



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION IV
1600 E. LAMAR BLVD.
ARLINGTON, TX 76011-4511

June 9, 2017

Mr. William F. Maguire
Site Vice President
Entergy Operations, Inc.
River Bend Station
5485 US Highway 61N
St. Francisville, LA 70775

**SUBJECT: RIVER BEND STATION – NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000458/2017009 AND NOTICE OF
VIOLATION**

Dear Mr. Maguire:

On April 28, 2017, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at your River Bend Station. The NRC inspection team discussed the results of this inspection with Mr. Marvin Chase, Director, Regulatory & Performance Improvement, and other members of your staff. The results of this inspection are documented in Enclosure 2.

The NRC inspection team reviewed the station's corrective action program and the station's implementation of the program to evaluate its effectiveness in identifying, prioritizing, evaluating and correcting problems, and to confirm that the station was complying with NRC regulations and licensee standards for corrective action programs. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

The team also evaluated the station's processes for use of industry and NRC operating experience information and the effectiveness of the station's audits and self-assessments. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

Finally, the team reviewed the station's programs to establish and maintain a safety-conscious work environment, and interviewed station personnel to evaluate the effectiveness of these programs. Based on the team's observations and the results of these interviews the team found no evidence of challenges to your organization's safety-conscious work environment. Your employees appeared willing to raise nuclear safety concerns through at least one of the several means available.

The enclosed report discusses a Severity Level IV violation associated with a finding of very low safety significance (Green). The NRC evaluated this violation in accordance Section 2.3.2.a of the NRC Enforcement Policy, which can be located at <http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html>. The violation is cited in

the enclosed Notice of Violation (Notice) and the circumstances surrounding it are described in detail in the subject inspection report. The violation is being cited because the licensee failed to restore compliance with a Title 10 of the *Code of Federal Regulations* (10 CFR) 50.59 violation associated with the failure to obtain a license amendment that resulted in a more than minimal increase in the frequency of occurrence of an accident previously evaluated in the final safety analysis report when implementing a design change to the reactor core isolation cooling injection location. The NRC previously identified this violation as non-cited violation (NCV) 05000458/2015007-02.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. The NRC's review of your response will also determine whether further enforcement action is necessary to ensure your compliance with regulatory requirements.

If you contest the violation or significance of the violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region IV; the Director, Office of Enforcement; and the NRC resident inspector at the River Bend Station.

If you disagree with the cross-cutting aspect assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region IV; and the NRC resident inspector at the River Bend Station.

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

Sincerely,

/RA Jeffrey Clark for/

Thomas R. Hipschman, Team Leader
Inspection Program and Assessment Team
Division of Reactor Safety

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

Enclosure 1: Notice of Violation
Enclosure 2: Inspection Report 05000458/2017009
w/ Attachments: Supplemental Information &
Information Request

cc w/ encl: Electronic Distribution

NOTICE OF VIOLATION

Entergy Operations, Inc.
River Bend Station

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

During an NRC inspection conducted April 10 – 28, 2017, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is listed below:

10 CFR 50.59(c)(2) requires, in part, that a licensee shall obtain a license amendment pursuant to 10 CFR 50.90 prior to implementing a proposed change, test, or experiment if the change, test, or experiment would result in more than a minimal increase in the frequency of occurrence of an accident previously evaluated in the final safety analysis report (as updated).

Contrary to the above, as of April 28, 2017, the licensee failed to obtain a license amendment pursuant to 10 CFR 50.90 prior to implementing a change, test, or experiment that resulted in a more than minimal increase in the frequency of occurrence of an accident previously evaluated in the final safety analysis report (as updated). Specifically, on July 3, 1999, the licensee implemented a design change to the reactor core isolation cooling injection location from the reactor vessel head to a feedwater line, but failed to correctly evaluate that a spurious reactor core isolation cooling actuation into the feedwater line resulted in a more than minimal increase in the frequency of occurrence of the loss of feedwater heating accident previously evaluated in the updated final safety analysis report.

This is a Severity Level IV violation (NRC Enforcement Policy Section 6.1.d.2).

Pursuant to the provisions of 10 CFR 2.201 Entergy Operations, Inc. is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001 with a copy to the Regional Administrator, Region IV, 1600 E. Lamar Blvd, Arlington, Texas 76011, and a copy to the NRC resident inspector at the River Bend Station, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation," and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation or severity level; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response.

If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

If you contest this enforcement action, you should also provide a copy of your response, with the basis for your denial, to the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001.

Enclosure 1

Your response will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html>. To the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the public without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected, and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.390(b), to support a request for withholding confidential commercial or financial information).

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days of receipt.

Dated this 9th day of June 2017

**U.S. NUCLEAR REGULATORY COMMISSION
REGION IV**

Dockets: 05000458

License: NPF-47

Report: 05000458/2017009

Licensee: Entergy Operations, Inc.

Facility: River Bend Station

Location: 5485 U.S. Highway 61N
St. Francisville, LA 70775

Dates: April 10 through April 28, 2017

Team Lead: R. Azua, Senior Reactor Inspector

Inspectors: H. Freeman, Senior Reactor Inspector
P. Jayroe, Project Engineer
B. Parks, Resident Inspector

Approved By: T. Hipschman, Team Leader
Inspection Program and Assessment Team
Division of Reactor Safety

SUMMARY

IR 05000458/2017009; 04/10/2017 – 04/28/2017; River Bend Station; Problem Identification and Resolution (Biennial)

