety culture principles to ensure that it is always the overriding priority. Additionally, individuals are not challenging the organization vertically and horizontally to uphold the highest nuclear safety standards. At times, workers have lowered their standards which have contributed to site challenges such as fuel handling errors, housekeeping deficiencies, and inappropriate internet usage.

3. **OP5D** - Inadequate communication within the organization.

Leaders do not always communicate important decisions and their bases to the workforce in such a way to build trust and reinforce a healthy safety culture.

4. **OP2D** – Lack of organization authority for program implementation.

Lack of program ownership has resulted in gaps in the implementation of some key station programs and processes (i.e. Fuel Handling & Housekeeping). Continued acceptance of these conditions has eroded the station's nuclear safety culture.

D. Safety Culture Evaluation

A safety culture evaluation was performed using EN-LI-118 Attachment 9.6. The root cause and two contributing cause descriptions were compared to the thirteen safety culture components for applicability. Applicability's were found in the following components:

- Decision Making
- Resources
- Work Control
- Work Practices
- Corrective Action Program
- Self- and Independent Assessments
- Environment for Raising Concerns
- Preventing, Detecting, and Mitigating Perceptions of Retaliation
- Accountability
- Continuous Learning Environment
- Organizational Change Management

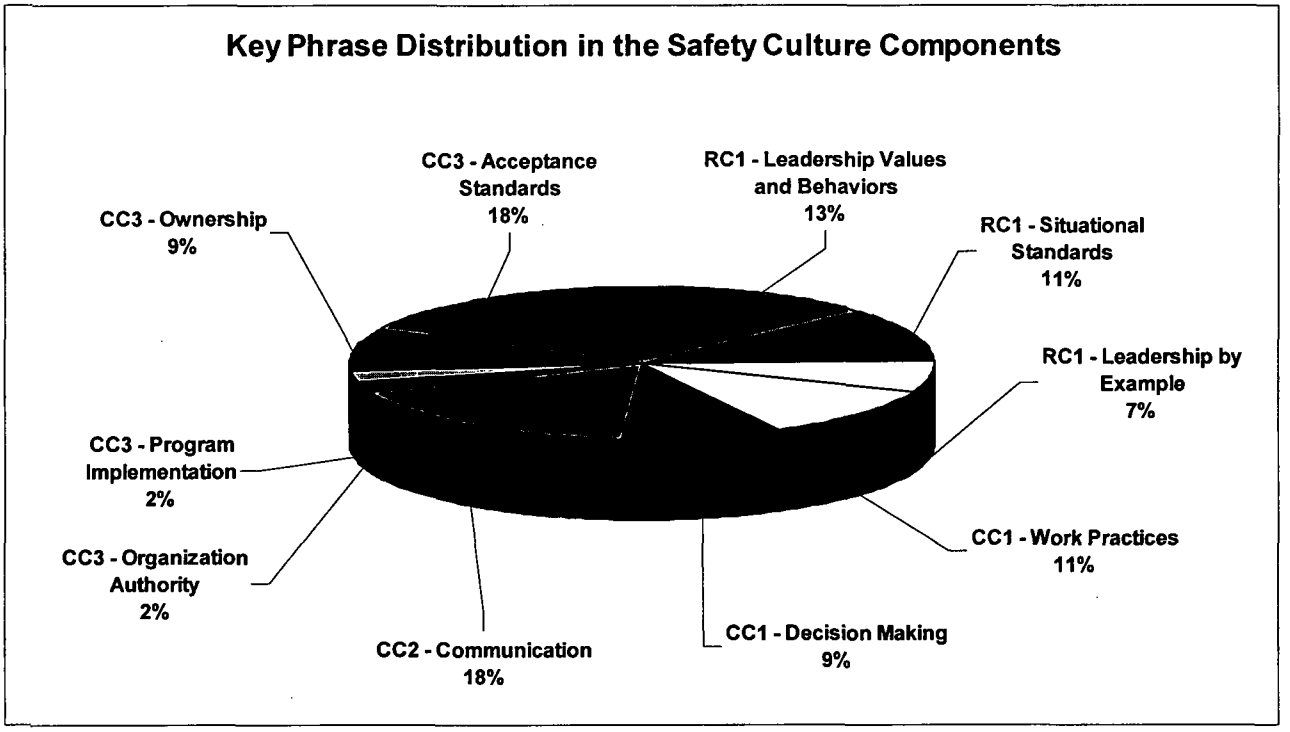
Key phrases in the Root Cause and Contributing Cause descriptions were evaluated against the safety culture components and detailed review for applicability. The key phrases selected included:

- RC_1 – Leaders' ineffective modeling of nuclear safety culture values and behaviors
- RC_1 – Situational standards
- RC_1 – Inconsistency on "leadership by example"
- CC_1 – Work Practices
- CC_1 – Decision Making
- CC_2 – Inadequate communication
- CC_3 – Lack of ownership
- CC_3 – Gaps in program implementation
- CC_3 – Lowered acceptance standards

The top five issues to surface under the evaluation are as follows:

- CC_3 – Lowered acceptance standards. Acceptance of ownership gaps had applicability in eight of the safety culture components.
- CC_2 – Inadequate communication. This issue had applicability in eight of the safety culture components.
- RC_1 – Leaders' ineffective modeling of nuclear safety culture values and behaviors. This issue had applicability in six of the safety culture components.
- RC_1 – Situational standards had applicability in five of the safety culture components.
- CC_1 – Work practices among individuals had applicability in five of the safety culture components.

The remainder of the key phrases had hits in four or fewer components.



These results suggest the following focus areas to pursue:

- RC_1 – Leaders' ineffective modeling of nuclear safety culture values and behaviors
- RC_1 – Situational standards
- CC_1 – Work practices
- CC_2 – Inadequate communication
- CC_3 – Lowered acceptance standards

Corrective actions in this Root Cause Evaluation address these identified weaknesses.

Generic Implications: Extent of Condition and Extent of Cause

Extent of Problem/Condition:

An adverse trend in Nuclear Safety Culture has resulted in declined personnel performance and equipment challenges.

Safety Culture is defined as an organization's values and behaviors which are modeled by its leaders and internalized by its members that serve to make nuclear safety the over-riding priority.

There is no further extent of condition. By its nature, safety culture does encompass the entire station and organization including Human Performance, Equipment and Process/Organizational issues.

The frequency of occurrence (probability) of a safety culture incident is considered to be High, as safety culture encompasses the entire organization. The consequences of an incident resulting from a weak safety culture could potentially impact nuclear safety, personnel/industrial/radiological safety as well as impact station electric production and operation costs. Therefore, the consequence of a weak safety culture at any level of the organization is a HIGH (unacceptable).

Based on the consideration of the combination of probability and consequence, the overall risk rates as HIGH. Although rated HIGH, the team believes that the station's Nuclear Safety Culture functions acceptably under normal operating conditions but at times, declines in high stress situations. The station's Nuclear Safety Culture needs improvement; however, the team believes continued operation is acceptable. Interim actions to perform focused crew assessments will identify any immediate shortfalls that compromise nuclear safety culture until proposed corrective actions from this evaluation are implemented.

Extent of Cause:

A. ROOT CAUSE

1. **RC_1 OP5AE** - The values and behaviors that comprise a strong nuclear safety culture are not effectively and consistently modeled by some station leaders.

   Safety Culture is defined as an organization's values and behaviors which are modeled by its leaders and internalized by its members that serve to make nuclear safety the over-riding priority.

   The probability of the condition rates as HIGH, due to the fact that numerous conditions occur daily across the organization that has the potential for a nuclear safety condition to occur.

   The consequences of a safety culture condition are HIGH and could impact nuclear safety, personnel/industrial/radiological safety and station production and operating costs.

The overall risk rates as HIGH, based primarily on the probability of occurrence. The station's Nuclear Safety Culture needs improvement; however, the team believes continued operation is acceptable. Interim actions to perform focused crew assessments will identify any immediate shortfalls that compromise nuclear safety culture until proposed corrective actions from this evaluation are implemented.

The Corrective Action Plan for this root cause will address the extent of cause.

B. CONTRIBUTING CAUSE(S)

1. **CC_1 OP5E** – Inadequate work practices and decision making.

Individuals are not consistently practicing nuclear safety culture principles to ensure that it is always the overriding priority. Additionally, individuals are not challenging the organization vertically and horizontally to uphold the highest nuclear safety standards. At times, workers have lowered their standards which have contributed to site challenges such as fuel handling errors, housekeeping deficiencies, and inappropriate internet usage.

The probability of the condition rates as HIGH, due to the fact that numerous conditions occur daily across the organization that have the potential for a nuclear safety condition to occur.

The consequences of a safety culture condition are HIGH and could impact nuclear safety, personnel/industrial/radiological safety and station production and operating costs.

The overall risk rates as HIGH, based primarily on the probability of occurrence. The station's Nuclear Safety Culture needs improvement; however, the team believes continued operation is acceptable. Interim actions to perform focused crew assessments will identify any immediate shortfalls that compromise nuclear safety culture until proposed corrective actions from this evaluation are implemented.

The Corrective Action Plan for this contributor cause will address the extent of cause.

2. **CC_2 OP5D** - Inadequate communication within the organization.

The organization is not effectively communicating the values and behaviors required to make nuclear safety the overriding priority. Leaders do not always communicate important decisions and their bases to the workforce in such a way to build trust and reinforce a healthy safety culture.

The probability of the condition rates as HIGH, due to the fact that numerous conditions occur daily across the organization that have the potential for a nuclear safety condition to occur.

The consequences of a safety culture condition are HIGH and could impact nuclear safety, personnel/industrial/radiological safety and station production and operating costs.

The overall risk rates as HIGH, based primarily on the probability of occurrence. The station's Nuclear Safety Culture needs improvement; however, the team believes continued operation is acceptable. Interim actions to perform focused crew assessments will identify any immediate shortfalls that compromise nuclear safety culture until proposed corrective actions from this evaluation are implemented.

The Corrective Action Plan for this contributor cause will address the extent of cause.

3. **CC_3 OP2D** – Lack of organization authority for program implementation.

Lack of program ownership has resulted in gaps in the implementation of some key station programs and processes. Continued acceptance of these conditions has eroded the station's nuclear safety culture.

The probability of the condition rates as HIGH, due to the fact that numerous conditions occur daily across the organization that have the potential for a nuclear safety condition to occur.

The consequences of a safety culture condition are HIGH and could impact nuclear safety, personnel/industrial/radiological safety and station production and operating costs.

The overall risk rates as HIGH, based primarily on the probability of occurrence. The station's Nuclear Safety Culture needs improvement; however, the team believes continued operation is acceptable. Interim actions to perform focused crew assessments will identify any immediate shortfalls that compromise nuclear safety culture until proposed corrective actions from this evaluation are implemented.

The Corrective Action Plan for this contributor cause will address the extent of cause.

Previous Occurrence Evaluation

A search for applicable internal and external operating experience was made using the INPO operating experience database using the keywords 'safety culture'. A search was also performed in the paperless condition reporting system (PCRS) using the key words 'safety' and culture'.

This review included the operating experience information and a search of the plant events database.

1. **OE17755, Determination of Generic Causes Associated with Failure of Enforcement to Change Worker Behaviors Stemming from Common Cause and Root Cause Analyses.**

   Plant: Byron Unit 01 and 02 Identified: December, 2003

   Generic Cause 1: Lack of Alignment. Maintenance management is not completely aligned on standards and expectations

   Generic Cause 2: Lack of Monitoring. There is no formal program to periodically monitor alignment of standards and expectations within maintenance

   Generic Cause 3: Lack of oversight, monitoring, and trending of the Supervisor Working File (SWF) program. There is no periodic oversight or monitoring of the SWF program to ensure supervisors are meeting expectations.

   Contributing Cause 1: Change Management Not Used for rollout of new electronic SWF program. This resulted in no desktop procedure for the program and ineffective training. Without a desktop guide, supervisors did not have a consistent set of rules or expectations to follow. The training performed for the program was not documented and therefore not all supervisors were trained on the program.

   Contributing Cause 2: There is a culture of conflict avoidance within maintenance associated with challenging behaviors. When behaviors are challenged and strictly enforced, it is a natural result of putting workers outside their comfort zone to push back and become defensive.

   Contributing Cause 3: Multiple upper management changes in maintenance
   are exacerbating inconsistent standards and expectations between supervisors and departments.

   Contributing Cause 4: There is a perception of a blame culture associated with supervisors always being held accountable for worker errors.

   Corrective Actions: There were two Corrective Actions to Prevent Recurrence (CAPR) and six Corrective Actions (CA) for the

investigation.

CAPR 1 - The Maintenance Director will develop and implement written expectations that provide details on leadership and fundamentals principles that form the basis of Maintenance Fundamentals.

CAPR 2 - The Maintenance Director will establish a periodic monitoring system with Maintenance Superintendents/Department Heads to ensure enforcement and accountability standards are being upheld to the Maintenance Director's expectations.

CA 01 - Develop and implement a single, user-friendly performance-monitoring database that combines functionality of existing SWF database with the Score Card process to provide details of worker performance.

CA 02 - All First Line Supervisors (FLS) and above maintenance management personnel in the maintenance departments have attended the Managing Conflict Course.

CA 03 - Maintenance Director will perform a leadership assessment with direct reports. The purpose of this assessment is to identify personal strengths and weaknesses in order to make each maintenance discipline stronger.

CA 04 - Superintendents will perform leadership assessments for FLS. The purpose of this assessment is to identify personal strengths and weaknesses in order to make each maintenance discipline stronger.

CA 05 - Develop and implement a strategy to include workers in investigations (RCRs, ACEs, CCAs) to improve the identification of organizational/programmatic or latent organizational weaknesses.

CA 06 - Review the root cause with FLS SLP Committee for discussion in next FLS SLP Class.

2. **OE33278, Cross-Cutting Issues in Human Performance Identified**

Plant: H.B. Robinson Identified: March, 2011

Causes:
Senior management oversight and actions associated with plant support functions have not maintained a dedicated infrastructure necessary to implement and maintain a comprehensive procedures program or work planning program. (Root Cause)

Past performance was considered an indicator of future success resulting in no changes to existing practices and strategies. (Contributing Cause)

Attempts to manage limited resources with competing priorities have resulted in poor performance and untimely resolution of issues. (Contributing Cause)

Performance standards and expectations have been allowed to erode when compared to the regulations and the increasingly higher industry standards for procedure and work instruction quality and level of detail. (Contributing Cause)

Corrective Actions (Partial list):
Implement the Organizational Effectiveness Review Committee (ORR) responsible for review of items such as: key performance indicators for gaps in performance, ensuring they are representative of current industry best performance; closure plans to assure they clearly describe actions to achieve industry best performance; current and projected vacancies including the timeline to fill any vacancies; organizational or project needs for contractor support; etc.

Using the Systematic Approach to Training (SAT) process, train writers on process, procedures (writers guide) and qualified standard, providing examples of what a good procedure looks like.

3. CR-CNS-2009-1310

During the Nuclear Safety Culture Self-Assessment the following weakness was identified against Principle 3, "Trust Permeates the Organization:"

Managers are not regularly communicating to the workforce important decisions and their bases as a way of building trust and reinforcing a healthy safety culture. Worker understanding is not periodically checked. Results of site assessments, such as the recent INPO Evaluation and Assist Visit and other comprehensive reviews have not been effectively communicated across the organization.

Response:

The Safety Culture and SCWE Excellence Plan contains the following action, "Use various methods to communicate decision bases, including organizational changes and changes in key manager positions." This will be an ongoing action. The Safety Culture and SCWE Excellence Plan is being tracked to completion by CR 2009-01308.

In regard to assessments -- Significant site wide assessments and inspections are regularly communicated using multiple forums, including site news releases and All-Hands meetings. Attached are examples of notes and All-Hands presentations that indicate that information is provided. However, it is also recognized that the information provided to employees may not be enough. As a result, Leadership Alignment meetings are now held every other Wednesday. On the subsequent Friday, Meeting Notes are provided to the supervisors and the station stands down for an hour to allow supervisors to review the material with their staffs. The Friday

tailgates are not optional -- attendance is an expectation of the site vice president. Significant assessment results are included in the discussions.

4. **CR-IP2-2008-4079**

A Safety Culture Assessment identified the following: "Continuous learning at IPEC is inconsistently practiced. Some managers and departments demonstrate stronger commitment than others to improving knowledge, skills, and safety performance through benchmarking and other activities designed to solicit critical feedback. The quality of some training (e.g., PassPort) has been weak. Not all personnel are aligned with station priorities."

Response (Partial)

Entergy agrees that the training that was provided for Passport was weak. Entergy has identified this, and as a result, Indian Point personnel will receive work management academy training. The work management academy training will brief personnel on how they fit into the work management process. This training will show how their actions impact all groups around them. The difficulties with passport have been discussed at the fleet level. Individuals currently have sufficient run time using Passport, whereby weaknesses have been identified. For improvements to the work control process that have been taken, or are planned are discussed in the response to CR IP2 - 2008-04072.

To prevent this type of problem, the site identified the need to better identify, communicate and train personnel before a new process is introduced. The site believes that these lessons have been learned. A more successful example can be pointed to the implementation of Plateau. With Plateau, all individuals on site were trained in the major areas that they would need experience on. Plateau was populated with data that would allow training that people took to provide meaningful results (this was not the case with Passport training). The training was concrete and not abstract. The amount of training that was needed for Plateau was also considered effectively before implementation, based on the ease of use of the program.

The communications department has been given an assignment to review communications that deliver the site priorities and ensure that they are consistent with the current site priorities. A new action was assigned to the communications department to document the completion of this activity, due the end of October.

5. **CR-JAF-2010-0358**

"Per the CRG, Correct/Address the following condition: The Independent Safety Culture Assessment (ISCA) performed in October 2009 identified some site personnel did not understand the value of the Synergy Nuclear Safety Culture survey or the relationship of the survey to nuclear safety and the day-to-day work."

Response:

The Independent Safety Culture Assessment (ISCA) performed in October 2009 identified some site personnel did not understand the value of the Synergy Nuclear Safety Culture survey or the relationship of the survey to nuclear safety and the day-to-day work.

The ISCA was conducted before the fleet results of the survey were completed and communicated. Results were communicated by the CNO of Entergy Nuclear to managers and superintendents. Following final report issuance the site VP briefed the staff on survey results during 12/11/09 station update.Managers have also discussed specific responses with their departments during January and February 2010. Discussions with the site senior management team determined that recent communications of the synergy survey results, the action items and action plans from the survey are sufficient for site personnel. Ongoing communications from the action plan will occur as scheduled.

As an enhancement, a JAFLO has been written to communicate the value of the survey to the staff a month or two prior to the next scheduled survey which should be in June 2011. JAF-LO-2010-014 CA 30.

6. **CR-GGN-2009-2092**

The condition report problem description reads as follows: "This CR is to address the fact that VPP SAFETY ISSUE CR`S are being closed with no face to face communication with the originator. This was identified as a good practice to create a more safety conscious culture at the station, during the last VPP self assessment."

Response:

The CRG has previously established an expectation for any VPP issue closed as a 'D' to be held until feedback is given to the originator. Reinforcement of this expectation has taken place.

CA-02 issued to VPP Safety Committee Chairman to establish a set agenda item to review all VPP condition reports that have been closed since the last meeting. A function of the committee is to determine if the appropriate action are being taken to address safety concerns.

CA2 Reply: The safety committee agenda was modified on 5/14/09 to include CR reviews as a formal agenda item.

This condition report applies to discussions during the root cause evaluation related to the communication of information related to concerns raised by personnel.

Conclusion:

The review of INPO Operating experience and the condition reporting system across the fleet did not identify many situations directly related to CR-RBS-2011-3296. For the items listed above,

applicability of the previous events was determined by their relation to nuclear safety culture and their similarity to the causes determined in this root cause evaluation.

Actions reviewed from Byron and Cooper were used to develop the corrective action plan of the identified causes.

Safety Significance Evaluation

As indicated by the Condition Description of this CR, there have been a significant number of potentially consequential human performance-related events in a relatively short time. This has occurred despite efforts to elevate the awareness and the demands of operating in the special, unique environment of nuclear power. It also follows closely on the recognition by INPO that the use of performance improvement tools has been strengthened.

The safety significance of the individual events cited in the Condition Description has been evaluated on those pertinent CRs. In summary:

1. Fuel bundle loaded in wrong core location – There was no actual consequence to nuclear safety, as the fuel bundle that should have been loaded in the cell was of identical design as the fuel bundle that was mistakenly loaded there. Thus, safe shutdown margin required by Technical Specifications was not affected.

2. Bent refueling platform mast – The fuel bundle that was on the grapple at the time was inspected, and no apparent damage was found. However, it was conservatively decided to not reload that bundle over concerns with minor fuel pellet chipping, internal to the fuel pins. Thus, the fission product barrier of the pin cladding is not being challenged by operation in the core. The consequences of this event were strictly financial (i.e., platform down-time, critical path effects, mast repair costs, and lost service time on the affected fuel bundle).

3. "B" reactor recirc pump trip - The trip of a single recirculation pump is analyzed in RBS USAR. The event was analyzed for initial plant licensing, and was shown to be a mild transient. The plant responded appropriately.

4. Internet use in the ATC area – This activity had the potential to be a distraction to the reactor operators in their task of closely monitoring the stability of the plant. This is just one of several activities that are prohibited in the at-the-controls area by administrative procedures. No specific performance deficiencies with actual consequences were identified by that investigation.

5. Maintenance AFI – No specific adverse effects on nuclear safety were identified by the investigation of this condition.

While the individual events were of minimal actual significance with regard to nuclear safety, the aggregate effect of the declining trend in human performance is a challenge to the station. If the degradation of performance is not corrected, the vulnerability to a truly consequential event will increase.

Degraded human performance can be manifested in most any safety-significant activity on the site, ranging from performance of a hands-on task in the main control room to the development of a modification to the design of the plant. Attention to detail and rigorous application of error prevention techniques are required at all levels of the organization, whether they apply to implementing a procedure / work order, or to the coaching and mentoring of those activities. The failure to maintain peak performance in our everyday responsibilities will eventually result in events

that signal our inability to be a benchmark of excellence. To lose the confidence of the stakeholders in the safe operation of the plant is not acceptable.

This condition has been of no actual consequences to the health and safety of the public, or to the physical safety of the site employees. The purpose of this analysis is to eliminate any future potentially adverse effects in these areas.

Corrective Action Plan

All root and contributing causes, and generic implications must have corrective actions or a documented basis why no action is recommended.

Identified Cause	Corrective Actions	Responsible Dept.	Due Date
	Immediate Actions		
	All Employee Meeting held to relay to the organization recent events and their implications in safety culture and where the organization is headed.	VP	Complete
	Interim Actions		
	Perform Focused Crew Assessments to identify any immediate shortfalls in safety/performance.	All Major Departments	Ongoing
	Short & Long Term Actions		
RC-1 The values and behaviors that comprise a strong nuclear safety culture are not effectively and consistently modeled by some station leaders.	CAPR: Develop and implement a comprehensive program that establishes nuclear safety culture as the overriding station priority. (Reference actions from OE 17755, Byron) Integrate the existing discrete elements into the program and develop: • Nuclear Safety Culture Committee (model the Industrial Safety committee and Alara Sub-Committee) • Metrics • Monitoring • Evaluation • Communication	GMPO	8/3/11

Corrective Action Plan

Identified Cause	Corrective Actions	Responsible Dept.	Due Date
RC-1	Develop a Charter for the Nuclear Safety Culture Committee and present to CARB.	GMPO	6/15/11
RC-1	Update PCRS to include trend codes for specific Nuclear Safety Culture Attributes.	CA&A	6/15/11
RC-1, CC-2	Communicate the changes to PCRS to DPICs and CRG	CA&A	6/15/11
RC-1, CC-1	Perform a gap analysis between the Fundamentals and the Nuclear Safety Culture Principles/Attributes. Document the correlation between each fundamental and nuclear safety culture attributes and present to CARB. Initiate additional actions as necessary per the direction of CARB.	Human Performance	6/15/11
RC-1, CC-1	Perform a needs analysis using the SAT process to determine training requirements related to the Nuclear Safety Principles and Principles. Upon completion of the needs analysis, issue additional corrective actions as necessary to document completion of required training. If the TEAR process determines no training or modification is required, then the CARB must approve the change to the intent of the associated action plan. A new corrective action directing an alternate strategy to address the associated cause or correct the identified condition may be required.	Training	7/11/11
RC-1, CC-1	Brief Supervisors and above on the use of Nuclear Safety Culture Competencies within the PP&R process. Document how the briefing was performed.	GMPO	6/30/11
RC-1, CC-1	Develop and implement a process to use the nuclear safety culture principles during Level Set.	HR	8/3/11
CC-2	Communicate the results of the root cause to the site.	Communications	6/1/11
CC-2, OE Review (CNS)	Develop and implement a process to provide meeting notes (i.e. L&A) to supervisors to review with reports during a station stand down.	Communications	6/1/11

Corrective Action Plan

Identified Cause	Corrective Actions	Responsible Dept.	Due Date
CC-3	Perform a gap analysis on program ownership and implementation between the GOES model and owners as identified by INPO Performance Objectives & Criteria (PO&Cs) versus current station practices. Initiate follow-up actions as necessary	CA&A	7/15/11
RC-1, CC-1, and CC-2	Perform a gap analysis between the actions taken in this evaluation and the recommendations of SOER 10-2 and NEI 09-07. Initiate additional actions as necessary for any gaps identified.	CA&A	9/1/11

References

This section should contain an Effectiveness Review strategy that includes the following:

Method – Describe the method that will be used to verify that the actions taken had the desired outcome.

Attributes – Describe the process attributes to be monitored or evaluated.

Success – Establish the acceptance criteria for the attributes to be monitored or evaluated.

Timeliness – Define the optimum time to perform the effectiveness review.}

1. Effectiveness review actions are required for all CAPRs.

CAPR:

Develop and implement a comprehensive program that establishes nuclear safety culture as the overriding station priority.

Integrate the existing discrete elements into the program and develop:

Nuclear Safety Culture Committee
Metrics
Monitoring
Evaluation
Communication

	Action	Resp. Dept	Due Date
Method:	**Snapshot Assessment to include LEL entries, observations, condition reports, and employee interviews/survey. (ref metrics)**	**GMPO**	**2/1/2012**
Attributes:	**Nuclear Safety Culture Principles 1-8**		**2/1/2012**
Success:	**White/Green Metrics**		**2/1/2012**
Timeliness:	**6 months of run time to ensure that all applicable actions have been completed.**		**2/1/2012**

Documents reviewed:

References

LEL Observations
ADM-0099, *Performance Improvement Using Fundamentals*
EN-HU-101, *Human Performance Program*
SOER 10-2, *Engaged, Thinking, Organizations*
NEI 09-07, *Fostering a Strong Nuclear Safety Culture*
Condition Reports generated from 3/31/2010-4/14/2011
IAEA – *Self Assessment of safety culture in nuclear installations*
EN-MA-132, *Housekeeping*
EN-LI-102, *Corrective Action Process*

Personnel contacted:

Maintenance – I&C, Mechanical, Electrical, Support, FIN
Operators – SRO, STA, RO, SNEO
Engineering – DE, SE, EP&C
PS&O
MP&C
Licensing
Quality Assurance
Security
CA&A
Chemistry
Radiation Protection
Training
ASG
Glenn Krause
Eric Olson
Dale Vines

Team Members:

Jane Antoine
Terrie Sandlin
Clint Mallory
Jerrell Campbell
Ted Bordelon
Tim Sapp
Mark Kinsey
Kathy Beauchamp
Danny Williamson
Scott Dallas
Doug Myers
Jennifer Seymour

References

Analysis Methodologies employed:

1. Common Cause Analysis

Attachments:

I. Common Cause Analysis

II. Nuclear Safety Culture Survey

III. Interview Questions & Results

IV. Evaluation Cause Summaries

V. Nuclear Safety Culture Evaluation

Attachment I
Common Cause Analysis

Common Cause Analysis (CCA) Evaluation

Action Tracking Item Number: *CR-RBS-2011-3296*

Affected Facility: *RBS Unit 1*

CCA Evaluation report date: *4/28/11*

Evaluation Period: April 1, 2010 through April 14, 2011

CCA Evaluation Team Investigators:

See Root Cause Team members

Specific Issue Description/Methodology used:

On 4/4/11, the Vice President Nuclear Operations for River Bend Station initiated condition report CR-RBS-2011-03296. The condition report description states "There is an adverse trend in Nuclear Safety Culture at River Bend Station". The listed examples were cited.

Misplaced Bundle in the Core/Spent Fuel Pool	**CR-RBS-2011-01850/00866**
Bent Mast during Refueling	**CR-RBS-2011-00899**
"B" Recirculation Pump Trip	**CR-RBS-2010-06059**
Operators in the Control Room on the Internet	**CR-RBS-2010-05456**
Maintenance AFI from INPO Evaluation	**CR-RBS-2010-02953**

Attachment I
Common Cause Analysis

The causes for these evaluations are listed in Attachment IV and were incorporated into the common cause evaluation. For this evaluation, the population was expanded beyond the six events listed above to include a review of one year of PCRS data.

A root cause team was formed. The team selected multiple inputs to review including condition reports generated during the past year, human performance interview results conducted during the past year, and Leadership Effectiveness Log entries related to safety culture. Additionally, the team developed a safety culture survey to gather input from as large a portion of the population as possible. Based on the limits of this web-based survey tool, the team also developed a standard set of interview questions and conducted approximately 87 interviews with site personnel. These inputs were reviewed for common themes and used to develop causes.

Primary Analysis Results:

Condition Reports

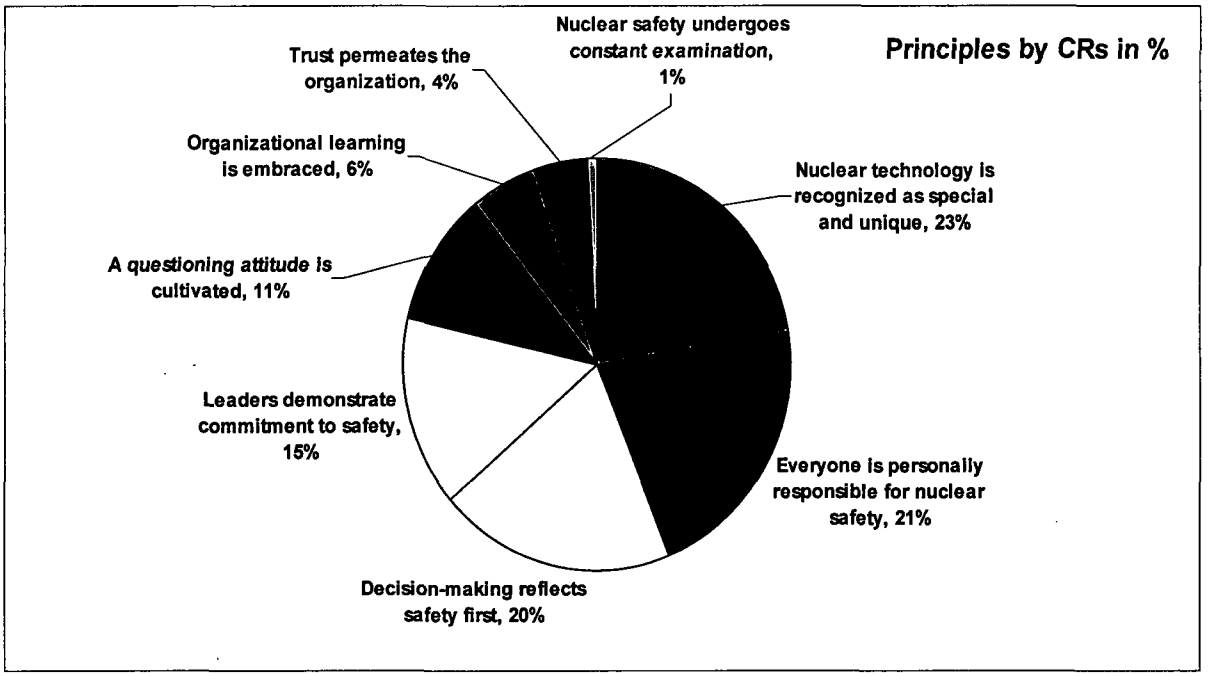
The team reviewed all Condition Reports generated during the period from April 1 2010 to April 14, 2011 to determine an initial population of data to review. The team selected condition reports that documented issues with safety culture. Each CR selected was assigned one of the 8 principles from *Principles for a Strong Nuclear Safety Culture.*

The initial population of over 8000 condition reports was reduced to 855. These results were binned to determine areas of focus.

Nuclear technology is recognized as special and unique	193	23%
Everyone is personally responsible for nuclear safety	183	21%
Decision-making reflects safety first	168	20%
Leaders demonstrate commitment to safety	127	15%
A questioning attitude is cultivated	91	11%
Organizational learning is embraced	48	6%
Trust permeates the organization	37	4%
Nuclear safety undergoes constant examination	8	1%

Attachment I
Common Cause Analysis

The data is represented graphically by the chart below:



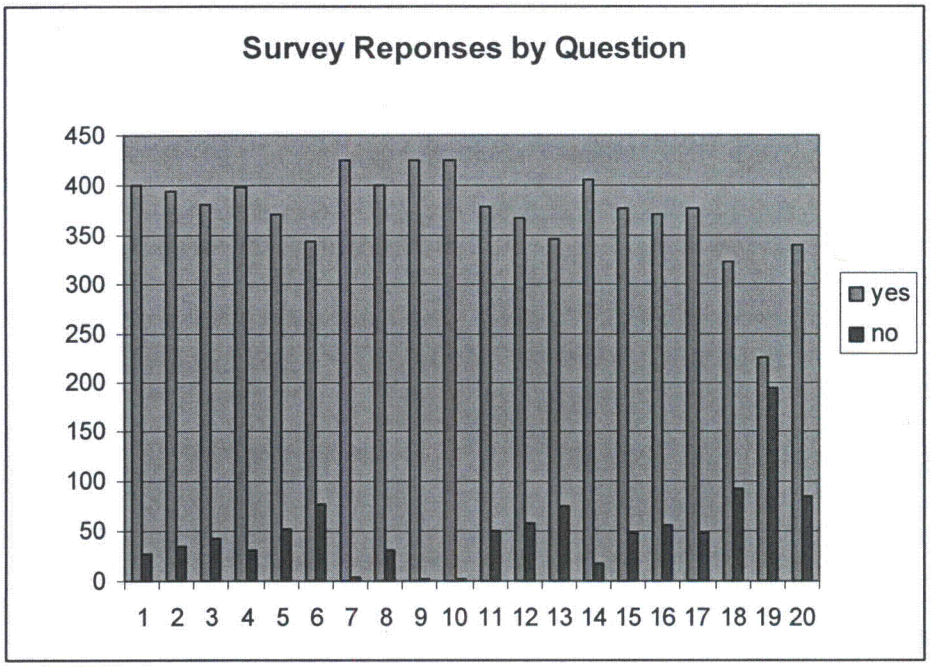
The top three focus areas were compared to focus areas determined via the employee interviews, employee survey results, input from the major event condition report root causes, and other team member insights and recent observations.

Employee Survey

An employee survey was developed using input from Columbia Generating Station and INPO. An electronic web based tool was used to capture results. Good response was noted from employees, with 430 employees participating. Respondents were asked to answer yes or no to a set of 20 questions. Respondents were only asked to identify themselves by department and whether bargaining or management. Additionally, employees were given the opportunity to provide comments; approximately 40 employees did so. The questions are included in Attachment 2.

