ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-458/95-06

License: NPF-47

Licensee: Entergy Operations, Inc.
P.O. Box 220
St. Francisville, Louisiana

Facility Name: River Bend Station

Inspection At: St. Francisville, Louisiana

Inspection Conducted: January 23 - 27, 1995

Inspectors: T. O. McKernon, Reactor Inspector, Operations Branch
Division of Reactor Safety

H. F. Bundy, Reactor Inspector, Operations Branch
Division of Reactor Safety

Accompanying Personnel: J. S. Debor, Human Factors Consultant

Approved: John L. Pellet 2/24/95
John L. Pellet, Chief, Operations Branch Date
Division of Reactor Safety

Inspection Summary

Areas Inspected: Routine, announced inspection of emergency operating procedures, the licensed operator requalification program, and followup to previous inspection findings.

Results:

Plant Operations

- Reactor operators exhibited good communication skills, both during the requalification examination and during observations of the on-shift operating crew (Sections 1.2 and 1.3).

- Operator performance during the requalification examination was generally good, with minor exceptions during one simulator scenario (Sections 1.2 and 1.3).

- Evaluator performance during the examination was good. The examiners used a systematic approach in their evaluation process (Sections 1.2 and 1.3).

- The use of crew lead instructors was considered a strength (Section 1.5).

- There appeared to be an effective feedback system to the training program and good communications between the operations and training departments (Section 1.5).

- Reviews of a sample of licensed operator license records and medical records appeared acceptable and satisfied the requirements of 10 CFR 55.53(e), (f), and (i) (Section 1.7).

- Reactor operators were knowledgeable and proficient in the use of emergency operating procedures as demonstrated during the dynamic simulator portion of the examination (Sections 1.2 and 2).

- Some simulator fidelity issues were identified during discussions with facility personnel and during the dynamic simulator portion of the examination (Section 1.6 and Attachment 2).

- A number of human factors deficiencies were identified during the review of the emergency operating procedures in the simulator, walkdowns of emergency operating procedures enclosures, and observation of in-plant job performance measures performance during the examination. When viewed in the aggregate, these deficiencies were indicative of an ineffective verification and validation program (Section 2).

- Overall, the inspectors concluded that the licensed operator requalification program was acceptable and effectively implemented (Section 1).

- Concerns identified in NRC Violation 50-458/9415-02 were satisfactorily addressed (Section 3).

Maintenance

Not Inspected

Engineering

Not Inspected

Plant Support

- Plant housekeeping and appearance observed during the walkthrough portion of the examination appeared good (Section 1.3).

- Some areas of the plant in which emergency operating procedure enclosure required actions are performed did not have emergency lighting installed (Section 2).

Management Overview

- Based on the types of findings identified during the licensed operator requalification program evaluation portion of the inspection, management provided sufficient oversight of the program. There appeared to be noted improvement in the training program as a result of rotating experienced personnel into the training department. Use of operating crew individual training instructors was noted as a strength.

- Based upon the types of human factors deficiencies observed during the emergency operating procedures portion of the inspection, management had not provided the necessary oversight in the verification and validation program associated with emergency and abnormal operating procedures. Many of the findings were similar to previous weaknesses identified in the emergency operating procedures inspection, NRC Inspection Report 50-458/90-07.

Summary of Inspection Findings:

- Violation 50-458/9415-02 was closed.
- Violation 50-458/9506-01 was opened.

Attachments:

- Attachment 1 - Persons Contacted and Exit Meeting
- Attachment 2 - Simulation Facility Report

DETAILS

1 LICENSED OPERATOR REQUALIFICATION PROGRAM EVALUATION (IP 71001)

During the inspection, the licensee's requalification program was assessed to determine whether the program incorporated appropriate requirements for both evaluating an operator's mastery of training objectives and revising the program in accordance with 10 CFR Part 55. The licensed operator requalification program assessment included a review of training material for the past 2 years, evaluation of the program's controls to assure a systems approach to training, and evaluation of operating crew performance during annual requalification examinations. This included a review of facility documents and an assessment of the facility evaluators' effectiveness in conducting examinations.

1.1 Licensed Operator Requalification Examination Preparation

This part of the inspection was conducted to determine the licensee's methods used to develop and construct the requalification examinations and assess the effectiveness of the examinations to identify retraining needs and measure the examinee's subject knowledge. The inspectors also determined the validity of the licensee's examinations to provide a basis for evaluating the examinee's knowledge of abnormal and emergency operating procedures.