The inspection activities described in this report were performed between April 10 and April 28, 2017, by three inspectors from the NRC's Region IV office and the resident inspector at the River Bend Station. The report documents one finding of very low safety significance (Green). This finding involved a violation of NRC requirements; this violation was determined to be Severity Level IV under the traditional enforcement process. The significance of inspection findings is indicated by their color (Green, White, Yellow, or Red), which is determined using Inspection Manual Chapter 0609, "Significance Determination Process." Their cross-cutting aspects are determined using Inspection Manual Chapter 0310, "Aspects Within the Cross-Cutting Areas." Violations of NRC requirements are dispositioned in accordance with the NRC Enforcement Policy. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

Assessment of Problem Identification and Resolution

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

The licensee appropriately evaluated industry operating experience for relevance to the facility and entered applicable items in the corrective action program. The licensee incorporated industry and internal operating experience in its root cause and apparent cause evaluations. The licensee performed effective and self-critical nuclear oversight audits and self-assessments. The licensee maintained an effective process to ensure significant findings from these audits and self-assessments were addressed. However, the team identified a potential weakness in the station's timeliness for processing certain 10 CFR Part 21 notifications through the operating experience and corrective action programs. The licensee acknowledged this potential weakness and indicated their plan to address this through the Entergy fleet.

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

Cornerstone: Initiating Events

- Green. The NRC identified a Severity Level IV violation for the licensee's failure to restore compliance for a non-cited violation (NCV) associated with failure to obtain NRC approval prior to making a change to the reactor core isolation cooling injection point. Specifically, as of April 28, 2017, the licensee had not restored compliance with a violation the NRC identified on October 8, 2015. This violation described a previously made change to the facility without prior NRC approval in violation of 10 CFR 50.59, "Changes, Tests, and Experiments." The team determined that the licensee's failure to restore compliance within a reasonable amount of time was a performance deficiency. Title 10 CFR 50, Appendix B, Criterion XVI, requires in part that, "measures shall be established to assure that conditions

adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.” The licensee entered this issue into their corrective action program as Condition Report CR-RBS-2017-03505.

The finding was more than minor because it is associated with the initiating events aspect of the reactor safety cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The finding is of very low safety significance (Green) because it did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding has a human performance cross-cutting aspect associated with procedural adherence because individuals failed to follow the procedures delineated by the corrective action program [H.8]. Originally, the licensee met the criteria for dispositioning the issue (50.59) as a NCV. However, based upon the fact that the condition report, which documented the NCV, was closed without restoring compliance, the licensee no longer met the criteria for a NCV and therefore, this violation is being cited in a notice of violation (4OA2.5).

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (71152)

The team based the following conclusions on a sample of corrective action documents that were open during the assessment period, which ranged from July 12, 2015, to the end of the on-site portion of this inspection on April 27, 2017.

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

a. Inspection Scope

The team reviewed approximately 200 condition reports (CRs), including associated root cause analyses and apparent cause evaluations, from approximately 20,000 that the licensee had initiated or closed between July 12, 2015, and April 27, 2017. The majority of these (approximately 20,000) were lower-level condition reports that did not require cause evaluations. The inspection sample focused on higher-significance condition reports for which the licensee evaluated and took actions to address the cause of the condition. In performing its review, the team evaluated whether the licensee had properly identified, characterized, and entered issues into the corrective action program, and whether the licensee had appropriately evaluated and resolved the issues in accordance with established programs, processes, and procedures. The team also reviewed these programs, processes, and procedures to determine if any issues existed that may impair their effectiveness.

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

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

licensee had changed the significance level after initial classification to determine whether the level changes were in accordance with station procedures and that the conditions were appropriately addressed.

The team considered risk insights from both the NRC's and the River Bend Station's risk models to focus the sample selection and plant tours on risk-significant systems and components. The team focused a portion of its sample on the control building heating and ventilation (HVAC) system and automatic depressurization system, which the team selected for a five-year in-depth review. The team conducted walk-downs of the HVAC system and other plant areas to assess whether licensee personnel identified problems at a low threshold and entered them into the corrective action program. In addition, the team also reviewed the licensee's use of operational experience and the 10 CFR Part 21 (Part 21) process' with respect to these systems.

b. Assessments

1. Effectiveness of Problem Identification

During the 22-month inspection period, licensee staff generated approximately 20,000 condition reports. The team determined that most conditions that required generation of a condition report per Procedure EN-LI-102, "Corrective Action Program," were entered appropriately into the corrective action program. However, the Team identified a few errors in the development and processing of CR's:

- These errors included assigning the wrong priority to a CR, and/or closing CRs to a lesser CR, contrary to plant procedures. In most of these instances, the subsequent actions taken to correct these issues were appropriate to the higher priority designation. One instance was noted where actions taken were not commensurate with the required actions for a condition adverse to quality. Specifically, Condition Report CR-RBS-2015-7259, which was issued in response to a 10 CFR 50.59 NCV. The licensee closed the CR to a Licensing Action Request process, which was not an approved process in the corrective action program. This failure by the licensee to follow their process contributed to the failure to address the issue in a timely manner, which resulted in a cited violation. (Section 40A2.5)

Overall, the team concluded that the licensee generally maintained a low threshold for the formal identification of problems and entry into the corrective action program for evaluation. Licensee personnel initiated over 760 CRs per month during the inspection period. Most of the personnel interviewed by the team understood the requirements for condition report initiation; most expressed a willingness to enter newly identified issues into the corrective action program at a very low threshold.

2. Effectiveness of Prioritization and Evaluation of Issues

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

determinations to assess the quality, timeliness, and prioritization of these determinations.

Based on the walk-down of the risk-significant systems selected for the five-year in-depth review, the team observed that the material condition of these systems appeared to be adequate. With regard to the HVK system, the team noted that the plant had experienced a number of recurring issues with this system, over several years, where corrective actions appeared to have been previously ineffective. This was one of the reasons the team selected this system for review.