Responses were generally favorable. The question with the most negative responses was question 19, *Change management plans that affect my department are developed with my input.* This response indicates a potential communication issue. Data indicates multiple departments with negative responses.

Attachment I
Common Cause Analysis



Employees generally appear to feel free to raise issues related to Nuclear Safety via multiple processes. Responses to each question were compared by department to determine any outliers. Radiation Protection (RP) was noted to be an outlier in the number of negative responses. This information was provided to RP management.

Of particular interest to the team was question 20 which states "**I feel that I will be as positively recognized for stopping a job that may impact nuclear safety as I would for completing the job on schedule.** A larger number of negative responses (indicating the employee did not believe that stopping a job with a nuclear safety concern would be viewed positively) were noted than expected, particularly in Engineering and Radiation Protection. This information was provided to Engineering and RP management. Operations and Maintenance both had strong positive responses to this question, with team members stating that this expectation was strongly reinforced in day to day briefs and conversation in these two departments.

Survey comments were reviewed and supported themes seen in other inputs including concerns over resource shortages, decision making by senior management (for example laying off workers that were to assist with post-outage cleanup) and some lack of action and subsequent feedback when concerns are brought up.

Attachment I
Common Cause Analysis

Interviews

In order to obtain more detailed responses than possible with the web-based survey tool, a set of interview questions was developed, using the guidance in IAEA-TECDOC-1321, Self-Assessment of Safety Culture in Nuclear Installations – Highlights and Good Practices. Eight questions were asked, and the results summarized in Attachment III. A cross section of the organization was interviewed, and included managers, supervisors, and exempt and bargaining unit individual contributors.

The first question centered on our continuous improvement culture and indicators of performance – do we have a true picture of our performance and are we a learning organization. Answers were mixed. There were some responses that indicated a belief that performance indicators are being "managed", while other respondents felt that the indicators are a true reflection of station performance and indicated a current decline. Responses on the site's success as a learning organization were also mixed. When combined with the responses to question two, individuals provided barriers to being a learning organization including the time availability to truly learn from the information provided, the communication of issues both up and down the organization and laterally across departments, and questions regarding the efficacy of the site trending programs to identify and learn from issues.

Answers to question three on commitment to a strong nuclear safety culture by all levels of supervision were generally strong, reflecting the responses seen in the survey. Director level and above were almost unanimous in observing a commitment to nuclear safety. However, some gaps were perceived at the manager level and below, with concerns voiced over the impact of high workload on safety culture, and a "production" mentality taking over during refueling outage performance. This mirrored information seen in the answers to question 20 on the survey as noted above, that production is perceived to be more highly valued than safety in some areas.

Question four relates to station work management processes. Answers were largely negative, including a belief that it is too easy to defer important work, and accountability issues within the process. The process itself was not felt to be flawed, but station execution of the process is not properly managed.

Question 5, 6, and 8 were all related to availability of required resources, including the impact of resource sharing. Answers were largely negative and included a belief that resource allocation is crisis driven, concern for attrition rates, and poor succession planning at the individual contributor level. Communication between departments was again noted as an issue in managing resources. Resource sharing was noted as a negative impact when our resources are away, although it was universally perceived as a benefit when we receive resources.

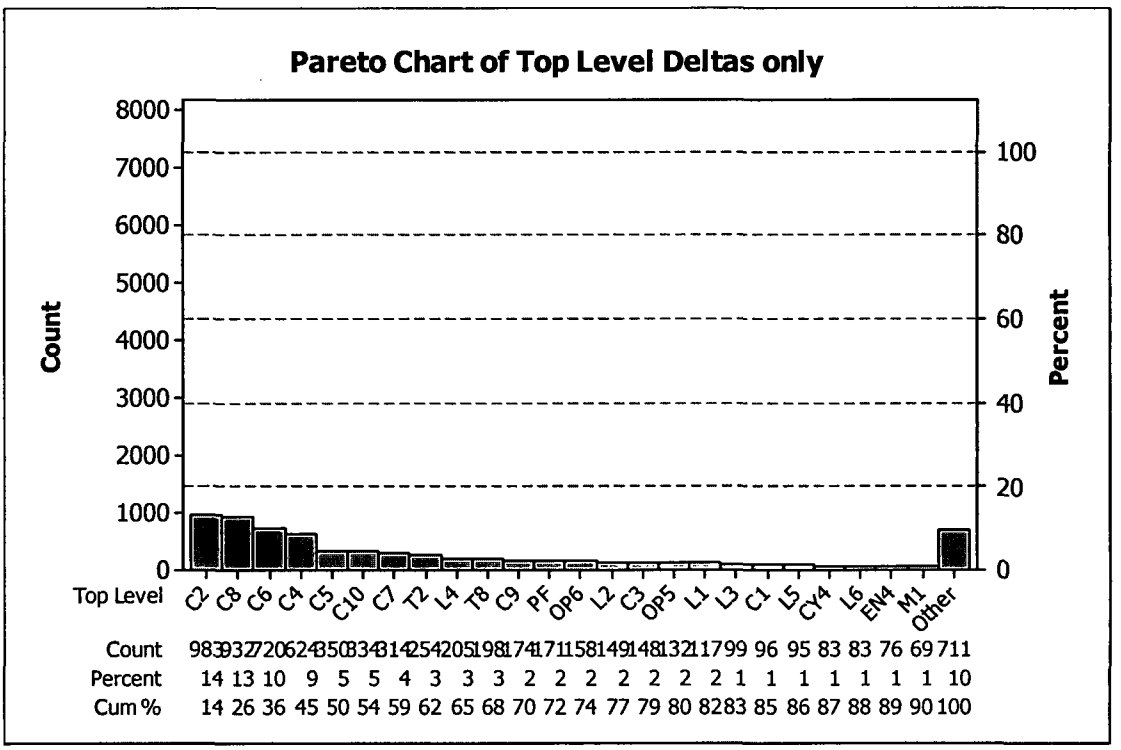
Question 7 related to effectively managing negative external influences, and the impact on worker morale. Knowledge of specific actions taken by management to counter external influences was erratic.

Attachment I
Common Cause Analysis

Many respondents stated that external events are much less influential on morale than internal conditions.

During the discussion of survey results, the team determined that a review of the Leadership Effectiveness Log (LEL) entries may provide additional information regarding behaviors related to Nuclear Safety Culture. LEL log entries were reviewed for the past year. There are two specific fundamentals directly related to Nuclear Safety, C1. Nuclear Safety, and L1. Safety. Other fundamentals also may have elements of nuclear safety as well. Additionally, it is noted in ADM-99 that fundamentals are provided for the eight principles in *Principles for a Strong Nuclear Safety Culture* (listed as SC8 in Attachment 2), however, these fundamentals are not currently available in the LEL database, and are not being selected and trended. A corrective action has been initiated to perform a gap analysis between the fundamentals in the LEL database and the Nuclear Safety Culture Principles/Attributes to present the results to CARB.

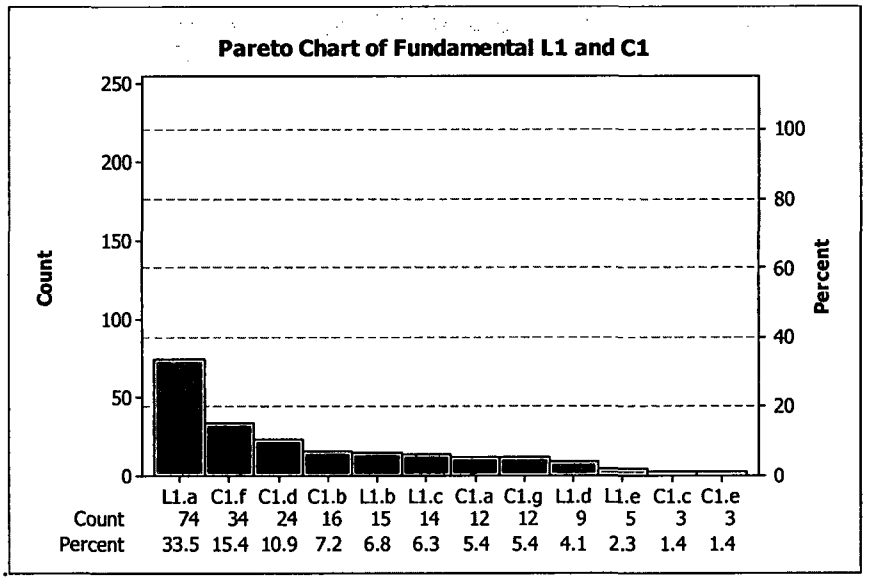
The team reviewed all entries that were coded as "Delta" (pre-December 2010) or "Below Standards" or "Improvement Opportunity" (post December 2010). Note the "Other" block is a combination of all the other remaining codes after 90% of the data is included. All were single hits in a specific fundamental.



The team noted an overall small number of entries coded with the specific safety culture fundamentals. The top codes being coached to change behaviors are C2. – Industrial Safety, C8. – Personal Responsibility and Accountability, and C6. – Group Use Tools. This indicates a potential lack of recognition of safety culture behaviors; the leadership team is coaching on behaviors that clearly are

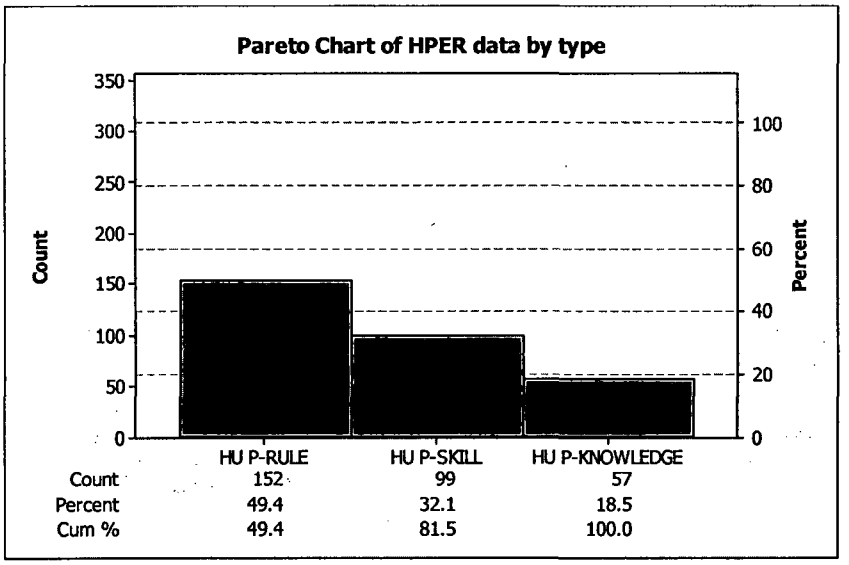
related to safety culture, but not recognizing and including the safety culture element to allow trending and identification of areas where behavior changes may be required. This also represents a missed opportunity to communicate the commitment to a strong nuclear safety culture when providing coaching to station personnel.

Coaching to improve behavior was reviewed based on which specific nuclear safety fundamental was coached on. Three fundamentals accounted for over 50% of the "delta" coaching entries, L1.a, *Safety is our number one priority*, C1.f *Implement timely corrective actions*, and C1.d *Write a condition report when problems or potential problems are identified.* The specific entries were reviewed. The entries for L1.a are 99% industrial safety related. There was no discussion provided relating to one of the 8 principles indicating that the site leadership team is equating regulatory safety requirements to industrial safety. Most of the entries for C1.f were related to the corrective action program, many related to timeliness of issue resolution. Entries coded as C1.d were primarily coaching on failure to promptly write a condition report, with a few examples of improving information provided in a condition report.



One final input reviewed was Human Performance Error Review (HPER) results. Events were grouped into bins based on whether the error was rule based, skill based, or knowledge based.

Attachment I
Common Cause Analysis



Issues are generally classified as rule based, which is defined in EN-HU-101 as "A rule-based error is made when a rule (from training, procedure, etc.) is misapplied or a shortcut is taken." A more detailed review of these issues was not performed as no new insights were noted.

Based on these inputs, the following common themes were identified for further discussion.

Common Group /Issue

Communications

Ownership

Outage and Time Pressured Situations

Common Cause Analysis:

Each of the three common areas was further evaluated to determine common themes, and impacts on site nuclear safety culture.

Attachment I
Common Cause Analysis

Communications:

Communication at the station is lacking in many areas as noted in the interview responses, and the survey responses.

- Lack of information sharing between departments as related to RBS as a learning organization
- Feedback on condition report disposition, employee concern disposition is lacking
- Condition report trending process/results lack adequate communication
- Lack of entries in the Leadership Effectiveness Log (LEL) on Nuclear Safety

The opportunity to share information among departments, such as lessons learned, is not being utilized. Interview question results related to the ability of the site to be a learning organization indicate transfer of information is erratic. Personnel also reported that condition reports are being closed without feedback to personnel. CA&A was contacted and stated that the initiator of a condition report is notified via email when the condition report is closed. The team was not able to resolve this apparent gap. Communication of trend identification and resolution to the supervisors and individual contributors was reported to be erratic via the interview results. The lack of communication of these kinds of issues contributes to the station overall safety culture as related to being a learning organization (Principle 7) and organizational trust (Principle 3). Additionally, as already noted, lack of communication of coaching on the safety principles misses an opportunity for communication of standards and making ties between day to day activities and the principles.

The question with the most negative responses was question 19, **"Change management plans that affect my department are developed with my input"**. Survey comments documented two responses specific to procedure changes. Data indicates multiple departments with negative responses; based on the limited information available from the survey tool, it was not possible to evaluate further during this analysis. Condition report 2011-4014 was initiated to evaluate this condition. Change management plans are a communication tool which assist in ensuring gaps during a change are recognized and managed.

Ownership

Issues with ownership surfaced in interview responses, and can also be seen in condition reports, tied to high numbers of CRs tagged in principle 1, Everyone is Responsible for Nuclear Safety. Examples include:

- Some programs do not have clear owners (i.e. Fire Protection – multiple owners of multiple elements).
- Some programs are not implemented as written (Housekeeping, DPIC portion of CAP)

Lack of program ownership has resulted in gaps in the implementation of some key station programs and processes. Input for this discussion came from interviews, recent station condition reports, and team observations. Some ownership issues were in the implementation of responsibilities in station

programs. Ownership of specific program elements is defined, but not consistently implemented, for example Housekeeping. This behavior is an accountability issue. In other examples, ownership issues result from a lack of clear owner, either due to a lack of definition (for example Fuel Movement) or programs with multiple owners of multiple elements (for example Fire Protection.)

These ownership issues are contributing to station inability to achieve desired standards in some areas. In a program with multiple element owners, it is difficult to determine consistent standards to apply. In a program with no clearly defined owner, standards are not consistently implemented.

Outage and Time Pressured Situations

This area was identified based on interview results, survey results, and a review of the five events identified in the condition report description. The site has experienced multiple significant events during the refuel outage or during high workload time periods such as pre-refuel preparation periods. From interview data and team observations, the site becomes more schedule focused during outage periods, and therefore tends to be more production oriented. The number of negative responses to question 20 which states "**I feel that I will be as positively recognized for stopping a job that may impact nuclear safety as I would for completing the job on schedule.**" Discussed earlier indicates that a production over safety culture exists for some individuals. Team observations related to the Outage Control Center (OCC) interactions with workers during RF16 provided insights as to how OCC direction can be delivered and understood to make production a priority over safety due in part to the intrusive nature of the OCC.

Based on the identification of an issue related to high work load periods, the team discussed the impact of available resources on the organizational safety culture. Some interview results primarily in the Engineer department noted a concern that organizational work load may impact nuclear safety in the organization. Examples were provided by team members of other resource-based decisions that have the potential to impact nuclear safety, such as decisions within the work planning process to push out work orders that are to resolve extent of condition items in to future years. This resource impact was not noted in every department. The team determined resources do not rise to a contributing or root cause.

The team re-evaluated this issue and determined the underlying issue not to be the heavy workload itself, but the rigor to which standards are maintained. Based on interview questions, and survey results, it appears that supervision in general has adopted the Principles document, and accepts the importance of a strong safety culture. However, issues are occurring when a challenge is present, resulting in the site not making positive nuclear safety choices. The team determined that this is the root cause of the safety culture issues being seen at the site.

RC_1 OP5AE – The values and behaviors that comprise a strong nuclear safety culture are not effectively and consistently modeled by some station leaders.

The term "situational standards" was used by the team to describe this behavior. Strong evidence was present in the interviews and survey that the issue is not being caused by a total lack of buy-in to the safety culture principles, but rather by choosing to not apply the principles in specific events.

Two contributing causes were also identified.

CC_1 OP5D – Inadequate communication within the organization

As discussed earlier, weakness in communication at the station is contributing to the safety culture issues. As discussed earlier, the lack of communication of station issues contributes to the station overall safety culture as related to being a learning organization (Principle 7) and organizational trust (principle 3). Additionally missed opportunities for reinforcement of the standards via the fundamentals/coaching process are being missed. Resolution of the communication issue alone would not prevent the issues; as noted in the root cause discussion the cause is selective application of the standard, not lack of knowledge of the standards. Therefore, this cause was identified as a contributing cause.

CC_2 OP2D – Lack of organization authority for program implementation.

As discussed earlier, lack of clear program ownership in some areas has contributed to gaps in some key station processes. Continued acceptance of these gaps has contributed to an erosion of the station safety culture. Lack of strong program ownership can be one of the external influences challenging the consistent implementation of standards. Again it is noted resolution of this issue alone would not prevent the issues, therefore it was identified as a contributing cause.

Validation:

The INPO 2010 plant evaluation results were reviewed for related issues. Two Areas For Improvement (AFIs) were identified during the evaluation that appear to be related to this CR. CR-RBS-2010-5456 was written documenting an AFI in area MA-1:

Maintenance workers and supervisors do not consistently follow procedures and work instructions as written. This has resulted in an extended power reduction, loss of refueling cavity inventory, challenges to safety system operability, and rework. Contributing is maintenance management has not clearly communicated and enforced the correct behaviors in the field.

This area for improvement indicates a weakness with Principle 1 of Principles for a Strong Nuclear Safety Culture. This principle addresses the need for everyone to be responsible for nuclear safety. Specifically that all personnel understand the importance of adherence to nuclear safety standards and the leaders exercise healthy accountability for shortfalls in meeting standards.

The "B" level apparent cause evaluation for this CR was reviewed. The cause was determined to be:

OP4E – Personnel do not clearly understand the rules for procedure and work order use and adherence.

A contributing cause of was identified:

Attachment I
Common Cause Analysis

OP2K – Management monitoring of activities did not identify problems with procedure use and adherence.

Comments in the ACE make a direct tie to Principle 1 of Principles for a Strong Nuclear Safety Culture, stating personnel do not understand the importance of adherence to nuclear safety standards indicating a weakness with this principle. This issue is also seen in the data evaluated for this common cause, specifically with interview results pointing to adherence to standards during production-focused time periods. This AFI supports what the team found in the investigation.

A second AFI received in the 2010 evaluation was also reviewed. CR-RBS-2010-5629 was written documenting an AFI in area OR-2:

Station leaders have not fully anchored some behaviors throughout the organization such as understanding the broader significance of degraded conditions and legacy issues, investigating and understanding precursor behaviors, and appropriately completing corrective maintenance. This has the potential to limit future strategic initiatives and impact achieving the success factors and desired outcomes of continuous performance improvement. This is caused by managers not consistently coaching and reinforcing these prevention-detection behaviors, primarily with the middle level managers.

The "B" level apparent cause evaluation for this CR was reviewed. The cause was determined to be

OP5B, OP5D, OP4B: Leader continuous performance improvement and prevention-detection behavior expectations were not clearly established and communicated. Clear and consistent leadership behavior expectations for understanding the broader significance of degraded conditions and legacy issues, investigating and understanding precursor behaviors and operating a level below their roles were not effectively established and communicated such that these expectations were well known and understood.

Additionally, a second apparent cause was identified as

OP2B There was little if any feedback on the desired behaviors. In regard to working a level below, focused observations and coaching are not performed to ensure all leaders get feedback.

Again the AFI centers on understanding expectations and standards, and reinforcing those standards through coaching and feedback. These same behaviors are noted as the root cause for this CR, in that standards are not being consistently applied, reinforced and communicated.

Attachment II
Survey Questions

Please take a moment and complete this brief survey. The questions are asked in a fashion as to require a yes/no response. The intent of the survey is to gauge each individual's current view point/opinion on the Nuclear Safety Culture at River Bend Station (RBS).

For the purposes of this survey, Management is defined as the personnel that you personally report to. Senior Management is defined as Site Directors, the GMPO, and the Site VP.

1. Employees in other work groups are watchful for conditions or activities that can have an undesirable effect on nuclear safety.

2. Decision-making at RBS reflects nuclear safety first.

3. Sr. Management demonstrates commitment to nuclear safety in both word and action.

4. My Management's expectations regarding nuclear safety and quality are clear.

5. My Management is willing to listen to my problems and concerns.

6. My Management follows through on concerns brought to his/ her attention.

7. I am responsible for identifying problems and adverse conditions.

8. I feel free to approach Management regarding any nuclear safety concern.

9. I am aware of the Ethics Hotline.

10. I am aware of the Employee Concerns Program (ECP).

Attachment II
Survey Questions

11. I can use the Ethics Hotline without fear of retaliation.

12. I can use ECP without fear of retaliation.

13. I believe issues reported through ECP are thoroughly investigated and appropriately resolved.

14. I feel free to contact the NRC regarding any concern.

15. I believe that Management wants employees to report concerns.

16. I am comfortable questioning management on decisions affecting nuclear safety.

17. I feel free to raise nuclear safety/quality concerns through the Corrective Action Program without fear of retaliation.

18. I am informed of steps taken in response to my concerns entered into CAP.

19. Change management plans that affect my department are developed with my input.

20. I feel that I will be as positively recognized for stopping a job that may impact nuclear safety as I would for completing the job on schedule.

Attachment III
Interview Questions & Results

Summary of interview results

1. Does our continuous improvement process/culture reveal the real health of our organization and promote the evolution of the learning organization?

   Answers were evenly split. Specific comments included:

   a. There is not enough time to adequately evaluate / document all issues we are faced with
   b. We are too wrapped up in day-to-day tasks to be an effective learning organization
   c. A "closed to trend" culture has been developed
   d. Meaningful trending is largely in response to events
   e. Performance Indicators are being "managed"

2. Is information shared in such a way that organizational learning is encouraged?

   Answers were evenly split. Specific comments included:

   a. People are not self-critical enough
   b. Sharing of useful information is too event-driven
   c. We are overloaded with distribution of irrelevant information
   d. Downward transfer of useful information is erratic
   e. Department-to-department of useful information is erratic

3. Provide your assessment of Management's commitment to a strong nuclear safety culture.

   a. Directors and above

      Answers were almost unanimously positive. A few responses questioned the directors' dedication to "walk the talk."

   b. Supervisors through Managers

      Answers were mostly positive. Specific comments were:

      i. More responses questioned the dedication to "walk the talk"
      ii. The managers' workload inhibits their ability to commit to a strong nuclear safety culture
      iii. A "production" (as opposed to "safety") mentality takes over during refueling outages

Attachment III
Interview Questions & Results

4. Does the station work planning process effectively identify the scope of work, accountabilities, and milestones?

Answers were largely negative. Specific comments included:

a. Important work is too easily deferred
b. Accountability for overall implementation of the process is hard to identify
c. Departments operate in silos
d. The adverse effects of individual component defects is poorly identified
e. The process is mismanaged

5. Are resources (human, financial, etc.) adequate to implement solutions to station-determined priorities?

Answers were largely negative. Specific comments included:

a. The new-hire attrition rate is too high, and is hampering the knowledge transfer process
b. Resource allocation is crisis-driven
c. Staffing is not maintained
d. Succession planning is poor
e. Department-to-department communication is lacking

6. Do the skills and competencies of the work force extend beyond technical areas and include communication, leadership, and inter-personal skills?

(see question no. 5)

7. Does Management effectively counter the external influences regarding the future of nuclear power that tend to demoralize workers?

No specific adverse effects of external events were identified by the respondents. Knowledge of any particular efforts in this area is erratic. External events are much less influential on morale than internal conditions.

8. What impact, in your opinion, does Shared Resources have on RBS? Is it a benefit or a burden? Explain why.

Answers were evenly split. Specific comments included:

a. There are lots of good benefits of resource sharing

b. Support of resource sharing adversely effects ability to sustain department workload
c. Development of a dedicated "outage team" is seen as potentially beneficial
d. "Problem children" tend to be sent here on shared resource assignments, adversely effecting our safety culture

Attachment IV
Evaluation Causes

1. CR-RBS-2010-02953

AC1:

OP2H – policy guidance or management expectations were not well defined or understood by personnel involved in performing the task.

In response to the incident at JAF in 2005, steps were taken at JAF to block internet access by MCR PCs. This was communicated via email to at least some of the other Entergy sites. However, no steps were taken to ensure the process for controlling the blocking or restricting of internet acess was handled uniformly by all sites or that it was formalized to ensure the restrictions were maintained as PCs were replaced. In addition, apparently not all sites received the "white list" or implemented restricted access for MCR PCs other than the ATC position. An IT policy, procedure or other guidance should have been written and clear management expectations communicated to all site IT personnel regarding the control of internet access by MCR PCs.

CC1:

OP4P- there is evidence that previous industry or in-house operating experience was not effectively used to prevent problems and an event occurred because the information was not properly assimilated by the organization (missed opportunity)

As discussed above, previous events at RBS and JAF occurred and were not adequately communicated and formalized within the IT organization to ensure internet restrictions were established and maintained to prevent this occurrence at RBS.

2. CR-RBS-2010-05456

AC-1:

OP4E - Personnel do not clearly understand the rules for procedure and work order use and adherence

Work order users, including management, are not familiar with the specifics of the procedure use and adherence process requirements and the application of the understanding and execution are inconsistent. Procedure guidance exists but personnel are not effectively adhering to procedures when executing procedures and work instructions. The standards for adherence are interpretive and not well defined and are inconsistently applied. Personnel knowledge of procedure adherence requirements is inconsistent.

Attachment IV
Evaluation Causes

CC1:

OP2K - Management monitoring of activities did not identify problems with procedure use and adherence.

Supervisors are not consistently identifying and documenting worker procedure use and adherence deficiencies. There are differences in procedure and work order understanding and application. This is between workers in the various departments and disciplines and they were not identified.

Interviews revealed that some supervisors/ superintendents are not familiar with the specifics of procedure use and adherence process requirements and supervisors do not agree with how to execute all of the expectations.

CC2:

OP5M – There is evidence that work orders are not the appropriate tools to use to do some jobs.

Review of this finding and interview results indicates that work orders may not contain the level of detail necessary to conduct some work activities resulting in frequent changes to work orders in the field. Worker feedback indicates that some activities need greater details and development and execution rigor than are required by the work order planning criteria and field change processes. This added rigor is available in the procedure process.

Work orders do not require the same level of rigor as procedures in their development, change, and approval. Maintenance procedures could be written to perform work to add this rigor that does not exist. Maintenance procedures could add to improved adherence and document quality.

3. CR-RBS-2010-6059

RC1:

EF1J – (The Root Cause of this event is indeterminate, after rigorous and thorough investigation.)

The failure mode for this evaluation, after a rigorous and thorough review of all the available data, is a seven second loss of DC control power, with no Root Cause identified.

4. CR-RBS-2011-0899

RC_1: Human performance tools and defenses were not adequately applied to prevent errors during fuel movement activities. (WP3Z)

The Driver failed to refocus and self check after reviewing the move sheet resulting in the bridge being moved with a fuel bundle grappled and only partially withdrawn from the core.

The Spotter and ROV Operator failed to perform their required duties for fuel movement activities as delineated in REP-0029, FHP-0002, & FHP-0003.

The SRO failed to provide management oversight and refocus the crew after identifying that the Driver stopped to speak with the Spotter after only withdrawing the bundle 10 inches.

Corrective actions for this root cause will be tracked in CR-RBS-2011-1107 CA 13. Individual performance issues will be handled outside the corrective action program.

CC_1: Less than adequate decision-making and task tracking. (OP5E, OP5Q).

The Refueling SRO did not immediately identify that the bridge was being moved with a fuel bundle not fully withdrawn which resulted in damage to the refueling bridge mast and potential damage to the fuel bundle.

The Refueling SRO determined that it was acceptable for the crew to continue with move 553 after identifying that the bridge was moved with a fuel bundle grappled but not fully withdrawn from the core.

CC_2: Ineffective Change Management (CM1Z, OP2H)

A procedural change required the Driver to perform concurrent verification with the Spotter of all locations on the STS. This process added additional distractions for the driver, requiring the driver to refocus after each evolution. The procedure was not revised until 1/11/2011 which was one week before fuel movement began.

CC_3: Insufficient details for roles & responsibilities during fuel movement activities. (OP4A)

REP-0029, Fuel Movement, rev 28 was issued 1/11/2011 with major changes to the procedural requirements and responsibilities with insufficient time before the outage to clarify the new roles and ensure they were correct and feasible.

5. CR-RBS-2011-1850/866

RC_1:

WP3D – Self checking was not applied to ensure the correct component

Attachment IV
Evaluation Causes

Self Checking was not applied to ensure correct component, concurrently, by Bridge Driver, Spotter, and SRO. All three individuals involved failed to adequately perform their roles and responsibilities in accordance with FHP-0003 and REP-0029.

RC_2:

OP4A, OP4D – Fuel Handling program contains insufficient procedural details to adequately perform all fuel movement activities including the required verification process.

REP-0029, Fuel Movement, rev 28 was issued 1/11/2011 with changes to the procedural requirements and responsibilities. REP-0029 Section 3.15 for expectations during fuel movement was included in this revision (reference Attachment VI.) This flowchart outlines the responsibility of the driver and spotter to verify two of three during fuel movement, however gives no detail on how to perform this function outside of the vessel with no mast camera available. REP-0029 rev 28 requires the verification of fuel movement by two of the three following methods:

- X-Y coordinates as displayed in driver cab
- Visual verification via camera feed
- Counting cells to X-Y location

Contrary to this direction, the mast camera had failed and no alternate camera (ROV) had been provided.

FHP-0003, Refuel Platform Operation revision 22 contains a Bridge Movement Checklist (reference Attachment VII). This checklist illustrates that the Spotter/FMS and Driver are to verify two of three by ensuring the "X"-"Y" bridge encoder display matches the STS. This cannot be accomplished in the upper containment pool based on the STS containing the rack locations vice coordinates.

The FMS responsibilities were transferred to the ROV operator. This removed an additional barrier from the refuel bridge and allowed the function of the FMS to be performed only during core alterations. The ROV operator did not have the ability or direction to provide verification responsibilities outside of the vessel during fuel movement.

CC_1:

DC1A – Original design inadequate.

The Upper Containment Pool storage racks are labeled with the column numbers, but are not labeled with the row letter.

Attachment IV
Evaluation Causes

The containment storage rack at Grand Gulf has both columns and rows visually labeled on the racks in the Upper Containment Pool. Other plants have labels or marking for the trolley on the bridge and on the pool for the bridge location.

CC_2:

EF1H - Unforeseen failure

The Mast camera failed several times during the outage and was not available.

Significant efforts were made to ensure that a working mast camera was available. However, these efforts were not successful, and the camera was not fully functional most of the outage. Spare camera parts are maintained, but even with preventive maintenance and use of these spare components, multiple unforeseen failures did not allow reliable use of the camera.