The inspectors reviewed the licensee's simulator scenarios and job performance measures used in the examination observed. The inspectors also reviewed the licensee's administrative procedures for developing, administering, grading, and evaluating the examinations and conducted interviews with training management, instructors, evaluators and examinees. The licensee's training staff stated that they used the guidelines of NUREG-1021, "Operator Licensing Examiner Standards," for the development and administration of the licensed operator requalification examination.

The job performance measures (JPMs) were developed using the guidance of NUREG-1021 with performance standards that were clear, objective, and relevant. The JPMs contained clear and well defined critical task acceptance criteria for measuring the examinee's performance. The JPMs adequately supported topic areas from the licensed operator requalification program 2-year training plan.

The scenarios were also developed using the guidance of NUREG-1021 and contained clearly stated objectives. The initial conditions of the scenarios were realistic and the scenarios consisted of related events. The scenarios had been previously validated by the training staff and allowed the evaluators to measure the examinees' competencies commensurate with the scenario objectives. The inspectors further verified that the scenarios had not been used for training during the requalification cycle.

1.2 Dynamic Simulator Examinations

The inspectors observed one operating crew consisting of a control operating foreman, a control room supervisor, three reactor operators, and a shift technical advisor on three scenarios using the River Bend Station plant-specific simulation facility and the training department evaluators in their function of assessing the crew's competencies. The evaluators rated the examinees' competencies by comparing actual performance during the scenarios against expected performance in accordance with NUREG-1021, Section 303, Revision 7, as required by Training Program Procedure TPP-7-011, Revision 4.

For the simulator scenarios, the post-examination critiques by the evaluators were effective in identifying strengths and weaknesses of the operators and crews and were consistent with the performance observed by the inspectors. In one instance involving a crew weakness in performing a critical task, the evaluators properly used the guidance in NUREG-1021, Section 604 in evaluating the crew. Sensitivity to the safety significance of the deficiency was demonstrated. The operations training supervisor stated that although the crew was rated satisfactory, remedial training would be conducted to address the observed deficiency.

The inspectors observed that the evaluators used a systematic approach in assessing the examinees' competencies. Evaluators were assigned duties such that they were not involved in training the crew being evaluated. Two of the evaluators were from the operations department. The evaluators were thorough in their assessments of the operators' performances and their findings in detail to assist in future training or in potential remediation instances. The examinees were briefed and sequestered at times appropriate for examination security. The evaluated operating crew passed the dynamic simulator portion of the examination. Individual crew members passed all competency ratings for their assigned functions. The examinees demonstrated good communication practices and were knowledgeable and proficient in the use of emergency operating procedures.

1.3 Walkthrough Examinations

The inspectors observed the licensee evaluators and the requalification examinees during conduct of system-oriented JPMs related to job tasks within the scope of their potential duties. This included nonlicensed equipment operator tasks outside the control room and the performance of some tasks in the simulator in the dynamic mode.

During the walkthroughs, the inspectors observed housekeeping and the appearance of the plant to be good. Communications between the examinees and the evaluators were observed to be good, as were the communications practiced by the on-shift operating crew. The inspectors noted that the facility evaluators thoroughly reviewed the results of the individual walkthroughs and that none of the examinees failed the JPM portion of the examination.

However, the inspectors observed difficulties in the performance of one JPM related to station blackout directed actions. This concern is further discussed in Section 2.

1.4 Remediation

The remedial training program was effective. Licensees who failed annual, biennial, or simulator examinations were suspended from licensed duties until remedial training was successfully completed. It was a requirement to complete remedial training for failing a module examination within 12 weeks. The operations training supervisor stated that their goal was to remediate training failures within a week. The inspectors' review of training failures for 1994 confirmed that this goal was generally achieved. For each failure a remedial training plan had been issued and approved by the operations training supervisor. One-on-one interviews with the trainees were used in developing the remedial training plans. In the event of a second failure, training manager approval of the remedial training plan was required.

All licensed operators interviewed expressed satisfaction with the remedial training program. Their comments indicated that remedial training was tailored to the specific training deficiencies identified, and followup examinations reliably verified correction of the performance weaknesses. The inspectors observed that the grades for remedial training examinations were usually higher than 90 percent, and that there were no remedial failures in 1994.