The team's focused review of the licensee's more recent actions, with regard to the HVK system, indicated a more rigorous effort was being applied by the licensee to get this issue under control. One such action was the licensee's placement of this system in their Top Ten Equipment Reliability Action Plan, which focuses more plant resources to listed systems in an effort to correct identified problems. Interviews with licensee staff also indicate that a more concerted effort was being made by plant management to address identified problems with the HVK system with more permanent solutions. Having said that, this effort is in its nascent stage. The NRC will continue to monitor these systems to ascertain the effectiveness of the licensee's corrective actions over time.

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

3. Effectiveness of Corrective Actions

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

The team identified that since early 2016, there has been a reduction in the number of adverse events caused by human performance errors and work management deficiencies on the part of River Bend Station employees. However, this positive data point was tempered by the team having noticed that a potential area of vulnerability may still exist in the area of supplemental (contract) employees, for example transmission and distribution personnel. The licensee stated that they were aware of this vulnerability and indicated were working to address it.

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The team examined the licensee's program for reviewing industry operating experience, including reviewing the governing procedures. The team reviewed a sample of eight industry operating experience communications and the associated site evaluations to assess whether the licensee had appropriately assessed the communications for

relevance to the facility. The team also reviewed assigned actions to determine whether they were appropriate.

b. Assessment

Overall, the team determined that the licensee appropriately evaluated industry operating experience for its relevance to the facility. Operating experience information was incorporated into plant procedures and processes as appropriate. The licensee was effective in implementing lessons learned through operating experience. They took full advantage of being part of the Entergy fleet, to give a thorough review of the operational experience from a variety of sources. Licensee personnel ensured that significant issues were dealt with in a thorough and timely manner. This was also true for the Part 21 process that is within the licensee's operational experience program.

The team further determined that the licensee appropriately evaluated industry operating experience when performing root cause analysis and apparent cause evaluations. The licensee appropriately incorporated both internal and external operating experience into lessons learned for training and pre-job briefs.

The team identified one potential weakness with respect to the timeliness of review of Part 21 notices. Specifically, with regard to Part 21's received where the River Bend Station was not identified as being affected. In these instances, the notices would be sent to Entergy's Corporate Supply office to be researched. If during this research the Part 21 was determined to apply to the River Bend Station, the information would be returned to the site. However, there were no further timeliness goals regarding when this item should be entered into the corrective action program. The team identified four examples where the time that lapsed between the publication of a Part 21 notice and entry into the corrective action program was excessive (80 days to 105 days). None of the examples identified had an adverse impact on the safety of the plant. Following discussions with the licensee staff, they acknowledged this insight and indicated that they plan to address it through the Entergy fleet. The licensee entered this issue into their corrective action program (Condition Reports CR-RBS-2017-03549 and CR-HQN-2017-00617).

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

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

b. Assessment

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

.4 Assessment of Safety-Conscious Work Environment

1. Inspection Scope

The team interviewed 26 individuals in five focus groups. The purpose of these interviews was: (1) to evaluate the willingness of licensee staff to raise nuclear safety issues, either by initiating a condition report or by another method, (2) to evaluate the perceived effectiveness of the corrective action program at resolving identified problems, and (3) to evaluate the licensee's safety-conscious work environment (SCWE). The focus group participants included personnel from Engineering, Maintenance (Mechanical, Electrical, and Instrumentation and Controls), Security and Supplemental (Contract) Engineering personnel. At the team's request, the licensee's regulatory affairs staff selected the participants blindly from these work groups, based partially on availability. To supplement these focus group discussions, the team interviewed the Employee Concerns Program manager to assess her perception of the site employees' willingness to raise nuclear safety concerns. The team reviewed the Employee Concerns Program case log and select case files. The team also reviewed the minutes from the licensee's most recent safety culture monitoring panel meetings.

2. Assessment

1. Willingness to Raise Nuclear Safety Issues

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

The team questioned focus group participants whether they were able to submit a condition report anonymously. Most individuals were aware that they could submit condition reports anonymously, and were knowledgeable of the process. The team noted that the number of anonymous CRs has dropped over the last year. This, in conjunction with the positive staff comments during interviews, was considered an indicator of improving personnel confidence in the plant and plant management.

2. Employee Concerns Program

All interviewees were aware of the Employee Concerns Program. Most explained that they had heard about the program through various means, such as posters, training, presentations, and discussion by supervisors or management at meetings. All interviewees stated that they would use Employee Concerns if they felt it was necessary. All expressed confidence that their confidentiality would be maintained if they brought issues to Employee Concerns.

4. Preventing or Mitigating Perceptions of Retaliation

When asked if there have been any instances where individuals experienced retaliation or other negative reaction for raising issues, all individuals interviewed stated that they had neither experienced nor heard of an instance of retaliation, harassment, intimidation or discrimination at the site. The team determined that processes in place to mitigate these issues were being successfully implemented.

Responses from the focus group interviewees indicate that they believe that management has established and promoted a safety-conscious work environment where individuals feel free to raise safety concerns without fear of retaliation. Overall, employees indicated that they have noticed an improved culture on-site. As described, there was a sense that management is more interested now in addressing issues in a manner that will result in more lasting solutions. They indicated that there is more management support for their efforts.

.5 Findings

Failure to restore compliance for a 10 CFR 50.59 Violation

Introduction. The team identified a Green, Severity Level IV, violation for the licensee's failure to restore compliance for a NCV associated with the licensee's failure to obtain NRC approval prior to making a change to the reactor core isolation cooling injection point. Specifically, as of April 28, 2017, the licensee had not restored compliance with the NCV the NRC identified on October 8, 2015. This violation described a change, which was previously made to the facility without prior NRC approval in violation of 10 CFR 50.59, "Changes, Tests, and Experiments," because the evaluation did not provide adequate justification as to why the change did not result in a more than minimal increase in the frequency of occurrence of an accident previously evaluated in the final safety analysis report.