ATTACHMENT V
Safety Culture Evaluation

TABLE 1 – SAFETY CULTURE COMPARISON

SAFETY CULTURE COMPONENT	DESCRIPTION	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
1. Decision-Making	Licensee decisions demonstrate that nuclear safety is an overriding priority:	RC_1 – **Applicable – Note 1** CC_1 – **Applicable – Note 1** CC_2 – **Applicable – Note 1** CC_3 – **Applicable – Note 1**
2. Resources	The licensee ensures that personnel, equipment, procedures, and other resources are available and adequate to assure nuclear safety.	RC_1 – **Applicable – Note 2** CC_1 – n/a CC_2 – n/a CC_3 – **Applicable– Note 2**
3. Work Control	The licensee plans and coordinates work activities, consistent with nuclear safety.	RC_1 – **Applicable – Note 3** CC_1 – n/a CC_2 – **Applicable – Note 3** CC_3 – **Applicable – Note 3**
4. Work Practices	Personnel work practices support human performance.	RC_1 – **Applicable – Note 4** CC_1 – **Applicable – Note 4** CC_2 – **Applicable – Note 4** CC_3 – **Applicable – Note 4**
5. Corrective Action Program	The licensee ensures that issues potentially impacting nuclear safety are promptly identified, fully evaluated, and that actions are taken to address safety issues in a timely manner, commensurate with their significance.	RC_1 – **Applicable – Note 5** CC_1 – **Applicable – Note 5** CC_2 – **Applicable – Note 5** CC_3 – **Applicable – Note 5**

ATTACHMENT V
Safety Culture Evaluation

SAFETY CULTURE COMPONENT	DESCRIPTION	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
6. Operating Experience	The licensee uses operating experience (OE) information, including vendor recommendations and internally generated lessons learned, to support plant safety.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – n/a
7. Self- and Independent Assessments	The licensee conducts self- and independent assessments of their activities and practices, as appropriate, to assess performance and identify areas for improvement.	RC_1 – n/a CC_1 – **Applicable – Note 7** CC_2 – **Applicable – Note 7** CC_3 – **Applicable – Note 7**
8. Environment For Raising Concerns	An environment exists in which employees feel free to raise concerns both to their management and/or the NRC without fear of retaliation and employees are encouraged to raise such concerns.	RC_1 – **Applicable – Note 8** CC_1 – **Applicable – Note 8** CC_2 – **Applicable – Note 8** CC_3 – n/a
9. Preventing, Detecting, and Mitigating Perceptions of Retaliation	A policy for prohibiting harassment and retaliation for raising nuclear safety concerns exists and is consistently enforced.	RC_1 – **Applicable – Note 9** CC_1 – n/a CC_2 – n/a CC_3 – n/a
10. Accountability	Management defines the line of authority and responsibility for nuclear safety.	RC_1 – **Applicable – Note 10** CC_1 – **Applicable – Note 10** CC_2 – n/a CC_3 – **Applicable – Note 10**

ATTACHMENT V
Safety Culture Evaluation

SAFETY CULTURE COMPONENT	DESCRIPTION	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
11. Continuous learning environment	The licensee ensures that a learning environment exists.	RC_1 – n/a CC_1 – **Applicable – Note 11** CC_2 – **Applicable – Note 11** CC_3 – n/a
12. Organizational change management	Management uses a systematic process for planning, coordinating, and evaluating the safety impacts of decisions related to major changes in organizational structures and functions, leadership, policies, programs, procedures, and resources. Management effectively communicates such changes to affected personnel.	RC_1 – **Applicable – Note 12** CC_1 – n/a CC_2 – **Applicable – Note 12** CC_3 – **Applicable – Note 12**
13. Safety policies	Safety policies and related training establish and reinforce that nuclear safety is an overriding priority.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – n/a

ATTACHMENT V
Safety Culture Evaluation

Notes

1	**Decision Making — Licensee decisions demonstrate that nuclear safety is an overriding priority.** • **Applicable to RC_1 on the "values and behaviors" and "lead by example" parts.** • **Applicable to CC_1 on the "work practices" and "decision making" parts.** • **Applicable to CC_2 on the "communications" part.** • ***Applicable to CC_3 on the "organization authority" and "acceptance standards" parts.***
2	**Resources — The licensee ensures that personnel, equipment, procedures, and other resources are available and adequate to assure nuclear safety.** • **Applicable to RC_1 on the "values and behaviors" and "situational standards" parts.** • **Applicable to CC_3 on the "ownership" and "acceptance standards" parts.**
3	**Work Control — The licensee plans and coordinates work activities, consistent with nuclear safety.** • **Applicable to RC_1 on the "situational standards" part.** • **Applicable to CC_2 on the "communications" part.** • **Applicable to CC_3 on the "ownership" and "acceptance standards" parts.**
4	**Work Practices — Personnel work practices support human performance.** • **Applicable to RC_1 on the "values and behaviors" and "lead by example" parts.** • **Applicable to CC_1 on the "work practices" part.** • **Applicable to CC_2 on the "communications" part.** • **Applicable to CC_3 on the "acceptance standards" part.**
5	**Corrective Action Program — The licensee ensures that issues potentially impacting nuclear safety are promptly identified, fully evaluated, and that actions are taken to address safety issues in a timely manner, commensurate with their significance.** • **Applicable to RC_1 on the "values and behaviors" and the "situational standards" parts.** • **Applicable to CC_1 on the "decision making" part.** • **Applicable to CC_2 on the "communication" part.** • **Applicable to CC_3 on the "ownership" and "acceptance standards" parts.**
7	**Self- and Independent Assessments — The licensee conducts self- and independent assessments of their activities and practices, as appropriate, to assess performance and identify areas for improvement.** • **Applicable to CC_1 on the "decision making" part.** • **Applicable to CC_2 on the "communications" part.** • **Applicable to CC_3 on the "ownership" and "acceptance standards" parts.**

ATTACHMENT V
Safety Culture Evaluation

8	**Environment for Raising Concerns — An environment exists in which employees feel free to raise concerns both to their management and/or the NRC without fear of retaliation and employees are encouraged to raise such concerns.** • **Applicable to RC_1 on the "situational standards" part.** • **Applicable to CC_1 on the "work practices" and "decision making" parts.** • **Applicable to CC_2 on the "communications" part.**
9	**Preventing, Detecting, and Mitigating Perceptions of Retaliation — A policy for prohibiting harassment and retaliation for raising nuclear safety concerns exists and is consistently enforced.** • **Applicable to RC_1 on the "situational standards" part.**
10	**Accountability — Management defines the line of authority and responsibility for nuclear safety.** • **Applicable to RC_1 on the "values and behaviors" and the "lead by example" parts.** • **Applicable to CC_1 on the "work practices" part.** • **Applicable to CC_3 on the "program implementation" and "acceptance standards" parts.**
11	**Continuous Learning Environment — The licensee ensures that a learning environment exists.** • **Applicable to CC_1 on the "work practices" part.** • **Applicable to CC_2 on the "communications" part.**
12	**Organizational Change Management — Management uses a systematic process for planning, coordinating, and evaluating the safety impacts of decisions related to major changes in organizational structures and functions, leadership, policies, programs, procedures, and resources. Management effectively communicates such changes to affected personnel.** • **Applicable to RC_1 on the "values and behaviors" part.** • **Applicable to CC_2 on the "communications" part.** • **Applicable to CC_3 on the "acceptance standards" part.**

ATTACHMENT V
Safety Culture Evaluation

TABLE 2 – DETAILED SAFETY CULTURE COMPONENT REVIEW

		Description	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
1. Decision-Making		**Licensee decisions demonstrate that nuclear safety is an overriding priority. Specifically (as applicable):**	
	H.1(a)	The licensee makes safety-significant or risk-significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained. This includes formally defining the authority and roles for decisions affecting nuclear safety, communicating these roles to applicable personnel, and implementing these *roles and authorities as designed and obtaining interdisciplinary input and reviews on safety-significant or risk-significant decisions.*	RC_1 – **Applicable** CC_1 – **Applicable** CC_2 – **Applicable** CC_3 – n/a
	H.1(b)	The licensee uses conservative assumptions in decision making and adopts a requirement to demonstrate that the proposed action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action. The licensee conducts effectiveness reviews of safety-significant decisions to verify the validity of the underlying assumptions, identify possible unintended consequences, and determine how to improve future decisions.	RC_1 – **Applicable** CC_1 – **Applicable** CC_2 – **Applicable** CC_3 – **Applicable**
	H.1(c)	The licensee communicates decisions and the basis for decisions to personnel who have a need to know the information in order to perform work safely, in a timely manner.	RC_1 – n/a CC_1 – n/a CC_2 – **Applicable** CC_3 – n/a
2. Resources		**The licensee ensures that personnel, equipment, procedures, and other resources are available and adequate to assure nuclear safety. Specifically, those necessary for:**	
	H.2(a)	Maintaining long term plant safety by maintenance of design margins, minimization of long-standing equipment issues, minimizing preventative maintenance deferrals, and ensuring maintenance and engineering backlogs which are low enough to support safety.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – **Applicable**

ATTACHMENT V
Safety Culture Evaluation

		Description	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
	H.2(b)	Training of personnel and sufficient qualified personnel to maintain work hours within working hours guidelines.	RC_1 – **Applicable** CC_1 – n/a CC_2 – n/a CC_3 – n/a
	H.2(c)	Complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – **Applicable**
	H.2(d)	Adequate and available facilities and equipment, including physical improvements, simulator fidelity and emergency facilities and equipment.	RC_1 – **Applicable** CC_1 – n/a CC_2 – n/a CC_3 – **Applicable**
3. Work Control		**The licensee plans and coordinates work activities, consistent with nuclear safety. Specifically (as applicable):**	
	H.3(a)	The licensee appropriately plans work activities by incorporating ▪ risk insights; ▪ job site conditions, including environmental conditions which may impact human performance; plant structures, systems, and components; human-system interface; or radiological safety; and ▪ the need for planned contingencies, compensatory actions, and abort criteria.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – **Applicable**

ATTACHMENT V
Safety Culture Evaluation

		Description	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
	H.3(b)	The licensee appropriately coordinates work activities by incorporating actions to address: ▪ the impact of changes to the work scope or activity on the plant and human performance. ▪ the impact of the work on different job activities, and the need for work groups to maintain interfaces with offsite organizations, and communicate, coordinate, and cooperate with each other during activities in which interdepartmental coordination is necessary to assure plant and human performance. ▪ the need to keep personnel apprised of work status, the operational impact of work activities, and plant conditions that may affect work activities. ▪ the licensee plans work activities to support long-term equipment reliability by limiting temporary modifications, operator work-arounds, safety systems unavailability, and reliance on manual actions. Maintenance scheduling is more preventive than reactive.	RC_1 – **Applicable** CC_1 – n/a CC_2 – **Applicable** CC_3 – **Applicable**
4. Work Practices		**Personnel work practices support human performance. Specifically (as applicable):**	
	H.4(a)	The licensee communicates human error prevention techniques, such as holding pre-job briefings, self and peer checking, and proper documentation of activities. These techniques are used commensurate with the risk of the assigned task, such that work activities are performed safely. Personnel are fit for duty. In addition, personnel do not proceed in the face of *uncertainty or unexpected circumstances.*	RC_1 – **Applicable** CC_1 – **Applicable** CC_2 – **Applicable** CC_3 – n/a
	H.4(b)	The licensee defines and effectively communicates expectations regarding procedural compliance and personnel follow procedures	RC_1 – **Applicable** CC_1 – **Applicable** CC_2 – **Applicable** CC_3 – **Applicable**
	H.4(c)	The licensee ensures supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported.	RC_1 – **Applicable** CC_1 – n/a CC_2 – n/a CC_3 – **Applicable**

ATTACHMENT V
Safety Culture Evaluation

		Description	GR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
5. Corrective Action Program		**The licensee ensures that issues potentially impacting nuclear safety are promptly identified, fully evaluated, and that actions are taken to address safety issues in a timely manner, commensurate with their significance. Specifically (as applicable):**	
	P.1(a)	The licensee implements a corrective action program with a low threshold for identifying issues. The licensee identifies such issues completely, accurately, and in a timely manner commensurate with their safety significance.	RC_1 – **Applicable** CC_1 – **Applicable** CC_2 – n/a CC_3 – **Applicable**
	P.1(b)	The licensee periodically trends and assesses information from the CAP and other assessments in the aggregate to identify programmatic and common cause problems. The licensee communicates the results of the trending to applicable personnel.	RC_1 – n/a CC_1 – n/a CC_2 – **Applicable** CC_3 – **Applicable**
	P.1(c)	The licensee thoroughly evaluates problems such that the resolutions address causes and extent of conditions, as necessary. This includes properly classifying, prioritizing, and evaluating for operability and reportability conditions adverse to quality. This also includes, for significant problems, conducting effectiveness reviews of corrective actions to ensure that the problems are resolved.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – **Applicable**
	P.1(d)	The licensee takes appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity.	RC_1 – **Applicable** CC_1 – n/a CC_2 – **Applicable** CC_3 – **Applicable**
	P.1(e)	If an alternative process (i.e., a process for raising concerns that is an alternate to the licensee's corrective action program or line management) for raising safety concerns exists, then it results in appropriate and timely resolutions of identified problems.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – n/a

ATTACHMENT V
Safety Culture Evaluation

		Description	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
7. Self- and Independent Assessments		**The licensee conducts self- and independent assessments of their activities and practices, as appropriate, to assess performance and identify areas for improvement. Specifically (as applicable):**	
	P.3(a)	The licensee conducts self-assessments at an appropriate frequency; such assessments are of sufficient depth, are comprehensive, are appropriately objective, and are self-critical. The licensee periodically assesses the effectiveness of oversight groups and programs such as CAP, and policies.	RC_1 – n/a CC_1 – **Applicable** CC_2 – n/a CC_3 – **Applicable**
	P.3(b)	The licensee tracks and trends safety indicators which provide an accurate representation of performance.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – n/a
	P.3(c)	The licensee coordinates and communicates results from assessments to affected personnel, and takes corrective actions to address issues commensurate with their significance.	RC_1 – n/a CC_1 – **Applicable** CC_2 – **Applicable** CC_3 – **Applicable**
8. Environment For Raising Concerns		**An environment exists in which employees feel free to raise concerns both to their management and/or the NRC without fear of retaliation and employees are encouraged to raise such concerns. Specifically (as applicable):**	
	S.1(a)	Behaviors and interactions encourage free flow of information related to raising nuclear safety issues, differing professional opinions, and identifying issues in the CAP and through self assessments. Such behaviors include supervisors responding to employee safety concerns in an open, honest, and non-defensive manner and providing complete, accurate, and forthright information to oversight, audit, and regulatory organizations. Past behaviors, actions, or interactions that may reasonably discourage the raising of such issues are actively mitigated. As a result, personnel freely and openly communicate in a clear manner conditions or behaviors, such as fitness for duty issues that may impact safety and personnel raise nuclear safety issues without fear of retaliation.	RC_1 – **Applicable** CC_1 – n/a CC_2 – **Applicable** CC_3 – n/a

ATTACHMENT V
Safety Culture Evaluation

		Description	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
	S.1(b)	If alternative processes (i.e., a process for raising concerns or resolving differing professional opinions that are alternates to the licensee's corrective action program or line management) for raising safety concerns or resolving differing professional opinions exists, then they are communicated, accessible, have an option to raise issues in confidence, and are independent, in the sense that the program does not report to line management (i.e., those who would in the normal course of activities be responsible for addressing the issue raised).	RC_1 – **Applicable** CC_1 – **Applicable** CC_2 – **Applicable** CC_3 – n/a
9. Preventing, Detecting, and Mitigating Perceptions of Retaliation		**A policy for prohibiting harassment and retaliation for raising nuclear safety concerns exists and is consistently enforced in that:**	
	S.2(a)	All personnel are effectively trained that harassment and retaliation for raising safety concerns is a violation of law and policy and will not be tolerated	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – n/a
	S.2(b)	Claims of discrimination are investigated consistent with the content of the regulations regarding employee protection and any necessary corrective actions are taken in a timely manner, including actions to mitigate any potential chilling effect on others due to the personnel action under investigation.	RC_1 – **Applicable** CC_1 – n/a CC_2 – n/a CC_3 – n/a
	S.2(c)	The potential chilling effects of disciplinary actions and other potentially adverse personnel actions (e.g., reductions, outsourcing, and reorganizations) are considered and compensatory actions are taken when appropriate.	RC_1 – **Applicable** CC_1 – n/a CC_2 – n/a CC_3 – n/a

ATTACHMENT V
Safety Culture Evaluation

		Description	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
10. Accountability		**Management defines the line of authority and responsibility for nuclear safety. Specifically (as applicable):**	
	A.1(a)	(a) Accountability is maintained for important safety decisions in that the system of rewards and sanctions is aligned with nuclear safety policies and reinforces behaviors and outcomes which reflect safety as an overriding priority.	RC_1 – **Applicable** CC_1 – n/a CC_2 – n/a CC_3 – n/a
	A.1(b)	(b) Management reinforces safety standards and displays behaviors that reflect safety as an overriding priority.	RC_1 – **Applicable** CC_1 – n/a CC_2 – n/a CC_3 – n/a
	A.1(c)	(c) The workforce demonstrates a proper safety focus and reinforces safety principles among their peers.	RC_1 – n/a CC_1 – **Applicable** CC_2 – n/a CC_3 – **Applicable**
11. Continuous learning environment		**The licensee ensures that a learning environment exists. Specifically (as applicable):**	
	C.2(a)	(a) The licensee provides adequate training and knowledge transfer to all personnel on site to ensure technical competency.	RC_1 – n/a CC_1 – n/a CC_2 – n/a CC_3 – n/a
	C.2(b)	(b) Personnel continuously strive to improve their knowledge, skills, and safety performance through activities such as benchmarking, being receptive to feedback, and setting performance goals. The licensee effectively communicates information learned from internal and external sources about industry and plant issues.	RC_1 – n/a CC_1 – **Applicable** CC_2 – **Applicable** CC_3 – n/a

ATTACHMENT V
Safety Culture Evaluation

		Description	CR-RBS-2011-3296 An Adverse Trend in Nuclear Safety Culture Exists at River Bend Station
12. Organizational change management			
	Organizational change management	**Management uses a systematic process for planning, coordinating, and evaluating the safety impacts of decisions related to major changes in organizational structures and functions, leadership, policies, programs, procedures, and resources. Management effectively communicates such changes to affected personnel.**	RC_1 – **Applicable** CC_1 – n/a CC_2 – **Applicable** CC_3 – **Applicable**

RBG-47190

Enclosure 4

Site Procedure ADM-0099

*G12.1.1

Entergy

RIVER BEND STATION
STATION OPERATING MANUAL
***ADMINISTRATIVE PROCEDURE**

**RIVER BEND STATION CONTINUOUS IMPROVEMENT PROCESSES*

PROCEDURE NUMBER:	***ADM-0099**
REVISION NUMBER:	***06**
Effective Date:	***6/16/2011**

NOTE : SIGNATURES ARE ON FILE.

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*INDEXING INFORMATION

TABLE OF CHANGES

LETTER DESIGNATION TRACKING NUMBER	DETAILED DESCRIPTION OF CHANGES

TABLE OF CONTENTS

1 PURPOSE

1.1 The purpose of this procedure is to provide:

1.1.1. A description of the overall Entergy Performance Improvement Process

1.1.2. A description of the Human Performance Improvement Process embedded in the overall process

1.1.3. A description of the Accountability model used at RBS

1.1.4. A description of the Focused Crew Observation process used at RBS per EN-HU-105

1.1.5. A description of the Department and Crew Level Performance Improvement Notebook process

1.1.6. A structured approach to performance improvement

1.1.7. A structured approach to performance management

1.2 The purpose of this document is to provide guidance for supervisors and above related to fundamental behaviors and actions that are necessary to create and sustain an accountability culture that rewards desired behaviors and corrects those that do not reflect standards of excellence. This procedure is applicable to all site and supplemental employees. Functional areas that have developed fundamentals will comply with the Department Fundamentals. Supervisors and above will comply with the Leadership Fundamentals.

2 REFERENCES

2.1 EN-HU-101, "Human Performance Program"

2.2 EN-HU-102, "Human Performance Tools"

2.3 EN-HU-103, "Human Performance Error Reviews"

2.4 EN-HU-104, "Engineering Task Risk and Rigor"

2.5 EN-HU-105, "Human Performance – Managed Defenses"

2.6 ENS-HR-113, "Compensation Procedures for Exempt and Non-exempt Employees"

2.7 ENS-HR-135, "Disciplinary Actions"

2.8 ENS-HR-136, "Level Set Process"

2.9 EN-HR-138, "Executive Review Board Process"

INFORMATION USE

2.10 EN-NS-102, "Fitness for Duty Program"

2.11 EN-LI-102, "Corrective Action Program"

2.12 EN-LI-121, "Entergy Trending Process"

2.13 EN-OE-100, "Operating Experience Program"

2.14 EN-QV Series Procedures

2.15 Procedure EN-TQ-201, "Systematic Approach to Training Process"

2.16 EN-FAP-OM-001, "Leadership Forums for Continuous Improvement"

2.17 INPO Document, "Leadership Fundamentals to Achieve and Sustain Excellent Station Performance", September 2007

2.18 INPO Document, "Human Performance Tools for Managers and Supervisors," December 2007

2.19 INPO 05-005, "Guidelines for Performance Improvement at Nuclear Power Stations," August 2005

2.20 INPO Document, "Principles for a Strong Nuclear Safety Culture Addendum I: Behaviors and Actions That Support a Strong Nuclear Safety Culture," October 2009

2.21 INPO Document, "Fundamentals for Operations, Engineering, Maintenance, Radiological Protection, Chemistry, and Training", October 2006

2.22 INPO 05-005, "Guidelines for Performance Improvement at Nuclear Power Stations", August 2005

2.23 INPO 09-011, "Achieving Excellence in Performance Improvement," September 2009
INPO Document, "Leadership Fundamentals to Achieve and Sustain Excellent Station Performance," September 2007

2.24 SOER 94-1 Recommendation 1 Non-Conservative Decision Making

3 DEFINITIONS

3.1 Accountability: Completion of an action by a supervisor (at any level) that provides positive or negative reinforcement (consequences) for the behavior taken by an individual who works for the supervisor.

3.2 Crew/Work Group: A cohesive team within a functional area that have daily interactions (e.g., Maintenance supervisor and direct reports)

3.3 Common Fundamentals: Those fundamentals that are common across all functional areas.

3.4 Department Performance Improvement Notebook: A department level performance monitoring process utilized by managers and superintendents to drive intrusive engagement within each assigned department functional area

3.5 Department Fundamentals: Basic behavior expectations defined for a functional area or work group.

3.6 Executive Review Board: A cross-discipline team that includes managers, supervisors, and HR representation assembled as needed to review events that may involve performance management.

3.7 Fundamentals: The essential knowledge, skills, behaviors, and practices personnel need to apply to conduct their work properly.

3.8 Leadership Fundamentals: Fundamental leadership behaviors and actions that contribute to high levels of plant performance.

3.9 Leadership Effectiveness Logbook (LEL): Used to record interactions with site personnel. These interactions are focused on behaviors of individuals in reference to the Common, Departmental and Leadership Fundamentals

3.10 Process: A continuous series of actions or operations accomplishing a defined result.

3.11 Supervisor Crew Notebook: A crew level performance monitoring process utilized by supervisors to drive intrusive engagement within each assigned crew functional area.

3.12 Working File: A place (hard copy or electronic) where supervisors and above keep records of work examples, positive and negative reinforcement, and other performance management documents for each individual in his/her group.

4 RESPONSIBILITIES

4.1 Site Vice President – Responsible for implementation and maintenance of the processes described in this procedure for creating and sustaining a culture of accountability.

4.2 Site Human Resources (HR) Manager - Responsible for implementation of the referenced HR processes. Responsible for implementation and maintenance of the performance management process.

4.3 Entergy GMPO, Directors, Managers, Superintendents, Supervisors and Supplemental Supervisors - are accountable for:

(a) The implementation and reinforcement of the Common, Departmental and Leadership Fundamentals per EN-FAP-OM-001.

(b) Ensuring new employees are assessed using the fundamentals, and to identify the need to perform additional fundamental observations based on performance

(c) Identifying performance gaps and developing improvement plans

(d) Maintaining and using the Department/Crew Level Performance Improvement Notebooks.

(e) Documenting performance in LEL and maintaining employee working files

(f) Fostering an accountability culture by following the actions described in the accountability model

4.4 Entergy Line Supervisors and Supplemental Supervisors – are accountable for:

(a) Establishing clear expectations for performance in accordance with functional area fundamentals

(b) Providing frequent interactions and performing field observations of employees

(c) Providing immediate coaching and positive reinforcement while conducting field observations

(d) Identifying opportunities for improvements and trends

(e) Developing individual and group improvement opportunities with individual and group input

(f) Providing consequences and/or tangible positive reinforcement as appropriate

5 PROCEDURE

5.1 All personnel (individuals, supervisors, managers and above) shall actively internalize and comply with the fundamentals.

5.2 All levels of supervision shall reinforce the fundamentals per EN-FAP-OM-001. Attachment 1, "Human Performance Improvement Process" describes the Entergy performance improvement process and how human performance improvement is accomplished.

5.3 Long-term Supplemental Supervisors will participate in the Maintenance Department Fundamentals process and meetings. Short-term Supplemental Supervisors onsite for evolutions such as Refuel Outage or Forced Outages are required to participate in the fundamentals reinforcement observation process, but are exempt from participating in the departmental fundamentals meetings. All fundamentals meeting shall be performed in accordance with EN-FAP-OM-001.

5.4 All levels of supervision shall continuously use and reinforce the accountability culture by using the Accountability Model. Attachment 8, "Accountability Model," describes the River Bend accountability model process and how to foster an accountability culture for continuous improvement.

5.5 Department supervisors and managers will meet periodically to assess individual and crew/work group performance.

5.5.1. Attachment 1, "Human Performance Improvement Process" provides guidance in regard to individual and crew/work group performance assessment.

5.5.2. Attachment 2, "Department Performance Review Meeting Scorecard" provides an objective meeting grading criteria to be used during DPRMs.

5.5.3. Attachment 3, "Focused Crew Observations" provides guidance in regard to individual and crew/work group performance observations per EN-HU-105.

5.5.4. Attachment 4, "Department and Crew Level Performance Improvement Notebook Process" provides guidance in regard to the Department/Crew Notebook process.

5.5.5. Attachment 5, "Department Level Performance Improvement Notebook Template" provides a template for use in regards to the Department Level Performance Improvement Notebook.

5.5.6. Attachment 6, "Crew Level Performance Improvement Notebook Template" provides a template for use in regards to the Crew Level Performance Improvement Notebook.

5.5.7. Attachment 7, "Station Expectations" contains the Site Vice President's and GMPO's performance expectations for several core business areas.

5.5.8. Attachment 8, "Accountability Model" provides guidance in regard to instituting and managing an accountability culture.

5.5.9. Attachment 9, "Accountability Matrix" provides a quick reference in regard to managing individual accountability.

5.6 Department supervisors and managers will meet on the second Wednesday of each month to assess department performance using the Department Performance Review Meeting (DPRM) process. Refer to EN-FAP-OM-001 for guidance in regard to DPRM process.

NOTE

Performance improvement is a continuous process utilizing a variety of programs and processes. Elements of the programs and processes include identifying performance gaps and adverse trends, developing action plans and monitoring the results. The performance improvement programs include but are not limited to:

1. NRC Inspection Reports
2. Corrective Action Program (EN- LI-102)
3. Operating Experience (EN-OE-100)
4. QA Audits, Assessments and Observations (EN-QV series)
5. Assessment and Benchmarking (EN-LI-104)
6. Behavior Observations/Feedback (EN-HU-101, EN-HU-102 and EN-HU-105)
7. Trend Reports (EN-LI-121)
8. Data trending and performance indicators

HUMAN PERFORMANCE IMPROVEMENT PROCESS

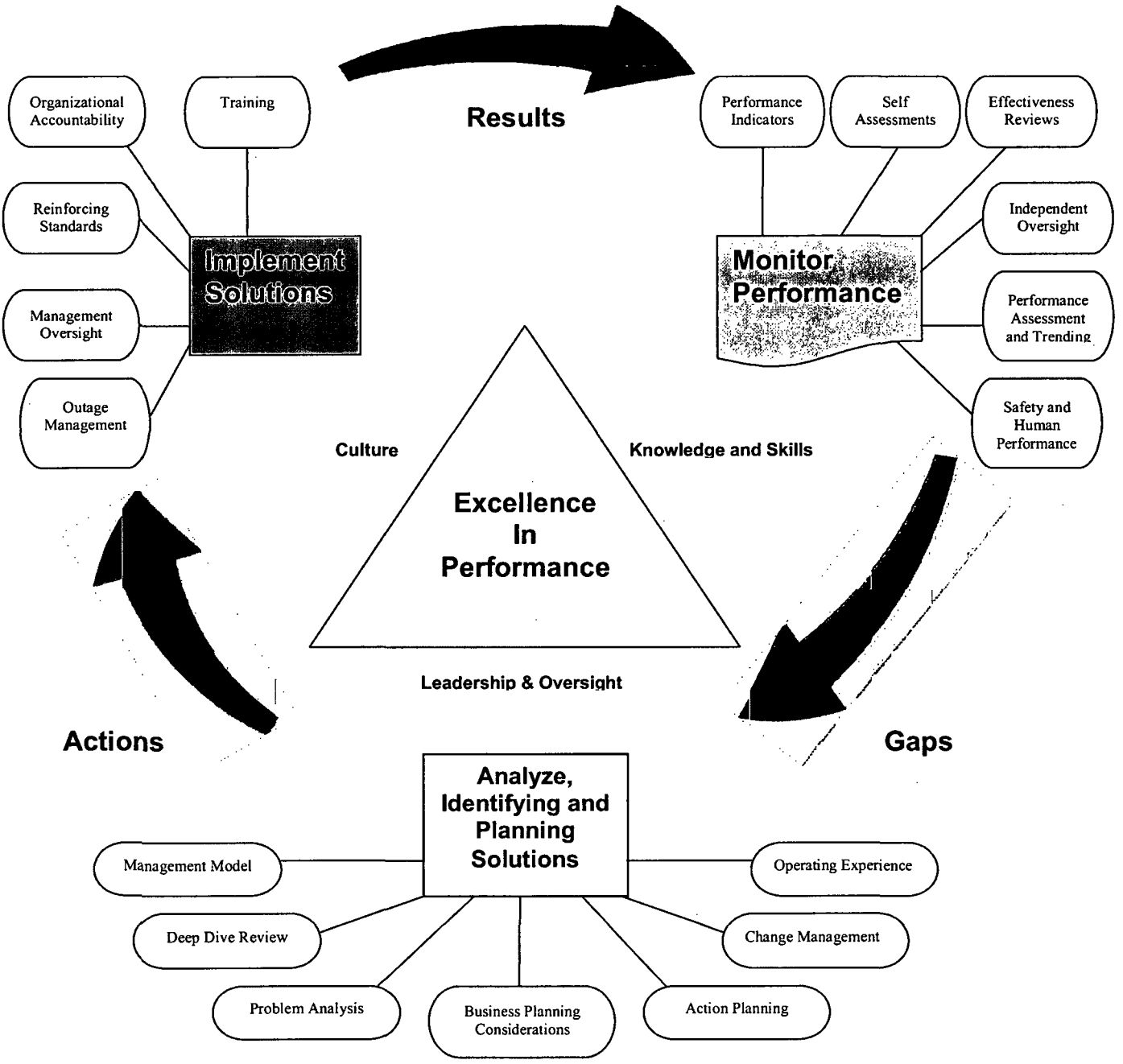


Figure 1

HUMAN PERFORMANCE IMPROVEMENT PROCESS

The **Human Performance Improvement Process** (part of the overall Performance Improvement Process) is also a continuous process focusing on improving individual performance in worker fundamental behaviors. (See Figure 1 as an example) Elements of the Human Performance Improvement Process are:

a. Coaching (Influencing Behaviors)
b. Documenting feedback
c. Analyzing performance / Developing action plans
d. Communicating feedback / Implementing action plans
e. Continue the process

COACHING (Influencing Behaviors)

Definition:
Coaching - observing individual behaviors. Positively reinforcing desired behaviors and immediately correcting behaviors that do not meet expectations. (Specific instruction on how to perform coaching can be found in EN-HU-102)

- Look for behaviors to positively reinforce such as stopping a job that is unsafe, active participation in pre-job briefs, and thoughtful questioning.
- Do not be afraid to correct unsafe work behaviors. Be willing to enforce safety standards. Set the example for others to follow.
- Do not be afraid to correct work practices that are not in control.

To further enhance the supervisor's ability to influence behaviors, the following structure is outlined below:

Daily:

1. Have face-to-face interaction with direct reports with focus on fundamental behaviors that are listed in the Leadership Effectiveness Log book (LEL)
2. First Line Supervisors (FLS) perform a minimum of 1 hour in field coaching and 4 – 6 quality interactions. (Managers can make adjustments)
   - Supervisors are expected to observe and provide feedback when interfacing with employees at all times
3. Know the standards. Inputs into coaching observations are the fundamentals, procedures and policies, and action plans to improve behaviors.
4. Provide immediate, candid and professional feedback.
5. Spot check activities in progress to ensure proper use of Fundamentals.
6. Begin turnover meeting with safety and human performance message.
7. Participate in pre-job briefs ensuring proper focus on critical steps and error likely situations.
8. Ask questions to better gauge workers awareness of the issues and the safety rules for performing the task at hand.
9. Communicate and ensure all supervisors reinforce high standards.

HUMAN PERFORMANCE IMPROVEMENT PROCESS

Weekly:

1. Superintendent or Manager observes FLS field coaching (Paired Coaching).
2. Superintendent/Manager validates Leadership Effectiveness Logbook entries with person being coached (spot check) to ensure feedback was received and understood.
3. Superintendent/Manager spot checks supervisor's Leadership Effectiveness Logbook and ensure appropriate focus on fundamentals.
4. If applicable to your department, perform coaching on backshifts, weekends or off-Fridays (coach may be from your department or another department).

Monthly:

1. Prepare inputs for the Department Performance Review Meeting (See EN-FAP-OM-001 for meeting details)
2. Prepare inputs for Department/Crew Level Performance Improvement Notebooks

DOCUMENTING FEEDBACK

Documenting feedback is essential for several reasons

- Identifies specific behaviors observed
- Represents the quality of feedback given
- Records performance of individuals
- Provides a tool to evaluate trends

Document feedback in the LEL database. A paper copy may also be maintained.

ANALYZING PERFORMANCE / DEVELOPING ACTION PLANS

Analyzing performance, identifying gaps and correcting behaviors are essential (See Figure 2 as an example). Upon identification of a performance gap, supervisors are to take action to hold workers accountable. Additionally, EN-FAP-OM-001 outlines a structured approach to analyzing performance and bridging gaps.

COMMUNICATE FEEDBACK / IMPLEMENT ACTION PLANS

Communicating feedback and following through on actions are also essential to influencing behaviors. EN-FAP-OM-001 contains a template for Fundamentals and Issues Windows, which provides a picture of departmental performance. It also provides a structure to communicate the action plan and outlines the feedback and accountability.

CONTINUE THE PROCESS

Human Performance Improvement is a never ending process. Constant focus, leadership engagement and being intrusive is required to maintain continuous improvement.

