



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

September 13, 2013

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

**SUBJECT: RIVER BEND STATION – NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 0500005000458/2013008**

Dear Mr. Olson:

On July 12, 2013, the U.S. Nuclear Regulatory Commission completed the onsite portion of a Problem Identification and Resolution biennial inspection at your River Bend Station. The enclosed inspection report documents the inspection results which were discussed on August 1, 2013, with Mr. Terry Evans, Director, Nuclear Safety Assurance, and other members of your staff.

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

Based on the inspection sample, the inspection team concluded that the implementation of the corrective action program and overall performance related to identifying, evaluating, and resolving problems at River Bend Station was generally effective. Licensee identified problems were entered into the corrective action program at a low threshold. In general, problems were effectively prioritized and evaluated commensurate with the safety significance. Corrective actions were implemented in a timely manner commensurate with their importance to safety and addressed the identified causes of problems. Lessons learned from industry operating experience were generally reviewed and applied when appropriate. Audits and self-assessments were effectively used to identify problems and appropriate actions. A safety-conscious work environment had been established at River Bend Station where individuals surveyed felt free to raise safety concerns without fear of retaliation.

No findings were identified during this inspection.

E. Olson

- 2 -

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

Sincerely,

/RA/

Ray L. Kellar, P.E., Chief
Technical Support Branch

Docket: 05000-458
License: NPF-47

Enclosure: Inspection Report 05000458/2013008
w/Attachments
1. Supplemental Information
2. Information Request – April 16, 2013

Electronic Distribution River Bend

Electronic distribution by RIV:

Acting Regional Administrator (Steven.Reynolds@nrc.gov)
 Acting Deputy Regional Administrator (Thomas.Bergman@nrc.gov)
 DRP Director (Kriss.Kennedy@nrc.gov)
 DRP Deputy Director (Troy.Pruett@nrc.gov)
 DRS Director (Tom.Blount@nrc.gov)
 DRS Deputy Director (Jeff.Clark@nrc.gov)
 Senior Resident Inspector (Grant.Larkin@nrc.gov)
 Resident Inspector (Andy.Barrett@nrc.gov)
 RBS Administrative Assistant (Lisa.Day@nrc.gov)
 Acting Branch Chief, DRP/C (Jesse.Quichocho@nrc.gov)
 Senior Project Engineer (Bob.Hagar@nrc.gov)
 Public Affairs Officer (Victor.Dricks@nrc.gov)
 Public Affairs Officer (Lara.Uselding@nrc.gov)
 Project Manager (Alan.Wang@nrc.gov)
 Branch Chief, DRS/TSB (Ray.Kellar@nrc.gov)
 RITS Coordinator (Marisa.Herrera@nrc.gov)
 ACES (R4Enforcement.Resource@nrc.gov)
 Regional Counsel (Karla.Fuller@nrc.gov)
 Technical Support Assistant (Loretta.Williams@nrc.gov)
 Congressional Affairs Officer (Jenny.Weil@nrc.gov)
 RIV/ETA: OEDO (Daniel.Rich@nrc.gov)
 ROPreports

R:\REPORTS\RB 2013008-PI&R-HAF.docx

ML13256A367

SUNSI Rev Compl.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	ADAMS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Reviewer Initials	HAF
Publicly Avail.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Sens. Type Initials	HAF
SRI:TSB	SRI: PSB2	PSI:PSB1	RI:DRP/C	BC:DRP/C	BC:TSB
HAFreeman	IAAnchondo	MKBrooks	AJBarrett	JFQuichocho	RLKellar
/RA/	/RA/	/RA/	/RA/	/RA/	/RA/
9/11/13	9/10/13	9/6/13	9/12/13	9/12/13	9/13/13

OFFICIAL RECORD COPY

U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket: 05000458
License: NPF-47
Report: 05000458/20013008
Licensee: Entergy Operations, Inc.
Facility: River Bend Station
Location: 5485 U.S. Highway 61
St. Francisville, LA 70775

Dates: June 24 through July 12, 2013
Team Leader: H. Freeman, Senior Reactor Inspector, Technical Support Branch
Inspectors: I. Anchondo, Senior Reactor Inspector, Plant Support Branch 2
A. Barrett, Resident Inspector, Reactor Projects Branch B
M. Brooks, Physical Security Inspector, Plant Support Branch 1

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

SUMMARY OF FINDINGS

IR 05000458/2013008 "Biennial Baseline Inspection of the Identification and Resolution of Problems."