The inspectors interviewed licensed operators and instructors to determine the actions taken to correct operational problems observed during a reactor trip with complications which occurred on September 9, 1994. Because some of the operator performance deficiencies were related to training, the inspectors verified that appropriate corrective actions had been implemented. Operations and engineering provided input to requalification training plan upgrades. The event was recreated to the extent possible on the simulator. However, the simulator did not correctly model the effect that opening of a safety relief valve had on the reactor pressure vessel (RPV) water level. The inspectors noted that the licensee promptly upgraded the simulator model and changed procedures to allow realignment of the standby gas treatment system to facilitate access to the auxiliary building. Also, the licensee revised procedures to provide guidance on identifying motoring of the main generator and specific instructions on when it is to be manually tripped. Finally, the licensee revised procedures to place equipment which was de-energized as a result of a slow bus transfer during the event on preferred buses. Although none of the licensed operators interviewed had been trained prior to the event to anticipate the slow bus transfer, the licensee conducted shift briefings to cover the significant lessons learned resulting from the event. All licensed operators interviewed were extensively familiar with the lessons learned from this event.

1.5 Feedback System

The system for training feedback was reviewed to ascertain if multiple methods of feedback to the training program existed and if these systems were effective in adjusting the program to meet the needs of the licensed operators. The inspectors were informed that a major effort was underway to consolidate and streamline the training administrative procedures. The new procedures incorporated some changes to the training materials configuration control and training feedback programs. The inspectors did not review the revised procedures since the upgrade program was not fully completed. The following assessment was based on the programs in effect on the dates of the inspection.

All licensed operators and instructors interviewed were satisfied with the training materials configuration control and feedback programs and considered them effective. Each student completed a course critique following completion of each training module. This data, together with data collected from examination analyses, management evaluations, and post-training surveys and/or interviews, were summarized by the instructional technologists and forwarded to the training review group for information and/or action. Action items initiated by the training review group were tracked by the instructional technologists. The action item backlog was reasonable and appropriately managed. Anyone could initiate a training request form, which would then be processed by an instructor assigned by the operations training supervisor. Also, following completion of each simulator training module, the operations training supervisor issued a memorandum to the operations supervisor identifying observed generic weaknesses.

The licensed operators interviewed regarded the training request form as an effective method for obtaining desired training. However, they stated that an informal request to the lead instructor or training supervisor usually achieved the desired results. In fact, all personnel interviewed were of the opinion that the training department was responsive to all training requests. In the past six months, the licensee had implemented the use of individual trainers assigned to specific operating crews. It was the responsibility of these individuals to interface with the crew for training needs, review the crew's and individual's performances, and act as a single point of contact in the training department for the operating crew. Based on the interviews, the use of operating crew lead instructors was considered a strength. Also, communications between the operations and training departments were excellent.

Configuration control of training materials was in accordance with the training material review and revision process. The librarian initiated a material review documentation form for each document received which potentially affected training. Various technical representatives were required to initial the form after they had reviewed the material. After the reviews were complete, the assigned instructor initiated a training material review and revision form to change the affected training materials, if appropriate. This process appeared to be supportive of training needs. The

inspectors were informed that a quality action plan had been initiated to review processing of operating experience information.

1.6 Simulator Fidelity

Discussions with reactor operators and other plant personnel indicated that existing simulator fidelity problems were known, and that appropriate action plans had been initiated. The coordinator of simulator support reviewed all plant design changes and modifications and notified training supervisors of potential impacts on training. Nevertheless, not all simulator fidelity problems had been identified and corrected. For instance, prior to the reactor trip with complications occurring in September 1994, the simulator did not properly model the effect that opening of a safety relief valve had on RPV water level. The level effect was much larger than indicated by the simulator. The inspector verified that the event had been recreated on the simulator, and an appropriate modeling change had been made.

Continuing simulator fidelity problems were being addressed by long term simulator upgrade projects. One operator noted that realistic data were not supplied directly from the simulator during emergency response drills. The coordinator of simulator support responded that the current safety parameter display system (SPDS) would not provide input from the simulator to the emergency operations facility and technical support center. He went on to state that upgrade of the SPDS to provide this function was targeted for 1996. The operator also stated that the simulator did not properly model changes in feedwater flow. The coordinator of simulator support responded that this problem would be resolved by installation of a new core and thermal hydraulics model prior to starting the next requalification cycle in 1995. He also stated that new containment and activity transport models would be installed in 1995. The simulator computer system had been replaced in 1993.

All personnel interviewed indicated that there was strong management support for simulator upgrades. Through discussions with the operators and instructors, the inspectors were told that the simulator fidelity problems did not have a negative impact on training. These issues and another concerning lockout of the plant monitoring system during the dynamic simulator portion of the examination are detailed in Attachment 2.