HUMAN PERFORMANCE IMPROVEMENT PROCESS

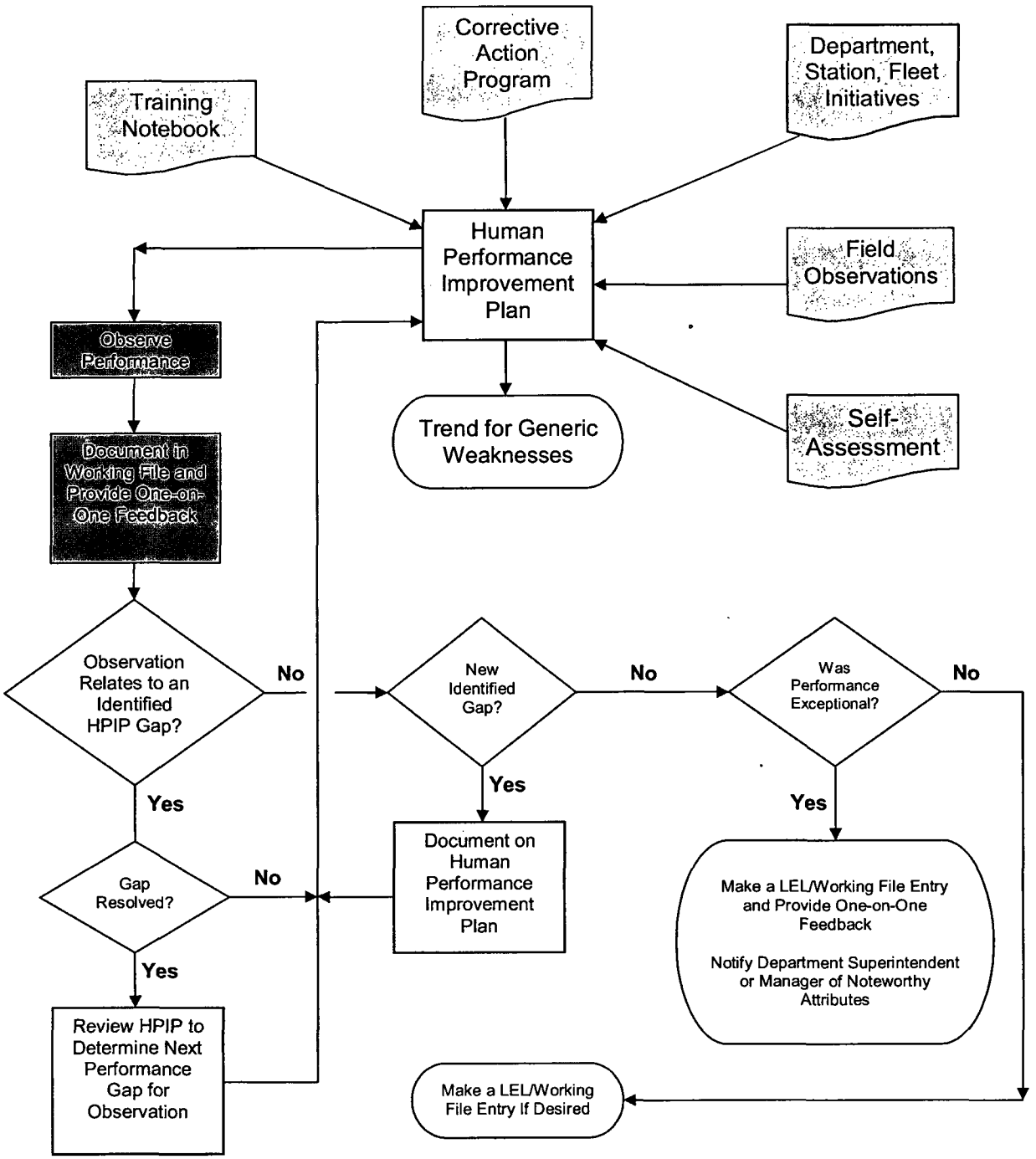


Figure 2

HUMAN PERFORMANCE IMPROVEMENT PROCESS

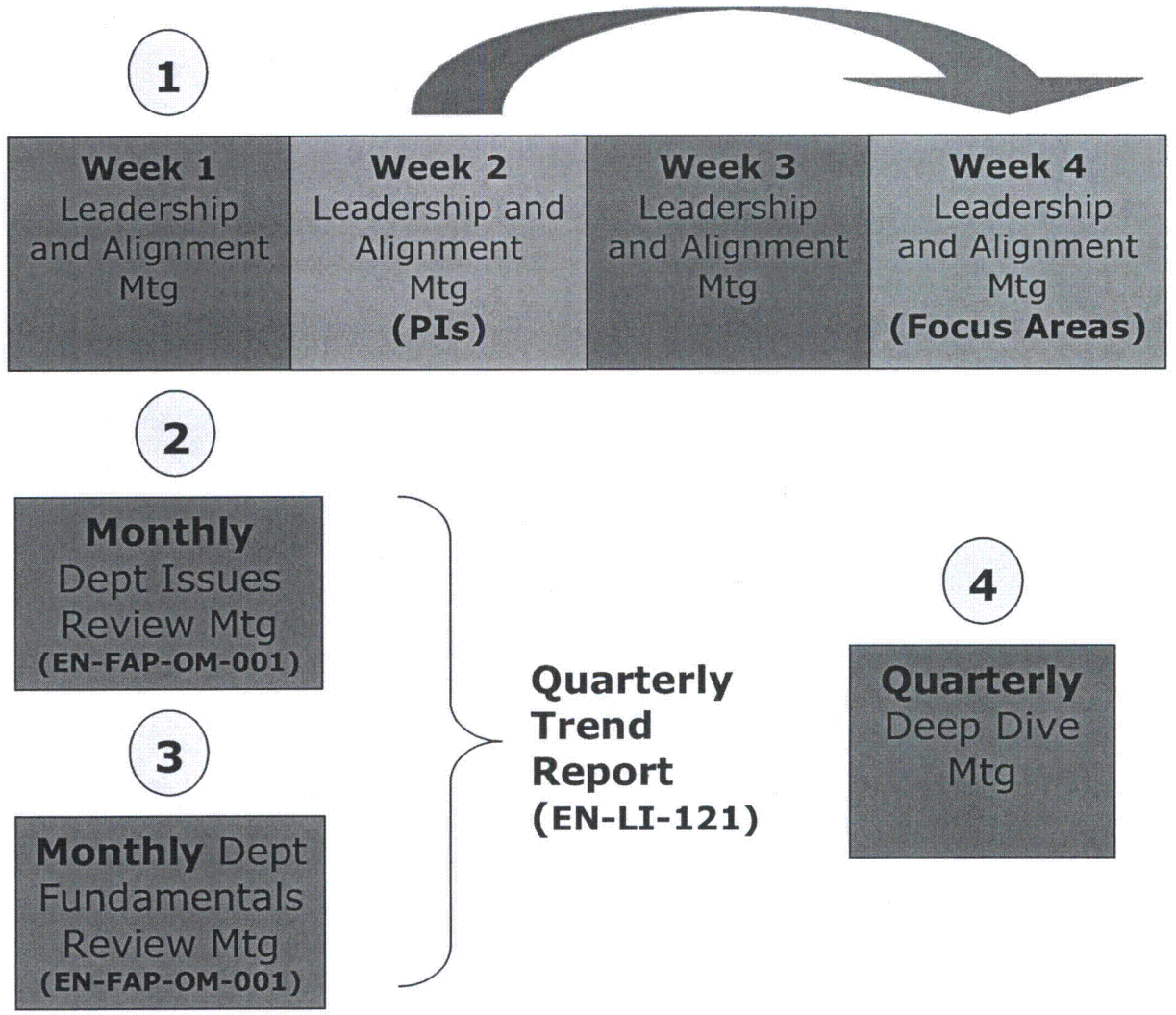


Figure 3

DEPARTMENT PERFORMANCE REVIEW MEETING SCORECARD
(Used to Score DPRMs per EN-FAP-OM-001)

DPRM CRITERIA	Scoring	Observers Comments
1. MEETING ATTENDANCE • Department Leadership team present • Department Improvement Coordinator present • Training representative present • Site Vice President or GMPO present (optional)	**0 (does not address criteria) to 6 (addresses all criteria)** **SCORE =____ out of 6**	
2. DEPARTMENT/CREW DPRM MEETINGS • Agenda aligns with procedure requirements/inputs • Issues/Fundamentals are discussed separately • Issues – Programs/Processes/Performance Indicators • Fundamentals – LEL observations (behaviors)	**0 (does not address criteria) to 6 (addresses all criteria)** **SCORE =____ out of 6**	
3. INPUTS • Performance Indicators • Condition Reports • LEL fundamentals observations • Benchmark or Assessment results (as applicable) • External Reports (INPO, NRC, ANI, etc.) • Last months issue and fundamentals windows and action plans	**0 (does not address criteria) to 6 (addresses all criteria)** **SCORE =____ out of 6**	
4. Department Issues (Program/Processes) • Assess performance against annunciator windows • Each window is presented by the assigned owner • Team is critical and challenges each window color • Team selects windows where gaps exist for focus areas (Window color may be red even though PI is Green based on the desire to apply more focus in the specific area) • Problem statements are created and actions developed are **S.M.A.R.T.** and "next level performance" oriented • Actions are assigned with ***owners***, ***due dates***, ***basis for color change*** and ***success criteria*** to ensure the actions are effective at closing the indentified gaps • Issue (window colors) align with departmental performance	**0 (does not address criteria) to 16 (addresses all criteria)** **SCORE =____ out of 16**	

DEPARTMENT PERFORMANCE REVIEW MEETING SCORECARD

DPRM CRITERIA	Scoring	Observers Comments
5. Department/Crew Fundamentals (Behaviors) • Adequate number of observations by the manager/superintendent/supervisors • Observation ratios are reasonable/self critical (Goal = 4 positive to every 1 critical) • Quality of the LEL entries were evaluated prior to meeting using the Leader 1/Leader 2 rollups as indicated by the Coaching Quality report • Team openly/critically discusses department behaviors • Team selects fundamental behaviors where gaps exist for focus areas over the next 30 days • Problem statements are created and actions developed are **S.M.A.R.T**. and "next level performance" oriented • Actions are assigned with ***owners***, ***due dates***, ***basis for color change*** and ***success criteria*** to ensure the actions are effective at closing the *indentified gaps* • Fundamentals (window colors) align with departmental performance • Determine if the team is self-critical, challenging and capable of effectively identify existing gaps in fundamental behaviors	**0 (does not address criteria) to 16 (addresses all criteria)** **SCORE =____ out of 16**	

Scoring will be assigned for each Department Performance Review Meeting using the following scale:

0 - 39 Significant weaknesses indicating lack of preparation, engagement and / or commitment to process.

40 - 44 Most requirements met; minor improvements needed to improve overall meeting effectiveness.

45 – 50 All or essentially all requirements are met; no changes needed other than coaching using the mentoring process.

- (Note - significant weakness in any area(s) that have not already been identified should be documented using the corrective action process)
- Mentor/Observer – Ensure the meeting observation is captured in the LEL database with a focus on the Leadership Fundamentals
- Reference Procedure EN-FAP-OM-001, "Leadership Forums for Continuous Improvement"

RIVER BEND STATION FOCUSED CREW OBSERVATIONS

Summary
Focused Crew Observations will involve Operations, Maintenance, Radiation Protection, Chemistry, Security and periodically MP&C. Numerous actions have been implemented to communicate and reinforce site standards, expectations and fundamentals. As part of our managed defenses per EN-HU-105, "Managed Defenses," it is essential our leadership demonstrates a commitment to the sites success and constantly reinforces the use of human performance tools through engaged and intrusive observations.

The intent of this guidance is to provide additional Focused Crew Observation details for River Bend Station and meets the minimum requirements of EN-HU-105, "Managed Defenses," for conducting Focused Crew Observations.

Who does the Observations?
The observations are typically completed by the SVP (optional), GMPO, HU/IS Superintendent, NSA Director, Operations Manager, Maintenance Manager, Training Manager, Licensing Manager, EP Manager, Outage Manager, PS&O Manager, Radiation Protection Manager, Engineering Managers, Chemistry Manager, the Superintendents from each discipline, and others as designated by the GMPO.

What does the observations look like?
Each discipline will have a designated group lead that will be responsible to coordinate, assign and brief the designated team members on the focus areas to observe each week. Rotating positions will be assigned from a manager pool by the GMPO at two month intervals. If the need arises, the GMPO has the discretion to assign a manager at ANY time to fill a vacated slot.

This is what the schedule will look like each month for the Focused Crew Observations. The observations will be scheduled from ~0530 – 1100 which includes attending the department morning meeting, attending any pre-job briefs, and then a 2-4 hour field observation. Observation team leads should assign at least one team member to focus on supervisor activities as a paired observation to gauge supervisor effectiveness. Other observers should focus on worker behaviors and activities. Following the field observation time, the observation team will debrief the manager/superintendent and then the manager/superintendent will debrief the department.

By performing the observations we can improve performance across the site by being engaged and intrusive. The focused crew observations will tell us where the weaknesses are throughout our organization so we can go address the gaps identified. Remember, it is critical to the observation that we are focusing on the individuals first, then the work being performed.

Areas identified to observe are as follows:

- INPO 09-011 "Achieving Excellence in Performance Improvement" (Leader and Individual behaviors that exemplify problem prevention, detection and correction)
- Nuclear, Radiological, Environmental and Industrial Safety
- Supervisor involvement and engagement in the pre-job briefs and in the field
- Use of human performance tools and managed defenses IAW EN-HU-102, 105 (Are supervisors/individuals generalizing?)
- Procedure use and adherence IAW EN-AD-102
- The tagging process IAW EN-OP-119 **(walk-down the tagging request with the Operator or supervisor to ensure that tagging errors are eliminated)**
- Plant configuration control

RIVER BEND STATION FOCUSED CREW OBSERVATIONS

Additionally, managers and superintendents should take advantage of creating opportunities to perform/document-paired observations with their staff or others.

Where do we document the observations?

Document the observations in the LEL observation database and identify that the observation was completed by inputting "Focus Crew Assessment." This will be easy to identify this activity and review and trending can be done. Any process or program conditions identified as adverse to quality should be captured using Condition Reports as applicable.

Below is the monthly schedule on when the observations should take place. In order to add value, on some occasions it is prudent for more than one observer to be present and teams of two observers need to watch the same job. This will give additional insight on what is seen during the observation and can be used as a paired observation.

Week	Monday	Tuesday	Wednesday	Thursday	Friday
1			Maintenance ***Mechanical***, Security, RP, Chemistry Operations, MP&C		**AWS OFF**
2			**Designated day for Department Performance Review Meetings (DPRMs)**		
3			Maintenance ***I&C*** and ***Support,*** Security, RP, Operations		**AWS OFF**
4			Maintenance ***Electrical***, Security, Chemistry, Operations, MP&C		

This is the schedule for the Focused Crew Observations. The observations need to be scheduled from 0530 – 1100, which includes attending the department morning meeting, attending the pre-job brief, and then a 2-4 hour field observation. Afterwards, the assessment team will debrief the manager and then debrief the department. ***Security briefs start at 0530. Operations briefs start at 0600.***

Feedback (Both Positive and Critical)?

Feedback (both positive and critical) shall to be provided to all individuals involved including the supervisor and the manager. A copy of the observation guide identifying the positives and gaps will be provided to the department manager/superintendent and de-briefed so actions to close the gaps can be taken and expectations can be reinforced as needed.

RIVER BEND STATION FOCUSED CREW OBSERVATIONS

Additional Duties

Individuals performing observations will be required during the second week of the month to look at ALARA. We need to identify during the observation what individuals are doing to try to reduce online dose. Observers need to look at work preparation, ALARA principles and practices, and the work plan.

INPO 09-011

Appendix A

Typical Behaviors Representative of Performance Improvement as Core Business

Desired Outcome	Individuals	Managers & Supervisors	Senior Managers
The Picture of Excellence Is Well Known	• Understand current performance with an historical perspective (know where station performance has come from, where it is now, and your role in advancing it toward excellence) • Report problem trends to supervisors	• Know how our work groups and station compare to industry excellence, and communicate any gaps widely • Periodically lead self-assessment teams • Make it a habit to personally look at problems in the field • Know how work is really being done • Demonstrate through daily routines how we value a low threshold problem reporting culture	• Help people at all levels of the organization understand their roles in achieving a continuous improvement culture • Set increasingly challenging performance goals to avoid complacency • Use self-assessments and benchmarking strategically, to attain business and safety outcomes • Keep performance gaps visible to the workforce
Problems Are Prevented and Mistakes are Avoided	• Question unexpected conditions • Report near misses • Adopt the "if in doubt, fill it out" philosophy for reporting problems at a low threshold • Use knowledge of major station and industry events to internalize work practices that prevent them from recurring • Solicit feedback on performance from peers and supervisors	• Reward good catches • Welcome—and respond promptly to—reports of near misses • Model prevention and detection behaviors so that the need for corrective actions is minimized • Promote a culture of prevention by providing a way for individuals to share examples of how they have avoided problems • Help subordinates make the connection between operating experience lessons learned and their daily work practices • Monitor corrective action timeliness and backlogs to achieve a culture of "fixing today's problems today"	• Promote a vision of problem prevention and detection through rewards and recognition • Use leading indicators to prompt intervention before little problems become big ones • Establish a culture that recognizes and overcomes the difficulty of using and internalizing operating experience • Assess overall plant performance regularly to determine how resources spent on performance improvement activities add value
Performance Gaps Are Thoroughly Analyzed and Efficiently Solved	• Fix minor problems quickly, and document them for trending • Participate actively in event investigations, and help ensure resulting corrective actions will really fix the problem • Be persistent and remind managers if problems we've identified are not being fixed in a timely manner • When assigned a corrective action, ensure the desired result is understood and the action is fully completed before closure • Hold managers accountable for supporting initiatives that come from self-assessments and benchmarking • After attending training that was designed to correct performance shortfalls, put this learning into practice on the job	• While screening daily problem reports, identify opportunities to learn more about—and fix—organizational problems • Choose the right level of problem investigation to match the actual/potential consequences of events • Raise the level of cause investigation when a problem thought to be solved happens again • Give investigation teams the right expertise and oversight • Challenge improvement initiative goals to pass the SMART test (specific, measurable, achievable, realistic, timely) • Verify the effectiveness of significant corrective actions • Make sure periodic trend reviews do more than provide a status report—they need to add value by being action oriented • Follow through on self-assessment and benchmarking actions • Observe and provide feedback to workers on how well they are putting into practice work habits taught in training • Know precisely how change is progressing by monitoring change initiatives	• Select the near-miss events that will be treated—for learning purposes—as if the last barrier had failed • Lead efforts to resolve organizational contributors to events • Kick off training sessions when training has been identified as a solution to an organizational problem • Reward problem analyzers as well as finders and fixers • Help the organization learn from the subtle, underlying causes of performance trends, including overseeing the right level of causal analysis • Ensure a methodical process is used to determine whether organizational or individual accountability underlies problems • Confirm that corrective action or management review committees are adding value efficiently • Build and sustain improvement momentum by communicating tangible accomplishments of improvement initiatives
Performance Improvement Is Ingrained as Core Business	• Identify and communicate to managers examples of performance improvement processes that do not work well together (self-assessments, benchmarking, corrective action program, training, operating experience) • Point out when due date priorities, established by routine PI processes, are inconsistent with real needs • Notify managers of low-value performance improvement activities that could be eliminated or changed • Embrace performance improvement activities as part of your daily work habits	• Remove bottlenecks and expedite the handling of problem reports • Improve the integration of PI activities • Focus on the right performance metrics, and avoid overfocusing on any single metric • Ensure corrective action turnaround time is short enough to avoid adverse consequences from identified problems	• Model behaviors that demonstrate PI is a core business value, and overtly demonstrate support of PI • Provide efficient PI tools that are helpful in managing daily work • Confirm that improvements, once attained, are anchored in the organization's culture • Be an advocate for PI activities during budget meetings • Reinforce the use of an integrated mix of self-assessments, benchmarking, training, and operating experience to understand and solve problems

DEPARTMENT AND CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK PROCESS

The **Performance Improvement Notebook** process (part of the overall Performance Improvement Process) is also a continuous process focusing on incrementally improving department and crew level performance.

By maintaining the Department/Crew Performance Improvement Notebooks we can improve performance across the site by being engaged and intrusive. The Notebooks are an all inclusive look at department and/or crew level performance and gives the senior leadership team a "real-time" look at how well each leader is driving performance in their respective area. Periodic reviews of the Notebooks by the senior leadership team will ensure that weaknesses are being identified and addresses appropriately and that each responsible leader is being engaged and intrusive and is driving performance by changing worker behaviors. Elements of the Performance Improvement Notebook process are:

Department Level (Manager & Superintendent)
(Refer to Attachment 5 for Flow-chart reference)

a. Department Fundamentals Review meeting results
b. Department Issues Review meeting results
c. Focused Crew Observations Feedback
d. Department Coaching performance
e. Department Training Performance
f. Department ALARA Accountability actions
g. Department Accountability actions
h. Departmental Positive Reinforcement actions
i. Department Personnel Development actions

Crew Level (Supervisor)
(Refer to Attachment 6 for Flow-chart reference)

a. Department Fundamentals Review meeting results
b. Department Issues Review meeting results
c. Focused Crew Observations Feedback
d. Crew Training Performance
e. Crew ALARA Accountability actions
f. Crew Accountability actions
g. Crew Positive Reinforcement actions

Who is responsible for maintaining a Department Performance Improvement Notebook?
The Department Level Performance Improvement Notebooks are maintained by the Operations Manager, Maintenance Manager, Training Manager, PS&O Manager, Radiation Protection Manager, Engineering Managers, Chemistry Manager, Training Superintendents and Maintenance Superintendents from each discipline, and others as designated by the GMPO.

Who is responsible for maintaining a Crew Performance Improvement Notebook?
The Crew Level Performance Improvement Notebooks are maintained by Operations Supervisors, Maintenance Supervisors, Planning Supervisor, Radiation Protection Supervisors, Engineering Supervisors, Chemistry Supervisors, and others as designated by the GMPO.

DEPARTMENT AND CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK PROCESS

What does the Department and Crew Level Performance Improvement Notebook look like?

Department Level Notebook: All the Department Level Notebook elements are listed above for reference (See Attachment 5 for a typical reference template). Each element is expected to be maintained up to date by each responsible department manager and/or superintendents. Periodic reviews (Monthly) will occur with Department Notebook owners and their supervision to validate department performance improvement, ownership and accountability is occurring.

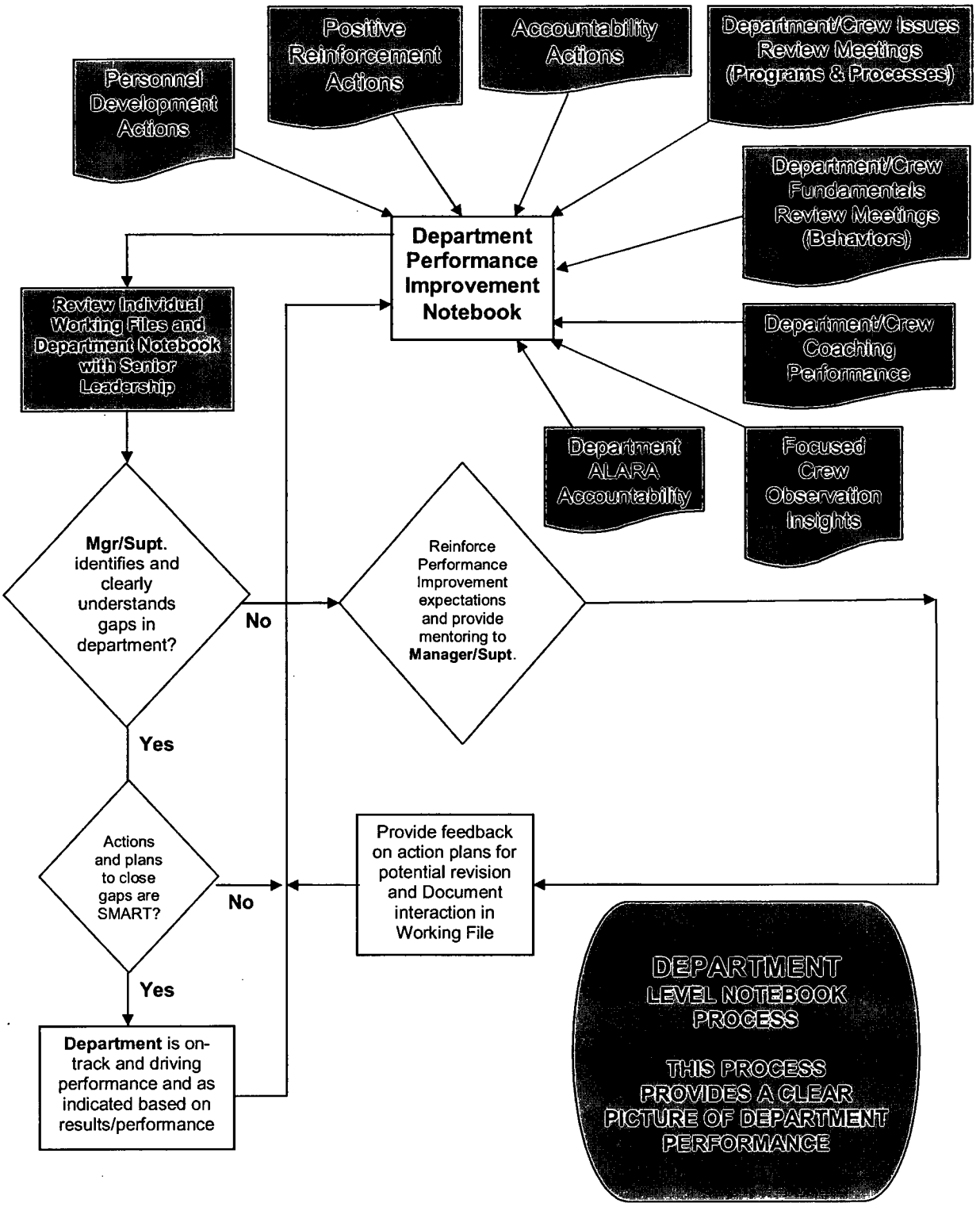
Crew Level Notebook: All the Crew Level Notebook elements are listed above for reference (See Attachment 6 for a typical reference template). Each element is expected to be maintained up to date by each responsible department supervisor. Periodic reviews (Monthly) will occur with Crew Notebook owners and their supervision to validate crew performance improvement, ownership and accountability is occurring.

(Department)
(Manager/Superintendent)
(Template – Typical)

CONFIDENTIAL INFORMATION
DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK

MONTHLY REVIEW
(Insert Date to Insert Date)

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE



DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Department Members

Director: _____

Manager: _____

Superintendent(s): _____

_____

_____

_____

Supervisors: _____

_____

_____

_____

_____

_____

DEPARTMENT/CREW PERFORMANCE

Department Performance Review Meeting per EN-FAP-OM-001

(Attach Department Fundamental/Issues Windows **HERE** with associated Actions Plans)

*****Vertical Alignment*****

Department Leadership must ensure the Department Fundamental/Issues windows and associated action plans are regularly communicated to all department personnel. Department personnel need to clearly understand what the departmental gaps are, and what actions are being taken to close the gaps, and what role they have in improving department performance.

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Focused Crew Observation Insights

Insert Focused Crew Observation results/insights identified to ensure all gaps are properly actioned and addressed to ensure the behavior/issues are resolved.

Fundamental Behavior /Issue	Problem Statement/ GAP Identified	Action to close GAP	WT#/ CR#	Owner	Due Date

Department/Crew personnel changes for this period

Insert Personnel changes as applicable based on promotion, new hires etc.

Individual	Personnel Change Description	Supervisor/Superintendent

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Department Positive Recognition or Accomplishments

Positive Reinforcement Actions (Rewards & Recognition, Good Catch CRs and other accomplishments)

Actions Taken	Why?	Supervisor/Superintendent

Department/Crew Clock Resets

Incidents (HU Event, Error, NCE w/ HPER-1, OSHA Recordable Injuries)

CR#	Brief Description	Event, Error or NCE	OSHA Recordables	Who was involved? (Workers and Supervisors?)

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Department ALARA Accountability

ALARA Initiatives for departments

1. Support ALARA Manger's Committee- Goal 100% attendance
2. Support ALARA Sub-Committee- Goal 100% attendance
3. Maintain department dose ≤10% under the monthly estimated dose
4. Initiate ≥ 5 department ALARA suggestions per quarter
5. Track actual dose savings for completed work- End of Year Goal ≤10% of department annual dose estimate.

Ongoing Initiatives	Current Results

Department Accountability

Accountability Actions (MARC process, verbal, written and beyond)

Actions Taken	Why?	Supervisor/Superintendent

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Department Personnel Development

Personnel on Performance Improvement/Development Plans

Individual	Status (On-track or behind schedule, etc.)	Assigned Mentor	End Date	Supervisor/Superintendent

Coaching Performance

Coaching Department Report (Available in LEL)

Coaches Name	Contact Time	Exceeds Expectation Entries %	Meets Expectations Entries %	Improvement Opportunity Entries %	Below Standard Entries %	Entries/ Month	Quality Indicator (%)

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Department Projects

Project Lead	Project Description	Estimated Completion Date	On-Track/Off Track

OIT HIT Teams

Project Lead	Project Description	Estimated Completion Date	On-Track/Off Track

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Training and Qualifications

Current Qualifications

Crew Individual	Qualification Level	Qualifications completion %	Latest Promotion Date

Potential Training Opportunities Identified

Potential Training Opportunity	TEAR# Generated	TEAR Status

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Training to Improve Performance (TQ-208)

Training Gap Identified	Training Conducted to Close Identified Gap	Anecdotal Evidence of how Training Improved Performance (Example)

Manager/Superintendent Comment Section (Subjective Summary)

(Insert a subjective summary of department performance)

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

CRITERIA	Scoring	Comments
1. Leadership Engagement and Intrusiveness • Department Leadership is prepared and knowledgeable to discuss all material presented • Department Leadership demonstrates engagement and intrusiveness by "knowing what the standards of his/her department are." • Department Leadership knows "what excellence looks like" and department performance improvement strategies and actions align with current performance • Department Leadership is using training to improve performance • Department Leadership is driving accountability and developing individuals	**0 (does not address criteria) to 10 (addresses all criteria)** **SCORE =____ out of 10**	
2. Performance Improvement Notebook Inputs • DPRM Issues and Fundamentals (Current Month) • Focused Crew Observation Insights • ALARA Accountability Actions • Accountability Actions • Personnel Development Actions • Department Coaching performance • Department Training performance • All inputs are current and updated prior to meeting	**0 (does not address criteria) to 14 (addresses all criteria)** **SCORE =____ out of 14**	
3. Department Issues (Program/Processes) • Department Leadership is self-critical, challenging and capable of effectively identify existing gaps in fundamental behaviors • Problem statements are created and actions developed are S.M.A.R.T. and "next level performance" oriented • Actions are assigned with owners, due dates, basis for color change and success criteria to ensure the actions are effective at closing the indentified gaps • Issue (window colors) align with departmental performance	**0 (does not address criteria) to 12 (addresses all criteria)** **SCORE =____ out of 12**	

DEPARTMENT LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

CRITERIA	Scoring	Comments
4. Department Fundamentals (Behaviors) • Department Leadership is self-critical, challenging and capable of effectively identify existing gaps in fundamental behaviors • Problem statements are created and actions developed are S.M.A.R.T. and "next level performance" oriented • Actions are assigned with owners, due dates, basis for color change and success criteria to ensure the actions are effective at closing the indentified gaps • Issue (window colors) align with departmental performance	**0 (does not address criteria) to 12 (addresses all criteria)** **SCORE =____ out of 12**	
5. Department Coaching Performance • Total observations by the manager, superintendent, and supervisors meet expectations • Observations are being performed in the field observing the worker behaviors • Managers and Superintendents are performing Paired and Focused Crew observations as required • *Observation ratios are reasonable/self critical* (Goal = 4 positive to every 1 critical) • Leader 1/Leader 2 Roll-up reviews are being performed with quality by ensuring all supervisor LEL entries are evaluated as indicated by the Coaching Quality report • Department coaching is changing behaviors based on department/crew performance	**0 (does not address criteria) to 12 (addresses all criteria)** **SCORE =____ out of 12**	

Scoring will be assigned for each Department Performance Improvement Notebook meeting using the following scale:

0 – 39 Significant weaknesses indicating lack of preparation, intrusiveness, engagement and / or commitment to process.

40 – 49 Most requirements met; minor improvements needed to improve overall process effectiveness.

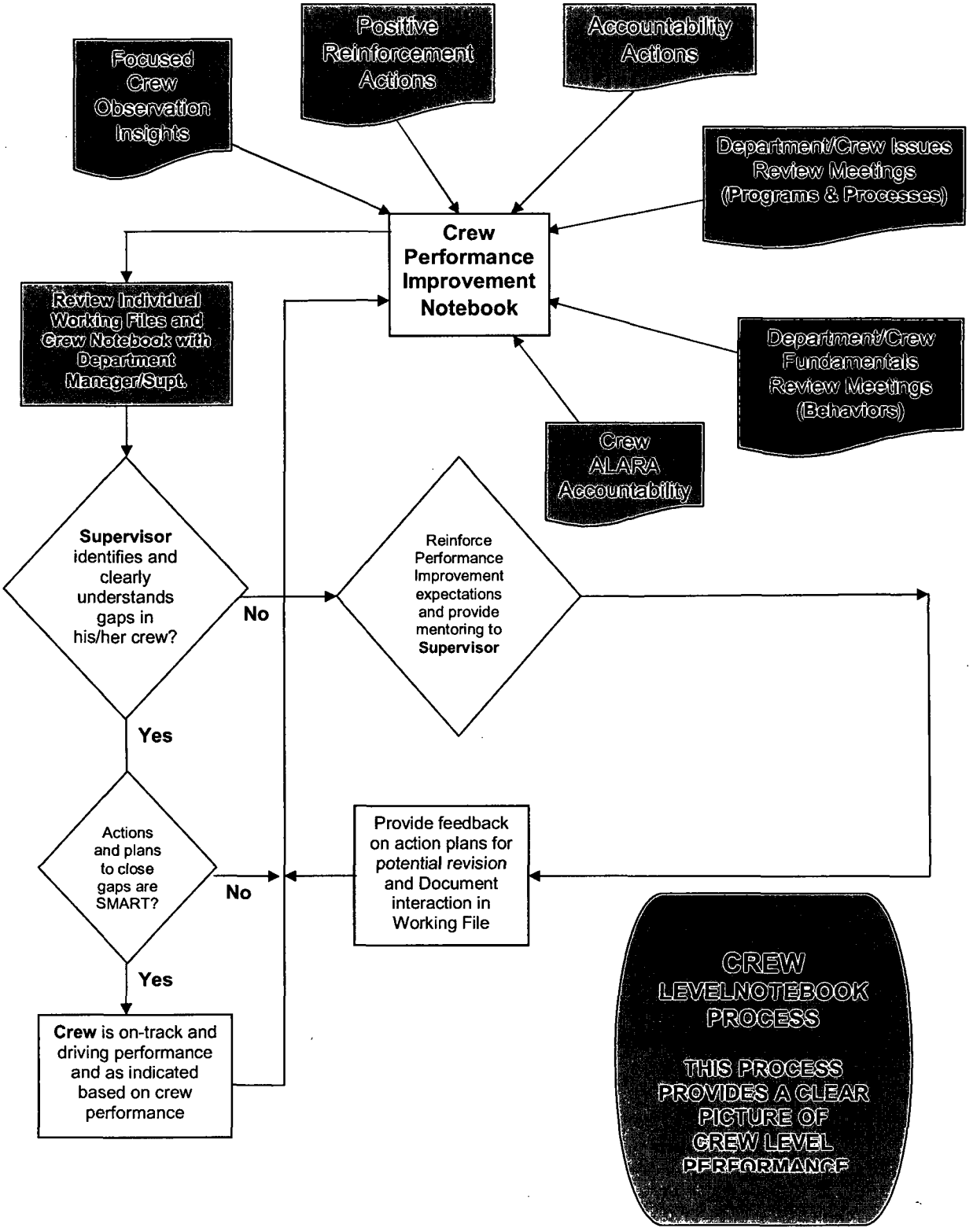
50 – 60 All or essentially all requirements are met; no changes needed other than coaching using the mentoring process.

(Department/Crew)
(Supervisor)
(Template – Typical)

CONFIDENTIAL INFORMATION
CREW LEVEL
PERFORMANCE IMPROVEMENT NOTEBOOK

MONTHLY REVIEW
(Insert Date to Insert Date)

CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE



CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Crew Personnel

Crew Supervisor	
Crew Individual	
Crew Individual	
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CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

DEPARTMENT/CREW PERFORMANCE

Department Performance Review Meeting (DPRM) per EN-FAP-OM-001

(Attach Department Fundamental/Issues Windows **HERE** with associated Actions Plans)

*****Vertical Alignment*****

Department Leadership must ensure the Department Fundamental/Issues windows and associated action plans are regularly communicated to all department personnel. Department personnel need to clearly understand what the departmental gaps are, and what actions are being taken to close the gaps, and what role they have in improving department performance.

CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Focused Crew Observation Results

Insert Focused Crew Assessment results/insights identified to ensure all gaps are properly actioned and addressed to ensure the behavior/issue is resolved.

Fundamental Behavior /Issue	Problem Statement/ GAP Identified	Action to close GAP	WT#/CR#	Owner	Due Date

Crew Positive Recognition or Accomplishments

Positive Reinforcement Actions (Rewards & Recognition, Good Catch CRs and other accomplishments)

Actions Taken	Why?	Supervisor

CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Crew ALARA Accountability

ALARA Initiatives Accountability
(Sub-committee support, Monthly and YTD Dose Performance, ALARA suggestions)

Ongoing Initiatives	Current Results

Crew Accountability

Accountability Actions (MARC process, verbal, written and beyond)

Actions Taken	Why?	Supervisor/Superintendent

Crew Performance Indicator Review

Crew Individual	Condition Report Totals	Work Request Totals

CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Training and Qualifications

Current Qualifications

Crew Individual	Qualification Level	Qualifications completion %	Latest Promotion Date

Crew Training Exam Performance

Individual	Cycle#	Cycle#	Cycle#	Cycle#	Individual Average

CREW LEVEL PERFORMANCE IMPROVEMENT NOTEBOOK TEMPLATE

Potential Training Opportunities Identified

Potential Training Opportunity	TEAR# Generated	TEAR Status

Training to Improve Performance (TQ-208) (Results)

Training Gap Identified	Training Conducted to Close Identified Gap	Describe How Training has Improved Performance (Example)

Additional Comments:

STATION EXPECTATIONS

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This Station Expectations document provides the framework for clear communications of the high standards expected in the River Bend Station leadership team. It is intended to be a living document, revised with the leadership's team consent, to continuously pursue performance improvement excellence.

STATION EXPECTATIONS

- **Fundamentals**
- **Performance Management**
- **Goals**
- **Training**
- **Corrective Action**
- **Management Observations**
- **Communication**
- **Work Sites**
- **Configuration Management**
- **Meetings**
- **Functional Area Improvement Plans**
- **Financial**

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FUNDAMENTALS

The Fundamentals, defined as the essential knowledge, skills, behaviors, and practices personnel need to apply to conduct their work properly, are clearly communicated, are reflected in the behaviors of all station personnel, and are modeled by its leaders.