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

Identification and Resolution of Problems

The team reviewed approximately 300 condition reports, work orders, engineering evaluations, root and apparent cause evaluations, and other supporting documentation to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team reviewed a sample of system health reports, self-assessments, trending reports and metrics, and various other documents related to the corrective action program. The team found that licensee was generally effective at identifying problems and putting them into the corrective action program; however, there were a few instances identified during the assessment period where the licensee had missed identification of problems. The licensee was also generally effective in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. The licensee's corrective action process was generally found to be effective; however, six findings were documented during the assessment period associated with the effectiveness indicating attention to this aspect of the corrective action program may be warranted.

The licensee used industry operating experience when performing root cause and apparent cause evaluations; however, three findings were documented during the assessment period associated with the licensee's failure to institutionalize industry information and may warrant attention by the licensee. The licensee generally evaluated industry operating experience for relevance to the facility and entered applicable items in the corrective action program. The licensee performed effective quality assurance audits and self-assessments, as demonstrated by self-identification of poor corrective action program performance and identification of ineffective corrective actions.

A. NRC-Identified and Self-Revealing Findings

No findings of significance were identified.

B. Licensee-Identified Violations

None

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (71152)

The team based the following conclusions on the sample of corrective action documents that were initiated in the assessment period, which ranged from May 13, 2011, through to the end of the on-site portion of this inspection on July 12, 2013.

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

a. Inspection Scope

The team reviewed 300 condition reports, including associated root cause, apparent cause, and direct cause evaluations, issued between May 13, 2011, through July 12, 2013, to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team found that concerns were being entered into the licensee's corrective action process as condition reports, which included issues and concerns, both safety-related and non-safety-related. During the assessment period, the licensee initiated 17,807 condition reports of which 5,537 or approximately 30 percent were classified as conditions adverse to quality.

The team reviewed a sample of system health reports, operability determinations, self-assessments, trending reports and metrics, and various other documents related to the corrective action program. The team evaluated the licensee's efforts in establishing the scope of problems by reviewing selected logs, work requests, self-assessments results, audits, system health reports, action plans, and results from surveillance tests and preventive maintenance tasks. The team reviewed work requests and attended the licensee's review committee meetings. One such meeting was the Condition Review Group (CRG) meeting that assessed the reporting threshold, prioritization efforts, and significance determination process of the condition reports. The CRG also provided oversight of the interfaces with the operability assessment and work control processes, when applicable. The team's review included verifying the licensee considered the full extent of cause and extent of condition for problems, as well as how the licensee assessed generic implications and previous occurrences. The team assessed the timeliness and effectiveness of corrective actions, completed or planned, and looked for additional examples of similar problems. The team conducted interviews with plant personnel to identify other processes that may exist where problems may be identified and addressed outside the corrective action program.

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

The team considered risk insights from both the NRC's and River Bend Station risk assessments to focus the sample selection and plant tours on risk significant systems and components. The team selected the control and auxiliary build chiller systems for in-depth review. The samples reviewed by the team focused on, but were not limited to, these systems. The team conducted a walk down of these systems to assess whether problems were identified and entered into the corrective action program.

b. Assessment

1. Assessment - Effectiveness of Problem Identification

River Bend Station is one of several licensees in Entergy's fleet of nuclear power plants. The corrective action process is a corporate program that is managed at the corporate level. Licensee personnel implement the corrective action process based on the corporate program.

The team concluded that the licensee was generally effective in identifying issues and adverse conditions in accordance with the licensee's corrective action program guidance and the NRC requirements. The team noted that licensee personnel had a very low threshold for entering issues into the corrective action program as evidenced by the more than 17 thousand condition reports issued over the two-year assessment period. The team found that the licensee was identifying and documenting control room deficiencies at appropriate levels. While the team identified two issues that were not placed in the corrective action program that were associated with the use of operating experience, they were addressed and corrected by other means. The team also noted that the NRC had identified two other instances where the licensee had failed to identify conditions adverse to quality over the assessment period.

- Noncited violation 05000458/2012012-02 was issued for failure to promptly identify and correct a condition adverse to quality. Specifically, following a turbine trip/load reject and subsequent reactor scram, reactor vessel level rose to the point of receiving a high level isolation signal (Level 8) and the licensee failed to identify this as an unexpected condition. This failure was due in part because the licensee had failed to periodically trend and assess information from the corrective action program and other assessments in the aggregate to identify programmatic and common cause problems.
- Noncited violation 05000458/2012012-02 was issued for failure to promptly identify and correct a condition adverse to quality in that the licensee failed to classify the high-level isolation that occurred on December 23, 2011, as an unexpected condition, or as a condition adverse to quality. The finding was due in part because the licensee had failed to trend and assess information in the aggregate to identify programmatic and common cause problems.

2. Assessment - Effectiveness of Prioritization and Evaluation of Issues

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

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

The team found that in general, condition reports were appropriately prioritized and evaluated; however, the team noted two examples of ineffective prioritization and evaluation had been previously documented during the assessment period which included:

- Noncited violation 05000458/2011008-01 was issued for "inadequate testing of Division I and Division III standby diesel generators." Specifically, prior to October 27, 2011, the licensee failed to ensure surveillance testing procedures of Division I and III standby diesel generators incorporated the correct acceptance limits for maximum expected load at max frequency and voltage specified in design basis documents. The finding had a crosscutting aspect in the area of problem identification and resolution because the licensee failed to thoroughly evaluate problems such that the resolutions address causes and extent of condition.
- Noncited violation 05000458/2012012-05 was issued for "failure to correct the maintenance organizations inadequate procedure use and adherence." Specifically, the licensee identified that the maintenance organization's improper procedure use and adherence was an extent of cause (condition adverse to quality). The licensee credited actions in another root cause evaluation to correct the identified extent of cause, however the actions taken did not address the maintenance organizations procedure use and adherence issue. The finding has a cross-cutting aspect in the area of problem identification and resolution because the licensee failed to thoroughly evaluate the problem such that the resolution addressed the cause.

3. Assessment – Effectiveness of Corrective Action Program

The team found that the corrective actions associated with adverse conditions were generally effective; however, the team observed some corrective actions that were not effective in addressing issues. These included corrective actions closed to other condition reports which did not directly align with the documented condition, corrective actions to conduct training that did not document what individuals or organizations were trained and did not include the training syllabus, and corrective action to conduct training that was cancelled without adequate justification, etc. The team also noted that there were six findings documented during the assessment period associated with the adequacy of corrective actions that indicates additional attention may be warranted in this area.