1.7 Licensed Operator License Conformance

The inspectors reviewed the licensee's records for tracking licensed operators' qualifications and status. These included the training attendance records, operations timekeeping records, operations watch bill, required manipulations, and medical records. The inspectors verified that the records for four randomly selected individuals supported the current active status of their operator licenses. Further, the inspectors verified that the licensee maintained an appropriate program for deactivating and reactivating operator licenses. The inspectors concluded that the licensee's program met the requirements of 10 CFR 55.53(e), (f), and (i).

2 EMERGENCY OPERATING PROCEDURES REVIEW (IP 42001)

During this portion of the inspection, the inspectors performed a followup inspection to previously identified issues related to the emergency operating procedures (EOPs). This review included a table top evaluation of the EOPs and the associated EOP corrective action process. The review also included control room, simulator, and in-plant walkdown of a sampling of EOPs, EOP enclosures, and abnormal operating procedures (AOPs).

The table-top review consisted of a comparison of Procedure OSP 0009, "EOP Writer's Guide," and Procedure OSP-0008, "Verification and Validation of EOPs," to the EOPs. The EOPs consisted of 6 EOP flow charts and 28 enclosures. The enclosures were entered by reference from the flowcharts.

The EOP network was supplemented by a set of AOPs. The AOPs were event-specific procedures, for example: reactor scram, loss of instrument air, and station blackout. The AOPs were entered by reference from the EOP flowcharts (i.e., EOP-1, Section RQ; reactor scram only) and annunciator alarm response procedures.

The inspectors identified a number of human factors related concerns similar to those previously identified during NRC Inspection 50-458/90-07 conducted in April 1990. The concerns identified included:

- Four of the EOP entry conditions could not be read on control room post-accident instruments to the accuracy stated in the EOPs. The entry conditions included:

  RPV Level of 9.7 inches
  RPV Pressure of 1064.7 psig
  Containment pressure of .3 psig
  Drywell pressure of 1.68 psid.

  This concern was similar to a NRC Inspection Report 50-458/90-07 statement that control room instrumentation design, in some cases, did not support quick and clear identification of EOP entry conditions and decision making.

  The licensee compensated for the lack of instrument accuracy by highlighting EOP entry related annunciators with red hashmarks. For example, the annunciator LPCI/ D/G INITIATION DW PRESSURE is highlighted with red hashmarks because it alarms at 1.68 psig, which is the RPV control entry condition.

  The licensee stated that these values corresponded to reactor scram setpoints and the operators had been trained extensively on these setpoints. During telecon discussions on February 15, 1995, the licensee reiterated their position related to this finding. The licensee stated that the operators' EOP entries were initiated upon

annunciation of the entry condition parameter(s), the operators had been trained to readily recognize the annunciator alarm windows in the control room, and that changing the EOP instructions would result in added confusion to the operators. The licensee considered that changing the EOPs would not result in a significant safety benefit and could potentially have a negative impact.

During this inspection, the inspectors did not observe any operator difficulties in determining EOP entry points. The operators appeared knowledgeable and proficient in their use of the EOPs. However, the inspectors still considered the EOP entry conditions as a potential human factors concern.

- The inspectors observed that the control operating foreman, the control room supervisor, and the shift technical advisor primarily used the SPDS monitors for plant parameter indications. In some instances, the safety parameter display system (SPDS) indications were found to be inconsistent with EOP entry requirements. For example, EOP 1 - RPV Control entry condition of 1.68 psid drywell pressure is inconsistent with the SPDS drywell pressure alarm that is set at 1.7 psig. The control room supervisor who reads the EOPs and the shift technical advisor both rely on the SPDS displayed parameters.

  The SPDS drywell alarm is based on the pressure difference between the drywell and outside atmosphere (i.e., drywell pressure with respect to absolute pressure reference). The EOP entry condition is based on the pressure difference between the drywell and the primary containment atmosphere. Therefore, the drywell pressure indication and alarm on the SPDS critical plant variable screen is different than the EOP entry condition.

  This finding was further discussed with the licensee during a telecon on February 15, 1995. At that time, the licensee stated their intentions to resolve the SPDS inconsistency. The inspectors reiterated their concern for potential inconsistent operator responses.

- The graphic caution statement icon is not applicable to three of the six bulleted items in EOP 1, Step RL-4. The caution icon is placed to indicate applicability to all six items, while the plant specific technical guidelines indicate that the caution for pump net positive suction head refers to high pressure core spray, low pressure core spray and low pressure core injection. It does not apply to condensate and feedwater, control rod drive flow, or low RPV pressure isolation. The licensee indicated that the caution was placed at the beginning of Step RL-4, because of the physical size of the graphic icons. However, the layout problem was solved by incorrectly making the caution appear applicable to all six items.

- Several action verbs used in EOP 5 - Enclosures were not defined in the either of the Writer's Guides. These included, for example: clamp, drive, inspect, and prevent.

- Action verbs are used inconsistently between the EOP flowcharts and enclosures. For example, "defeat" is used in the flowcharts, while "bypass" is used in the enclosures. By the licensee's definitions, defeat and bypass have different meanings.

- Two new EOP-related labels were not added to local circuit breakers that were to be opened as part of EOP Enclosure 23, "Containment Water Level Determination." The licensee had recently completed a special labeling program in the plant to designate valves, circuit breakers, and displays associated with specific EOP enclosures. However, new labels were not installed on:

  DIV I Hydrogen Analyzer Sample Pump ICMS*P7A breaker
  DIV II Hydrogen Analyzer Sample Pump ICMS*P7B breaker

- During a walkdown of Enclosure 17, "Venting CRD Overpiston Volumes," the inspectors observed that while the procedure directed obtaining "hoses and tools" from the emergency locker, it did not specify which type of tools. As a result, the nonlicensed equipment operator performing the enclosure did not identify the necessary tools for the task and did not realize the need for such tools until reaching the hydraulic control units area. Further investigation indicated that the tools were bagged and stored in the emergency locker; however, labeling in the lower area of the locker did not indicate tools needed to perform Enclosure 17 were stored in that area. In addition, there was no ladder staged in or near the area, even though it appeared necessary to perform the task. Furthermore, there was no emergency lighting in the overhead region where the task would be performed. Under certain conditions, the operator would be required to climb with tools and a flashlight into the overhead area to perform the task.

  This condition was previously identified in Inspection Report 50-458/90-07. While the licensee had corrected a portion of the problem by staging hoses and tools, the need for further evaluation was warranted.

  During telecon discussions on February 15, 1995, the licensee stated their intentions to resolve part of this concern by initiation of a plant hardware modification. Other concerns, such as emergency lighting would be evaluated.

- During the performance of JPM 700-06 "Station Blackout, Opening Control Room Panel Doors," the inspectors observed the examinees executing Enclosure 6 of AOP-0050, Revision 6, "Station Blackout". The enclosure required the operator to open specific control room panel doors for

increased air circulation. It was determined that a typographical error listing Panel P633 was specified in the enclosure. Followup investigation determined the correct designation should have been P631. The inspectors noted that the procedure had been revised in June 1994; however, the error had not been detected at that time nor during the pre-examination JPM validation effort.

During telecon discussions on February 15, 1995, the licensee clarified the circumstances contributing to this finding. The licensee further discussed differences between the EOP and AOP validation and verification processes and their intentions to initiate periodic audit surveillances of the AOPs similar to the existing audit surveillance program conducted for the EOP enclosures.

Additionally, the inspectors evaluated the licensee's corrective action process involving EOPs. This evaluation included an audit of the process for identifying and implementing procedure revisions in the EOPs. For example, the licensee changed the content and limits for Cautions 2 and 5 in EOP 1. The initial safety and environmental checklist was completed along with the safety and environmental evaluation applicability checklist on June 17, 1994. These evaluations included:

- Safety Evaluation (USQD)
- Environmental Evaluation (UEQD)
- Reason for Evaluation
- USAR, Tech Specs, SRP, and other documents reviewed
- Conclusion

Procedure OSP 0008, "Verification and Validation of Emergency Operating Procedures," Revision 5, was followed in the verification and validation of the EOPs. The process included:

- PSTG Verification Checklist
- PSTG Discrepancy Sheet
- EOP Verification Checklist - Human Factor/Technical Correctness
- EOP Discrepancy Sheet
- EOP Validation Checklist
- Procedures Cross-Reference Sheet

Although the inspectors sampled relatively few procedures and performed a limited number of walkdowns, several weaknesses similar to those previously discussed in NRC Inspection Report 50-458/90-07 were identified. In the aggregate, these weaknesses were indicative of an ineffective verification and validation process to the EOPs. Supplement 1 to NUREG-0737 requires that a program for validating the upgrade of EOPs be documented. Procedure OSP-0008, Attachments 3 and 7, specifies the criteria and attributes of the EOP verification and validation process. Item 4 of Section 2.2, "Compatibility," of Attachment 7 to OSP-0008 lists the criteria, "Was all information and equipment adequately specified for the operator to accomplish his task?" One

identified example involved EOP Enclosure 17, "Venting CRD Overpiston Volumes," which did not identify the specific tools for the task. This is a violation of Technical Specification 6.8.1.b, "Requirements of NUREG-0737 and Supplements Thereto" (458/9506-01). Further, no ladder was staged in or near the task area, even though it appeared necessary to perform the task. The other findings listed in Sec' .on 2 of this report also should have been identified and resolved as a result of implementing OSP-0008.

3 FOLLOWUP ON CORRECTIVE ACTIONS TO PREVIOUS INSPECTION FINDINGS (92902)

3.1 (Closed) Violation 50-458/9415-02 "Reactor Mode Switch Out of Position"

This violation involved a failure to comply with Technical Specification 3.3.1-1.b, Table 3.3.1-1, Action 9, which requires, in part, that the reactor mode switch be locked in the "shutdown" position within 1 hour of the time that less than the minimum operable channels per trip system are operable. On June 10, 1994, the reactor mode switch was out of the "shutdown" position for approximately 4 hours during a period when both divisions of the manual scram functional unit were not operable.

A review of the violation documentation indicated that the root cause of the problem was inadequate communications between the work management center supervisor and the control room supervisor. While physical work on the Division II reactor protection system had been completed, functional testing had not been performed. The control room supervisor was erroneously informed that the system was operable and this led the control room supervisor to place the mode switch in the "Startup/Hot Standby" position.

As corrective action for the violation, the licensee conducted the appropriate training with the individuals involved and later incorporated lessons learned training into the LORQ classroom training. In addition, the licensee's Operations Policy 16, "Work Management Center Guidelines," was revised to clarify the responsibilities of the control room supervisor assigned to the work management center regarding compliance with LCO requirements. The licensee's corrective actions appeared sufficient to resolve the concern.

ATTACHMENT 1

1 PERSONS CONTACTED

1.1 Licensee Personnel

*O. Bulich, Licensing Manager
*T. Gates, Licensing Surveillance
*D. Hance, Sr. Licensing Engineer
*M. Jones, Senior Operations Instructor
*L. Lewis, Manager Training
*R. Lundholm, Supervisor, Operations Engineering
*J. McGaha, Vice President Operations
*J. Peters, Licensing Support
*W. Trudell, Operations Superintendent
*J. Venable, Operations Manager
*L. Woods, Supervisor, Operations Training
*G. Zinke, Manager Quality Assurance

1.2 NRC Personnel

*W. Smith, Senior Resident Inspector

In addition to the personnel listed above, the inspectors contacted other personnel during this inspection period.

*Denotes personnel that attended the exit meeting.

2 EXIT MEETING

An exit meeting was conducted on January 27, 1995. During this meeting, the inspectors reviewed the scope and findings of the inspection. The licensee acknowledged the inspection findings as they were presented. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors.

Subsequent to the inspection exit meeting, the licensee did express a position on the findings of this inspection during a conference call conducted on February 15, 1995. The licensee's position is further discussed in Section 2 of this report.

ATTACHMENT 2

SIMULATION FACILITY REPORT

Facility Licensee: Entergy Operations Incorporated (River Bend Station)

Facility Docket: 50-458

Requalification Operating Test Administered on: January 26, 1995

These observations do not constitute audit or inspection findings and are not, without further verification and review, indicative of noncompliance with 10 CFR 55.45(b). These observations do not affect NRC certification or approval of the simulation facility, other than to provide information which may be used in future evaluations. No licensee action is required in response to these observations.

ITEM	DESCRIPTION
Plant Monitoring System (PMS)	During a scenario in which a control rod drifted and a steam leak developed in the RCIC room, the plant monitoring system locked up. The display screens defaulted to their screen saver display.
SPDS does not provide information to the EOF and TSC	During discussions with key simulator staff personnel, it was noted that the simulator's SPDS signal was not transmitted to the EOF and technical support center (TSC) during exercises. The facility is aware of the problem and has a target date of 1996 to correct the problem.
RPV Level modeling	During discussions with operations and key simulator staff personnel, it was noted that RPV level control is not accurately linked with feedwater injection control. The facility is aware of this discrepancy and has targeted 1995 to correct the problem when the new core and thermo-hydraulic computer model is installed.