- **Fundamentals will be reviewed and understood in accordance with EN-FAP-OM-001, "Leadership Forums for Continuous Improvement."**

- **Per management expectation, Department Performance Review Meetings (DPRMs) will be conducted on the second week of the month and per EN-FAP-OM-001.**

PERFORMANCE MANAGEMENT

Performance management is an ongoing, continuous process of communicating and clarifying job responsibilities, priorities and performance expectations in order to ensure mutual understanding between supervisor and employee. This process values and encourages employee development through a style of management which provides frequent feedback and fosters teamwork. It emphasizes communication and focuses on adding value to the organization by promoting improved job performance and encouraging skill development. Performance Management involves clarifying the job duties, defining performance standards, and documenting, evaluating and discussing performance with each employee.

- **Clearly define what the employee's roles and responsibilities are as applied to his/her job**
- **Define what the performance standards, expectations and fundamentals are for the employee**
- **Document the employee's performance using employee working files**
- **Evaluate the employee's performance on a periodic basis**
- **Periodically meet with your employee to discuss job performance**

STATION EXPECTATIONS

Entergy

GOALS

These goals should be created and maintained within the PP&R process. A compelling vision of excellence and a clear, integrated, and effectively communicated plan drive resource allocation, station priorities, and improvement.

- **Supervisors will provide exempt employees under their direction a set of goals for their use.**
- **Both the supervisor and the employee will develop goals with input and buy-in by the employee.**
- **Goals will include personal development, as well as organization goals.**
- **Goals will be developed each year.**
- **Goals will include a stretch goal for each employee.**
- **Goals will be reviewed with each employee in accordance with the Entergy performance management process.**

STATION EXPECTATIONS

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TRAINING

Training is the foundation to build continuous performance improvement and drive towards excellence. Achieving best of best performance will not be possible without a strong commitment to training.

- **Managers and their direct reports will conduct training observations as follows:**
  - **Weekly while your discipline classes are in session.**
  - **Monthly for general sessions.**
- **Once a quarter, managers will observe training of a discipline other than their own.**
- **Scheduled training will be attended.**
- **Make-up training will be the exception and will require approval by the line manager.**
- **Instructors will conduct training in a professional manner.**
- **Students will take an active role in the class.**
- **Training feedback, both critical and positive, will be provided on a regular basis.**
- **Feedback responses will be provided by training to the initiator if requested.**
- **Managers/Supervisors will kick-off major training sessions.**
- **All personnel will continually look for ways to use training to improve plant and personnel performance.**

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CORRECTIVE ACTIONS

A healthy corrective action program is a cornerstone for continuous performance improvement. Strength and timeliness of corrective action programs can be directly related to plant performance.

- **Corrective action backlogs will be tracked and trended weekly as part of the organization's indicators. Departments should have action plans in place to ensure the backlogs are consistently lower then goal.**
- **Per management expectations, all corrective actions due on the required due date shall be closed or extended with extension approval per procedure prior to 1600.**
- **Ensure corrective actions are closed with quality and rigor.**
- **Trending shall be conducted in accordance with EN-LI-121.**
- **Department Superintendents/Managers/Directors shall provide a briefing to the Site VP for any overdue corrective actions.**
- **Per management expectations, the five oldest corrective action items in your organization will have a plan for closure.**

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MANAGEMENT OBSERVATIONS

Field observations are by far one of the most honest and accurate feedback measures available for performance improvement. Detecting and preventing problems is our core business as leaders and we have to be engaged and intrusive with all aspects of our job to fulfill that commitment.

- **Managers and Superintendents will conduct field observations per ADM-0099.**
- **Managers and Superintendents' direct reports will conduct field observations per ADM-0099.**
- **Managers and their direct reports will conduct training observations as follows:**
  - **Weekly while your discipline is in session.**
  - **Monthly on a general basis.**
- **All managers, superintendents and their direct reports will make frequent plant tours. During these tours, take frequent opportunities to ask intrusive questions to the employees and discuss the standards and expectations of the organization with employees in order to gauge the employee's knowledge.**
- **When standards, expectations or fundamental behaviors are not being met, take immediate action to correct the situation. Failure to notice or failure to take immediate action when expectations are not being met constitutes acceptance of that behavior.**
- **Managers are required to attend the quarterly NRC exits.**
- **Managers and their direct reports are required to attend QA Audit exits for their respective areas.**

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COMMUNICATION

One of the most important tools that a successful organization needs is the ability to communicate. This communication must be up, down, and across an organization in order to be effective.

- **Each manager /superintendent should hold one-on-one meetings with their direct reports at least bi-monthly utilizing the Crew Level Performance Improvement Notebooks.**

- **Each manager should have one-on-one meetings with the Site Vice President or GMPO on a monthly basis. Utilize the Department Level Performance Improvement Notebooks. At a minimum, the following items will be discussed – improvement initiatives, fundamentals, NRC/INPO interactions, management observation results, department accountability and budget.**

- **Once a quarter, each manager should attend another group's staff meeting or department DPRM.**

- **Communications that span the whole organization will utilize point papers to ensure a consistent message is delivered.**

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WORK SITES AND HOUSEKEEPING

The appearance of a work site is a direct measure of the standards of the site personnel. It's important to both the outside observer and our peers that our work sites have an aura of professionalism. Work sites are not just where maintenance is working on a piece of equipment; they include offices, laboratories, conference rooms, control rooms, plant areas, outside areas, surveillance areas, etc.

- **All workspaces will be kept neat and orderly.**
- **Work sites will be picked up regularly through the course of the activity being performed, not just when the job is complete.**
- **Work sites will be picked up at the end of each shift.**
- **Managers/Superintendents will tour workspaces on a frequent basis.**
- **During maintenance, the worksite will be posted with the supervisor's name, work request number, and the telephone number of the supervisor in charge.**
- **Managers/Superintendents will tour workspaces and the plant with their direct reports on a frequent basis.**
- **Per EN-MA-132, "Housekeeping/Facility and Grounds Maintenance," area owners are responsible for conducting monthly area inspections and ensuring the area housekeeping and material condition is meticulous.**
- **When work sites are found not to be up to standard, immediate action will be taken to correct the situation, rather than generating a list.**
- **All managers/superintendents must present a professional no nonsense approach toward worksite and plant appearance.**

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CONFIGURATION MANAGEMENT

Configuration management ensures that the construction, operation, maintenance, and testing of the plant are in accordance with the design requirements as expressed in the design documentation. This configuration must maintain this consistency throughout the operational life-cycle of the plant. Some examples of plant configured equipment that must maintain design faction include the following:

- **Security doors (must be verified closed in order to provide access barrier function)**
- **Fire Doors (must be verified closed in order to provide fire barrier function)**
- **Secondary Containment doors (must be verified closed in order to provide a fission product release barrier function)**
- **Doors used as ventilation paths (must be verified closed in order to provide ventilation design function)**
- **Plant valves and components (must be positioned in accordance with procedures to satisfy the design function) – Plant components positions are only changed in accordance with procedures or the tagging process.**

STATION EXPECTATIONS

Entergy

MEETING CONDUCT

When used properly, meetings can be an effective tool. When not used properly, they are a waste of time.

- **Meetings will have agendas with allocated time for topics.**
- **Meeting agendas will be followed.**
- **Meetings will begin and end on time.**
- **Be punctual for meetings.**
- **Attend required meetings (as follows in order of expectation):**
  - **In person.**
  - **Provide a knowledgeable designated alternate from your organization.**
  - **Make pre-arranged plans to have another individual at the meeting represent you and your organization.**

DEPARTMENTAL BUSINESS PLANS

Continuous improvement requires both tactical and strategic initiatives in each departmental area. It is vital that we continue to develop departmental business plan improvement initiatives in four key areas – Safety, Operations, Cost and People.

- **Each department will have a business plan with both tactical and/or strategic initiatives ongoing in the areas of Safety, Operations, Cost and People.**
- **Each initiative will be laid out in the plan and will include the action, problem statement with assigned owners and due dates.**
- **Departmental initiatives will be visible to the organization.**
- **Departmental Initiatives will be statused with the Site Vice President on a quarterly basis.**

STATION EXPECTATIONS

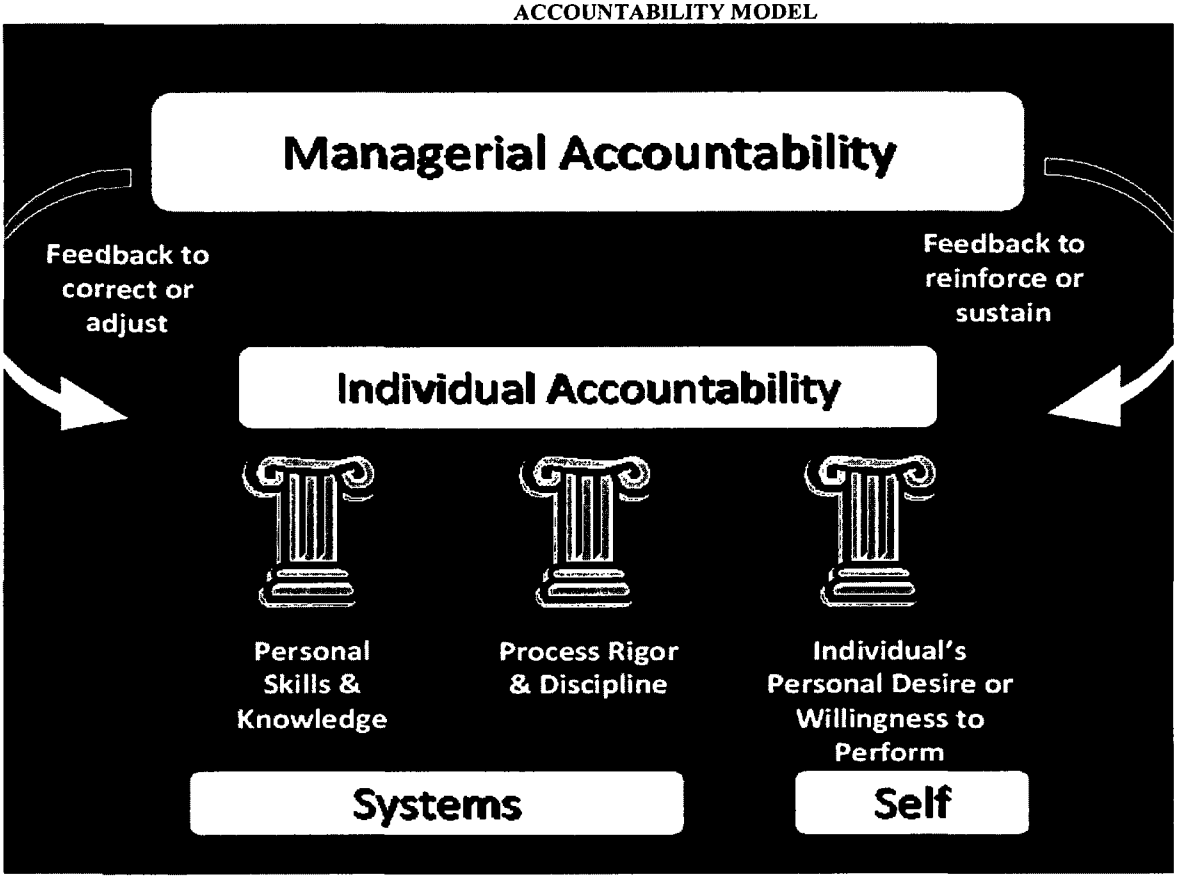
Entergy

FINANCIAL

Site management and personnel have a fiscal responsibility to ensure that the site meets or comes in under budget on all costs aspects, including outage, operations and maintenance (O&M), and capital. If challenges at the site threaten those financial responsibilities, it is the entire site's responsibility to bring these issues to the forefront.

- **Senior Site Management will support and set expectations for a strong financial culture at the site.**
- **Financial responsibility is recognized as a critical part of a manager's job and not considered Site Finance's responsibility.**
- **Project managers recognize their responsibility for managing not only their project budget, but also funding project ceilings and total site budget.**
- **All project managers and project leads are responsible for their capital and/or O&M projects. This includes following appropriate procedures to obtain funding for projects, tracking of projects, and closing of projects on a timely basis.**
- **All departments must live within their means and meet or under run their departmental O&M budgets.**
- **All departments must bring any exceptions to the senior management team before any dollars are spent that are not budgeted.**

ACCOUNTABILITY MODEL



ACCOUNTABILITY MODEL

1 ACCOUNTABILITY MODEL

Accountability defined – an obligation or willingness to accept responsiblity or to account for one's actions.

What happens in an atomosphere where there is a lack of accountability? Nonperforming employees thrive while the diligent employees pick up the slack. The stress level rises, effective communications suffer and the organization performs at a less than optimal level.

How does an organization go about creating a culture of accountability where everyone agrees to work together for the good of the organization and actually does so? The culture of a business unit takes on an element of accountability when employees are self-motivated to contribute to the overall success of the business unit.

So, the standard of accountability must rely on something other than external control. Experts have noted that organizational success happens when all the employees are focused on the same goal. Here is how this happens:

1. All employees need to hear and internalize what the organization's mission, vision and goals are...and hear about it repeatedly.

2. The second part of these conversations includes a specific plan for everyone in the organization to follow in order that their piece of meeting the organizational objective is followed. Everyone from top to bottom should feel like they own an important piece of the process in order for the organization's overall goal to be achieved. Employees should see that their job and the way it is done makes a difference and produces results. Business unit leaders need to implement a program that consists of processes and specific behaviors that will lead to the business unit reaching its goals. When achieving the business unit's goals become important to the employee so that it drives strong behaviors, accountability levels tend to be very high and remain at that level on a consistent basis.

3. Employees need regular feedback about how the business unit is doing and the importance of their efforts to the overall organizational success. When success is not achieved, leaders need to search for systemic reasons why rather than look for someone to blame.

4. Success needs to be recognized, celebrated and rewarded.

This model describes how to influence behaviors of employees by applying positive and negative reinforcement as appropriate. Coaching alone will not change behavior. Observing workers in the field and coaching on observed behaviors is part of the supervisory actions needed. To change behavior, there must be a direct connection between the in-field behaviors and rewards. An employee's results are NOT an indicator of achieving desired behaviors. Short-cuts can lead to completing work faster, but is that the behavior that will lead to consistent excellent performance? The focus is on performance that equals strong behaviors plus results or:

Performance = Strong Behaviors + Results

ACCOUNTABILITY MODEL

1.1 **BASIC PERFORMANCE MODEL – EXPECTATIONS AND REINFORCEMENT** – The key to this model is to recognize that people choose their behaviors based on expected consequences. The in-field actions by our employees are a reflection of their training, experience, direct oversight, and previous coaching. The following four steps are the foundation for the behavior of our employees.

1.1.1. **Defining standards, expectations and fundamental behaviors** – All work involves a set of work standards, expectations and fundamental behaviors. Documenting our standards, expectations and fundamental behaviors in procedures and work instructions is the best way to ensure consistent understanding. Verbal expectations are appropriate at times, but not as lasting as when they are written.

1.1.2. **Communicating standards, expectations and fundamental behaviors and confirming understanding** – Once we have defined work standards, expectations and fundamental behaviors, they must be communicated to our employees. We typically communicate standards, expectations and fundamental behaviors through training, briefings, and required reading. Before we allow our employees to start work, we need to confirm that they understand the standards, expectations and fundamentals. In the training environment, we confirm understanding through tests and task performance evaluation. As a supervisor, you may ask your employees questions about the standards, expectations and fundamentals.

1.1.3. **Observing, coaching, and reinforcing standards, expectations and fundamental behaviors** – To ensure that our employees understand how to correctly apply standards, expectations and fundamentals and to make sure that bad habits are not developing; it is a critical step in the process to observe our employee behaviors in the work environment. Observations can be done individually or as paired observations. The purpose is to see if the employees are applying standards, expectations and fundamentals correctly in the field. Paired coaching is very effective and necessary to ensure supervisors are setting and holding their workers accountable to the appropriate standards, expectations and fundamentals. Coaching is the act of giving feedback to the observed employee about how well he/she was meeting the standards, expectations or fundamentals while executing the task. This step is important for several reasons:

- If we never observe employees in the field, they will likely develop bad habits or use short-cuts, many times unconsciously.
- The leader's presence in the field shows the employee that he/she and the tasks they perform are important.
- We need to confirm that our training, briefings, and instructions were fully understood when it comes time to apply them.

ACCOUNTABILITY MODEL

1.1.4. **Feedback and changing behavior** – To close the loop with the coaching, the individual being coached must understand what the specific standards, expectations or fundamentals are the subject of the coaching, and how well his/her performance met the expectations. Consider the following feedback methodology:

- **Specific** – Pinpoint the standards, expectations or fundamentals that are being coached and the observed behaviors related to them. Remember, coaching can be positive or critical. If there was a deviation from standards, expectations or fundamentals, clearly identify the delta and effectively communicate the deviation.
- **Sincere** –Effective coaching involves a sincere interest in seeing the person perform better the next time.
- **Immediate** – Feedback needs to be immediate; preferably on the spot, but usually no later than the next day.
- **Personal** – In general, coaching is most effective when it is one-on-one. There are times when group coaching may be needed, but is not the preferred method.

1.2 ACTIONS THAT ENHANCE A STRONG NUCLEAR SAFETY AND ACCOUNTABILITY CULTURE

1.2.1. The following actions improve or support a constructive accountability culture.

1. **Regular positive reinforcement** – Studies have demonstrated that providing positive reinforcement for desired behaviors is the most effective way to achieve exceptional performance and encourages discretionary effort by employees.

2. **Vertical communication** – Our employees want to know what's going on and why. Providing information about company and plant activities makes our employees feel more involved and part of the team. It is essential for our employees to know what role they have in improving the departmental and station performance. Remember to share information about key operational decisions (like ODMIs and downpowers), organizational changes, emerging trends, L&A meetings and the results from your Department Performance Review Meetings (DPRMs).

3. **Respond to feedback** – Whether delivered in person or by CR, demonstrate your willingness to receive feedback by doing something about it. If the concern or idea does not require any action, then as a minimum, close the communication loop by providing an explanation to the originator.

4. **Walk-the-talk** – Lead by example and be a role model for our standards, expectations and fundamental behaviors. In the eyes of our employees, actions speak louder than words.

ACCOUNTABILITY MODEL

1.3 ACCOUNTABILITY FOR ACTIONS AND BEHAVIORS – This section addresses how to hold our employees accountable for their actions. The approach is summarized in Attachment A. This document refers to other existing Entergy processes that need to be used in conjunction with this standard.

1.3.1. **Managing normal performance, day-to-day activities** – This section describes the main area where we expect to operate – solid performance that consistently meets expectations. The following actions are typical in this region:

- Observations and coaching in accordance with ADM-0099.
- Regular positive reinforcement for accomplishing work that meets or exceeds expectations.
- Ongoing dialogue to understand each individual's circumstances.
- Delivering information about company and plant issues.
- Providing technical guidance on how to approach assignments.
- Monitoring progress on assigned tasks.
- Implementing performance review actions and rewarding performance appropriately.
- Most coaching is in the positive reinforcement area, with occasional delta observations for deviations that are usually corrected on the first instance.

a If a standard, expectation or fundamental behavior is not satisfactory, then coaching is necessary. Document the coaching in an LEL. If the occurrence involves a significant adverse consequence or near-miss, go to ***section 1.3.4***.

1.3.2. **How to handle exceptionally good performance** – There are times when individuals perform well beyond expectations and deserve some form of reward. Just as a reminder, by law, Entergy policy does not allow employers to provide gifts to employees. The following are examples of several company approved mechanisms to reward good behavior:

- A simple "Thank You" either verbally, by email or a note
- Positive Feedback provided after a coaching session
- Human Performance/Industrial Safety good behavior ticket
- Impact Awards using "People Soft"

1.3.3. **How to handle below expectations performance** – This section describes how to handle minor performance deviations that do not involve chronic problems; department HU/IS clock reset incidents, or more significant single occurrences.

1. When performance does not meet the standards, expectations or fundamental behaviors, the supervisor is expected to provide immediate coaching. This is normally done in an objective, non-threatening way. The coaching should be done as follows:

- Find a private place to provide the coaching.
- Describe the relevant standard, expectation or fundamental behavior, citing the reference as specifically as possible (e.g., procedure EN- TQ-212 step 5.2.3 states…)

- Describe how the individual's behavior did not meet the defined standard, expectation or fundamental behavior.
- Describe how the standard, expectation or fundamental behavior should have been met.
- Have the individual paraphrase his/her understanding of the standard, expectation or fundamental behavior, what the performance deviation was, and how he/she should have met the standard, expectation or fundamental behavior.
- Close the coaching session with an open ended question about the situation and if the worker has any other questions.
- Document the coaching in LEL and the individuals working file.

2. Use the monthly LEL roll-up reviews to look for patterns of undesired behavior that may warrant greater attention as described in the next section.

3. Accountability for minor deviations that are coached on an ongoing basis is achieved in the performance review process. The working file review, PP&R process and level set process allows the supervisor to consider the balanced view of accomplishments with deviations, leading to the consequences of a particular rating and associated raise and/or performance-based incentive.

1.3.4. **How to handle chronic substandard performance** – This section describes how to provide accountability when an individual's performance develops a pattern of being below expectations. Supervisors are encouraged to refer to their MARC Process training for these cases as the primary resource. When ongoing review indicates a pattern of substandard performance by an individual, the recommended processes are as follows:

- MARC process
- Performance Review Process (PP&R)
- EN-HR-135, "Disciplinary Action"
- EN-HR-138, "Executive Review Board Process"

1.3.5. **How to handle significant undesired actions** – This final section describes how to handle single events or situations where an individual's actions caused an HU/IS error or event, serious policy/procedure infractions (e.g., vandalism, unsafe acts, and willful failure to follow prescribed procedures) or significantly deviated from management expectations. Refer to the following processes to address significant undesired actions:

- EN-HU-101, "Human Performance Program"
- EN-HU-103, "Human Performance Error Reviews"
- EN-NS-102, "Fitness for Duty Program"
- EN-HR-135, "Disciplinary Action"
- EN-HR-138, "Executive Review Board Process"

ACCOUNTABILITY MATRIX

Performance Level	Examples	Relevant Procedures/Processes	Supervisor Actions
Normal Performance	- Solid performance (VC level) - Completes all work on time w/quality - Receptive to coaching - Supports and coaches peers (Team Player)	**Performance Review Process**	- Coaching and LEL entries - PP&R for goals and reinforcement - IDP to reach next level - Maintain a working file for each individual to document both positive and negative behaviors
Exceptionally Good	- High performer (HC level) - Goes above and beyond normal required duties - Led significant improvement project	**Performance Review Process**	- Coaching and LEL entries - PP&R for goals and reinforcement - IDP to reach next level - Impact Awards - Submit good catch to recognize individual
Chronic Deviations	- Low performer - Recurring (typically >4 times in a 6-month period) late, absence, failure to meet commitments, etc. - Quality of work regularly below standard	**Performance Review Process** **MARC Process** **ENS-HR-135** **EN-HR-138**	- Involve HR for guidance - Maintain detailed records of Performance (Working File) - Implement an IDP as required (Work with Human Resources)
	- Human Performance incidents that caused a department clock reset or more severe error, injury or event - Willful violation of procedures, policies or management expectations	**EN-HU-101** **EN-HU-103** **EN-NS-102** **ENS-HR-135** **EN-HR-138**	- Consider"For Cause" FFD Testing or as required - Perform a Level 1 HPER - Perform Culpability assessment - Conduct fact-finding investigation - Determine need for Executive Review Board - Involve HR and submit copies as necessary

RBG-47190

Enclosure 5

Fleet Procedure EN-FAP-OM-001

Leadership Forums for Continuous Improvement

Fleet Administrative Procedure Contains NMM eB REFLIB Forms: YES ☒ NO ☐

Effective Date	Governance Owner:	Kevin Mulligan
	Title:	VP, Operations Support
9/23/2011	Site:	HQN

Fleet Administrative Procedure Summary

- Establish a standard schedule, format and content for regular forums intended to drive:
- Effective monitoring of performance on a departmental, site and fleet level.
- Regular and effective interactions between supervisors and workers.
- Alignment of the management team and workforce on performance issues and performance improvement actions.
- Accountability for achieving progress on performance improvement goals and meeting established performance and behavioral expectations.

Documents Canceled or Superseded by this Fleet Administrative Procedure

None

Change Statement

- Clarified wording throughout document to improve readability and conform to formatting standards, including minor re-wording to clarify intent or scope, capitalizations, abbreviations and other similar items.
- Added Attachments 7.10; Department Performance Review WILL Sheet & 7.11; Standard DPRM Agenda
- Clarified wording in Section 2 to improve readability and conform to formatting standards
- Added reference to the meeting days for the CRG, OPS Focus,
- Added the Industrial Safety Committee to listing in 3.1[1] and added section 3.1.12 to describe the meeting purpose.
- Clarified allowance of GMPO to Cancel an OPS Focus meeting in step 3.1.2 [7]
- Added flexibility for the SVP to the setting of the L&A meeting date in section 3.1.5 [1]
- Included section 3.1.6 [2] to provide additional direction for the use of the DPRM as a tool for managers to focus staff for the next 30 days.
- Eliminated requirement for Quarterly DPRM Performance in step 3.1.6 [5]
- Added DPRM review requirement for site HU/IS superintendents in section 3.1.6[8]
- Added Reference to EN-FAP-LI-001,(CRG), EN-FAP-LI-003,(CARB), and EN-FAP-LI-006,(SARB) to their corresponding descriptions in Section 3 & 5.
- Added additional detail to step 3.1.1 [3] for participants to the POD Meeting
- Updated window color requirements in Attachment 7.9 to conform to other procedural applications.

TABLE OF CONTENTS

1.0 PURPOSE

[1] Establish a standard schedule, format and content for regular forums intended to drive:

(a) Effective monitoring of performance on a departmental, site and fleet level.

(b) Regular and effective interactions between supervisors and workers.

(c) Alignment of the management team and workforce on performance issues and performance improvement actions.

(d) Accountability for achieving progress on performance improvement goals and meeting established performance and behavioral expectations.

2.0 RESPONSIBILITES

[1] **Vice President, Operations Support** is responsible for driving alignment and accountability for achieving performance improvement at the nuclear headquarters through implementation of this procedure. He/she is also responsible for approving changes to this procedure.

[2] **Senior Management** at each site is responsible for driving alignment and accountability for achieving performance improvement at their site through implementation of this procedure.

[3] **General Manager, Fleet Operations Support** has overall responsibility for the maintenance and administration of this fleet administrative procedure.

[4] **Site Vice Presidents (SVP),** are responsible for chairing the site all-hands meeting and for periodically attending department performance review meetings.

[5] **General Managers, Plant Operations (GMPO)** are responsible for leading the leadership and alignment meetings and periodically attending department performance review meetings.

[6] **Department Managers / Superintendents** are responsible for chairing department performance review meetings and driving the use of the standard fundamentals to continuously improve performance and ensuring accountability to standards and expectations within in their organizations.

3.0 DETAILS

3.1 STANDARD SITE FORUMS

[1] The following is a list of standard site meetings associated with the overall process for monitoring and driving performance improvement. Details for meetings designated by an asterisk are provided in this procedure. The remaining meetings are covered in detail in other procedures referenced throughout this procedure.

- Plan of the Day meeting (POD)*
- Operational Focus meeting*
- Condition Review Group (CRG)
- Corrective Action Review Board (CARB)
- Leadership and Alignment meeting*
- Department Performance Review Meeting (DPRM)*
- Site All-hands meeting*
- Operational Excellence Management Review Meeting (OE MRM)
- Equipment Reliability Management Review Meeting (ER MRM)
- Human Performance Review Board (HURB)
- Senior Assessment Review Board (SARB)
- Industrial Safety Committee Meeting
- Outage Success Team Meetings
- Outage Oversight Meetings

[2] Refer to Attachment 7.1 for the standard site meeting schedule.

3.1.1 Plan of the Day Meeting (POD)

[1] The POD meeting is conducted at the start of each normal work day to ensure clear understanding of plant status, significant operational and maintenance activities, and challenges to operations. The goal is clear alignment of station departments in support of safe and efficient plant operations.

3.1.1 cont

[2] Shift Managers are responsible for chairing the POD meeting.

[3] Participants are to be at working level, such as Work Week Managers and department level coordinators or representatives of the following departments: RP, Chemistry, Security, Engineering, Fuel Services, FIN, Mech Maint, Elect/Relay Maint, I&C Maint, Maint Support, and HU/IS.

[4] Key managers, such as the SVP, GMPO, Operations Manager, etc., should be present as observers.

[5] The meeting structure and content should be similar to and not detract from the standard example agenda except when it is not applicable to the plant. Refer to Attachment 7.3 for the standard POD meeting agenda example.

3.1.2 Operational Focus Meeting

[1] The Operational Focus meeting is conducted on working Mondays, Tuesdays, and Thursdays to ensure the regular review of performance, behaviors, and issues in selected functional areas.

[2] This meeting provides a forum for responsible managers and individuals to present the status of programs, action plans, and key indicators. Meeting participants are expected to provide challenges and assistance where appropriate to ensure successful achievement of performance goals and action plans. The goal of the meeting is clear alignment of station departments in support of achieving and maintaining high levels of performance in selected areas.

[3] The Operational Focus meeting is not designed to revisit POD information.

[4] The Operations Manager or designee is responsible for chairing the meeting.

[5] Attendees should consist of the SVP, GMPO, directors, managers, and others as appropriate to discuss scheduled agenda topics or emergent issues.

[6] The meeting structure and content should be similar to and not detract from the standard agenda except when it is not applicable to the plant. Refer to Attachment 7.4 for the standard Operational Focus meeting agenda.

[7] The meeting may be canceled or the standard agenda modified by the GMPO with the concurrence of the SVP based on the following guidelines:

- Emergent plant or fleet issues require additional focus. This should be limited to the timeframe that the emergent issue exists.

3.1.2 cont

- If operating cycle priorities dictate (e.g. approaching start of a refueling outage) the GMPO may modify the agenda with concurrence of the SVP. The modified agenda shall be reviewed against the standard agenda to ensure all areas have adequate oversight during the agenda period. The timeframe that the modified agenda is in place should be limited by the condition dictated by the operating cycle.

3.1.3 Condition Review Group (CRG)

[1] The CRG meets on working Mondays, Tuesdays, Thursdays, and Fridays.

[2] The CRG provides for the regular management team review of inputs to the corrective action program. The CRG is responsible for condition report review, categorization, and assignment of responsibilities. The corrective action program is a key part of the overall performance monitoring and improvement process.

[3] Refer to EN-LI-102, "Corrective Action Process" for attendee requirements, structure, and functions. Refer to EN-FAP-LI-001, "Condition Review Group" for guidance for standardizing the activities and products (process, reports, forms, etc).

3.1.4 Corrective Action Review Board (CARB)

[1] The CARB is responsible for the review and approval of all root and selected apparent cause evaluations and proposed corrective action plans. The CARB consists of a cross-section of managers and other personnel familiar with a particular condition report.

[2] Refer to EN-LI-102, "Corrective Action Process" for attendee requirements, structure, and functions. Refer to EN-FAP-LI-003, "Corrective Action review Board (CARB) Process" for guidance for standardizing the activities and outcomes (process, reports, forms, etc).

3.1.5 Leadership and Alignment (L&A) Meeting

[1] L&A meetings are normally held weekly. Each SVP may determine the day of the week and the time for his/her site's meetings.

[2] The objectives of the leadership and alignment meeting are to:

- Engage the management team from first line supervisors and key program owners up to the SVP in an interactive session directed at plant performance.
- Ensure the management team is aligned on the problems facing the station.
- Discuss performance gaps and plans to close the gaps.

3.1.5 [2] cont

- Ensure the management team is aligned on who owns the problem.
- Define teams and ways to assist the key program owners.
- Validate that appropriate actions are planned and are being implemented.
- Develop healthy, challenging, team behaviors.
- Coach and reinforce effective leadership principles and behaviors.
- Provide an opportunity for supervisor training.

[3] The GMPO is responsible for chairing the meeting or designating a chair in his/her absence.

[4] All supervisors and above on-site are expected to attend the weekly leadership and alignment meetings unless directed otherwise due to emergent plant issues or station priorities.

[5] Refer to Attachment 7.5 for the standard leadership and alignment meeting structure and agenda.

[6] The standard agenda may be modified by the GMPO with the concurrence of the Site VP based on the following guidelines:

- Emergent plant or fleet issues require additional focus. This should be limited to the timeframe that the emergent issue exists.
- If operating cycle priorities dictate (e.g. approaching start of a refueling outage) the GMPO may modify the agenda with concurrence of the SVP. The modified agenda shall be reviewed against the standard agenda to ensure all areas have adequate oversight during the agenda period. The timeframe that the modified agenda is in place should be limited the condition dictated by the operating cycle.

3.1.6 Department Performance Review Meeting (DPRM)

[1] The objectives of the department performance review meeting are to:

- Review and analyze performance data from the corrective action program, performance indicators, observations, coaching, etc. as compiled based on procedure EN-LI-121, "Entergy Trending Process".
- Prompt interactive discussion and learning opportunities

3.1.6 [1] cont

- Ensure timely identification of low-level department performance trends, issues or focus areas.
- Ensure plans to correct identified performance gaps are developed and implemented.
- Facilitate timely development of the departmental quarterly trend report required by procedure EN-LI-121, "Entergy Trending Process".
- Coach and reinforce effective leadership principles and fundamental behaviors.

[2] The DPRM is intended as a tool for the department manager to involve members of his/her staff in identification of low-level focus areas. These focus areas may or may not have risen to the level of a formal adverse trend. They should be used as a tool for the manager to focus the department staff for the next 30 days. Should more significant issues be identified, they should be entered into the corrective action process for resolution.

[3] The department manager is responsible for scheduling and chairing the meeting.

[4] Attendees include department supervision, the departmental performance improvement coordinator (DPIC), training representative, and individuals responsible for selected programs and issues as determined by the department manager / superintendent.

[5] The meeting shall be conducted monthly by the Chemistry, Engineering, Maintenance, MP&C, Operations, PS&O, Radiation Protection, Security, and Training departments. Monthly meetings may be waived for months including refueling or extended forced outages with the approval of the GMPO.

[6] The GMPO may direct additional departments to implement all, or portions of the DPRM process, if deemed appropriate. The meeting periodicity for departments not listed in [5], above, is up to the GMPO.

[7] Issues related to Human Performance identified in department performance review meetings should periodically be presented to the HURB per EN-HU-105, "Human Performance –Managed Defenses" to provide for a cross discipline review and challenge. The department issue and fundamental behavior action plans (see Attachment 7.9) developed in the department performance review meeting should be the basis for the periodic department presentation to the HURB.

3.1.6 cont

[8] Each site's HU/IS Superintendent shall ensure that a quarterly aggregate review of common fundamental behaviors, based on monthly departmental fundamental behavior window DPRM results, is performed to identify potential site wide common fundamental behavior trends. The results of this aggregate review are presented to the Senior Assessment Review Board (SARB) in conjunction with the Site Quarterly Trend Report.

[9] The SVP and GMPO should each periodically attend department performance review meetings. The objectives of this requirement are to promote consistent conduct of these meetings and to provide coaching to the department managers. SVP and GMPOs should attend different department performance review meetings and cycle through as many different meetings over the course of a year as practical.