- Noncited violation 05000458/2011008-02 was issued for “failure to use conservative design assumptions in the ultimate heat sink inventory calculation,” because the licensee failed to assure that the design basis information for expected heat loads to the ultimate heat sink was correctly translated into the ultimate heat sink 30-day inventory analysis. Specifically, the licensee’s analysis used less conservative assumptions for heat loads by using a frictionless form of the conservation of energy equation to determine the 30-day inventory necessary for the ultimate heat sink during a design basis event. The finding has a crosscutting aspect in the area of problem identification and resolution because the licensee failed to thoroughly evaluate problems such that the resolutions address cause and extent of condition.
- Noncited violation 05000458/2012003-03 was issued for failing to correct a known deficiency – specifically, deficiencies associated with high pressure core spray diesel generator bearing lubrication. Instead of addressing the cause of the condition, the licensee focused on returning the equipment to an operable status.
- Noncited violation 05000458/2012005-02 was issued for inadequate procedures for lubrication of the standby liquid control pumps motor bearings. Specifically, the station incorrectly applied the Electrical Power Research Institute guidance and over greased the bearings by adding twice the amount of grease required. The finding has a cross-cutting aspect in the area of problem identification and resolution because the licensee failed to fully evaluate previously identified inadequate lubrication of motors issues.
- Finding 05000458/2012012-01 was issued for failure to identify and correct a condition adverse to quality. Specifically, the licensee identified both inadequate guidance and oversight of a supplemental worker as causes for the inadequate crimp on the B reactor feedwater pump; however, the corrective actions taken only addressed the oversight of supplemental workers, and no actions were taken to address the insufficient guidance provided by the station work order. This finding had a cross-cutting aspect in the area of problem identification and resolution because the licensee failed to thoroughly evaluate problems such that the resolutions address causes.
- Finding 05000458/2011004-02 was issued for inadequate corrective actions in response to a failure in the main steam equalizing header drain bypass valve, resulting in a steam leak and an unplanned plant down power. Specifically, plant personnel failed to properly address the dual indication on the bypass valve and fluid flow through the valve caused water to flash to steam accelerating pipe wall erosion and piping failure.
- Noncited violation 05000458/2012004-02 was issued for failure to ensure that conditions adverse to quality were promptly identified and corrected. Specifically, the lack of a program to complete periodic testing of installed safety related 480 VAC molded-case circuit breakers and unitized motor starters was a condition adverse to quality, and measures established by the licensee failed to assure that that condition was promptly corrected, in that after that condition had

been identified in October 2008, the licensee did not begin the associated testing until October 2011.

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

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

b. Assessment

The operating experience (OE) program is another Entergy corporate process. Representatives from the various operating reactor licensees within the corporation review all operating experience at the corporate level. Applicable OE is then assigned to affected licensee sites. Site coordinators also scan the data and assign specific OE to department representatives who are then responsible to review the OE and to initiate a condition report for review and evaluation if applicable.

The team found that the licensee was generally reviewing and initiating actions to address operating experience. However, the team identified two examples of operating experience associated with security that were not addressed under the corrective action program as required. The inspectors verified that these issues had been evaluated and actions taken in response to the OE. The team determined that this was a failure to use the site corrective action program to track, trend, correct, and prevent recurrence of failures and deficiencies in the physical protection program that is not subject to enforcement action in accordance with the NRC's Enforcement Policy.

Overall, the team determined that the licensee adequately evaluating industry operating experience for relevance to the facility. The licensee had entered applicable items in the corrective action program in accordance with station procedures. While the team found that the licensee was generally implementing operating experience into the corrective action program, several examples documented over the assessment period indicate that this area may warrant additional attention. These examples include:

- Finding 05000458/2012010-06, was issued for failure to establish an adequate cable reliability program in that the licensee failed to distinguish between wetted and dry splices. This finding has a problem identification and resolution cross cutting aspect in that the licensee did not implement and institutionalize operating experience through changes to station processes and procedures to support plant safety.

- Noncited violation 05000458/2011008-08 was issued for inadequate emergency and abnormal procedures for standby diesel generator fail to load sequences. Specifically, prior to October 27, 2011, the licensee failed to include appropriate quantitative or qualitative acceptance criteria in procedures for control room operators to recognize and recover a standby diesel generator that starts but fails to load with the remaining standby diesel generator out of service during a loss-of-offsite-power event. This finding had a crosscutting aspect in the area of problem identification and resolution because the licensee did not implement and institutionalize operating experience through changes to station processes, procedures, equipment, and training programs.
- Noncited violation 05000458/2012004-03 was issued for failure to appropriately tune the reactor core isolation cooling turbine speed controller. Specifically, during operation, this performance deficiency resulted in improper tuning of the turbine speed control system, which caused the turbine exhaust check valve to repeatedly slam against its open and shut valve stops and abnormally large turbine governor valve oscillations. This finding has a cross-cutting aspect in the area of problem identification and resolution because the licensee did not implement and institutionalize industry knowledge, including vendor recommendations, to support plant safety.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

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

b. Assessment

The team concluded that the licensee had an adequate self-assessment process that was identifying deficiencies in the corrective action process and was critical and specific. In particular, the team noted that the Quality Assurance Corrective Action Program Audit, of which the team attended the exit meeting, identified issues similar to observations by the team. These findings included the identification of misalignment between the Corrective Action Program (CAP) investigations and the resulting Corrective Actions, closure of corrective actions without actions taken to address the initial condition or without quality, timeliness of corrective actions, and issues with the control of non-conforming conditions. Discussions with licensee management and observations during licensee meetings (such as the condition review group) indicated that the licensee had a viable plan to address these deficiencies.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The inspection team conducted individual interviews with approximately 35 individuals. The interviewees represented various functional organizations and ranged across contractor, staff, and supervisor levels. The team conducted these interviews to assess whether conditions existed that would challenge the establishment of a safety conscious work environment at River Bend Station. The team reviewed the results of the last two safety culture surveys and discussed the results with licensee management. Finally, the team reviewed a sample of employee concerns program case files initiated during the assessment period associated with safety-culture and safety conscious work environment.

b. Assessment

The team determined that the licensee has established and maintained a safety-conscious work environment at River Bend Station where individuals felt free to raise safety concerns to the licensee and to the NRC without fear of retaliation. Individuals were aware of the corrective action process and knew that they were able to submit a concern via the condition report process. Front-line individuals typically stated that they were able to raise safety concerns directly to their supervisor and/or write condition reports. Some individuals who did not routinely use the corrective action system felt uncomfortable initiating a condition report but none indicated that this would impact them from raising safety concerns.

The team did not identify anything in the licensee's 2012 safety culture survey results that negatively impacted the safety conscious work environment. The team concluded the licensee's plan for improvement was reasonable.

40A6 Meetings

Exit Meeting Summary

On August 1, 2013, the team presented the inspection results to Mr. Terry Evans, Director, Nuclear Safety Assurance, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspector asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

40A7 Licensee-Identified Violations

None

ATTACHMENTS: Supplemental Information
Information Request April 16, 2013

KEY POINTS OF CONTACT

Licensee Personnel

Terry Evans, Director, Nuclear Safety Assurance
Peggy Lucky, Manager, Corrective Action and Assessments
Joey Clark, Manager, Licensing
Lenny Woods, Manager, Quality Assurance
Kristi Huffstatler, Sr. Licensing Specialist

NRC Personnel

Grant Larkin, Senior Resident Inspector, River Bend Station

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened

None

Opened and Closed

Closed

None

Discussed

None

LIST OF DOCUMENTS REVIEWED

Procedures

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
EN-DC-324	Preventive Maintenance Program	8
EN-DC-345	Equipment Reliability Clock	1
EN-EC-100	Guidelines for Implementation of the Employee Concerns Program	6
EN-EC-100-01	Employee Concern Coordinator Training Program	1
EN-FAP-OP-006	Operator Aggregate Input Index Performance Indicators	0
EN-HU-103	Human Performance Error Reviews	7

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
EN-LI-100	Process Applicability Determination	10
EN-LI-102	Corrective Action Process	21
EN-LI-118	Root Cause Evaluation Process	18
EN-LI-119	Apparent Cause Evaluation (ACE) Process	16
EN-LI-121	Entergy Trending Process	12
EN-OE-100	Operating Experience Program	18
EN-OP-104	Operability Determination Process	6
EN-WM-100	Work Request Generation	8
EN-WM-101	On-line Work Management Process	10
EN-WN-105	Planning	11
STP-309-0206	Division 1 Diesel Generator 184 Day Operability Test	24

Condition Reports

CR-HQN-2012-684	CR-RBS-2010-27	CR-RBS-2010-4710	CR-RBS-2010-6742
CR-RBS-2011-2209	CR-RBS-2011-2227	CR-RBS-2011-2782	CR-RBS-2011-2821
CR-RBS-2011-2904	CR-RBS-2011-3296	CR-RBS-2011-3412	CR-RBS-2011-3488
CR-RBS-2011-3675	CR-RBS-2011-4175	CR-RBS-2011-4592	CR-RBS-2011-4658
CR-RBS-2011-4684	CR-RBS-2011-4820	CR-RBS-2011-4994	CR-RBS-2011-5189
CR-RBS-2011-5366	CR-RBS-2011-5372	CR-RBS-2011-5481	CR-RBS-2011-5482
CR-RBS-2011-5713	CR-RBS-2011-6133	CR-RBS-2011-6250	CR-RBS-2011-6286
CR-RBS-2011-6321	CR-RBS-2011-6365	CR-RBS-2011-6528	CR-RBS-2011-6554
CR-RBS-2011-6593	CR-RBS-2011-6806	CR-RBS-2011-6881	CR-RBS-2011-7010
CR-RBS-2011-7062	CR-RBS-2011-7195	CR-RBS-2011-7250	CR-RBS-2011-7250
CR-RBS-2011-7257	CR-RBS-2011-7311	CR-RBS-2011-7325	CR-RBS-2011-7326
CR-RBS-2011-7342	CR-RBS-2011-7395	CR-RBS-2011-7434	CR-RBS-2011-7576
CR-RBS-2011-7872	CR-RBS-2011-7878	CR-RBS-2011-7918	CR-RBS-2011-7979
CR-RBS-2011-7990	CR-RBS-2011-7991	CR-RBS-2011-8062	CR-RBS-2011-8062
CR-RBS-2011-8068	CR-RBS-2011-8109	CR-RBS-2011-8222	CR-RBS-2011-8236
CR-RBS-2011-8239	CR-RBS-2011-8268	CR-RBS-2011-8323	CR-RBS-2011-8327
CR-RBS-2011-8367	CR-RBS-2011-8395	CR-RBS-2011-8449	CR-RBS-2011-8508
CR-RBS-2011-8570	CR-RBS-2011-8580	CR-RBS-2011-8645	CR-RBS-2011-8647
CR-RBS-2011-8649	CR-RBS-2011-8700	CR-RBS-2011-8757	CR-RBS-2011-8822
CR-RBS-2011-8894	CR-RBS-2011-9013	CR-RBS-2011-9013	CR-RBS-2011-9162
CR-RBS-2012-1019	CR-RBS-2012-106	CR-RBS-2012-1157	CR-RBS-2012-1244
CR-RBS-2012-132	CR-RBS-2012-1390	CR-RBS-2012-1480	CR-RBS-2012-1488
CR-RBS-2012-1532	CR-RBS-2012-1551	CR-RBS-2012-1551	CR-RBS-2012-1566

Condition Reports

CR-RBS-2012-1732	CR-RBS-2012-1750	CR-RBS-2012-1774	CR-RBS-2012-1814
CR-RBS-2012-1845	CR-RBS-2012-1858	CR-RBS-2012-1904	CR-RBS-2012-1904
CR-RBS-2012-1956	CR-RBS-2012-1985	CR-RBS-2012-2076	CR-RBS-2012-2078
CR-RBS-2012-2125	CR-RBS-2012-2205	CR-RBS-2012-2209	CR-RBS-2012-2211
CR-RBS-2012-2236	CR-RBS-2012-2323	CR-RBS-2012-2387	CR-RBS-2012-2393
CR-RBS-2012-2416	CR-RBS-2012-242	CR-RBS-2012-2428	CR-RBS-2012-243
CR-RBS-2012-2479	CR-RBS-2012-2580	CR-RBS-2012-2615	CR-RBS-2012-2650
CR-RBS-2012-2666	CR-RBS-2012-2690	CR-RBS-2012-2698	CR-RBS-2012-2770
CR-RBS-2012-2821	CR-RBS-2012-2890	CR-RBS-2012-2983	CR-RBS-2012-2993
CR-RBS-2012-3154	CR-RBS-2012-3155	CR-RBS-2012-3173	CR-RBS-2012-3270
CR-RBS-2012-3273	CR-RBS-2012-3385	CR-RBS-2012-3385	CR-RBS-2012-3407
CR-RBS-2012-3412	CR-RBS-2012-3439	CR-RBS-2012-3440	CR-RBS-2012-3524
CR-RBS-2012-3534	CR-RBS-2012-3534	CR-RBS-2012-3548	CR-RBS-2012-3550
CR-RBS-2012-3739	CR-RBS-2012-3780	CR-RBS-2012-3816	CR-RBS-2012-3817
CR-RBS-2012-3817	CR-RBS-2012-3842	CR-RBS-2012-3855	CR-RBS-2012-3857
CR-RBS-2012-3863	CR-RBS-2012-3868	CR-RBS-2012-3986	CR-RBS-2012-4006
CR-RBS-2012-4129	CR-RBS-2012-4246	CR-RBS-2012-4292	CR-RBS-2012-4293
CR-RBS-2012-4294	CR-RBS-2012-4295	CR-RBS-2012-4412	CR-RBS-2012-4527
CR-RBS-2012-4542	CR-RBS-2012-4543	CR-RBS-2012-4552	CR-RBS-2012-479
CR-RBS-2012-485	CR-RBS-2012-4875	CR-RBS-2012-4900	CR-RBS-2012-4916
CR-RBS-2012-494	CR-RBS-2012-501	CR-RBS-2012-5111	CR-RBS-2012-5252
CR-RBS-2012-5327	CR-RBS-2012-5483	CR-RBS-2012-5509	CR-RBS-2012-5544
CR-RBS-2012-5545	CR-RBS-2012-5545	CR-RBS-2012-5545	CR-RBS-2012-5588
CR-RBS-2012-5621	CR-RBS-2012-5650	CR-RBS-2012-5903	CR-RBS-2012-5921
CR-RBS-2012-6008	CR-RBS-2012-6015	CR-RBS-2012-6247	CR-RBS-2012-6274
CR-RBS-2012-6278	CR-RBS-2012-6308	CR-RBS-2012-6378	CR-RBS-2012-641
CR-RBS-2012-6464	CR-RBS-2012-6473	CR-RBS-2012-6559	CR-RBS-2012-6591
CR-RBS-2012-6619	CR-RBS-2012-6898	CR-RBS-2012-6937	CR-RBS-2012-7008
CR-RBS-2012-7027	CR-RBS-2012-7198	CR-RBS-2012-7250	CR-RBS-2012-7320
CR-RBS-2012-7324	CR-RBS-2012-7325	CR-RBS-2012-7328	CR-RBS-2012-7497
CR-RBS-2012-7513	CR-RBS-2012-7540	CR-RBS-2012-7540	CR-RBS-2012-7673
CR-RBS-2012-7704	CR-RBS-2012-7746	CR-RBS-2012-7776	CR-RBS-2012-7835
CR-RBS-2012-873	CR-RBS-2013-1007	CR-RBS-2013-103	CR-RBS-2013-1423
CR-RBS-2013-1454	CR-RBS-2013-1557	CR-RBS-2013-1731	CR-RBS-2013-1825
CR-RBS-2013-1871	CR-RBS-2013-206	CR-RBS-2013-207	CR-RBS-2013-208
CR-RBS-2013-209	CR-RBS-2013-210	CR-RBS-2013-211	CR-RBS-2013-212
CR-RBS-2013-213	CR-RBS-2013-214	CR-RBS-2013-2189	CR-RBS-2013-2413
CR-RBS-2013-2485	CR-RBS-2013-2494	CR-RBS-2013-2527	CR-RBS-2013-2706
CR-RBS-2013-2716	CR-RBS-2013-292	CR-RBS-2013-295	CR-RBS-2013-296
CR-RBS-2013-2967	CR-RBS-2013-3075	CR-RBS-2013-3118	CR-RBS-2013-3150
CR-RBS-2013-3154	CR-RBS-2013-3168	CR-RBS-2013-3170	CR-RBS-2013-3174
CR-RBS-2013-3273	CR-RBS-2013-3281	CR-RBS-2013-3291	CR-RBS-2013-3379
CR-RBS-2013-3417	CR-RBS-2013-3595	CR-RBS-2013-3701	CR-RBS-2013-3720
CR-RBS-2013-3760	CR-RBS-2013-3772	CR-RBS-2013-3772	CR-RBS-2013-3809
CR-RBS-2013-3825	CR-RBS-2013-3907	CR-RBS-2013-3956	CR-RBS-2013-4034
CR-RBS-2013-4102	CR-RBS-2013-4119	CR-RBS-2013-4174	CR-RBS-2013-4232
CR-RBS-2013-4509	CR-RBS-2013-4536	CR-RBS-2013-4541	CR-RBS-2013-457
CR-RBS-2013-457	CR-RBS-2013-461	CR-RBS-2013-4637	CR-RBS-2013-470

Condition Reports

CR-RBS-2013-4722	CR-RBS-2013-4905	CR-RBS-2013-501	CR-RBS-2013-554
CR-RBS-2013-555	CR-RBS-2013-564	CR-RBS-2013-571	CR-RBS-2013-651
CR-RBS-2013-703	CR-RBS-2013-779	CR-RBS-2013-868	CR-RBS-2013-934
CR-RBS-2013-964	LO-HQNLO-2012-59	LO-RLO-2013-2	

WORK ORDERS

WO 00191826	WO 00217906	WO 00262102	WO 00269442
WO 00271559	WO 00279590	WO 00293641	WO 00308606
WO 00310523	WO 00310524	WO 00310525	WO 00313121
WO 00314499	WO 00315125	WO 00322455	WO 00340061
WO 00343049	WO 00345178	WO 00349682	WO 52425501

WORK REQUESTS

WR 183768	WR 251620	WR 266339	WR 269920
WR 271707	WR 299942	WR 302296	

WORK TRACKING DOCUMENTS

WT-WTRBS-2013-00190, Corrective Action 1
WT-WTRBS-2013-00190, Corrective Action 2
WT-WTRBS-2013-00190, Corrective Action 3
WT-WTRBS-2013-00190, Corrective Action 5
WT-WTRBS-2013-00190, Corrective Action 7

<u>MISCELLANEOUS</u>	<u>TITLE</u>	<u>DATE/REVISION</u>
---	On-Line Operations Aggregate Index (OAI)	May 31, 2013
FCBT-GET-PATSS	Entergy Fleet Specific Plant Access Training	
7216.210-085-002A	Engineering Analysis for Model 17FA443 B 114 Fa14 FA10 Serial Numbers 24200-24203	April 12, 2010
SWP-PVY32A	SWP-PVY32A EC-41429	1
OSP-0028	Log Report – Normal Switchgear, Control, and Diesel Generators Buildings	74
RBS ER 98-0174	Recommended Control Building Chiller Water System Monitoring	2
	1st Quarter 2012 Security Trend Report 2nd Quarter Security Trend Report 3rd Quarter Security Trend Report 4th Quarter Security Trend Report	

<u>MISCELLANEOUS</u>	<u>TITLE</u>	<u>DATE/REVISION</u>
CR-RBS-2012-1968	Root cause Evaluation Report	March 18, 2012
CR-RBS-2013-4637	Root cause Evaluation Report	August 6, 2013
CR-RBS-2012-05153	Apparent Cause Evaluation Report	August 27, 2012
EP-M-12-012	ERO Team "D" Evaluated Exercise	August 6, 2012
	1st Quarter Emergency Communication Test TEAR/Task User Guide	March 4, 2013
FPCS-SUPV-SIS	Supervisor Interaction Skills (SIS) Course Summary	6
FLP-SUPV-50.5, 50.9, 50.7	10 CFR 50.5, 50.9 and 50.7 (Training)	
FCBT-GET-PATSS	Entergy Fleet Specific Plant Access Training	

Information Request
April 16, 2013
Biennial Problem Identification and Resolution Inspection
River Bend Station
Inspection Report Number 05000458/2013008

This inspection will cover the period from May 13, 2011, through June 27, 2013. All requested information should be limited to this period up to the day provided unless otherwise specified. To the extent possible, the requested information should be provided electronically in Microsoft Office format. Lists of documents should be provided in Microsoft Excel or a similar sort-able format. Please provide the information on a compact disc (one for each team member), if possible. This information may also be uploaded on the Certrec IMS website if so desired.

Please provide the following no later than May 13, 2013:

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

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

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

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

Attention: Harry Freeman

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