Description. In 1998, the licensee modified the reactor core isolation cooling injection point from the reactor head spray nozzle to the 'A' feedwater line via the 'A' residual heat removal shutdown cooling return line. At that time, the licensee's evaluation stated that the modification did not increase the probability of occurrence of an accident evaluated previously in the Safety Analysis Report (SAR) and, as a result, did not represent an unreviewed safety question which would have required NRC approval.

In October 2015 the NRC reviewed the licensee's modification to the reactor core isolation cooling injection point as one of the samples during an inspection on evaluations of changes, tests, and experiments and permanent plant modifications (Inspection Procedure 71111.17T). The NRC determined that the licensee's evaluation for this modification was inadequate because the licensee had failed to correctly evaluate that a spurious reactor core isolation cooling actuation injecting through the feedwater line would also result in the same characteristics, (and therefore increase the probability of occurrence) of another accident previously evaluated (loss of feedwater heating) and that this would be more than a minimal increase in frequency.

The requirements governing the authority of production and utilization facility licensees to make changes to their facilities without prior NRC approval are contained in

10 CFR 50.59. At the time of implementation of this modification, the regulation provided that licensees may make changes to the facility or procedures as described in the safety analysis report (SAR), without prior Commission approval, unless the proposed change, test, or experiment involved a change to the Technical Specifications incorporated in the license or an unreviewed safety question. Section 50.59(a)(2), stated the following:

A proposed change, test, or experiment shall be deemed to involve an unreviewed safety question: (i) if the probability of occurrence or the consequences of an accident or malfunction of equipment important to safety previously evaluated in the safety analysis report may be increased; (ii) if a possibility for an accident or malfunction of a different type than any evaluated previously in the safety analysis report may be created; or (iii) if the margin of safety as defined in the basis for any technical specification is reduced.

At the time of the modification, any increase in probability of occurrence or consequence was considered an unreviewed safety question. On October 4, 1999, the NRC issued a revision to 10 CFR 50.59 in the Federal Register (64 FR 53582), effective 90 days after approval of Regulatory Guide 1.187 (issued in November 2000). Among the changes implemented to the revised rule, the NRC eliminated the term “unreviewed safety question,” and clarified the requirements to allow changes, which involved only “minimal increases” in probability or consequences to be made without prior NRC approval.

Because this performance deficiency did not meet the requirements of the revised rule (which allowed for a minimal increase in frequency), it did not meet the criteria for enforcement discretion, and therefore, was documented as a Severity Level IV, NCV, consistent with the Enforcement Policy. On October 29, 2015, the NRC documented this issue in NRC Inspection Report 05000458/2015007. The licensee entered the performance deficiency into their corrective action program as Condition Report CR-RBS-2015-7259 and did not deny the violation.

During the current inspection, the NRC team selected Condition Report CR-RBS-2015-7259 as one of the samples reviewed to assess the adequacy of the licensee’s problem identification and resolution program. The team found that the licensee had not restored compliance with the rule and found several aspects associated with how the licensee addressed the NCV that deviated from their corrective action program as specified in Procedure EN-LI-102, Revision 25. These aspects include:

- The licensee initiated the condition report as significance C and directed it be upgraded to a significance “B ACE CARB” [apparent cause evaluation, corrective action review board] when the finding was issued as a NCV. The NRC documented the finding on October 29, 2015, and yet the licensee did not upgrade the condition report until December 17, 2015. This delayed initiation of the apparent cause evaluation.
- The licensee initially characterized the condition report as a significance C even though it met two of the criteria listed in Attachment 9.1, “Condition Report Classification Guidance,” of Procedure EN-LI-102 to be classified as significance B. These examples included inadequate 10 CFR 50.59 review, evaluation or screening, and Green NCV, Green finding violation, or traditional enforcement from the NRC.

- The licensee closed the significance B condition report without having corrected the condition adverse to quality (namely the 10 CFR 50.59 violation for failure to obtain NRC approval prior to making a change to the facility). In order to restore compliance, the licensee had three choices: (1) restore the facility to a condition that did not require NRC approval (restore original design); (2) perform an adequate evaluation that provided justification as to why the change did not increase the probability or consequences of an accident by more than a minimal amount [based upon the current standard] and deny the violation; or (3) submit a license amendment request requesting NRC approval [after the fact] for a change to the facility as described in the safety analysis report.
- The licensee closed the condition report to a process that was not allowed by the corrective action program. Section 5.5[5] “CR [condition report] Disposition Requirements” of Procedure EN-LI-102 allows a condition report to be closed to another condition report as long as the condition report being closed is the same as or lower category level than the remaining condition report. Attachment 9.6 “CR and CA [corrective action] Closure to WMS [Work Management System] and Tracking,” also allows a condition report/corrective action to be closed to the work management system if they have Condition Review Group approval. In this case, the licensee closed the condition report to a licensing action request system, which was neither another condition report nor part of the work management system, and therefore, not allowed by the corrective action program. The licensee’s license action request system did not have comparable controls or requirements for due date extensions as specified by the corrective action program.
- The corrective actions did not meet the guidance of Section 5.6[2] “Corrective Action Initiation” of Procedure EN-LI-102 for crafting corrective actions, which states that corrective action content should be “specific, measurable, achievable, realistic, and timely.” The licensee did not initiate a corrective action to specifically address the adverse condition. The action that was initiated was an indirect action that was assigned to the Design Engineering department to provide technical input to the Licensing department to support generation of a license amendment request for submission to the NRC. Once the technical input was provided, the corrective action and the condition report were closed. An adequate corrective action should have required the Licensing department to obtain a license amendment accepting the design change prior to closing the condition report. The failure to restore compliance continues to exist up until the licensee receives a license amendment.
- The closure review performed by the assigned manager failed to identify that the condition adverse to quality had not been corrected and that the condition report was not ready to close. Specific questions contained in Attachment 9.2, “Checklist for Level B CR Closure” of Procedure EN-LI-102 that could have identified that the condition report was not ready for closure include:
 - Question 13 stated, “verify the corrective actions corrected the condition identified ...” was checked “SAT” even though no corrective actions had been generated to restore compliance.

- Question 14 stated, “verify that each corrective action identified in the evaluation and that was otherwise issued to address the condition was completed as intended. Recommendations and enhancements may be tracked by other processes,” was checked “SAT” even though a sub question (also marked SAT) stated, “Verify the action item was not closed to a promise of a future action item.” In this case, the future action was implied that the Licensing department would submit and obtain approval from the NRC for a license amendment.
- Questions 15 through 17 were left unchecked even though they were required to be checked “SAT,” including Question 16 which states, “verify the corrective action is not closed to another process other than WO [work order] approved by the CRG [Condition Review Group].” In this case the implied corrective action (obtaining NRC approval) was closed to another process, which was not a work order approved by the Condition Review Group.
- Question 19 (left blank) states, “if this quality closure review identifies an unsatisfactory closure of a checklist item annotated “SAT,” issue a corrective action using the “UNSAT RESPONSE PI” action type, with specific recommendations or identified discrepancies that need further review.” As noted above, three questions that should have been annotated “SAT,” were left blank and a corrective action was not generated using the “UNSAT RESPONSE PI,” as required.
- Question 20 (left blank) states: “When all items in the checklist are satisfactorily completed, the CR is ready to close.”
- Corrective Action 14 was closed on October 6, 2016, even though the attached closure checklist was not completed.

On April 12, 2017, the team determined that the licensee had not restored compliance with this ongoing violation within a reasonable amount of time for NCV 05000458/2015007-02, and that any future corrective actions could not be considered timely and commensurate with the significance. The team concluded that while the licensee originally met the criteria for dispositioning the 10 CFR 50.59 issue as a NCV, based upon the fact that the condition report that documented the violation was closed and the licensee had not restored compliance within a reasonable time (nearly 18 months), the team determined that the licensee no longer met the criteria for a NCV, and therefore, this violation would be cited in a notice of violation.

Analysis. The team determined that the licensee’s failure to restore compliance within a reasonable amount of time for a violation of regulatory requirements associated with a design modification was a performance deficiency. Specifically, on October 29, 2015, the NRC notified the licensee that a plant design change, which was implemented in 1999, had increased the probability of a loss-of-feedwater accident by more than a minimal amount and was made without requesting prior NRC approval, was a violation of 10 CFR 50.59 requirements. Title 10 CFR 50, Appendix B, Criterion XVI, requires in part that, “measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.” As of April 28, 2017, the licensee failed to correct a condition adverse to quality by restoring compliance with 10 CFR 50.59.

The finding was more than minor because it is associated with the initiating events aspect of the reactor safety cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 1, "Initiating Events Screening Questions," dated June 19, 2012, the team determined that the finding is of very low safety significance (Green). This was because the finding did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding has a human performance cross-cutting aspect associated with procedural adherence because individuals failed to follow the procedures delineated by the corrective action program [H.8].

The reactor oversight process' (ROP's) significance determination process does not specifically consider the regulatory process impact in its assessment of licensee performance. Therefore, it is necessary to address this violation, which impedes the NRC's ability to regulate, using traditional enforcement to deter non-compliance. Since the violation is associated with a Green reactor oversight process violation, the traditional enforcement violation was determined to be a Severity Level IV violation, consistent with the example in paragraph 6.1.d(2) of the NRC Enforcement Policy.

The NRC's Enforcement Policy dictates that severity level IV violations and violations associated with green ROP findings are normally dispositioned as NCVs if they meet all of the following: (1) the violation is placed into a corrective action program to restore compliance and address recurrence; (2) the licensee must restore compliance within a reasonable period of time (commensurate with the significance); (3) the violation must either not be repetitive as a result of inadequate corrective action, or if repetitive, the repetitive violation must not have been identified by the NRC (does not apply to green ROP findings); and (4) the violation must not be willful. For the purposes of Criterion 2, this includes actions taken to stop an ongoing violation from continuing (which should be as soon as possible). The team concluded that while the licensee originally met the criteria for dispositioning the issue 10 CFR 50.59 as a NCV; based upon the fact that the licensee closed the condition report without restoring compliance, the licensee no longer met the criteria for a NCV, and therefore, this violation will be cited in a notice of violation.

Enforcement. The team identified a Severity Level IV, Green violation of 10 CFR 50.59, "Changes, Tests, and Experiments," Section (c)(2) which states in part that, "a licensee shall obtain a license amendment pursuant to Section 50.90 prior to implementing a proposed change, test, or experiment if the change, test, or experiment would result in more than a minimal increase in the frequency of occurrence of an accident previously evaluated in the final safety analysis report (as updated)." Contrary to the above, as of April 28, 2017, the licensee failed to obtain a license amendment pursuant to Section 50.90, prior to implementing a change, test, or experiment that resulted in a more than minimal increase in the frequency of occurrence of an accident previously evaluated in the final safety analysis report (as updated). Specifically, on July 3, 1999, the licensee implemented a design change to the reactor core isolation cooling injection location from the reactor vessel head to a feedwater line. However, the licensee failed to correctly evaluate that a spurious reactor core isolation cooling actuation into the feedwater line resulted in a more than minimal increase in the frequency of occurrence

of the loss of feedwater heating accident, previously evaluated in the updated final safety analysis report. This performance deficiency was previously identified by the NRC and documented as NCV 05000458/2015007-02. In accordance with Section 2.3.2.a of the NRC Enforcement Policy, this finding is being cited because the licensee failed to restore compliance within a reasonable amount of time after the violation was initially identified. This finding was entered into the licensee's corrective action program as Condition Report CR-RBS-2017-03505, (VIO 05000458/2017009-01, "Failure to Obtain Prior NRC Approval for a Change in Reactor Core Isolation Cooling Injection Point.")

40A6 Meetings, Including Exit

Exit Meeting Summary

On April 28, 2017, the inspectors presented the inspection results to Mr. Marvin Chase, Director, Regulatory & Performance Improvement, and other members of the licensee staff. The licensee acknowledged the issues presented. The licensee confirmed that any proprietary information reviewed by the inspectors had been returned or destroyed.

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

M. Chase, Director, Regulatory & Performance Improvement
A. Coates, Sr. Engineer, Regulatory Assurance
R. Crawford, Supervisor, Engineering
K. Huffstatler, Sr. Licensing Specialist, Regulatory Assurance
J. Lea, HVK System Engineer
P. Lucky, Manager, Performance Improvement
B. Maguire, Vice President, Operations
J. Reynolds, Sr. Manager, Operations
T. Schenk, Manager, Regulatory Assurance
K. Stupak, Manager, Training
T. Trask, Director, Recovery
S. Vazquez, Director, Engineering

NRC Personnel

J. Sowa, Senior Resident, River Bend Station
A. Vogel, Director, Division of Reactor Safety

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000458/2017-009-01 NOV Failure to Obtain Prior NRC Approval for a Change in Reactor Core Isolation Cooling Injection Point (Section 40A2.5)

Discussed

05000458/2015-007-02 NCV Failure to Obtain Prior NRC Approval for a Change in Reactor Core Isolation Cooling Injection Point

LIST OF DOCUMENTS REVIEWED

Procedures

<u>Number</u>	<u>Title</u>	<u>Revision</u>
ADM-0073	Temporary Services and Equipment	307
AOP-0001	Reactor Scram	36
AOP-0029	Severe Weather Operation	38
CSP-0006	Chemistry Surveillance and Scheduling System	41

Procedures

<u>Number</u>	<u>Title</u>	<u>Revision</u>
CSP-0109	Chemistry Surveillance for Non-Routing Samples	0
EN-LI-102	Corrective Action Program	24
EN-LI-102	Corrective Action Program	25
EN-LI-102	Corrective Action Program	26
EN-LI-102	Corrective Action Program	27
EN-LI-102	Corrective Action Program	28
EN-LI-102	Corrective Action Program	29
EN-LI-104	Self-Assessment and Benchmark Process	13
EN-LI-118	Cause Evaluation Process	21
EN-LI-118	Cause Evaluation Process	22
EN-LI-118	Cause Evaluation Process	23
EN-LI-118	Cause Evaluation Process	24
EN-LI-121	Trending and Performance Review Process	18
EN-LI-121	Trending and Performance Review Process	19
EN-LI-121	Trending and Performance Review Process	20
EN-LI-121	Trending and Performance Review Process	21
EN-LI-121	Trending and Performance Review Process	22
EN-OE-100	Operating Experience Program	27
EN-OP-104	Operability Determination Process	11
EN-QV-109	Audit Process	32
EN-RP-110-004	Radiation Protection Risk Assessment Process	7
EN-TQ-201	Systematic Approach to Training Process	22
GOP-001	Plant Startup	84
GOP-001	Plant Startup	85
GOP-001	Plant Startup	97
GOP-002	Power Decrease/Plant Shutdown	70
GOP-002	Power Decrease/Plant Shutdown	71
GOP-002	Power Decrease/Plant Shutdown	72
GOP-002	Power Decrease/Plant Shutdown	77
GOP-005	Power Maneuvering	321

Procedures

<u>Number</u>	<u>Title</u>	<u>Revision</u>
GOP-005	Power Maneuvering	322
GOP-005	Power Maneuvering	323
GOP-005	Power Maneuvering	328
OSP-0014	Administrative control of Equipment and/or Devices	306
OSP-0022	Operations General Administration Guidelines	103
OSP-0043	Freeze Protection and Temperature Maintenance	30
SOP-0093	Condensate Demineralizer System	40
STP-000-0201	Monthly Operating Log	310
STP-000-0201	Monthly Operating Log	311
STP-251-3700	Fire System Yard Water Loop Flow Test	10
STP-251-3700	Fire System Yard Water Loop Flow Test	11

<u>Other Documents</u>	<u>Title</u>	<u>Revision/Date</u>
EC-000001578	B33-MOV067 A/B Stem to Upper Wedge Torque Value	0
EC-000052077	“Evaluation of the Shear Capability of the Wedge Pin for Double Disc Gate Valves B-33-MOVF023 A/B”	0
QA-9-2016-RBS-1	Fire Protection Audit	March 24, 2016
QA-14/15-2015-RBS-1	Radiation Protection / Radwaste Audit	October 19, 2015
RLO-2016-00049	Special Nuclear Material Pre-NRC Assessment	July 2, 2016
RLO-2016-00145	Pre-NRC Radiological Hazard Assessment and Exposure Control Performance Indicator Verification	January 17, 2017

Corrective Action Documents

Condition Reports

CR-RBS-1994-00830	CR-RBS-2013-2054	CR-RBS-2013-04083	CR-RBS-2013-05180
CR-RBS-2013-07316	CR-RBS-2014-00321	CR-RBS-2014-00711	CR-RBS-2014-03089
CR-RBS-2014-03150	CR-RBS-2014-03408	CR-RBS-2014-03413	CR-RBS-2014-04049
CR-RBS-2014-04802	CR-RBS-2014-05022	CR-RBS-2014-05209	CR-RBS-2014-06233
CR-RBS-2014-06284	CR-RBS-2014-06357	CR-RBS-2014-06581	CR-RBS-2015-00153
CR-RBS-2015-00626	CR-RBS-2015-01783	CR-RBS-2015-02245	CR-RBS-2015-02354

Condition Reports

CR-RBS-2015-02668	CR-RBS-2015-02855	CR-RBS-2015-03360	CR-RBS-2015-03373
CR-RBS-2015-03374	CR-RBS-2015-03437	CR-RBS-2015-03622	CR-RBS-2015-03829
CR-RBS-2015-03877	CR-RBS-2015-03951	CR-RBS-2015-03952	CR-RBS-2015-03974
CR-RBS-2015-04071	CR-RBS-2015-04259	CR-RBS-2015-04265	CR-RBS-2015-04298
CR-RBS-2015-04375	CR-RBS-2015-04413	CR-RBS-2015-04725	CR-RBS-2015-04790
CR-RBS-2015-04791	CR-RBS-2015-04794	CR-RBS-2015-04818	CR-RBS-2015-04937
CR-RBS-2015-05008	CR-RBS-2015-05038	CR-RBS-2015-05306	CR-RBS-2015-05469
CR-RBS-2015-05473	CR-RBS-2015-05474	CR-RBS-2015-05530	CR-RBS-2015-05549
CR-RBS-2015-05601	CR-RBS-2015-05644	CR-RBS-2015-06164	CR-RBS-2015-06369
CR-RBS-2015-06370	CR-RBS-2015-06371	CR-RBS-2015-06704	CR-RBS-2015-06891
CR-RBS-2015-06943	CR-RBS-2015-06952	CR-RBS-2015-06961	CR-RBS-2015-07011
CR-RBS-2015-07012	CR-RBS-2015-07013	CR-RBS-2015-07028	CR-RBS-2015-07142
CR-RBS-2015-07147	CR-RBS-2015-07259	CR-RBS-2015-07264	CR-RBS-2015-07331
CR-RBS-2015-07399	CR-RBS-2015-07532	CR-RBS-2015-07838	CR-RBS-2015-08332
CR-RBS-2015-08463	CR-RBS-2015-08508	CR-RBS-2015-08831	CR-RBS-2015-08892
CR-RBS-2015-08992	CR-RBS-2015-09052	CR-RBS-2016-00033	CR-RBS-2016-00095
CR-RBS-2016-00134	CR-RBS-2016-00150	CR-RBS-2016-00180	CR-RBS-2016-00210
CR-RBS-2016-00211	CR-RBS-2016-00251	CR-RBS-2016-00294	CR-RBS-2016-00310
CR-RBS-2016-00370	CR-RBS-2017-00513	CR-RBS-2016-00573	CR-RBS-2016-00608
CR-RBS-2016-00765	CR-RBS-2016-00887	CR-RBS-2016-00890	CR-RBS-2016-00893
CR-RBS-2016-01027	CR-RBS-2016-01031	CR-RBS-2016-01069	CR-RBS-2016-01152
CR-RBS-2016-01157	CR-RBS-2016-01226	CR-RBS-2016-01232	CR-RBS-2016-01971
CR-RBS-2016-02178	CR-RBS-2016-02200	CR-RBS-2016-02335	CR-RBS-2016-02355
CR-RBS-2016-02392	CR-RBS-2016-02398	CR-RBS-2016-02632	CR-RBS-2016-02645
CR-RBS-2016-02811	CR-RBS-2016-02813	CR-RBS-2016-02953	CR-RBS-2016-03152
CR-RBS-2016-03177	CR-RBS-2016-03212	CR-RBS-2016-03264	CR-RBS-2016-03344
CR-RBS-2016-03375	CR-RBS-2016-03533	CR-RBS-2016-03580	CR-RBS-2016-04010
CR-RBS-2016-04092	CR-RBS-2016-04095	CR-RBS-2016-04368	CR-RBS-2016-04385
CR-RBS-2016-04886	CR-RBS-2016-05016	CR-RBS-2016-05263	CR-RBS-2016-05478
CR-RBS-2016-05490	CR-RBS-2016-05539	CR-RBS-2016-05596	CR-RBS-2016-05600
CR-RBS-2016-05866	CR-RBS-2016-06055	CR-RBS-2016-06103	CR-RBS-2016-06108
CR-RBS-2016-06296	CR-RBS-2016-06393	CR-RBS-2016-06564	CR-RBS-2016-06619
CR-RBS-2016-06652	CR-RBS-2016-06694	CR-RBS-2016-06701	CR-RBS-2016-06807
CR-RBS-2016-06808	CR-RBS-2016-06809	CR-RBS-2016-06879	CR-RBS-2016-06880
CR-RBS-2016-06926	CR-RBS-2016-07098	CR-RBS-2016-07298	CR-RBS-2016-07753

Condition Reports

CR-RBS-2016-07796	CR-RBS-2016-08195	CR-RBS-2016-08577	CR-RBS-2017-00781
CR-RBS-2017-00836	CR-RBS-2017-00996	CR-RBS-2017-01658	CR-RBS-2017-02075
CR-RBS-2017-02113	CR-RBS-2017-02291	CR-RBS-2017-02314	CR-RBS-2017-02395
CR-RBS-2017-02403	CR-RBS-2017-02405	CR-RBS-2017-02529	CR-RBS-2017-02579
CR-RBS-2017-02828	CR-RBS-2017-02865	CR-RBS-2017-03549	CR-HQN-2017- 0617

Work Orders

174865	174866	316468	346576	346577	350485
419997	419999	438116			

Info Request
Biennial Problem Identification and Resolution
Inspection River Bend Station
January 23, 2017

Inspection Report: 50-458/2017009
On-site Inspection Dates: April 10-14 & 24-28, 2017

This inspection will cover the period from July 12, 2013, through April 28, 2017. All requested information is limited to this period or to the date of this request unless otherwise specified. To the extent possible, the requested information should be provided electronically in word-searchable Adobe PDF (preferred) or Microsoft Office format. Any sensitive information should be provided in hard copy during the team's first week on site; do not provide any sensitive or proprietary information electronically.

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

Please provide the following information no later than March 20, 2017:

1. Document Lists

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

- a. Summary list of all corrective action documents related to significant conditions adverse to quality that were opened, closed, or evaluated during the period
- b. Summary list of all corrective action documents related to conditions adverse to quality that were opened or closed during the period
- c. Summary lists of all corrective action documents that were upgraded or downgraded in priority/significance during the period (these may be limited to those downgraded from, or upgraded to, apparent-cause level or higher)
- d. Summary list of all corrective action documents initiated during the period that "roll up" multiple similar or related issues, or that identify a trend
- e. Summary lists of operator workarounds, operator burdens, temporary modifications, and control room deficiencies (1) currently open and (2) that were evaluated and/or closed during the period
- f. Summary list of safety system deficiencies that required prompt operability determinations (or other engineering evaluations) to provide reasonable assurance of operability

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

2. Full Documents with Attachments

- a. Root Cause Evaluations completed during the period; include a list of any planned or in progress
- b. Quality Assurance audits performed during the period
- c. Audits/surveillances performed during the period on the Corrective Action Program, of individual corrective actions, or of cause evaluations
- d. Functional area self-assessments and non-NRC third-party assessments (e.g., peer assessments performed as part of routine or focused station self- and independent assessment activities; do not include INPO assessments) that were performed or completed during the period; include a list of those that are currently in progress
- e. Any assessments of the safety-conscious work environment at the River Bend Station
- f. Corrective action documents generated during the period associated with the following:
 - i. NRC findings and/or violations issued to the River Bend Station
 - ii. Licensee Event Reports issued by the River Bend Station
- g. Corrective action documents generated for the following, if they were determined to be applicable to the River Bend Station (for those that were evaluated but determined not to be applicable, provide a summary list):
 - i. NRC Information Notices, Bulletins, and Generic Letters issued or evaluated during the period
 - ii. Part 21 reports issued or evaluated during the period
 - iii. Vendor safety information letters (or equivalent) issued or evaluated during the period
 - iv. Other external events and/or Operating Experience evaluated for applicability during the period
- h. Corrective action documents generated for the following:

- i. Emergency planning drills and tabletop exercises performed during the period
- ii. Maintenance preventable functional failures which occurred or were evaluated during the period
- iii. Adverse trends in equipment, processes, procedures, or programs that were evaluated during the period
- iv. Action items generated or addressed by offsite review committees during the period

3. Logs and Reports

- a. Corrective action performance trending/tracking information generated during the period and broken down by functional organization (if this information is fully included in item 3.c, it need not be provided separately)
- b. Corrective action effectiveness review reports generated during the period
- c. Current system health reports, Management Review Meeting package, or similar information; provide past reports as necessary to include ≥12 months of metric/trending data
- d. Radiation protection event logs during the period
- e. Security event logs and security incidents during the period (sensitive information should be made available during the team's first week on site—do not provide electronically)
- f. Employee Concern Program (or equivalent) logs (sensitive information should be made available during the team's first week on site—do not provide electronically)
- g. List of training deficiencies, requests for training improvements, and simulator deficiencies for the period

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

4. Procedures

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

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

- b. Quality Assurance program procedures (specific audit procedures are not necessary)
- c. Employee Concerns Program (or equivalent) procedures
- d. Procedures which implement/maintain a Safety Conscious Work Environment

5. Other

- a. List of risk-significant components and systems, ranked by risk worth
- b. Organization charts for plant staff and long-term/permanent contractors
- c. Electronic copies of the UFSAR (or equivalent), technical specifications, and technical specification bases, if available
- d. Table showing the number of corrective action documents (or equivalent) initiated during each month of the inspection period, by screened significance
- e. For each day the team is on site,
 - i. Planned work/maintenance schedule for the station
 - ii. Schedule of management or corrective action review meetings (e.g., operations focus meetings, condition report screening meetings, CARBs, MRMs, challenge meetings for cause evaluations, etc.)
 - iii. Agendas for these meetings

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

All requested documents should be provided electronically where possible. Regardless of whether they are uploaded to an internet-based file library (e.g., Certrec's IMS), please provide copies on CD or DVD. One copy of the CD or DVD should be provided to the resident inspector office at the River Bend Station; three additional copies should be provided to the team lead, to arrive no later than March 20, 2017:

Ray Azua
U.S. NRC Senior Reactor Inspector
Division of Reactor Safety, Region IV
1600 E. Lamar Blvd, Arlington, TX 76011
Office: (817) 200-1445
Cell: (817) 319-4376

W. Maguire

RIVER BEND STATION – NRC PROBLEM IDENTIFICATION AND RESOLUTION
INSPECTION REPORT 05000458/2017009 AND NOTICE OF VIOLATION – JUNE 9, 2017

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SUNSI Review: ADAMS: Non-Publicly Available Non-Sensitive Keyword: NRC-002
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OFFICE	SRI:DRS/IPAT	SRI:DRS/IPAT	PE:DRS/IP AT	RI:DRP/PBC	C:DRS/IPAT	C:DRP/PBC
NAME	RAzua	HFreeman	PJayroe	BParks	THipschman	JKozal
SIGNATURE	RA	RA	RA	RA	RA	/RA/
DATE	05/10/2017	05/22/2017	05/15/2017	05/23/2017	05/23/2017	06/08/2017
OFFICE	SEP:ORA/ACES	C:DRS/IPAT				
NAME	JKramer	THipschman				
SIGNATURE	/RA/	/RA/JClark for				
DATE	06/02/2017	06/09/2017				

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