[10] Attachment 7.9 provides additional guidance for the conduct of the department performance review meeting and templates for department fundamentals and issues windows and action plans.

[11] The Department Performance Review Meeting WILL Sheet in Attachment 7.10 should be used by DPRM observers in order to ensure consistent meeting conduct. The meeting observation should be captured in the Leadership Effectiveness Log (LEL) database with a focus on the Leadership Fundamentals and Alignment.

3.1.7 Site All-Hands Meeting

[1] The objectives of the Site All-Hands Meeting are to:

- Engage the entire site workforce in an interactive session directed at plant performance.
- Ensure clear communication of and alignment on issues, priorities, and actions in progress to close performance gaps.
- Develop healthy, challenging, team behaviors.
- Coach and reinforce effective leadership and worker behaviors.
- Provide routine, direct interaction between senior site leadership and all levels of the site workforce.

[2] The SVP is responsible for chairing the meeting. The GMPO is the alternate.

3.1.7 cont

[3] The agenda for this meeting should include:

- Safety message.
- Review of selected performance indicators / metrics.
- Discussion of actions planned or in progress to close performance gaps.
- Communication of general information important to the site.
- Question and answer session.

[4] All-hands meetings should be conducted on a quarterly basis. Exceptions can be made for quarters with refueling outages with the approval of the SVP.

[5] Multiple sessions covering the same agenda and material may be required in order to accommodate personnel on alternate schedules or due to space limitations.

3.1.8 Site Operational Excellence and Equipment Reliability Management Review Meetings

[1] These meetings provide a forum for responsible site managers and individuals to present the status of programs, action plans and key indicators to senior managers from throughout the fleet. Meeting participants are expected to provide challenges and assistance when appropriate to ensure successful achievement of site performance goals and action plans. The goal of these meetings is to drive accountability for achieving and maintaining high levels of performance and to identify where additional fleet support is required to achieve established goals.

[2] The agenda and format for these meetings are specified in the standard MRM templates maintained by the General Manager, Fleet Operations Support.

[3] Details on the content, conduct and scheduling of management review meetings are contained in reference 5.0 [2].

3.1.9 Human Performance Review Board (HURB)

[1] The HURB is a managed defense that acts as a barrier in the reduction of HU errors and events. The HURB is intended to provide cross-discipline review and challenge to department leaders concerning their observations, coaching, and interactions with workers. The goal is to drive accountability for leaders in setting and reinforcing high standards for compliance with expectations for the use of human performance tools and managed defenses throughout the workforce.

3.1.9 cont

[2] HURB meetings are required to be conducted quarterly. Each monthly participant department should have an opportunity to present selected fundamental behavior performance issues and actions taken to improve behaviors at least once each year.

[3] Refer to procedure EN-HU-105, "Human Performance – Managed Defenses" for attendee requirements, structure and functions of the HURB.

3.1.10 Senior Assessment Review Board (SARB)

[1] The SARB is a group composed of the appropriate members of the leadership team convened to provide oversight of selected assessment and benchmarking schedules, plans, and results. The SARB ensures that these key elements in identifying best practices and standards, performance, gaps, and improvement actions are intrusive and are performed with high quality.

[2] The SARB also provides a forum for site level review of quarterly trend information, department performance and behavioral issues, and actions identified during DPRMs. The SARB provides a cross-disciplinary review, identifies common issues and drives managerial accountability for results. This review is accomplished by department managers presenting a summary of the departmental quarterly trend report developed in accordance with procedure EN-LI-121, "Entergy Trending Process" to the SARB.

[3] Refer to procedure EN-LI-104, "Self-Assessment and Benchmark Process" for attendee requirements, structure, and functions of the SARB. Refer to EN-FAP-LI-006, "Senior Assessment Review Board (SARB) Process" for guidance for standardizing the activities and outcomes (process, reports, forms, etc). This procedure also provides guidance and expectations for SARB member qualifications, SARB meetings and other self assessment/benchmark process implementation actions.

3.1.11 Outage Meetings

[1] Outage Success Team Meetings are conducted in accordance with procedure EN-OU-001, "Refueling Outage Preparation and Milestones". Outage Oversight Meetings are conducted in accordance with procedure EN-FAP-OU-001, "Outage Planning and Execution Best Practices".

3.1.12 Industrial Safety Committee Meetings

[1] The Industrial Safety Committee is responsible for reviewing safety concerns identified by committee members, plant personnel, or any other means, and taking action to address the concerns. It promotes a cooperative relationship between management, labor, and the government to ensure a continuous improvement approach toward enhanced worker safety and health protection.

[2] Industrial Safety Committee Meetings are conducted in accordance with EN-IS-101, "Industrial Safety and Health Program".

3.2 STANDARD FLEET FORUMS

[1] The following is a list of the standard fleet calls/meetings:

- Engineering fleet call
    1. North region
    2. South region
- Fleet status call
- Outage call
- Fleet peer group calls
- Fleet management review meeting
- Engineering and Technical Services management review meeting (E&TS MRM)

[2] Refer to Attachment 7.2 for the standard fleet meeting schedule.

3.2.1 Engineering Fleet Call

[1] There is a separate call for each region. Refer to Attachment 7.2 for the standard fleet meeting schedule.

[2] Refer to Attachment 7.6 for engineering fleet call agenda.

3.2.2 Fleet Status Call

[1] Refer to Attachment 7.7 for the fleet status call agenda.

3.2.3 Fleet Outage Call

[1] The fleet outage call uses the refueling outage daily update report as its basis.

[2] Refer to Attachment 7.8 for an example of the refueling outage daily update report.

3.2.4 Fleet Peer Group Call

[1] The fleet peer group call structure and agenda is the responsibility of each fleet peer group chair.

3.2.5 Fleet and Engineering & Technical Services Management Review Meetings

[1] The Fleet and Engineering & Technical Services management review meetings provide a regular review of fleet performance and an appropriate forum for fleet level strategic planning and review. The goals of the meeting are to:

- Drive accountability for achieving and maintaining high levels of performance.
- Identify where additional fleet support is required to achieve established goals.
- Ensure alignment and support of fleet level improvement initiatives and strategies.

[2] Details on the content, conduct and scheduling of management review meetings are contained in reference 5.0 [2].

4.0 DEFINITIONS

None

5.0 REFERENCES

[1] Entergy Nuclear Operating System (ENOS)

[2] EN-FAP-OM-002, "Management Review Meetings"

[3] INPO SOER 10-02; "Engaged, Thinking Organizations"

[4] EN-FAP-LI-001; "Condition Review Group (CRG)"

[5] EN-FAP-LI-003, "Corrective Action review Board (CARB) Process"

[6] EN-FAP-LI-006, "Senior Assessment Review Board (SARB) Process"

6.0 INTERFACES

[1] EN-LI-102, Corrective Action Process

[2] EN-LI-121, Entergy Trending Process

[3] EN-LI-104, Self-Assessment and Benchmarking Process

[4] EN-OU-001, Refueling Outage Preparation and Milestones

[5] EN-FAP-OU-001, Outage Planning and Execution Best Practices

[6] EN-HU-105, Human Performance – Managed Defenses

7.0 ATTACHMENTS

7.1 Standard Site Meeting Schedule

7.2 Standard Fleet Meeting Schedule

7.3 Department Plan of the Day Meeting Structure and Agenda Example

7.4 Operational Focus Meeting Agenda

7.5 Leadership and Alignment Meeting Structure and Agenda

7.6 Engineering Fleet Call Agenda

7.7 Fleet Status Call Agenda

7.8 Refueling Outage Daily Update Report Example

7.9 Department Performance Review Meeting

7.10 Department Performance Review Meeting WILL Sheet

7.11 Standard DPRM Agenda

ATTACHMENT 7.1 STANDARD SITE MEETING SCHEDULE

Sheet 1 of 1

Local Time	Monday	Tuesday	Wednesday	Thursday	Friday
06:00					
06:15					
06:30					
06:45	Plan of the Day (POD) Meeting*				
07:00					
07:15					
07:30					
07:45					
08:00					
08:15					
08:30	**Ops Focus**	**Ops Focus**		**Ops Focus**	
08:45					
09:00					
09:15	**CRG**			**CRG****	
09:30					
09:45					
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15:30					
15:45					
16:00					
16:15					
16:30					
16:45					
17:00					

* Plan of the Day (POD) Meeting times may vary dependent on the start time of the site's work day.

** CRG will not meet on Alternate Off- Friday

Leadership Forums for Continuous Improvement

ATTACHMENT 7.2 — **STANDARD FLEET MEETING SCHEDULE**

Sheet 1 of 1

EST	CST	Monday	Tuesday	Wednesday	Thursday	Friday
06:00	**05:00**					
06:15	05:15					
06:30	05:30					
06:45	05:45					
07:00	**06:00**					
07:15	06:15					
07:30	06:30	Engineering Fleet Call North Region				
07:45	06:45					
08:00	**07:00**					
08:15	07:15					
08:30	07:30	Engineering Fleet Call South Region				
08:45	07:45					
09:00	**08:00**					
09:15	08:15					
09:30	08:30					
09:45	08:45					
10:00	**09:00**					
10:15	09:15					
10:30	09:30					
10:45	09:45					
11:00	**10:00**					
11:15	10:15					
11:30	10:30	North Fleet Status Call	North Fleet Status Call	*Outage Call when applicable*	North Fleet Status Call [short week only] *Outage Call when applicable*	North Fleet Status Call [long week only] [2nd working Fri Lost MWe report]
11:45	10:45					
12:00	**11:00**					
12:15	11:15					
12:30	11:30	South Fleet Status Call	South Fleet Status Call	*Outage Call when applicable*	South Fleet Status Call [short week only] *Outage Call when applicable*	South Fleet Status Call [long week only] [2nd working Fri Lost MWe report]
12:45	11:45					
13:00	**12:00**					
13:15	12:15					
13:30	12:30					
13:45	12:45					
14:00	**13:00**			Fleet Peer Group Calls		
14:15	13:15					
14:30	13:30					
14:45	13:45					
15:00	**14:00**					
15:15	14:15					
15:30	14:30					
15:45	14:45					
16:00	**15:00**					

NOTE: WEEKEND / HOLIDAY OUTAGE CALLS WILL BE HELD AT 0900 LOCAL TIME WHEN APPLICABLE

- ☐ Safety, Nuclear Safety or Radiological Safety (only one needed)
- ☐ Human Performance
- ☐ RP (BOTH Units) _____
- ☐ OE (BOTH Units) _____
- ☐ **Unit One Shift Manager** *(~6 minutes total)*
  - Unit One has been on line ___ days and is currently at ____% power
  - Current Unidentified RCS leak rate is _____ gpm.
  - Current Plant Risk is Minimal/Acceptable/High/Unacceptable

    Elevated risk is due to:_____
  - Highest planned Risk today is Minimal/Acceptable/High

    Planned risk is due to:_____

    U-1 Station Concerns:_____

    Shutdown LCOs:_____

    Other LCOs:_____

    Operations issues and Action Plan Items (from Plant Status Report)

    _____

    _____

    Discuss special trended parameters from front page:

    Elevated Industrial Safety Risk Potential U-1 Maintenance:

    _____
- ☐ Work Week Manager (Unit One Big Hitter/Action Item/Owner Review/Daily Meetings)
- ☐ Unit One Electrical _____
- ☐ Unit One Relay _____
- ☐ Unit One I&C _____
- ☐ Unit One Mechanical _____
- ☐ Fuel Services (if applicable)_____
- ☐ FIN Team _____
- ☐ Chemistry (Unit One CEI status and any other Chemistry input) _____
- ☐ ANY OTHER UNIT 1 ITEMS?

ATTACHMENT 7.3 **DEPARTMENT PLAN OF THE DAY MEETING STRUCTURE AND STANDARD AGENDA EXAMPLE**
Sheet 2 of 2

☐ **Unit Two Shift Manager** *(~6 minutes total)*

- Unit Two has been on line ___ days and is currently at ____% power
- Current Unidentified RCS leak rate is _____ gpm.
- Current Plant Risk is Minimal/Acceptable/High/Unacceptable

  Elevated risk is due to: _____
- Highest planned Risk today is Minimal/Acceptable/High

  Planned risk is due to: _____

  U-2 Station Concerns: _____

  Shutdown LCOs: _____

  Other LCOs: _____

  U-2 Operations Issues and Action Plans (from Plant Status Report)

  _____

  _____

  _____

  Discuss any special trended parameters:

  Elevated Industrial Safety Risk Potential U-2 Maintenance:

  _____

☐ Work Week Manager _____
(Unit Two Big Hitter/Action Item/Owner Review/Daily Meetings)

☐ Unit Two Electrical _____

☐ Unit Two Relay _____

☐ Unit Two I&C _____

☐ Unit Two Mechanical _____

☐ Fuel Services (if applicable) _____

☐ FIN Team _____

☐ Chemistry (Unit Two) _____

☐ Any Additional Items? _____

Reinforce the following:

1. Safety 2. Dose

(THANK YOU AND HAVE A SAFE DAY)

ATTACHMENT 7.4 — OPERATIONAL FOCUS MEETING AGENDA

Sheet 1 of 1

Weekly | Monthly

1st Monday	1st Tuesday	1st Thursday
1.ODMI / SDNC (Ops SM) 2.Top Technical Issue (Ops Mgr) 3.Work Week Planning PI (PSO Mgr) 4.Collective Rad Exposure (RP Mgr) 5.Review of Ops Issues (Ops Mgr) 6.Operator Aggregate Index & PIs(Ops Mgr)	1.Training Program (Trng Mgr) 2.Regulatory Commitments (Lic Mgr) 3.Licensing/NSA Topics (Lic Mgr) 4.Call Outs (Duty Mgr) 5.Elective Maint (Maint Mgr) 6.Fire Protection (Engr Mgr)	1.Work Week Critique (PSO Mgr) 2.Weekly Operating Report (PSO Mgr)* 3.Forced Outage Status (PSO Mgr) 4.LCOs, 72 Hours (PSO Mgr) 5.Rapid Response List (PSO Mgr) 6.P&S PI (PSO Mgr) 7.Work Mgmt Issues (PSO Mgr)
2nd Monday	**2nd Tuesday**	**2nd Thursday**
1.ODMI / SDNC (Ops SM) 2.Top Technical Issue (Ops Mgr) 3.Work Week Planning PI (PSO Mgr) 4.Collective Rad Exposure (RP Mgr) 5.Rad Protection PI (RP Mgr) 6.Ind Safety/Human Perf (IS/HU Supt)	1.Training Program (Trng Mgr) 2.Regulatory Commitments (Lic Mgr) 3.Call Outs (Duty Mgr) 4.Predictive Maint (Maint Mgr) 5. Preventative Maint (Maint Mgr) 6.Maintenance PI (Maint Mgr) 7.Security Issues (Sec Mgr)	1.Work Week Critique (PSO Mgr) 2.Weekly Operating Report (PSO Mgr)* 3.Force Outage Status (PSO Mgr) 4.LCOs, 72 Hours (PSO Mgr) 5.Rapid Response List (PSO Mgr) 6.Long Range Sched (PSO Mgr) 7.Material Issues (MPC Mgr)
3rd Monday	**3rd Tuesday**	**3rd Thursday**
1.ODMI / SDNC (Ops SM) 2.Top Technical Issue (Ops Mgr) 3.Work Week Planning PI (PSO Mgr) 4.Collective Rad Exposure (RP Mgr) 5.Chemistry PI (Chem Mgr) 6.Thermal Cycle Efficiency (Eng Mgr)	1.Training Program (Trng Mgr) 2.Regulatory Commitments (Lic Mgr) 3.Licensing/NSA Topics (Lic Mgr) 4.Call Outs (Duty Mgr) 5.Equipment Reliability (Eng Mgr) 6.Entergy Continuous Improvement (ECI Mgr)	1.Work Week Critique (PSO Mgr) 2.Weekly Operating Report (PSO Mgr)* 3.Forced Outage Status (PSO Mgr) 4.LCOs,72 Hours (PSO Mgr) 5.Rapid Response List (PSO Mgr) 6.Eng Projects (Projects Mgr)
4th Monday	**4th Tuesday**	**4th Thursday**
1.ODMI / SDNC (Ops SM) 2.Top Technical Issue (Ops Mgr) 3.Work Week Planning PI (PSO Mgr) 4.Collective Rad Exposure (RP Mgr) 5.CAP Health (CA&A Mgr) 6.CAP Performance Index (CA&A Mgr)	1.Training Program (Trng Mgr) 2.Regulatory Commitments (Lic Mgr) 3.Call Outs (Duty Mgr) 4.QA (QA Mgr) 5.Communication/Upcoming Events (Public Affairs) 6.Finance Report (Bus Sup Mgr)	1.Work Week Critique (PSO Mgr) 2.Weekly Operating Report (PSO Mgr)* 3.Forced Outage Status (PSO Mgr) 4.LCO's 72 Hours (PSO Mgr) 5.Rapid Response List (PSO Mgr) 6.Engr PI (Engr Mgr) 7.Maint Rule (Sys Eng Mgr)
5th Monday	**5th Tuesday**	**5th Thursday**
1.ODMI / SDNC (Ops SM) 2.Top Technical Issue (Ops Mgr) 3.Work Week Planning PI (PSO Mgr) 4.Collective Rad Exposure (RP Mgr)	1.Training Program (Trng Mgr) 2.Regulatory Commitments (Lic Mgr) 3.Licensing/NSA Topics (Lic Mgr) 4.Call Outs (Duty Mgr)	1.Work Week Critique (PSO Mgr) 2.Weekly Operating Report (PSO Mgr)* 3.Forced Outage Status (PSO Mgr) 4.LCOs, 72 Hours (PSO Mgr) 5.Rapid Response List (PSO Mgr)

Meetings will conclude with a Wrap Up of **Action Items** and the SVP/GMPO addressing **Safety Culture**

* Applicable to sites implementing the Dewolf, Boberg and Associates (DBA) process.

ATTACHMENT 7.5 LEADERSHIP AND ALIGNMENT MEETING STRUCTURE AND AGENDA

Sheet 1 of 3

Summary of Process:

An alternating rolling weekly schedule where key metrics are reviewed and communications are made to the supervisory and management team. It is an interactive session to obtain support and input for performance improvement activities.

Overview:

Week One – Leadership Behaviors (People Health)

This session focuses on issues that would be addressed in normal supervisor meetings. The SVP and GMPO control the agenda to communicate standards, expectations, and topics to align the organization toward excellence.

Week Two – Performance Gaps and Alignment (Plant Health)

Key metrics for the station are reviewed. Metrics not achieving goal and metrics seeing adverse trends are the focus items. This is a facilitated session led by someone selected by the SVP, which will include a review of all department coaching quality grades for the previous month and actions to improve performance. The outcome of the meeting is a selection of approximately three areas to be reviewed in depth on Week 4.

Week Three – Leadership Behaviors (People Health)

This session focuses on issues that would be addressed in normal supervisor meetings. The SVP and GMPO control the agenda to communicate standards, expectations and topics to align the organization towards excellence.

Week Four – Area Focus

Owners of areas selected in week two's metric review present action plans to recover the adverse conditions or trends. Each owner is given ~15 minutes to make the presentation. The presentation includes what comprises the deviation, causes, action plans, and assistance needed. Attendees are encouraged to offer insights, challenge, and assistance to achieve success on the issue.

Leadership and Alignment – Weekly Details

Weeks 1 & 3 – Leadership Behaviors (People Health)

Goal

Allow SVP and GMPO to communicate with the management team on areas of concern, alignment toward excellence, standards, and expectations.
Allow the supervisory team to give feedback and ask questions on relevant topics.
Reinforce principles of a strong safety culture, Operational Decision Making, Conservative Decision Making, etc.

Weeks 1 and 3 – Agenda

- Safety Message- pre-arranged to have a short message from an attendee
- ECI Update, metrics
- Message from VP and/or GMPO
- Q&A Rumors, fact or fiction
- Upcoming major events/milestones
- Clarify take away communications for 1st line to provide to employees
- Supervisory team training and development
- Leadership Effectiveness Log Books roll-ups and department coaching quality grade review

ATTACHMENT 7.5 LEADERSHIP AND ALIGNMENT MEETING STRUCTURE AND AGENDA

Sheet 2 of 3

Week Two – Performance Gaps and Alignment (Plant Health)

Goals

Pre-Meeting - Critically screen data and diverse metrics (e.g. Monthly Report Card metrics, MRM metrics, Functional Area Summary Report metrics, Adverse trends identified in Quarterly Trend Report, etc.)

Meeting - Review selected data, performance gaps and action plans to close gaps.
Identify focus areas for follow-up in Week 4.
Develop a vision of success for each focus area.
Ensure that ownership of each area is known.

Pre-Meeting

Responsible Person assigned by SVP, normally the equipment reliability lead, assembles the presentation. The lead reviews potential focus areas with the GMPO before the meeting

Review selected metrics, for example:

- Industrial Safety performance indicators
- Radiation Protection performance indicators
- Top Ten Equipment Issues
- Operational Challenges
    - Shutdown LCOs in last month
    - Unplanned LCOs due to equipment failure
    - Operations Aggregate Index
    - Reactivity Management Index
    - Protective Tagging Index
- NRC issues and themes
- Maintenance Work Management Performance
    - On-Line Backlogs
    - Fluid Leaks
    - PMs in Grace
    - Late and Deferred PMs
- Engineering Systems
    - Maintenance Rule status
    - System Mitigating Strategy Project Status
    - Systems in red or yellow
- Engineering Programs
    - Status of programs scored 1-4
    - High and Low Critical Equipment Failures
    - Thermal Reliability Index
    - Predictive Maintenance Component condition
- Equipment Reliability Index
- Fleet Equipment Reliability Indicator
- Other metrics from MRM, Monthly Score Card, or Functional Area Summary Reports

Note: Flexibility is allowed for individual sites to add metrics they find useful (Oldest Work Orders, Zone Inspection reports, Human Performance errors, etc.)

ATTACHMENT 7.5 LEADERSHIP AND ALIGNMENT MEETING STRUCTURE AND AGENDA
Sheet 3 of 3

Week Two – Agenda

- Safety Message – pre-arranged to have a short message from an attendee
- Metric Review – led by meeting coordinator
- Review of Potential Focus Areas
- Selection of ~ three areas to be the focus in Week 4 – Interactive, polling, show of hands, etc.
- Message from VP and/or GM

Week 4 – Area Focus

Goal
~Three focus areas from week two are reviewed
Presentations provided to Leadership and Alignment Coordinator in advance

Agenda Week 4
- Safety Message - pre-arranged to have a short message from an attendee
- Area 1
- Area 2
- Area 3
- SVP or GMPO Message
- Clarify take-away communications for first-line supervisors to provide to employees

- **Safety/HU:**
  - Safety Issues
  - First Aids / OSHA Recordables
  - Significant HU events,
  - Engineering Event Clock Resets

- **Plant Status:**
  - Reactor Power (% of thermal licensed power) explain if not 100%
  - Off normal indicators or adverse trends (i.e., Increased RCS leakage, Sum of 6 if applicable)

- **Equipment Problems** (last 24 hours)

- **Condition Reports:** A/B CRs, other significant or noteworthy CRs

- **LCO Status:** Any new LCOs entered and why/ LCOs continuing

- **ODMIs/OEs:** Involving Engineering

- **Other Plant Concerns:**
  - Assessments / inspections
  - Planned maneuvers

- **Help Needed:**

- **CR Count:** open/ready to close

- **Questions?**

ATTACHMENT 7.7 FLEET STATUS CALL AGENDA

Sheet 1 of 1

Please ensure at a minimum we cover (crisply is preferred) the following:

Any:

Safety issues

Human Performance Issues

Radiological issues

Immediate reportable items

Reactor Power, Generated MW's (Net/Gross)

Days on-line

Unidentified Leakage

CEI

Risk

Unplanned LCO's ≤ 72 hrs.

Planned LCO's ≤72 hours

New equipment performance issues/threats to generation

Planned down powers

Items of special interest

- ❖ Cat A/B CR's (new)
- ❖ Significant NRC activity
- ❖ Major accomplishments

On the 2nd working Friday of each month, the sites provide lost megawatt reports

ATTACHMENT 7.8 REFUELING OUTAGE DAILY UPDATE REPORT EXAMPLE

Sheet 1 of 4

WATERFORD 3 REFUELING-15 OUTAGE DAILY UPDATE
04/30/2008 0500 HOURS
DAY 3 of RF 15 SCHEDULED 25 DAYS and 12 HOURS

PERSONNEL SAFETY

Report Only:
First Aid Cases: 0
OSHA Recordables: 0
Lost Time Accidents: 0

RADIOLOGICAL SAFETY

Dose	Actual	Goal	PCEs	Actual		Goal	
Daily	5.922	7.105	Daily	Lvl 1	4	Lvl 1	N/A
				Lvl 2/3	0	Lvl 2/3	N/A
Total			Total	Lvl 1	9	Lvl 1	40
		121		Lvl 2/3	1	Lvl 2/3	

HUMAN PERFORMANCE

Station Event-Free Days: 58
Errors Past 24 Hours: 0
Total Outage Near Misses: ??
Total Outage Errors to Date: 0
Rapid Trending Focus Areas: PPE and Follow The Rules

UNIT STATUS:

Mode: 5
Time to Boil: 15 minutes
RCS Pressure: depressurized
Time to Core Uncovery: 1 hour
RCS Temperature: 95 Deg F
Containment Closure Time: 60 minutes
RCS Level: 13.5 feet

CONFIGURATION RISK:

Protected Train/Equipment: B
Overall Outage Risk Profile: Yellow
High Risk Evolutions in progress or planned in next 24 hours:

Decay Heat Removal: Yellow
Inventory Control: Green
Containment: Green
Electrical Distribution: Green
Reactivity Control: Green

HOURS AHEAD OR BEHIND SCHEDULE):

- 9 Hours

ATTACHMENT 7.8 REFUELING OUTAGE DAILY UPDATE REPORT EXAMPLE

Sheet 2 of 4

CRITICAL PATH ACTIVITIES (Past 24 Hours Performance, Work In Progress, Next 24 Hours):

Critical Path #1: Plant Shutdown & depressurization

Past 24 Hours:
- RCS drained to midloop

Work In Progress:
- OP-903-033 Cold Shutdown IST in progress
- External Reactor Head Disassembly
- S/G Primary Manway Removal

Next 24 Hours:
- Nozzles Dam Installation

Critical Path #2 SG Primary Side Eddy Current

Past 24 Hours:
- Containment Load-in eddy current equipment
- SG Platforms staged for Manway Removal

Work In Progress:
- Equipment setup and testing

Next 24 Hours:
- Continue Eddy Current equipment setup and checkout

Critical Path #3 Alloy 600 Weld Overlay

Past 24 Hours:
- Scaffold installed for all locations except top of Pressurizer
- Pressurizer heaters determed
- All insulation removed except for top of Pressurizer.

Work In Progress:
- Pressurizer top scaffold
- Running service lines to platforms/nozzles

Next 24 Hours:
- Weld overlay equipment staged for hot leg/surge line, pressurizer surge line nozzle, SDC, and pressurizer spray

ATTACHMENT 7.8 REFUELING OUTAGE DAILY UPDATE REPORT EXAMPLE

Sheet 3 of 4

CRITICAL INSPECTIONS/TESTING ACTIVITIES including RESULTS (Significant Discovery Activities):

Target Completed to Date: 6
Actual Completed to Date: 5
Total Critical Inspections in Outage: 62
Completed in Past 24 Hours (with results): None
-
Upcoming in next 24 hours:
Damaged LPT Tee Piece Flange Faces
RCP 2B Motor Cable Inspection (In Progress)
Pressurizer UT Overlay 4" Spray Nozzle

Program Area	Total	Original Target to Date	Actual to Date
AOVs (sum of all diagnostic tests, as found and as left)	**30**	**0**	**0**
MOVs (sum of all diagnostic tests, as found and as left)	**43**	**5**	**5**
Relief Valves (total either replaced or tested/reinstalled)	**28**	**1**	**0**
Check Valves (total tested by radiography or functional)	**7**	**0**	**0**
Snubbers (total tested)	**54**	**7**	**7**
LLRT **1. High Risk of Failure** (Full Contingency) 2. Other Process Penetrations 3. Electrical penetrations / hatches and doors	29	0	0
FAC (total inspection points)	**97**	**0**	**0**
ISI (total inspection points)	**69**	**0**	**0**
IVVI (BWRs)			
RPV Head (PWRs)			
S/G Tube (PWRs)			

OTHER MAJOR WORK COMPLETED (Past 24 Hours):

- ENI D old detector in trash can
- SG Platforms staged for manway removal

OTHER MAJOR WORK UPCOMING (Next 24 Hours):

- RCLA2 window opens (SI-336A disassembly in progress)
- Weld overlay setup
- Eddy Current setup and testing

ATTACHMENT 7.8 REFUELING OUTAGE DAILY UPDATE REPORT EXAMPLE

Sheet 4 of 4

EMERGENT ISSUE TEAM ASSIGNMENTS:	OWNER	ECD/T
Pressurizer Heater Leads Discolored/Brittle	Rachal/Brauner	

OTHER OUTAGE ISSUES:	OWNER	ECD/T

ADDITIONAL FLEET ASSISTANCE NEEDS:

OVERALL SCHEDULE PERFORMANCE:

Original Target Activities Remaining: 6140
Original Actual Activities Remaining: 6331
Emergent Activities Remaining: 118
Total Activities Scheduled to be completed in the last 24 hours: 435
Actual Activities Completed in the last 24 hours: 319

OUTAGE EXECUTION METRICS CONCERNS:

RF Team Metrics

OUTAGE SCOPE CONTROL SUMMARY (Since Outage Start):

Work Orders (including RT/STs) Added to Date: 22
Work Orders (including RT/STs) Deleted to Date: 4

SYSTEM WINDOW CLOSURE STATUS:

Target Systems Ready for Startup to Date: 0
Actual Systems Ready for Startup to Date: 0

TOTAL OUTAGE CONTRACTOR STAFFING LEVELS: (Capital and O&M)

Target Number to Date: 760
Actual Number to Date: 702

TOTAL OUTAGE SHARED RESOURCE STAFFING LEVELS:

Target Number to Date: 160
Actual Number to Date: 147

OUTAGE BUDGET:

Outage O&M: Forecast $29,328,000 vs Target $29,328,000
Outage Capital: Forecast $ 2,209,239 vs Target $ 2,209,239

UPCOMING MILESTONES:

- **SG Manway removal and Nozzle Dam installations**
- **Reactor Disassembly**

***Performance = Behaviors** (Observable) + **Results** (Measureable)*

The department performance review meeting (DPRM) provides a forum for leaders to review both department **performance issues** against established goals and metrics and individual and group performance against common leadership and department **fundamentals**. The standard Entergy fundamentals are captured in the LEL database. The standard agenda for this meeting is in Attachment 7.11, *Standard DPRM Agenda.*

Inputs to be reviewed at this meeting include:

- Performance indicators
- Condition reports
- LEL logbook and database entries
- Assessment and benchmark results
- QA Audits, surveillances and observations
- External reports (INPO, NRC, ANI, etc.)
- Last month's issue and fundamentals windows and action plans

Department Performance Issues Review (Programs and Processes)

Department performance issues are selected by department leaders as programmatic or process areas in which they want to drive improved performance. Improvement efforts may be required to close gaps to established performance goals or to incorporate newly identified best practices. Examples of department performance issues are:

- Radiological exposure
- Budget performance / Cost control
- Chemical control
- Staffing vacancies
- Worker qualifications
- Outage Preparation
- Personnel culpability/accountability issues that require addressing based on the previous month's behavioral observations

Department leaders should identify performance issues to monitor at each DPRM. Department issues may or may not overlap with station and fleet performance indicators. Corporate functional area managers may establish standard performance issues for all sites to monitor. Site specific issues can be added or deleted by department leadership as they deem appropriate. Use inputs listed above to rate and assign a window color (green, white, yellow or red) to each issue. **For window color selection information, refer to the DPRM Window Color Selection below.** Update the department performance issues window (sheet 6 of 7) with the current color and post in an area accessible to department personnel.

Develop specific and measureable actions to drive improved performance in areas rated "improvement needed / focus area" and document these in the department issues action plan (sheet 7 of 7). It is important that all focus areas and actions to close the identified gaps are discussed with department personnel on a frequent basis.

When developing action plans, consider soliciting input from individual contributors in the department. This practice will promote ownership and alignment on solutions to department issues. This promotes vertical alignment and ensures that all individuals clearly understand their role in improving department performance.

Department Fundamentals Review (Behaviors)

Department leaders should also review individual and group performance against the common and departmental fundamentals. Review data from the inputs listed above. The human performance scorecard (sheet 3 of 7) may be used as an aid in scoring performance against the fundamentals listed in the LEL database. Window colors (green, white, yellow or red) for each fundamental will automatically be calculated using the department fundamentals roll-up report in the LEL database. Update the department fundamentals window (sheet 4 of 7) with the current color and post in an area accessible to department personnel. Develop specific and measureable actions to drive improved performance in areas rated "improvement needed / focus area" and document these in the department fundamental behavior action plan (sheet 5 of 7). When developing action plans, consider soliciting input from individual contributors in the department. This practice will promote ownership and alignment on solutions to department issues. Present this action plan at least once each year to the human performance review board. It is important that all focus areas and actions to close the identified gaps are discussed with department personnel on a routine basis. This promotes vertical alignment and ensures that all individuals clearly understand their role in improving department performance.

DPRM Performance Issues Window Color Selection

To ensure department leaders have the latitude to make subjective determinations on window colors and what areas will require focused action plans to close the identified gaps, windows rated RED typically require focused action plans; however, YELLOW windows can be focus areas, but are normally used to raise departmental awareness by increased monitoring/trending and do not require action plans. Typically, two to three focus areas per month should be chosen. This allows departments to create specific, measurable, actionable, realistic, and timely (S.M.A.R.T) action plans to close the gaps in a short period of time. The codes in parentheses after each section refer to the LEL Database codes that reference each section.

SCORECARDS AND PERFORMANCE WINDOW TEMPLATES

Entergy Nuclear (Site)
Fundamental Behavior LEL Scorecard
(Name of) Department

Work Group _____

Supervisor Roll Up ☐ _____ Department Roll Up ☐

Dates: From _____ To _____

Fundamental	Score Color	Exceeds Expectations	Meets Expectations	Improvement Opportunity	Below Standard
Safety					
Nuclear Safety (C1)					
Industrial Safety (C2)					
Radiological Safety (C3)					
Human Performance Tools					
Procedure / Work Instructions (C4)					
Individual Use Tools(C5)					
Group Use Tools(C6)					
Principles					
Personal Responsibility & Accountability (C8)					
4 Key Platforms (PF)					
Teamwork(C9)					
Training					
Training & Qualifications (C7)					
Work Practices					
Work Management (C10)					
Tagging Performance (C11,OP3)					
(department fundamental)					
(department fundamental)					
(department fundamental)					

Score Chart

Red	**Improvement Needed / Focus Area**
Yellow	**Negative Trend**
White	**Monitor Trend**
Green	**No Issues**
Gray	**Limited Data – Less than 5 observations per department per month**

Entergy Nuclear
(Site)
(Name of) Department
Fundamentals Windows

Nuclear Safety	**Industrial Safety**	**Radiological Safety**
Procedures / Work Instructions	**Individual Use HU Tools**	**Group Use HU Tools**
Training and Qualification	**Personal Responsibility And Accountability**	**4 Key Platforms**
Teamwork	**Work Management**	**Tagging Performance**

3 Month	2 Month	Last
Current Month		

Red	**Improvement Needed / Focus Area**
Yellow	**Negative Trend**
White	**Monitor Trend**
Green	**No Issues**

(Departments with Fundamentals defined will have additional windows.)

Entergy Nuclear
(Site)
(Name of) Department
Fundamental Behavior Action Plan

Fundamental:		
Problem Statement		
Basis For Color		
(Communication tool for reason window color was changed)		
Success Metric		
(Target for clearing color)		
Action Item (include WT/CR Reference)	**Owner**	**Due Date**

Fundamental:		
Problem Statement		
Basis For Color		
(Communication tool for reason window color was changed)		
Success Metric		
(Target for clearing color)		
Action Item (include WT/CR Reference)	**Owner**	**Due Date**

Action Items: Specific – Measurable – Actionable – Realistic – Timely

Entergy Nuclear
(Site)
(Name of) Department
Department Issues Windows

(Dept Issue)	(Dept Issue)	(Dept Issue)
(Dept Issue)	(Dept Issue)	(Dept Issue)
(Dept Issue)	(Dept Issue)	(Dept Issue)
(Dept Issue)	(Dept Issue)	(Dept Issue)

3 Month	2 Month	Last
Current Month		

Red	Improvement Needed / Focus Area
Yellow	Negative Trend
White	Monitor Trend
Green	No Issues

Entergy Nuclear
(Site)
(Name of) Department
Department Issues Action Plan

Issue:		
Problem Statement		
Basis For Color		
(Communication tool for reason window color was changed)		
Success Metric		
(Target for clearing color)		
Action Item (include WT/CR reference)	**Owner**	**Due Date**

Issue:		
Problem Statement		
Basis For Color		
(Communication tool for reason window color was changed)		
Success Metric		
(Target for clearing color)		
Action Item (include WT/CR reference)	**Owner**	**Due Date**

**Action Items: Specific – Measurable – Actionable – Realistic – Timely*

ATTACHMENT 7.10 — DEPARTMENT PERFORMANCE REVIEW MEETING WILL SHEET

Sheet 1 of 2

Criteria	Results	Observers Comments
1. Meeting Attendance		
• Department Leadership team present	Yes / No	
• Department Performance Improvement Coordinator present	Yes / No	
• Training representative present	Yes / No	
• Site Vice President or GMPO present (optional)	Yes / No	
2. Department/ Crew DPRM meetings		
• Agenda aligns with procedure requirements/inputs	Yes / No	
• Issues/Fundamentals are separate discussions	Yes / No	
• Issues – Programs/Processes/Performance Indicators	Yes / No	
• Fundamentals – LEL observations (behaviors)	Yes / No	
3. Inputs		
• Performance Indicators	Yes / No	
• Condition Reports	Yes / No	
• LEL fundamentals observations	Yes / No	
• Benchmark or Assessment results (as applicable)	Yes / No	
• External Reports (INPO, NRC, ANI, etc.)	Yes / No	
• Last month's issues/fundamentals windows and action plans	Yes / No	
4. Department Issues (Program/ Processes)		
• Assess performance against annunciator windows (2)	Yes / No	
• Each window is presented by the assigned owner (2)	Yes / No	
• Team is critical and challenges each window color (3)	Yes / No	
• Team selects windows where gaps exist for focus areas (Window color may be red even though PI is Green based on the desire to apply more focus in the specific area) (2)	Yes / No	
• Problem statements are created and actions developed are **S.M.A.R.T.** and "next level performance" oriented (2)	Yes / No	
• Actions are assigned with ***owners***, ***due dates***, ***basis for color change*** and ***success criteria*** to ensure the actions are effective at closing the indentified gaps (3)	Yes / No	
• Issue (window colors) align with departmental performance (2)	Yes / No	

ATTACHMENT 7.10 — DEPARTMENT PERFORMANCE REVIEW MEETING WILL SHEET

Sheet 2 of 2

Criteria	Results	Observers Comments
5. Department/ Crew Fundamentals (Behaviors)		
• Adequate number of observations by the manager/superintendent/supervisors (2)	Yes / No	
• Observation ratios are reasonable/self critical (Goal = 4 positive to every 1 critical) (2)	Yes / No	
• Quality of the LEL entries were evaluated prior to meeting using the Leader 1/Leader 2 rollups as indicated by the Coaching Quality report (2)	Yes / No	
• Team selects fundamental behaviors where gaps exist for focus areas over the next 30 days (2)	Yes / No	
• Problem statements are created and actions developed are **S.M.A.R.T.** and "next level performance" oriented (2)	Yes / No	
• Actions are assigned with ***owners***, ***due dates***, ***basis for color change*** and ***success criteria*** to ensure the actions are effective at closing the indentified gaps (2)	Yes / No	
• Fundamentals (window colors) align with departmental performance (1)	Yes / No	
• Determine if the team is self-critical, challenging and capable of effectively identify existing gaps in fundamental behaviors (3)	Yes / No	

- (Note - significant weakness in any area(s) that have not already been identified should be documented using the corrective action process)
- Ensure the meeting observation is captured in the LEL database with a focus on the Leadership Fundamentals and Alignment

ATTACHMENT 7.11 STANDARD DPRM AGENDA

Sheet 1 of 2

Department Performance Review Meeting (DPRM) Standard Agenda
Department/ Crew/ Discipline:
Date/ Time:
Location:

Attendees:

Topic(s)	Facilitator	Targeted Duration
DPRM Meeting Attendance (Recommended Attendees) • Department Leadership team present • DPIC present • Individual program owners (as applicable) • Site Vice President or GMPO present (optional)	Department Leadership	~3 minutes
DPRM Inputs for Review • Performance Indicators • Condition Reports • LEL Fundamentals observations • Assessment and Benchmark results (as applicable) • Operating Experience (as applicable) • External Reports (INPO, NRC, ANI, etc.) • Last month's issues and fundamentals windows and actions	Leadership Team	~25 minutes
Department Performance Issues Review • Department performance vs. annunciator windows • Window owner present current data and associated plans • Team challenge of each window color • Team selection of windows where gaps exist for focus areas (Window color may be Red even though PI is Green based if desired to apply more focus in the specific area) • Ensure actions developed to address the identified gaps are S.M.A.R.T and directed towards "Next Level Performance" • Assigned actions, owners and due dates to ensure the actions are executed and single-point accountability is maintained • Final Check - ensure the department issue windows align with actual department performance	Leadership Team	~25 minutes
Break	All meeting attendees	10 minutes

Department Fundamentals Review • Review LEL reports (LEL Report Card & Department Quality report) to determine the number of observations, contact time, and coaching quality for managers/superintendents/supervisors and determine if expectations were met • Determine if the observation ratios are reasonable and self-critical (Goal = 4 positive (75%)/ 1 negative (25%)) • Evaluate the overall quality of the LEL entries • Discuss the fundamental behaviors with the team and ensure the discussions are open, challenging and critical • Team challenges the window colors and selects fundamental behaviors where gaps exist for focus areas over the next 30 days • Ensure the actions developed to address the identified gaps are S.M.A.R.T and directed towards achieving excellence • Review assigned actions, owners, and due dates to ensure the actions are executed and single-point accountability is maintained • Final Check - ensure the department issue windows align with actual department performance	Leadership Team	~25 minutes
DPRM Plus/Delta Session • Solicit meeting feedback from all meeting attendees and capture lessons learned • Finalize the DPRM Will Sheet and discuss the results with the team	Leadership Team	~10 minutes

RBG-47190

Enclosure 6

RBS Superviser Training

RSEM-*Rtype ____

NOTE
This form is used to approve training materials that do NOT have a review/approval block.

***TRAINING MATERIAL NUMBER:**

RSEM-SUPC-SAFCUL Rev 1

***TRAINING MATERIAL TITLE:**

Principles of a Strong Nuclear Safety Culture

☐ Handout ☐ Qualification Card Familiarization Guide ☐ Lab Guide ☐ Simulator Guide

☐ CMI Course ☐ Electronic Document ☒ Other Seminar

☐ New Material ☒ Minor Revision ☐ Major Revision

REASON FOR REVISION:
Added slide on Performance Improvement Ownership, Engagement, Accountability.

REVIEW / APPROVAL: ☐ Electronic Approval (_____)

Prepared By:	Mike Raymond Preparer	07/28/11 Date
Reviewed By:	Gary Degraw Technical Reviewer (e.g., SME, line management)	8/1/11 Date
Instructional Adequacy Determined By:	Bonnie D. Scott Qualified Instructor	08/1/2011 Date
Approved By:	Gary Degraw **Discipline Training Supervisor	8/1/11 Date
*Approval Date	8/1/2011	

**Indicates that the document has been reviewed by the Training Supervisor for inclusion of Management Expectations and items referenced on TQF-201-DD06, Training Material Checklist.

FLEET/REGIONAL PROGRAM CONCURRENCE: ☐ Fleet ☐ ENN ☐ ENS ☒Not Applicable

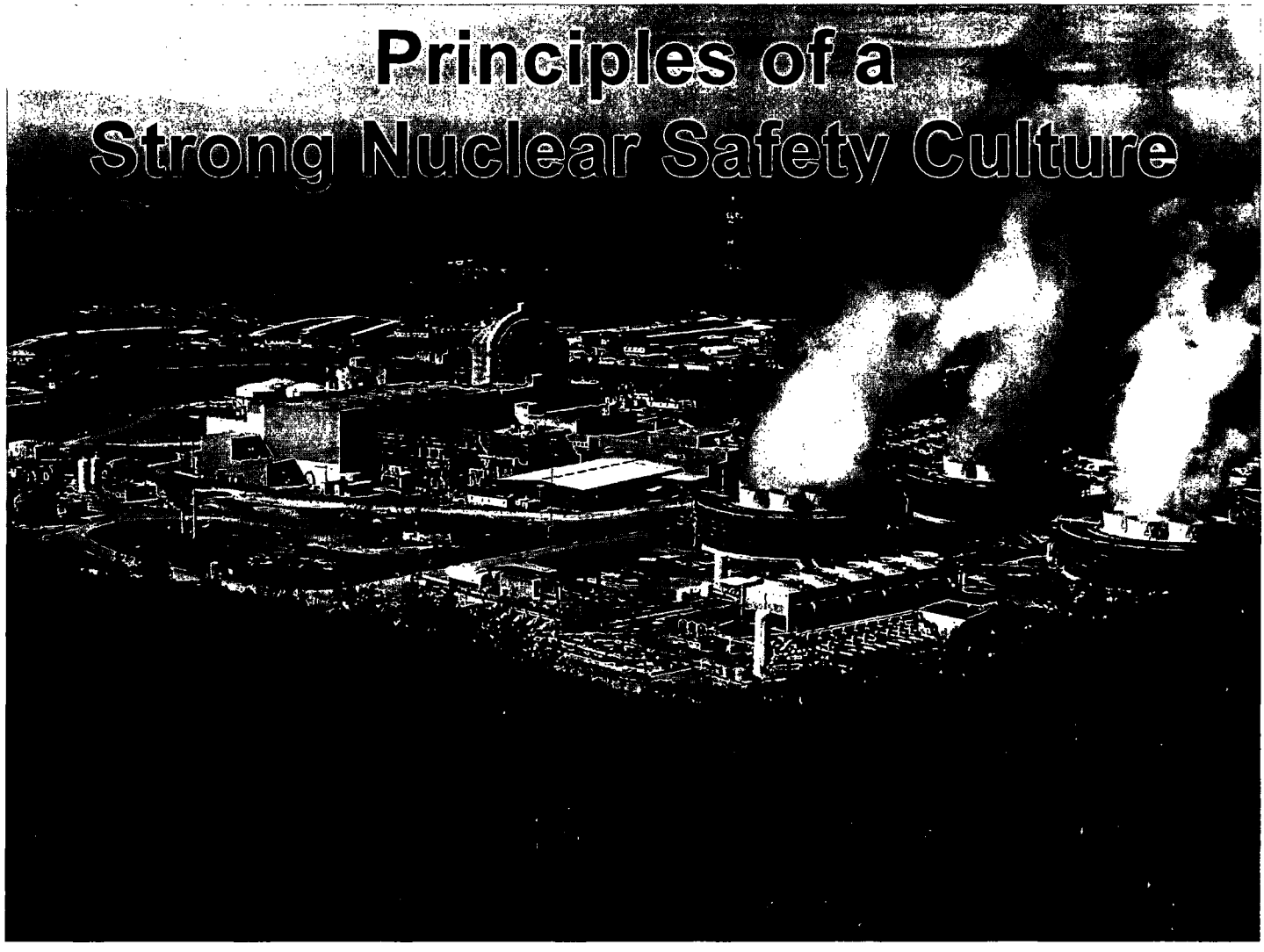
ANO		PNPS	
CNS		RBS	
ECH		VY	
GGNS		WF3	
IPEC		WPO	
JAF			

* Indexing Information

END OF DOCUMENT

Supervisor Training Seminar

Principles of a Strong Nuclear Safety Culture



Class Kickoff

- Plant Status
- Safety
- In the event of extreme weather…….
- Breaks about every hour
- Management Observers

Manager's Kickoff

- Why are we here?
- Where are we going?
- How can we get there?
- What should you expect today?

RSEM-SUPC-SAFCUL

Safety Culture

An Organization's Values and Behaviors – Modeled By Its Leaders and Internalized by Its Members – That Serve To Make Nuclear Safety The Overriding Priority.

Four Key Platforms

- *Trust, Honesty, Fairness, Integrity.*
- *Be deliberate – actions under control – follow the rules.*
- *Set and continuously reinforce high standards.*
- *Do what you say you will do.*

RSEM-SUPC-SAFCUL

CR-RBS-2011-03296

- Problem
  - An adverse trend in Nuclear Safety Culture has resulted in declined personnel performance and equipment challenges.

CR-RBS-2011-03296

- Root Cause
  - The values and behaviors that comprise a strong nuclear safety culture are not effectively and consistently modeled by some station leaders.
    - "Situational Standards"

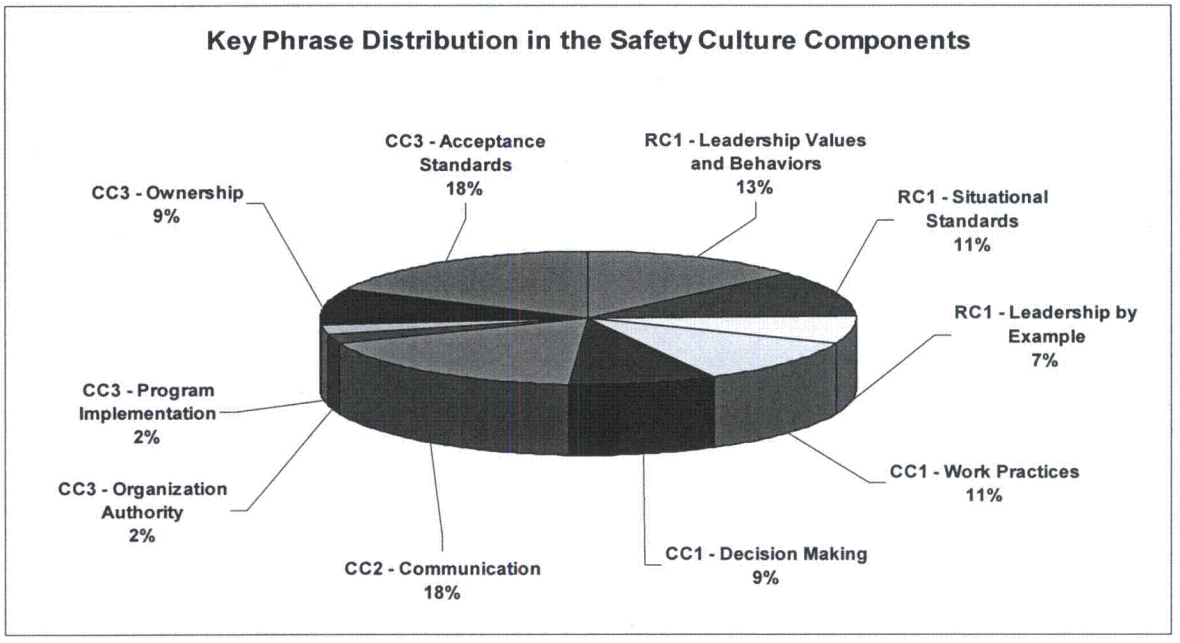
CR-RBS-2011-03296

- Contributing Causes
  - Inadequate work practices and decision making.
  - Inadequate communication within the organization.
  - Lack of organization authority for program implementation.

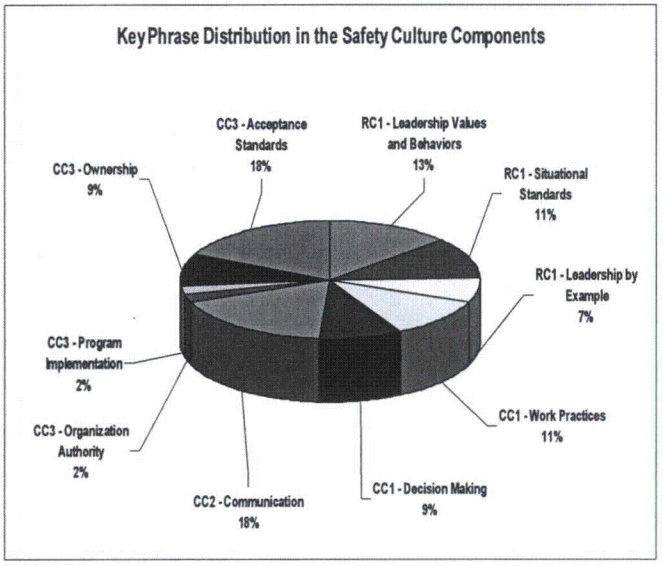
CR-RBS-2011-03296

- Events
  - Operators in the Control Room on the Internet (CR-RBS-2010-02953)
  - Maintenance AFI from INPO Evaluation (CR-RBS-2010-05456)
  - Fuse installed in the wrong location resulting in a back up scram and damage to the insert scram valves. (CR RBS-2011-867)
  - Misplaced Bundle in the Spent Fuel Pool (CR-RBS-2011-00886)
  - Misplaced Bundle in the Core (CR-RBS-2011-01850)
  - Bent Mast during Refueling (CR-RBS-2011-00899)

CR-RBS-2011-03296
Culture Survey results



What is this telling us?



- 85% of this is acceptance of standards, leadership behaviors and values, situational standards, ownership and communication, decision making and leading by example.

Terminal Objective

Employees internalize values and behaviors that serve to make Nuclear Safety an overriding priority in accordance with INPO policies, NRC regulations and Entergy policies.

Enabling Objectives

- Describe Nuclear Safety as the overriding priority in the operation of a commercial nuclear power plant.
- Discuss events and their relationship to Nuclear Safety.
- Describe the benefits of exercising a questioning attitude by challenging conditions and actions affecting nuclear safety.

Enabling Objectives

- Identify the behaviors and organizational factors within River Bend Station and how they apply to Nuclear Safety.
- Using case studies, identify the situational standards present and the impact of application of these standards.
- Discuss the application of Standards and Expectations in terms of organization pressure.

3 Phases in Developing and Strengthening Safety Culture

(1) Safety is compliance driven and is based mainly on rules and regulations

(2) Good Safety performance becomes an organizational goal and is dealt with primarily in terms of safety targets or goals.

(3) Safety is seen as a continuing process of improvement to which everyone can contribute

Key Issues in Safety Culture

- Commitment
- Use of Procedures
- Conservative Decision Making
- A Reporting Culture
- Challenging Unsafe Acts and Conditions
- The Learning Organization
- Communication, Clear Priorities, and Organization

TABLE I. TYPICAL PATTERN OF DECLINING SAFETY PERFORMANCE *(after INSAG-13 [2], para. 90)*

Stage 1: Overconfidence	This is brought about as a result of good past performance, praise from independent evaluations and unjustified self-satisfaction.
Stage 2: Complacency	In this phase, minor events begin to occur at the plant and self-assessments that are inadequate are performed to understand their significance singly or in total. Oversight activities begin to be weakened and self-satisfaction leads to delay or cancellation of some improvement programmes.
Stage 3: Denial	Denial is often visible when the number of minor events increases further and more significant events begin to occur. However, there is a prevailing belief that these are still isolated cases. Negative findings by internal audit organizations or self-assessments tend to be rejected as invalid and the programmes to evaluate root causes are not applied or are weakened. Corrective actions are not systematically carried out and improvement programmes are incomplete or are terminated early.

TABLE I. TYPICAL PATTERN OF DECLINING SAFETY PERFORMANCE
(after INSAG-13 [2], para. 90)

Stage 4: Danger	Danger sets in when a few potentially severe events occur but management and staff tend consistently to reject criticisms coming from internal audits, regulators or other external organizations. The belief develops that the results are biased and that there is unjust criticism of the plant. As a consequence, oversight organizations are often silent and afraid to make negative assessments and/or to confront the management.
Stage 5: Collapse	Collapse can be recognized most easily. This is the phase where problems have become clear to all parties and the regulator and other external organizations need to make special diagnostic and augmented evaluations. Management is overwhelmed and usually needs to be replaced. A major and very costly improvement programme usually has to be implemented.

Note: It is important that declining performance be recognized in the first two stages and at the latest by early in Stage 3.

SOER 10-2
Engaged, Thinking Organization

Let's review the causes and ask ourselves these questions.

- Where do we see ourselves in this area, Engaged and Thinking?

- What's different at River Bend because of SOER 10-2?

SOER 10-2
Engaged, Thinking Organization Common Causes

- Supervisors did not fulfill their expected oversight roles by becoming engaged in conducting activities. For example, at ANO shift managers tended to facilitate problem solving instead of delegating to support staff.

- Workers did not fully understand or anticipate the effects of their actions.

- Risk was not recognized or was inappropriately accepted by individuals or the organization without sufficient engagement of others in decision-making.

SOER 10-2
Engaged, Thinking Organization Common Causes

- Repetitive and long-standing issues were tolerated, and the consequences of not addressing them were not recognized.

- Subtle declines in standards and performance went unnoticed because managers and supervisors were not sufficiently engaged in activities. Often, the focus on results overshadowed the emphasis on correct behaviors.

- Significant operating experience was not used effectively to prevent the events, and managers were not engaged sufficiently to ensure the lessons were applied appropriately.

Nuclear Safety Vision Statement

Because we have internalized the right values and behaviors, nuclear safety is the overriding priority in everything we do.

RSEM-SUPC-SAFCUL

Reminder:

- Commit to do it right.
  - Know the rules, Follow the rules.
- Never walk away from a challenge
- Accept feedback

RSEM-SUPC-SAFCUL

Our Values

- *NEVER COMPROMISE SAFETY*
- *CONTINUOUSLY PURSUE EXCELLENCE*
- *BE A LEARNING ORGANIZATION*
- *MAKE SOUND ECONOMIC DECISIONS*
- *ABOVE ALL, ACT WITH INTEGRITY*

Principles for a Strong Nuclear Safety Culture

1. *Everyone is personally responsible for nuclear safety.*
2. *Leaders demonstrate commitment to safety.*
3. *Trust permeates the organization.*
4. *Decision-making reflects safety first.*
5. *Nuclear technology is recognized as special and unique.*
6. *A questioning attitude is cultivated.*
7. *Organizational learning is embraced.*
8. *Nuclear safety undergoes constant examination.*

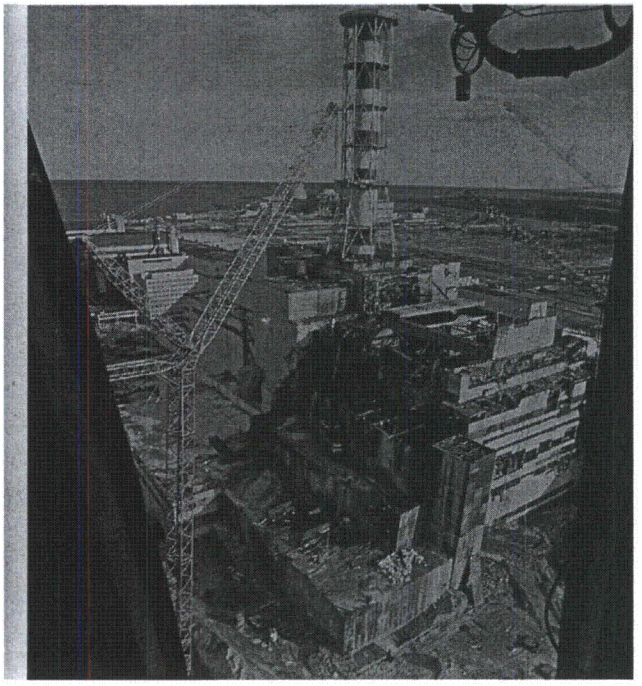
RSEM-SUPC-SAFCUL

Group Activity-
Guest Speakers

- Guest presents their narrative, focus on thoughts that drove the decision made at the time.
- Discuss presented material for the assigned event
- Identify the behaviors associated with the event that did not meet the standard and discuss where your groups may fall into that trap.
- ***Answer the question - "What can we learn from this activity to strengthen our nuclear safety culture at RBS?"***

Selected Clips - Chernobyl

- Clip 1
- Clip 2
- Clip 3



Case Study / Video Clip Summaries

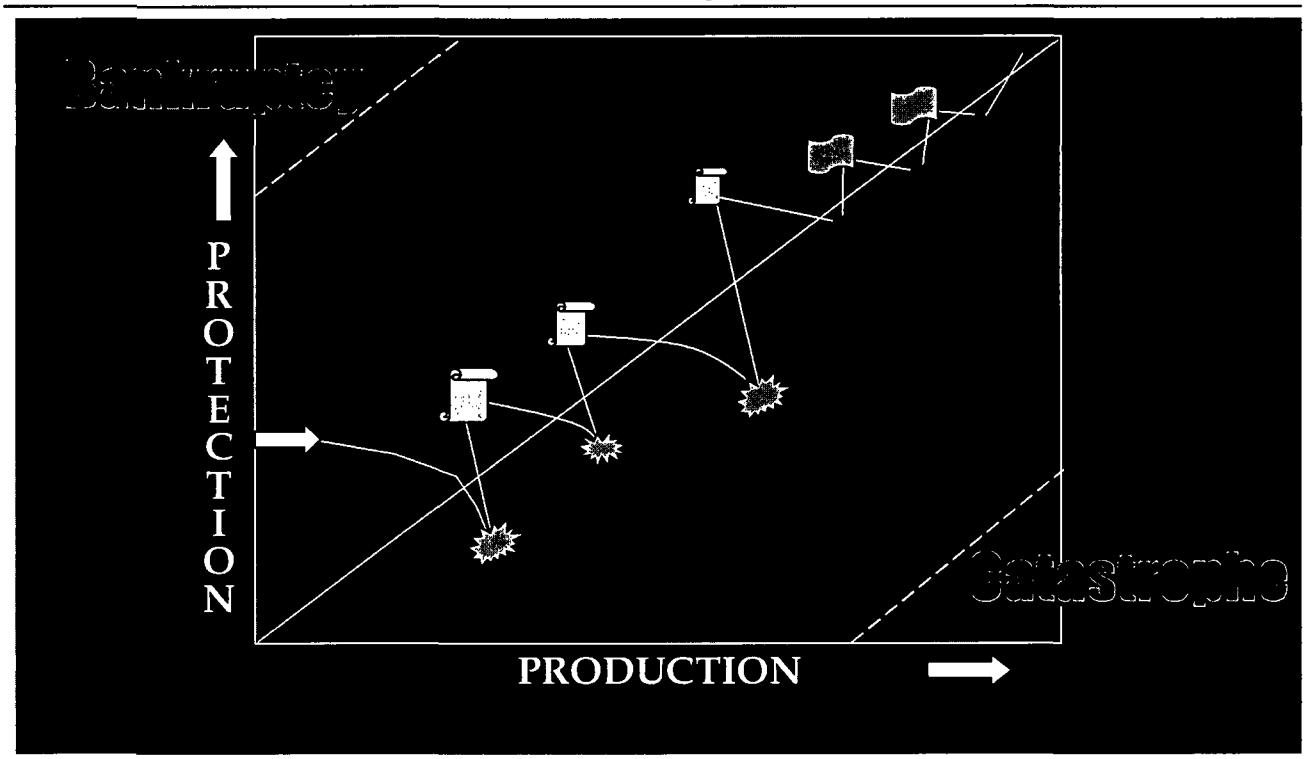
What can we learn from these presentations to strengthen our nuclear safety culture at RBS?"

RSEM-SUPC-SAFCUL

Three Key Principles

- Need to Perform all tasks to the Highest Standards.
  - Commit to do it right.
- Stand firm when Nuclear Safety is Challenged
  - Never walk away from a challenge.
- Expect and receive feedback on performance and actions.

Maintaining Safety Culture Is A Balancing Act:



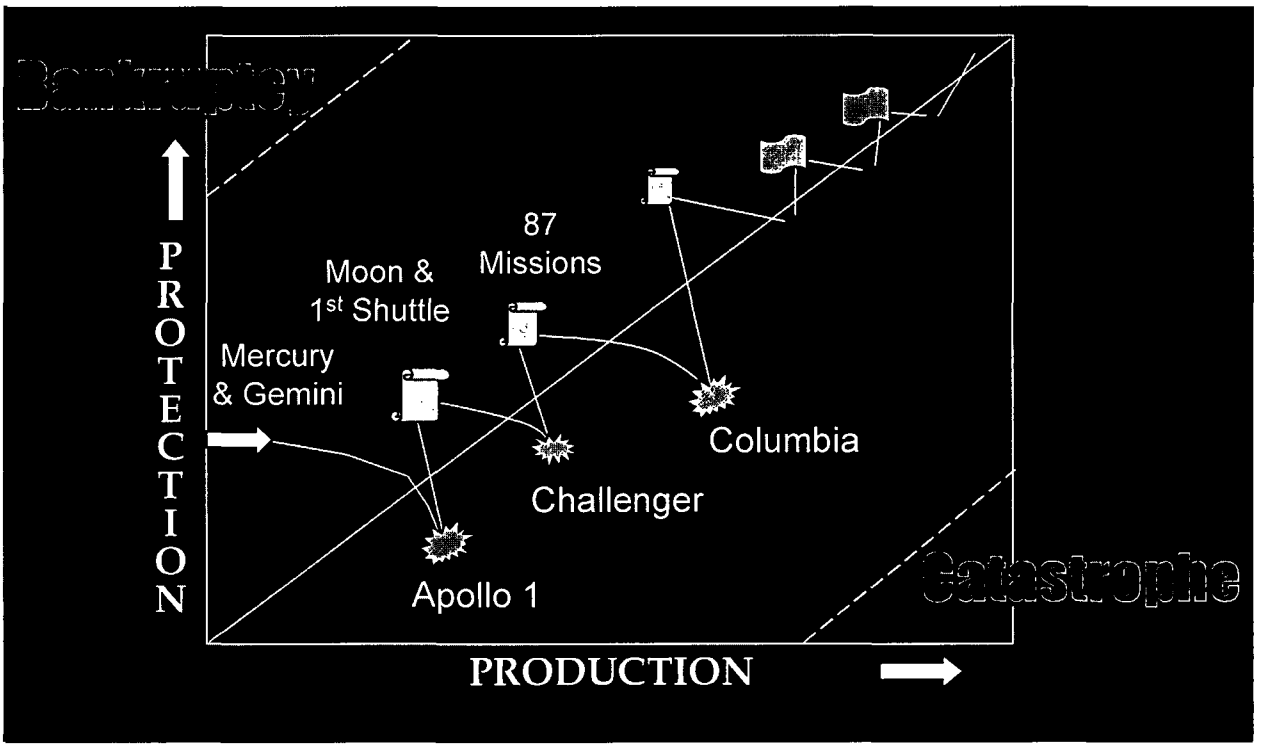
A Balancing Act

What is the single biggest impact that leaders have on how their people do work? (culture)

What leaders pay attention to, measure, and control.

What is happening to the standards we set when no reinforcement is occurring?

A Balancing Act:

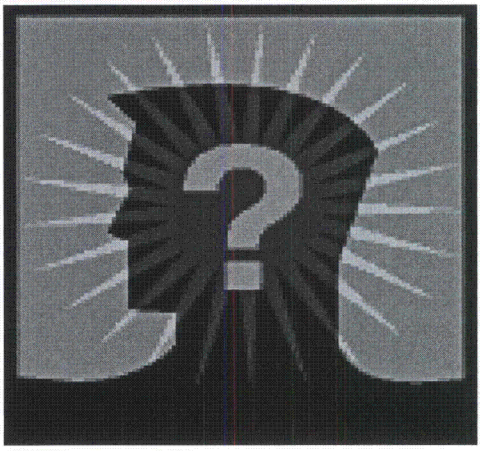


Safety Culture and You

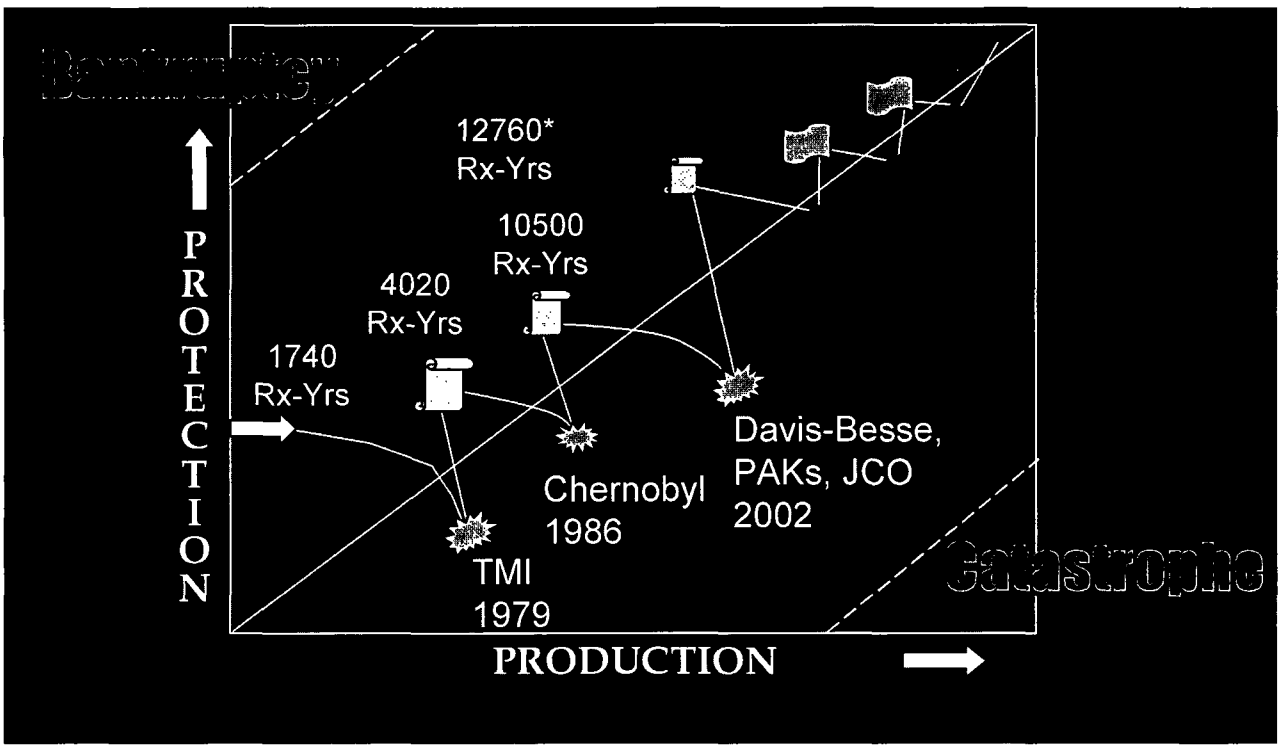
Beware the pressures:

What kind of overt or inadvertent pressures do leaders put on their employees that cause them to compromise decisions or how they do work?

- **What emotions were stimulated by what you heard?**
- **What facts did you hear?**



A Balancing Act:



A Balancing Act

How do you Drive for Results and maintain a Strong Nuclear Safety Culture?

- Define and Nurture a strong nuclear safety culture
- Focus on "What's Important"
- Operating Experience
- Worker knowledge
- Pride in plant conditions
- Goals, Plans, Visions

RSEM-SUPC-SAFCUL

Four Powerful Phrases

- "Let's go out and take a look"
- "What can I do to help?"
- "Now, let's hear why we SHOULDN'T do this."
- "Tell me how you did that."

Public Opinion of Nuclear Power

- **What emotions were stimulated by what you heard?**
- **What facts did you hear?**

"Perform even the simplest tasks to highest standards; appreciate that small mistakes can have large consequences."

Ed Frederick – TMI Control Room Operator, March 1979

Safety Culture

- **An Organization's Values and Behaviors – Modeled By Its Leaders and Internalized by Its Members – That Serve To Make Nuclear Safety The Overriding Priority.**

RBG-47190

Enclosure 7

Fleet Procedure EN-FAP-DC-007

Entergy	NUCLEAR MANAGEMENT MANUAL	FLEET ADMIISTRATIVE PROCEDURE	EN-FAP-DC-007	REV. 0
		INFORMATIONAL USE	PAGE 1 OF 38	

Engineering Focused Crew Assessments

Fleet Administrative Procedure Contains NMM eB REFLIB Forms: YES ☐ NO ☒

Documents Canceled or Superseded by this Fleet Administrative Procedure

None

Effective Date	Governance Owner:	Oscar Limpias
6/16/2011*	Title:	Vice President, Engineering
	Site:	HQN

Fleet Administrative Procedure Summary

Establishes a standard process for Engineering Focused Crew Assessments.

Change Statement

New administrative procedure.

*** PNPS - effective date is 7/31/2011.**

TABLE OF CONTENTS

1.0 PURPOSE

The purpose of Engineering Focused Crew Assessments is to provide guidance and structure on the performance of these assessments. It also ensures consistency across the fleet.

2.0 RESPONSIBILITIES

[1] The **Director, Site Engineering**, is responsible for:

(a) Overall responsibility for the performance of Engineering Focused Crew Assessments at your assigned site.

[2] **Engineering Managers** are responsible for:

(a) Setting the rolling schedule of topics to be assessed in their department.

(b) Determining the scope of required assessments.

(c) Holding periodic meetings IAW EN-FAP-OM-001with their supervisors to roll up the results of the assessments and assign additional actions as required.

(d) Briefing the Engineering Director on the result of these assessments.

[3] **Engineering Supervisors** are responsible for:

(a) Performing Focused Crew Assessments IAW the requirements of this procedure and per the schedule established by their Department Manager.

(b) Providing the aggregate results of assessments performed in your group.

3.0 DETAILS

3.1 Schedule and Scope of Assessments

[1] Managers will evaluate the need for each template in Attachments 7.1 through 7.15 for use in their department based on LEL entries, HU Trend Reports, Oversight Trimester Reports, and the CAP.

[2] Managers will setup a schedule and scope of assessments for each supervisor in their department.

[3] Each applicable template (as determined in 3.1 [1] above) will be performed at least twice per calendar year.

[4] Each supervisor will complete focused crew assessments per month per the schedule determined by their Manager.

[5] Engineering Focused Crew Assessments are performed in accordance with this procedure in lieu of EN-HU-105, Human Performance-Managed Defenses.

3.2 Monthly Department Performance Review Meeting

[1] Supervisors will provide the results of their bi-weekly assessments at the department performance review meeting IAW EN-FAP-OM-001

[2] Managers will roll up the results from each supervisor for inclusion in the monthly department performance review report.

[3] Additional actions will be assigned by the Managers to resolve issues identified by the aggregate reviews.

3.3 Administrative Controls of this program

[1] Each Manager will open a LO-WT for the calendar year to track assigned assessments.

[2] Each assigned assessment will be tracked in the department WT.

[3] Additional actions will be assigned in the department WT.

4.0 DEFINITIONS

None

5.0 REFERENCES

[1] EN-FAP-OM-001, Leadership Forums for Continuous Improvement

6.0 INTERFACES

None

7.0 ATTACHMENTS

7.1 Training Qualifications

7.2 System Notebooks

7.3 System Walkdowns

7.4 CAP Ownership

7.5 System Performance Monitoring

7.6 Component Health Reports

7.7 Program Health Reports

7.8 System Health Reports

7.9 Component Monitoring

7.10 Component Notebooks

7.11 Pre-Job Briefs

7.12 T-20

7.13 T-28

7.14 EC Ownership

7.15 Typical Blank Form

Focus: Training Qualifications - EN-TQ-104

Supervisor: _____

The supervisor will locate 4 engineers outside of their immediate group. The following activities should be observed.

Engineer: _____

1) Upon entering the work area, inquire on what they are working on.
2) Have the engineer demonstrate on how they know they are qualified to perform that task.
3) Upon their ability to enter plateau ensure the following:

Do they have a method to have them verify qualifications once a week?	Y	N
Can they verify their qualifications?	Y	N
Do they have any over due qualifications?	Y	N
Do they have any incomplete qualifications?	Y	N

Please provide any coaching for any no answer.

Engineer: _____

1) Upon entering the work area, inquire on what they are working on.
2) Have the engineer demonstrate on how they know they are qualified to perform that task.
3) Upon their ability to enter plateau ensure the following:

Do they have a method to have them verify qualifications once a week?	Y	N
Can they verify their qualifications?	Y	N
Do they have any over due qualifications?	Y	N
Do they have any incomplete qualifications?	Y	N

Please provide any coaching for any no answer.

ATTACHMENT 7.1 TRAINING QUALIFICATIONS

Engineer: _____

1) Upon entering the work area, inquire on what they are working on.
2) Have the engineer demonstrate on how they know they are qualified to perform that task.
3) Upon their ability to enter plateau ensure the following:

Do they have a method to have them verify qualifications once a week?	Y	N
Can they verify their qualifications?	Y	N
Do they have any over due qualifications?	Y	N
Do they have any incomplete qualifications?	Y	N

Please provide any coaching for any no answer.

Engineer: _____

1) Upon entering the work area, inquire on what they are working on.
2) Have the engineer demonstrate on how they know they are qualified to perform that task.
3) Upon their ability to enter plateau ensure the following:

Do they have a method to have them verify qualifications once a week?	Y	N
Can they verify their qualifications?	Y	N
Do they have any over due qualifications?	Y	N
Do they have any incomplete qualifications?	Y	N

Please provide any coaching for any no answer.

ATTACHMENT 7.2 SYSTEM NOTEBOOKS

Focus: System Notebooks - EN-MS-S-001-Multi

Supervisor: _____

The supervisor will review one System Notebook in detail with one engineer.

System: _____ Engineer: _____

System Notebook:

Does format and content meet EN-MS-S-001-MULTI.	**Yes**	**No**
Was the notebook readily accessible and was the SE knowledgeable of how it is to be used?	**Yes**	**No**

Sample one notebook for each other engineer in that group to ensure accessibility and understanding. Document findings.

General Comments:

Focus: System Walkdowns – EN-DC-178

Supervisor: _____
Date: _____

The supervisor will observe 2 system walkdowns with different engineers.

System: _____ Engineer: _____

At the beginning of the walkdown, question the SE on details of their walkdown plan. Is there a system specific walkdown and was the SE knowledgeable of the criteria?	**Yes**	**No**
Can the SE explain what field data is needed for input into the Performance Monitoring Plan?	**Yes**	**No**
Prior to this walkdown, has the supervisor performed a walkdown with this SE (this or other system) in the last quarter?	**Yes**	**No**
Prior to this walkdown, has the manager performed a walkdown with this SE (this or other system) in the last year?	**Yes**	**No**
Prior to this walkdown, has Operations or maintenance performed a walkdown with this SE (this or other system) in the last quarter?	**Yes**	**No**
Has walkdowns been performed at expected frequency for the past quarter?	**Yes**	**No**
During pre-job brief was SE familiar with system issues that need to be observed (i.e., TMods, WOs,)?	**Yes**	**No**
During the walkdown is the SE identifying all expected issues (i.e., house keeping, equipment leakage, loose or missing bolts)?	**Yes**	**No**
Does the SE document noted issues in the walkdown sheet, write appropriate WOs and CRs?	**Yes**	**No**

General Comments:

ATTACHMENT 7.3 SYSTEM WALKDOWNS

Date: _____

System: _____ Engineer: _____

At the beginning of the walkdown, question the SE on details of their walkdown plan. Is there a system specific walkdown and was the SE knowledgeable of the criteria?	**Yes**	**No**
Can the SE explain what field data is needed for input into the Performance Monitoring Plan?	**Yes**	**No**
Prior to this walkdown, has the supervisor performed a walkdown with this SE (this or other system) in the last quarter?	**Yes**	**No**
Prior to this walkdown, has the manager performed a walkdown with this SE (this or other system) in the last year?	**Yes**	**No**
Prior to this walkdown, has Operations or maintenance performed a walkdown with this SE (this or other system) in the last quarter?	**Yes**	**No**
Has walkdowns been performed at expected frequency for the past quarter?	**Yes**	**No**
During pre-job brief was SE familiar with system issues that need to be observed (i.e., TMods, WOs,)?	**Yes**	**No**
During the walkdown is the SE identifying all expected issues (i.e., house keeping, equipment leakage, loose or missing bolts)?	**Yes**	**No**
Does the SE document noted issues in the walkdown sheet, write appropriate WOs and CRs?	**Yes**	**No**

General Comments:

ATTACHMENT 7.4 CAP OWNERSHIP

Focus: CAP Ownership – EN-LI-102

Supervisor: _____

The supervisor will assess 2 engineers regarding their knowledge of expectations for ownership and control of CAP associated with their functional area.

Engineer: _____
Date: _____

Enter engineer's work area and question them on the number of CRs in their backlog. Also, ask how many are greater than 6 months old. Were they able to answer accurately?	**Yes**	**No**
Document number of open CRs in engineer's backlog.		
Document number of open CRs >6 months old in engineer's backlog.		
Are there CAs tracking WOs that can be closed to a WO?	**Yes**	**No**
Are there CAs tracking ARs?	**Yes**	**No**
Is the engineer knowledgeable of criteria for designating a CA as LTCA?	**Yes**	**No**
Are there CR actions for CRs > 6months old that should be designated LTCA that are not?	**Yes**	**No**
Is the engineer aware of CRs that are approaching 6 months old that are not on track for closure?	**Yes**	**No**
Is the engineer aware of the definition of enhancement as defined in the LI procedures?	**Yes**	**No**
Is the engineer aware of the Departmental CR goal?	**Yes**	**No**

General Comments:

ATTACHMENT 7.4 CAP OWNERSHIP

Engineer: _____

Date: _____

Enter engineer's work area and question them on the number of CRs in their backlog. Also, ask how many are greater than 6 months old. Were they able to answer accurately?	**Yes**	**No**
Document number of open CRs in engineer's backlog.		
Document number of open CRs >6 months old in engineer's backlog.		
Are there CAs tracking WOs?	**Yes**	**No**
Are there CAs tracking ARs?	**Yes**	**No**
Is the engineer knowledgeable of criteria for designating a CA as LTCA?	**Yes**	**No**
Are there CR actions for CRs > 6months old that should be designated LTCA that are not?	**Yes**	**No**
Is the engineer aware of CRs that are approaching 6 months old that are not on track for closure?	**Yes**	**No**
Is the engineer aware of the definition of enhancement as defined in the LI procedures?	**Yes**	**No**
Is the engineer aware of the Departmental CR goal?	**Yes**	**No**

General Comments:

Focus: System Performance Monitoring – EN-DC-159

Supervisor: _____

The supervisor will review a category 1 system monitoring plan with the engineer.

System: _____ Engineer: _____

System Monitoring Plan:

Is there a listing of the equipment being monitored?	**Yes**	**No**
Are the critical parameters listed for the equipment being monitored?	**Yes**	**No**
Is the trending method identified for each parameter?	**Yes**	**No**
Are there alert and action levels for the parameters monitored?	**Yes**	**No**
This there a listing of all the necessary actions that need to be taken when Alert or Action Levels are exceeded, to remedy an existing problem or prevent one that may occur?	**Yes**	**No**
Is there a frequency defined for each parameter being monitored?	**Yes**	**No**
When was the last System Monitoring Challenge board performed on this system and what were the results?	**Yes**	**No**

System Monitoring Performance:

Verify at least 10 parameters are being monitored as required per their plan.

Does each of the parameters being inspected have data trended/monitored within the required frequency?	**Yes**	**No**
Is there some historical tracking of the reason for any step changes that are identified?	**Yes**	**No**
Are there CRs generated for all parameters exceeding the alert limit?	**Yes**	**No**

Notes:

Summary / Conclusions

Focus: Component Health Reports - EN-DC-143

Supervisor: _____

The supervisor will review a component health reports with the engineers.

System: _____ Engineer: _____

System Summary Section:

Does the summary provide the status that addresses the component functional group (type) performance during the period and any significant changes or carryovers from the previous quarters?	**Yes**	**No**
For Red or Yellow Component Health Reports, does the summary reference the CR or LO associated with the PIP or Maintenance Rule a(1) Action Plan.?	**Yes**	**No**
Does the summary discuss the overall aggregate impact of open issues on component risk	**Yes**	**No**
If the system is not green, the date and actions for returning green are listed.	**Yes**	**No**

Performance Monitoring:

A list of critical parameters being trended or monitored is present.	**Yes**	**No**
The parameters that are improving or declining are listed	**Yes**	**No**
Predictive maintenance (vibration, thermography, lube oil analysis, etc.) and system chemistry are listed.	**Yes**	**No**
An evaluation of the trend is listed.	**Yes**	**No**

Maintenance Rule Status:

Discussion exists for the current state of component failures, degradation or unavailability that have directly resulted in a Maintenance Rule SSC either in (a)(1) or trending to (a)(1))	**Yes**	**No**
If (a)(1), a discussion of the (a)(1) Action Plan progress (exceeding, meeting, or behind schedule), including the reasons for any schedule delays and the currently planned date to return to (a)(2) is listed.	**Yes**	**No**
Identify actual vs. goal performance and include an evaluation of the performance.	**Yes**	**No**

Material Condition:

All critical component failures that occurred over the period are listed.	**Yes**	**No**
Open work orders resolving critical component failures are designated as Key System	**Yes**	**No**
All open Key System Health work orders, associated priority and due date are listed.	**Yes**	**No**
All open corrective maintenance issues, their impact, associated priority and due date are listed.	**Yes**	**No**
State the number of open elective maintenance issues and their aggregate impact are listed	**Yes**	**No**
Open ODMIs are listed	**Yes**	**No**
Chronic component problems are listed	**Yes**	**No**
Significant problems resolved / new ones discovered during the reporting period are listed	**Yes**	**No**
Preventative Maintenance tasks performed late or deferred are listed	**Yes**	**No**
Summary of any significant issues identified during component walkdowns are listed.	**Yes**	**No**
A discussion of the aggregate impact of the open issues is present.	**Yes**	**No**

Operations Impact:

A discussion of all unplanned shutdown LCOs ≤14 days that were entered within the past year is listed	**Yes**	**No**
All open work orders associated with OPS Deficiencies, OPS Burdens, OPS Workarounds, or other OPS Aggregate Impact Categories are listed	**Yes**	**No**
A discuss the overall aggregate impact of open issues on performance of the component functional group (type) is listed and includes any compensatory actions in place to support plant operation.	**Yes**	**No**

Configuration Management:

A discussion of any open operability evaluations (OE) on the component functional group and the plans to close them, *including dates are included*	**Yes**	**No**
Discuss any open temporary modifications on the component functional group, and the plans to remove them, including dates are included.	**Yes**	**No**
Discuss any margin issues identified in accordance with EN-DC-195, Margin Management are included.	**Yes**	**No**

Operating Experience:

A discussion of any actions taken in response to NRC bulletins, Part 21's, etc. since the last report are included	**Yes**	**No**
A description reviews performed of relevant and significant (potential to impact personnel safety or system/component operation) industry Operating Experience related to the system since the last report is listed	**Yes**	**No**
All open Operating Experience items are listed.	**Yes**	**No**
A detail plan of required short-term or long-term actions for improving or maintaining component functional group is listed.	**Yes**	**No**

Planning:

A detail plan of required short-term or long-term actions for improving or maintaining component functional group is listed.	**Yes**	**No**
This section identifies any modifications that are approved, funded, and ready for installation to assist in verifying the appropriate station priority is being placed on the highest priority modification.	**Yes**	**No**
Significant obsolescence / aging issues associated with the system are listed.	**Yes**	**No**
Significant equipment / system issues that require a forced, refueling outage or down power to resolve and the status of preparations are listed.	**Yes**	**No**

Notes:

Summary / Conclusions

Focus: Program Health Reports – EN-DC-143

Supervisor: _____

The supervisor will review a component health reports with the engineers.

Program: _____ Engineer: _____

Overall Program Performance Summary:

Is there a brief summary of the status of the overall program health with the overall color of the program in the performance indicators?	**Yes**	**No**	
Is there a brief summary of the projected future performance?	**Yes**	**No**	
If the program is RED/YELLOW, is there a CR listed documenting the program color.	**Yes**	**No**	
For RED/YELLOW programs, does the report contain an action plan with actions, owners and due dates to restore the program health?	**Yes**	**No**	**N/A**
For WHITE programs, does the report contain a list identifying ongoing initiatives to improve program performance?	**Yes**	**No**	**N/A**
For WHITE programs, does the report contain a list of potential program improvements and enhancements?	**Yes**	**No**	**N/A**
For GREEN programs, does the report contain a list that clearly identifies the best practices associated with the program?	**Yes**	**No**	**N/A**
For GREEN Programs, does the report identify ongoing initiatives to improve the program?	**Yes**	**No**	**N/A**

Program Personnel Cornerstone Summary:

Is there a brief summary of the status of the program personnel cornerstone with the overall color of PI rollup?	**Yes**	**No**

Program Infrastructure Cornerstone Summary:

Is there a brief summary of the status of the program infrastructure cornerstone with the overall color of PI rollup?	Yes	No

Equipment / Related Plant Performance Cornerstone Summary:

Is there a brief summary of the status of the equipment / related plant performance cornerstone with the overall color of PI rollup?	Yes	No

Recent Audits, Self-Assessments, Benchmarks and Significant OE

Is there a list of audits, self-assessments, benchmarks, and significant OE occurring in the last year?	Yes	No
Does there a list include INPO visits and regulatory audits applicable to the program?	Yes	No
Are the reports attached under the supporting details?	Yes	No

Relevant Trending Data Summary:

Is there a brief summary of the relevant trending data?	Yes	No
Are the trends or graphs attached under the supporting details?	Yes	No

Approved Exceptions to Grading Criteria:

Is there a listing of the grading criteria with exceptions approved in accordance with EN-DC-329 Section 5.6	Yes	No
Are the details of the exceptions listed under the supporting details?	Yes	No

Notes:

Summary / Conclusions

Focus: System Health Reports – EN-DC-143

Supervisor: _____

The supervisor will review 2 system health reports with the system engineers. One should be an (a) (1) system

System: _____ Engineer: _____

System Summary Section:

Does the summary provide the overall system status and aggregate impact of open issues?	**Yes**	**No**
If the system is not green, the date and actions for returning to green are listed.	**Yes**	**No**
If the system is red, the date and actions for returning yellow and white are listed.	**Yes**	**No**

Performance Monitoring:

A list of critical parameters being trended or monitored is present.	**Yes**	**No**
The parameters that are improving or declining are listed	**Yes**	**No**
Predictive maintenance (vibration, thermography, lube oil analysis, etc.) and system chemistry are listed.	**Yes**	**No**
An evaluation of the trend is listed.	**Yes**	**No**

Maintenance Rule Status:

Discussion exists for the current state of the system	**Yes**	**No**
If (a)(1), a discussion of the (a)(1) Action Plan progress (exceeding, meeting, or behind schedule), including the reasons for any schedule delays and the currently planned date to return to (a)(2) is listed.	**Yes**	**No**
The number of functional failures is listed.	**Yes**	**No**

ATTACHMENT 7.8 SYSTEM HEALTH REPORTS

Material Condition:

All critical component failures that occurred over the period are listed.	**Yes**	**No**
A Work Order whose completion will directly cause a system health area color to improve is designated as Key System.	**Yes**	**No**
All open Key System Health work orders, associated priority and due date are listed.	**Yes**	**No**
All open corrective maintenance issues, their impact, associated priority and due date are listed.	**Yes**	**No**
State the number of open elective maintenance issues and their aggregate impact are listed	**Yes**	**No**
Open ODMIs are listed	**Yes**	**No**
Significant problems resolved / new ones discovered during the reporting period are listed	**Yes**	**No**
Preventative Maintenance tasks performed late or deferred are listed	**Yes**	**No**
Summary of any significant issues identified during system walkdowns are listed.	**Yes**	**No**
A discussion of the aggregate impact of the open issues is present.	**Yes**	**No**

Operations Impact:

1) A discussion of all unplanned shutdown LCOs ≤14 days that were entered within the past year is listed
2) All open work orders associated with OPS Deficiencies, OPS Burdens, OPS Workarounds, or other OPS Aggregate Impact Categories are listed
3) A discussion of the overall aggregate impact of open issues on system operation is listed

Configuration Management:

1) A discussion of any open operability evaluations (OE) on the system and the plans to close them, including dates are included
2) Discuss any open temporary modifications on the system, and the plans to remove them, including dates are included.
3) Discuss any margin issues identified in accordance with EN-DC-195, Margin Management are included.

Operating Experience:

1) A discussion of any actions taken in response to NRC bulletins, Part 21's, etc. since the last report are included
2) A description reviews performed of relevant and significant (potential to impact personnel safety or system/component operation) industry Operating Experience related to the system since the last report is listed
3) All open Operating Experience items are listed.

Planning:

1) A detail plan of required short-term or long-term actions for improving or maintaining system health is listed.
2) This section identifies any modifications that are approved, funded, and ready for installation to assist in verifying the appropriate station priority is being placed on the highest priority modification
3) Significant obsolescence / aging issues associated with the system are listed.
4) Significant equipment / system issues that require a forced, refueling outage or down power to resolve and the status of preparations are listed.

Notes:

Summary / Conclusions

Focus: Component Monitoring – EN-DC-143

Supervisor: _____

The supervisor will review 2 component monitoring plans.

The supervisor will review one of the following component monitoring plans with the engineer. Circle the component reviewed:

- Large motors (>200 horsepower)
- Breakers
- Motor operated valves
- Air operated valves
- Pumps (IST and critical balance of plant)
- Check valves
- Relief valves and safety valves
- Heat exchangers (GL 89–13 and critical balance of plant)

Component Monitoring Plan:

Is there a listing of the parameters being monitored?	**Yes**	**No**
Is there a source provided for reading the parameter?	**Yes**	**No**
Is the frequency of monitoring delineated?	**Yes**	**No**
Is the type of monitoring provided?		
Are there alert and action levels for the parameters monitored?	**Yes**	**No**
This there a listing of all the necessary actions that need to be taken when Alert or Action Levels are exceeded, to remedy an existing problem or prevent one that may occur?	**Yes**	**No**
Is the bases provided for parameter being monitored?	**Yes**	**No**
When was the last Component Monitoring Challenge board performed on this system and what were the results?	**Yes**	**No**

Trending Spreadsheet for Monitoring Performance:

Is there an electronic database/spreadsheet for parameter trending?		
Does the trending spreadsheet track the number of deferred PM'?	**Yes**	**No**
Does the trending spreadsheet track the number of CM backlogs?	**Yes**	**No**
Does the trending spreadsheet track the number of EM backlogs?	**Yes**	**No**
Is monitoring being performed per the frequency required in the plan?	**Yes**	**No**
Is there a color assigned to each parameter being trended?	**Yes**	**No**
Is there a commentary provided for each parameter not green with an actions required to return it to green?	**Yes**	**No**
Is there an overall color assigned and is it equal to the lowest window color?	**Yes**	**No**

Notes:

Summary / Conclusions

ATTACHMENT 7.9 COMPONENT MONITORING

The supervisor will review one of the following component monitoring plans with the engineer. Circle the component reviewed:

- Large motors (>200 horsepower)
- Breakers
- Motor operated valves
- Air operated valves
- Pumps (IST and critical balance of plant)
- Check valves
- Relief valves and safety valves
- Heat exchangers (GL 89–13 and critical balance of plant)

Component Monitoring Plan:

Is there a listing of the parameters being monitored?	**Yes**	**No**
Is there a source provided for reading the parameter?	**Yes**	**No**
Is the frequency of monitoring delineated?	**Yes**	**No**
Is the type of monitoring provided?		
Are there alert and action levels for the parameters monitored?	**Yes**	**No**
This there a listing of all the necessary actions that need to be taken when Alert or Action Levels are exceeded, to remedy an existing problem or prevent one that may occur?	**Yes**	**No**
Is the bases provided for parameter being monitored?	**Yes**	**No**

Trending Spreadsheet for Monitoring Performance:

Is there an electronic database/spreadsheet for parameter trending?		
Does the trending spreadsheet track the number of deferred PMs?	**Yes**	**No**
Does the trending spreadsheet track the number of CM backlogs?	**Yes**	**No**
Does the trending spreadsheet track the number of EM backlogs?	**Yes**	**No**
Is monitoring being performed per the frequency required in the plan?	**Yes**	**No**
Is there a color assigned to each parameter being trended?	**Yes**	**No**
Is there a commentary provided for each parameter not green with an actions required to return it to green?	**Yes**	**No**
Is there an overall color assigned and is it equal to the lowest window color?	**Yes**	**No**

Notes:

Summary / Conclusions

Focus: Component Notebooks

Supervisor: _____ Component:_____

Technical Support: Are the following identified:

Structure – The roles and responsibilities of the various organizations in completing the program should be clearly defined	**Yes**	**No**
Scope – The scope of the program should be clearly defined, documented, and understood by the Program Owner.	**Yes**	**No**
Ownership – Fleet Owners and Program Owners should be clearly established. .	**Yes**	**No**
Ownership – Identification of qualified backup "owners" is listed.	**Yes**	**No**
Design and Regulatory Basis – The design basis and regulatory basis for the program shall be documented and well understood by the Program Owner.	**Yes**	**No**
Design and Regulatory Basis – A summary or reference to the design and regulatory basis is typically located in the program plan or implementing procedure.	**Yes**	**No**
Training - Training Requirements should be listed	**Yes**	**No**
Program Implementation – Implementation expectations should be clearly defined or referenced by the Program Notebook to include a description of tracking mechanisms. Tracking should include references to key historical documentation for task performance.	**Yes**	**No**
Program Infrastructure – Consideration should be given to including a list of the key procedures and other items which make up the program infrastructure.	**Yes**	**No**
Testing and Inspection – Testing and inspection requirements should be clearly defined in included documents or referenced documents.	**Yes**	**No**
Configuration Management – Configuration management should be clearly described in the included or referenced documents.	**Yes**	**No**

Self Assessment and Benchmarking – Are there referencing or including applicable assessment and benchmarking reports in the Program Notebook.	**Yes**	**No**
Operating Experience (OE) –Provide a list of OE incorporated into the program that include NOE LOs which did not result in programmatic changes but provided disposition for items with the potential to impact the program.	**Yes**	**No**

Notes:

Summary / Conclusions

Focus: Pre-job Briefs – EN-HU-102

Supervisor: _____ Department Interviewed: _____

1. The supervisor will interview an employee that has performed one of the following in the last two weeks
   Check the item performed:
   - Operability Determinations
   - Operational Decision-Making Issue (ODMI)
   - Complex Troubleshooting Plan Development
   - Documented Technical Evaluations
   - Apparent Cause, Common Cause and Root Cause Evaluations
   - Temporary Configuration Changes
   - Permanent Configuration Changes
   - Documented Responses to Regulatory Requests
   - Development of, or revision to, equipment operating or test procedures, including modification tests (Other than editorial changes)
   - Item Equivalencies, Commercial Grade Dedications, and Component and Part Classifications
   - Preparation of License Amendment or Technical Specification Change Requests
   - Calculations (formal, which become part of design basis)
   - Complex vendor issues (for oversight of material/parts or engineering services contracts)
   - Temporary Modifications
   - Leak Repairs
   - System Walkdowns

ATTACHMENT 7.11 PRE-JOB BRIEFS

Brief description of the task:

2. Check the if the could result in any of the following

☐ Personal injury, safety issue made or not addressed • Hot environment/heat stress • Diving activities • Hazardous materials • New or recurring Immediate Danger to Life or Health (IDLH) atmosphere	☐ Other unacceptable consequence not listed • Security compensatory actions • Fire protection comp. actions • Emergency plan affected • Environmental permit affected • High sensitivity issue with public • Potential adverse reduction in safety or production margins
☐ Reactivity Mgmt. Event (any level)	☐ Radiological release or exposure for this task or future plant work related to this task. 100 mREM for job Dose rate> 1 rem/hr Any unmonitored release Other
☐ Operability determination or operability evaluation not adequate due to complexity of the task.	☐ Reportable environmental consequence
☐ Regulatory open item created or not addressed (includes environmental, NRC, State Agencies, NEIL, or INPO)	☐ Introduction of foreign material
☐ Operator Workaround or challenge created or not addressed	☐ Unplanned Security vulnerability
☐ Unplanned Safety System Actuation/Loss	☐ Aggregate review: Are there any activities, conditions, or situations that, when combined with this activity, could cause undesirable consequences?
☐ Unplanned Component Unavailability	☐ Repeat functional failure of Maintenance Rule systems, structures or components with potential to create new (a)(1) system
☐ Scram, Lost/limited Generation (>5%) Also see EN-WM-101 for Production Risk screening.	☐ Reactor coolant or steam generator chemistry transient outside of acceptable band.
☐ Tech Spec violation	☐ Adverse impact on outage (≥2 hours) or project critical path
☐ Unplanned Tech Spec entry into a shutdown LCO	

3. If any blocks were checked in step 2, was there a pre-job brief performed using Attachment 9.4 of EN-HU-104. (circle the appropriate group)

Yes No N/A

Notes:

Summary / Conclusions

ATTACHMENT 7.12 T-20

Focus: T-20 – EN-WM-101

Supervisor: _____ Date: _____

T-20 Meeting:

Is there a quorum: System Engineering (Chairperson), Operations Work Management Center representative, Maintenance Coordinators, & Unit Coordinator?	Yes	No	
Was scope that does not accurately reflect station priorities and goals reviewed for removal?	Yes	No	N/A
Was scope that accurately reflects station priorities and goals reviewed for addition?	Yes	No	N/A
Was a scope established that is acceptable for on line performance?	Yes	No	N/A
Are there commitments to clear work order holds prior to T-3?	Yes	No	N/A
Was risk considered for the proposed scope?	Yes	No	N/A
Are resources loaded to approximately 100%	Yes	No	N/A
Is Engineering providing priority input to schedule scope considering key system health indicators, maintenance rule unavailability, predictive watch list, system performance indicators	Yes	No	N/A
Was availability hours for Maintenance Rule systems discussed	Yes	No	N/A
Are Maintenance Coordinators making scope addition/ deletion recommendations based upon review of backlog, assigned priority, work bundling and resource requirements	Yes	No	N/A

ATTACHMENT 7.12 T-20

Are Unit Coordinators ensuring scheduled work is appropriately bundled and communicates / resolving work bundling issues with the team.	Yes	No	N/A

Notes:

Summary / Conclusions

ATTACHMENT 7.13 T-28

Focus: T-28 - EN-WM-101

Supervisor: _____ Date: _____

T-28 Meeting:

Is there a quorum: EP&C Supervisor / designee (Chairperson), Operations Work Management Center representative, Maintenance Coordinator (Mechanical, Electrical, I&C), Unit Coordinator & PM Coordinator	Yes	No	
Were System Outage Coordinators and Project Managers are named?	Yes	No	N/A
Are unavailability challenges discussed?	Yes	No	N/A
Are long lead parts identified?	Yes	No	N/A
Are engineering deliverables identified?	Yes	No	N/A
Was status of modifications reviewed?	Yes	No	N/A
Was PM Feedback Performance reviewed	Yes	No	N/A
Were PMRQ report proposed changes discussed?	Yes	No	N/A
Was potential Manpower Challenges reviewed?	Yes	No	N/A
Did the PM Coordinator provides insight to the team based on their experience	Yes	No	N/A

Were the following actions identified as part of this meeting:			
Incomplete scope for LCO, system outage window, or FEGs	Yes	No	N/A
Ensure all PMs for the systems available to work in T-28 are in the correct T-12/13 windows for the cycle schedule.	Yes	No	N/A
Work in wrong system or train week	Yes	No	N/A
Ownership issues - lack of LCO/System Outage coordinator or Project Manager/Lead	Yes	No	N/A
Potential Manpower Gaps - get senior management buying for additional resources	Yes	No	N/A
PMCRs required by T-18	Yes	No	N/A
Mods schedule milestones - 10%, 50%, EQRT as minimum	Yes	No	N/A
Potential Plant Risk challenges	Yes	No	N/A
Incorrect priorities requiring re-review with Scope Team	Yes	No	N/A
Long Lead Parts	Yes	No	N/A

Notes:

Summary / Conclusions

ATTACHMENT 7.14 EC OWNERSHIP

Focus: EC Ownership

Supervisor: _____

The supervisor will assess 2 engineers regarding their knowledge of expectations for ownership and control of ECs associated with their functional area.

Engineer: _____
Date: _____

Enter engineer's work area and question them on the number of ECs in their backlog. Do you have a Level III schedule for each? Were they able to answer accurately?	**Yes**	**No**
Document number of ECs in engineer's backlog.		
Document number of ECs without a Level III schedule.		
Do you know the expectation for update of Level III EC schedules? (Once per week on Thursday – Supervisor review prior to sending to scheduler)	**Yes**	**No**
Do you know who has responsibility for update of Level III EC schedules?	**Yes**	**No**
Do you know what constitutes a key deliverable on a Level III EC schedule?	**Yes**	**No**
Do you know the process for changing a key deliverable date?	**Yes**	**No**
Do you know how key deliverable commitments affect the Weekly Online Rediness Indicator?	**Yes**	**No**
Do you know the status of your project / EC SIPDs? (funded, unfunded, Expected Completion Date, Expected Installation Date)	**Yes**	**No**
Do you know the Department goal for individual open ECs?	**Yes**	**No**
Are any of your ECs on the 2011 Commit List or RF17 List or Top Ten List?	**Yes**	**No**
Are all your ECs included in your departments Workload Spreadsheet? Show me.	**Yes**	**No**

General Comments:

ATTACHMENT 7.15 TYPICAL BLANK FORM

Focus:

Supervisor: _____

Engineer: _____
Date: _____

	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No

General Comments: