



NON-CONCURRENCE PROCESS COVER PAGE

The U.S. Nuclear Regulatory Commission (NRC) strives to establish and maintain an environment that encourages all employees to promptly raise concerns and differing views without fear of reprisal and to promote methods for raising concerns that will enhance a strong safety culture and support the agency's mission.

Employees are expected to discuss their views and concerns with their immediate supervisors on a regular, ongoing basis. If informal discussions do not resolve concerns, employees have various mechanisms for expressing and having their concerns and differing views heard and considered by management.

Management Directive, MD 10.158, "NRC Non-Concurrence Process," describes the Non-Concurrence Process (NCP).

The NCP allows employees to document their differing views and concerns early in the decisionmaking process, have them responded to (if requested), and include them with proposed documents moving through the management approval chain to support the decisionmaking process.

NRC Form 757, "Non-Concurrence Process," is used to document the process.

Section A of the form includes the personal opinions, views, and concerns of a non-concurring NRC employee.

Section B of the form includes the personal opinions and views of the non-concurring employee's immediate supervisor.

Section C of the form includes the agency's evaluation of the concerns and the agency's final position and outcome.

NOTE: Content in Sections A and B reflects personal opinions and views and does not represent the official agency's position of the issues, nor official rationale for the agency decision. Section C includes the agency's official position on the facts, issues, and rationale for the final decision.

1. If the process was discontinued, please indicate the reason (and skip to #3):

- Non-concurring employee(s) requested that the process be discontinued
- Subject document was withdrawn

2. At the completion of the process, the non-concurring employee(s):

- Concurred
- Continued to non-concur
- Agreed with some of the changes to the subject document, but continued to non-concur

3. For record keeping purposes:

- This record is non-public and for official use only
- This record has been reviewed and approved for public dissemination

NON-CONCURRENCE PROCESS (Continued)

Date
10/5/2020

Section A - To Be Completed By Non-Concurring Employee

2. Title of Subject Document MD 8.3 Evaluation Decision Documentation for Reactive Inspection - Duane Arnold Energy Center	3. ADAMS Accession Number Not yet available
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4. Document Signer Julio Lara	5. Document Signer's Phone Number (Enter 10 numeric digits) (630) 829-9600
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6. Title of Document Signer Director, Division of Reactor Projects	7. Office (Choose from the drop down list or fill in) RIII
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8. Name of Non-Concurring Employee(s) John David Hanna	9. Employee's Telephone Number (Enter 10 numeric digits) (630) 829-9746
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10. Title of Non-Concurring Employee Senior Reactor Analyst	11. Office (Choose from the drop down list or fill in) RIII
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12. Document Author Document Contributor Document Reviewer On Concurrence

13. Name of Non-Concurring Employee's Supervisor Julio Lara	14. Office (Choose from the drop down list or fill in) RIII
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15. Title of Non-Concurring Employee's Supervisor Director, Division of Reactor Projects	16. Supervisor's Telephone Number (Enter 10 numeric digits) (630) 829-9600
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17. I would like my non-concurrence considered and would like a written evaluation in Section B and C.
 I would like my non-concurrence considered, but a written evaluation in Sections B and C is not necessary.

18. When the process is complete, I would like management to determine whether public release of the NCP Form (with or without redactions) is appropriate (Select "No" if you would like the NCP Form to be non-public):
 Yes No

19. Reasons for the Non-Concurrence, Potential Impact on Mission, and the Proposed Alternatives

- Question B: "Involved a major deficiency in design, construction, or operation having potential generic safety implications."** With regard to the generic applicability to other sites, I believe that there may be a major deficiency in the design of Duane Arnold and other similar sites. The concern, which has been shared with HQ staff and Region 3 management is as follows:

Some population of our commercial reactor fleet may have unacceptably high risk due to (weather related) Losses of Offsite Power coincident with a challenge to the Ultimate Heat Sink (UHS). I am of the opinion that the Duane Arnold event is "telling us something" and I think we, as an agency, should listen. There may be a dependency between weather related LOOPs and service water systems that, if understood and/or estimated may cause the baseline risk for some of our plants to rise to unacceptable levels. To clarify, the population of plants would most likely be limited to: 1) single unit sites, 2) without an SBO EDG - or equivalent, 3) inability to crosstie between Safety Related buses, and 4) either a Service Water system that lacks defense-in-depth and/or has a vulnerable UHS. These are the characteristics all present at DAEC.

Though this is a concern and I am mentioning it here in this Non-Concurrence document, the safety concern IS being evaluated under another process. On/about September 28, 2020, I had asked HQ to review it under the LIC-504 process. NRR/DRA in consultation with Region 3 management has agreed to start the LIC-504 process to review

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the generic concern for other plants in the US fleet (most likely limited to the population described above.) However, it is worth noting that if a 'yes' answer had been given then an AIT or IIT might have been launched, and that type of effort typically reviews the generic applicability.

- **Question D: Led to the loss of a safety function or multiple failures in systems used to mitigate an actual event.**” Having reflected on it and spoken with the other SRA in the Region, I now believe that there was a loss of function and that we should have answered the question in the affirmative. Here are some technical reasons offered as to why it should have been considered a loss of function:
 - GDC 17 discusses the safety function of both the offsite and the onsite power systems. The fact that the system has regulatory requirements, is present in the Duane Arnold Technical Specifications, and is designed with sufficient capacity to support the mitigation of Abnormal Operating Occurrences and Design Basis Accidents informs us that it has a safety function. Modeling of these sources in Probabilistic Risk Assessment confirms that as well.

Criterion 17 --Electric power systems. An onsite electric power system and an offsite electric power system shall be provided to permit functioning of structures, systems, and components important to safety. The safety function for each system (assuming the other system is not functioning) shall be to provide sufficient capacity and capability to assure that (1) specified acceptable fuel design limits and design conditions of the reactor coolant pressure boundary are not exceeded as a result of anticipated operational occurrences and (2) the core is cooled and containment integrity and other vital functions are maintained in the event of postulated accidents.

- The fact that it is not safety-related and is assumed to be unavailable in Final Safety Analysis Report, Chapter 15 analyses does not mean the system does not have a safety function.
- Looking for clarification in the CFR, the definitions in 50.2 did not address “safety function” and only spoke to “safety-related”.
- In my professional opinion, an excessive focus on FSAR, Chapter 15 analyses and enforcement has narrowed our full understanding of safety. And specifically in our evaluation of the Duane Arnold LOOP event it caused us to very narrowly interpret the MD8.3 deterministic questions. Risk helps us to broaden that focus. I don't think we should use legal arguments for decision-making when evaluating whether to apply additional inspection effort.
- Additionally multiple failures did occur on August 10th, including all 6 offsite sources, the 'B' Service Water strainer (causing inoperability of both the 'B' train of Service Water and the 'B' Emergency Diesel Generator, and there was a near loss of the 'A' Service Water strainer. [I am not including the failed Spent Fuel Pool cooling pump 'B' which tripped during the event, because the language in the question states “used to mitigate an event” and I would not consider the SFP system as mitigating equipment.]

One specific concern regarding wording in the Remarks to **Question 'D.'**

I have a concern regarding the following sentence from the deterministic questions and the conclusion section describing the decision: **"The operating experience group is aware of this event and will consider the specifics for further learnings and dissemination."** The reasons I think that this sentence should be eliminated is: 1) it's committing the OpE group to follow-up on this item, and we shouldn't be dedicating resources from a different office in an MD8.3 document... that appears inappropriate to me, and 2) we don't currently know if the generic programs is the appropriate place to follow-up on this issue, namely that several of our plants may have unacceptably high risk from weather-related LOOPs and the dependency with the service water systems. And as you are aware LIC-504 is being considered right now as a possible avenue,

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so I would not want to bias DRA or DORL with this language.

- **Question E: “Involved possible adverse generic implications.”** This question likely should have been answered in the affirmative as well. See my concerns noted above for Question B.
- **Question G: “Involved repetitive failures or events involving safety-related equipment or deficiencies in operations.”** Based on a search of Operational Events conducted by OpE group I think this question should have been answered `yes'. There have been at least three events in Duane Arnold's history where both trains of Service Water were challenged. The details are below:
 - August 11, 2011 - forced shutdown due to excessive silting
 - September 7, 2005 - both RHR SW strainer affected by biological material
 - August 6, 2002 - both RHR SW strainer affected by biological material

Another reason for submitting this Non-Concurrence is that it was **potentially inconsistent with other agency decisions** (namely our regulatory response) when LOOPs have occurred at other sites. The following are examples where LOOPs occurred at Region 3 plants, and Special Inspections were launched:

- Point Beach LOOP on January 16, 2008 - MD8.3 evaluation performed and an SIT performed
- Monticello LOOP on September 17, 2008 - MD8.3 evaluation performed and an SIT performed
- Byron LOOP on January 30, 2012 - MD8.3 evaluation performed and an SIT performed

I am aware that there are also examples where LOOPs have occurred in which Region 3 did not launch a Special Inspection, or even evaluate under the MD8.3 process. That information *could be* used to support an argument that in the case of the Duane Arnold August 10th event, we were consistent with past practices. However I would note two points: 1) the known high risk of LOOPs to our facilities (particularly single unit sites, without SBO EDGs) should make us more likely to default to evaluating such events under the MD8.3 and to send an SIT, and 2) there is an ROP feedback form recently submitted by R3 to NRR recommending changes to the MD8.3 and IMC-0309 process. This feedback form was submitted in order to make the process more risk-informed and improve consistency across all four regions.

Potential Impact on Mission - By not responding in the affirmative to deterministic question(s), a larger and more comprehensive AIT or even IIT was not sent to Duane Arnold. [Please note that the ICCDP for this event ranged from 2E-4 up to 2E-3 and would place the event response in the AIT/IIT overlap region.] The impact of not sending a larger/more comprehensive team means that:

- certain technical aspects of the event (e.g., secondary containment functionality) were not reviewed, or could have been reviewed more rigorously.
- Though the applicability of OpE to DAEC was considered, the potential generic applicability *to other sites* in the US commercial fleet was not addressed. [As noted above, I have requested that the LIC-504 process be entered in order to assess this concern and NRR/DRA has tentatively agreed. However this concern could have been reviewed in a more timely fashion by an AIT or IIT.]
- Information has likely been irretrievably lost, particularly involving the Service Water strainers. The `B' Service Water strainer was significantly impacted during the event and the `A' strainer was degraded and the “proximity” to a Station Blackout due to the failure of both EDGs will be difficult to assess. This has potential impact on our understanding of the event and consequentially the Accident Sequence Precursor program and the yearly 2020 report to Congress.

20. Signature and Date of Non-Concurring Employee

John D. Hanna

Digitally signed by John D. Hanna
Date: 2020.09.22 10:32:33 -05'00'

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Date
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Section B - To Be Completed By Non-Concurring Employee's Supervisor

2. Title of Subject Document MD 8.3 Evaluation Decision Documentation for Reactive Inspection - Duane Arnold Energy Center	3. ADAMS Accession Number Not yet available
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4. Name of Non-Concurring Employee's Supervisor Julio Lara	5. Office (Choose from the drop down list or fill in) RIII
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6. Title of Non-Concurring Employee's Supervisor Director, Division of Reactor Projects	7. Supervisor's Telephone Number (Enter 10 numeric digits) (630) 829-9600
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8. Comments for the NCP Reviewer to Consider

The non-concurring employee presents disagreement in how three MD 8.3 Deterministic questions were answered by RIII staff:

Question D - "Led to the loss of a safety function or multiple failures in systems used to mitigate an actual event,"
 Question E - "Involved possible adverse generic implications," and
 Question G - "Involved repetitive failures or events involving safety-related equipment or deficiencies in operations."

The employee expresses a view that the questions should have been answered as "Y", thereby requiring a risk evaluation (which was performed), which in turn would have resulted in an agency decision to perform an AIT or IIT reactive inspection.

The draft MD 8.3 evaluation had been completed and concurred upon by the Duane Arnold Acting Branch Chief, non-concurring employee (SRA), and DRS Division Director. As the DRP Director, I was in the process of reviewing the draft MD 8.3 document when I was informed that the employee was no longer concurring on the draft MD 8.3.

In my review of the draft MD 8.3 document, I was informed by the guidance contained in MD 8.3, as well as the conclusions contained in the D. Dorman memo to M. Doane, "Implementing Commission Direction on Applying Risk Informed Principles in Regulatory Decision Making," dated, November 18, 2019. I will also note that a feedback form has been submitted to NRR/DRO to further provide flexibilities in answering the MD 8.3 deterministic questions consistent with the thoughts provided in Dorman-Doane memo.

For completeness, I am attaching the draft MD 8.3 document which was under my review. I note that the document for my review is different than that provided in the NCP submittal. I request that the employee and Reviewer review this document in establishing the Summary of Issues.

9. Signature and Date of Non-Concurring Employee's Supervisor Julio F. Lara	Digitally signed by Julio F. Lara Date: 2021.01.22 10:23:27 -06'00'
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Section C - To Be Completed By NCP Coordinator

2. Title of Subject Document MD 8.3 Evaluation Decision Documentation for Reactive Inspection - Duane Arnold Energy Center		3. ADAMS Accession Number Not yet available
4. Name of NCP Coordinator Geoffrey Miller	5. Office (Choose from the drop down list or fill in) RIV	
6. Title of NCP Coordinator Deputy Director, Division of Reactor Safety	7. Coordinator's Telephone Number (Enter 10 numeric digits) (817) 200-1180	

8. Agreed Upon Summary of Issues

1. Question B should be answered "Yes" because the event did involve a major deficiency in design of Duane Arnold having potential generic safety implications. Specifically, the common cause potential/unexpected system interactions associated with weather-related LOOPs and service water clogging/failures at single unit sites
2. Question D should be answered "Yes" because the event did involve both a loss of safety function (offsite power system, normal heat removal) and multiple failures in a system used to mitigate an actual event (service water/EDGs)
3. In the Remarks section of Question D, the sentence, "The operating experience group is aware of this event and will consider the specifics for further learnings and dissemination." should be deleted because it commits resources from another office and it is currently unknown if the generic programs is the appropriate place to follow-up on this issue, given that several of our plants may have unacceptably high risk from weather-related LOOPs and a dependency with Service Water failures (e.g., LIC-106 or LIC-504 might be needed).
4. Question E should be answered "Yes" because the event did involve potential generic consequences
5. Question G should be answered "Yes" because the event did involve repetitive events involving a safety-related system (service water)
6. The conclusion of "No additional inspection" is potentially inconsistent with NRC precedent for LOOP events.

9. Evaluation of Non-Concurrence and Rationale for Decision
Executive Summary

The August 10, 2020, event at Duane Arnold was potentially risk significant and warranted consideration for chartering a reactive inspection. The response determination and inspection activities conducted by Region III were appropriate given the facts and circumstances surrounding the event. However, the MD 8.3 evaluation should be revised to clarify the answers to the deterministic questions and the basis for the reactive inspection response.

In addition, the reviewer identified the deterministic questions in MD 8.3 are subject to interpretation and appear to have been inconsistently applied across regions and over time. Further, the structure of MD 8.3 to consider risk only after a deterministic criterion is met is inconsistent with Commission guidance and with the Agency's vision of becoming a more modern risk-informed regulator. MD 8.3 should be revised to direct risk consideration at the start of the decision-making process, with clarifying guidance in the form of deterministic criteria should the risk of the event warrant additional inspection consideration.

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RECOMMENDATIONS

1. Revise the response to Question D to provide only the basis for answering the deterministic question (e.g., "No; No safety-related systems were affected"). Relocate the remaining information in the existing document associated with the reactive inspection decision basis to the "Response Decision" section of the MD 8.3 evaluation, ensuring the full basis for the response decision is clearly documented.
2. Relocate the statement in Question D, "The operating experience group is aware of this event and will consider the specifics for further learnings and dissemination," to the cover letter for the MD 8.3 evaluation and rephrase it to something similar to "Region III will/has provided this information to NRR/IOEB for their consideration for action as appropriate." Consider issuing a memorandum from the Director, DRP/RIII to Director, NRR/DRO as an option to provide the information to the operating experience group. The cover letter could also capture additional actions being taken outside the inspection program in response to this event (i.e., LIC-504 process).
3. Revise Event Description section of MD 8.3 evaluation to clarify or remove the statement that the event had no impact on the ability to cool down the plant.
4. Request a revision of MD 8.3 to provide clarification of the intent of the deterministic questions and to require performance of a risk evaluation prior to considering deterministic criteria.

Scope of Review

In the performance of this assessment, the reviewer evaluated the information in the subject document against the information provided in Management Directive 8.3, "NRC Incident Investigation Program"; Inspection Manual Chapter (IMC) 0309, "Reactive Inspection Decision Basis for Reactors"; IMC 0305, "Operating Reactor Assessment Program"; Inspection Procedure (IP) 93812, "Special Inspection Team"; IP 93800, "Augmented Inspection Team"; D. Dorman memo to M. Doane, "Implementing Commission Direction on Applying Risk Informed Principles in Regulatory Decision Making," dated November 18, 2019; Region IV Operating Policy Guide 0801.6, "Management Directive 8.3 and Inspection Manual Chapter 0309 Reactive Team Inspection Decisions, Implementation, and Documentation for Power Reactors"; multiple past MD 8.3 evaluations completed in Region IV for events involving loss of offsite power and/or loss of normal heat removal events; and the reviewer discussed MD 8.3 deterministic criteria with Senior Reactor Analysts in RIV.

Results

The reviewer concluded the facts and circumstances of the event at Duane Arnold were understood well enough to preclude the need for additional reactive inspection by a reactive inspection team. As stated in MD 8.3, the objectives of an augmented inspection team are to conduct a timely, thorough, and systematic inspection related to significant events at facilities licensed by the NRC; assess the health and safety significance of the event and communicate to regional and headquarters management the facts and safety or security concerns related to the event so that appropriate follow up actions can be taken; and collect, analyze, and document factual information and evidence sufficient to determine the cause(s), conditions, and circumstances pertaining to the event. Per IP 93812, the inspection objective of a special inspection team is to promptly disseminate the facts, conditions, circumstances, and causes of significant events and to identify appropriate follow up actions. The reviewer concluded the cause of the August 10, 2020, event at Duane Arnold was clearly understood as the external weather event. Subsequent inspection by the resident inspection staff augmented by inspectors from the Region III office concluded the equipment at Duane Arnold responded as expected and consistent with the licensing basis of the facility and identified no substantive issues with operator performance. The reviewer therefore concluded the actions taken by

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Region III in response to the event were appropriate to the circumstances.

The reviewer's analysis of each of the specific concerns from the Summary of Issues is provided below:

1. Question B should be answered "Yes" because the event did involve a major deficiency in design of Duane Arnold having potential generic safety implications. Specifically, the common cause potential/unexpected system interactions associated with weather-related LOOPs and service water clogging/failures at single unit sites.

Disagree. The response of the structures, systems, and components at Duane Arnold to the event on August 10, 2020, was consistent with the licensing basis of the facility. **RECOMMENDATION:** no changes.

2. Question D should be answered "Yes" because the event did involve both a loss of safety function (offsite power system, normal heat removal) and multiple failures in a system used to mitigate an actual event (service water/EDGs).

Disagree; agree in part. Through review of prior MD 8.3 evaluations and discussions with senior reactor analysts, the reviewer identified a variation in the interpretation and response to this question. For example, prior MD 8.3 evaluations in Region IV for loss of feed events at boiling water reactors answered "Yes" to this question because feedwater is the preferred system for short-term decay heat removal at BWRs, whereas other evaluations answered "No" because feedwater is not safety-related. Similar arguments are found in MD 8.3 evaluations involving losses of offsite power. If the intent of this question is solely to drive the performance of a risk evaluation, a lower threshold involving nonsafety-related systems may be appropriate. In cases where the risk has been evaluated (as is the case with Duane Arnold), the threshold of safety-related systems relied upon in the accident analyses is more appropriate. The program office should revise and clarify the intent of this question, with consideration for performing a risk evaluation at the beginning of the process to risk-inform the decision-making process. **RECOMMENDATION:** Revise the response to Question D to provide succinctly only the basis for answering the deterministic question (e.g., "No: No safety-related systems were affected"). Relocate the remaining information in the existing document associated with the reactive inspection decision basis to the "Response Decision" section of the MD 8.3 evaluation. Request revision of MD 8.3 to provide clarification of the intent of this question and to perform a risk evaluation prior to considering deterministic criteria.

3. In the Remarks section of Question D, the sentence, "The operating experience group is aware of this event and will consider the specifics for further learnings and dissemination." should be deleted because it commits resources from another office and it is currently unknown if the generic programs is the appropriate place to follow-up on this issue, given that several of our plants may have unacceptably high risk from weather-related LOOPs and a dependency with Service Water failures (e.g., LIC-106 or LIC-504 might be needed).

Agree. The sentence does not provide support of the decision basis for the deterministic question being answered. **RECOMMENDATION:** Relocate this statement to the cover letter for the MD 8.3 evaluation and rephrase it to something similar to "RIII will/has provided this information to NRR/IOEB for their consideration for action as appropriate." Consider issuing a memorandum from the Director, DRP/RIII to Director, NRR/DRO as an option to provide the information to the operating experience group. The cover letter could further capture additional actions being taken outside the inspection program in response to this event (i.e., LIC-504 process).

4. Question E should be answered "Yes" because the event did involve potential generic consequences

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Disagree; agree in part. This question is very broad in that it does not provide a threshold for what could be considered "generic," which introduces a great deal of subjectivity to the responses. As with Question D, this question appears to have been subject to broad interpretation. **RECOMMENDATION:** Request revision of MD 8.3 to provide clarification of the intent of this question and to perform a risk evaluation prior to considering deterministic criteria.

5. Question G should be answered "Yes" because the event did involve repetitive events involving a safety-related system (service water).

Disagree. The essential service water system and emergency diesel generators functioned throughout the event. **RECOMMENDATION:** No changes.

6. The conclusion of "No additional inspection" is potentially inconsistent with NRC precedent for LOOP events.

Agree. Each event must be considered on a site-specific case by case basis. Given the wide variation in the licensing and design bases of the U.S. nuclear fleet, some level of variation is to be expected. This variation is exacerbated by the subjectivity inherent in some of the deterministic criteria as noted above.

RECOMMENDATION: Request revision of MD 8.3 to provide clarification of the intent of the deterministic questions and to perform a risk evaluation prior to considering deterministic criteria.

Though not included in the Summary of Issues, the reviewer determined the statement in the event description, "The loss of cooling towers had **no impact** on the plant's ability to shut/cool down or remain shut down" (emphasis added) should be clarified or deleted. The loss of the normal/preferred means of heat removal complicated operator response and would have resulted in this event being counted against performance indicator IE-04, "Unplanned Scrams with Complications," in recognition of the higher risk associated with such events as described in NEI 99-02, "Regulatory Assessment Performance Indicator Guideline." A more accurate statement would be "The loss of the cooling towers did not **preclude** the ability to shut/cool down the plant..." **RECOMMENDATION:** Revise event description to clarify or remove the statement that the event had no impact on the ability to cool down the plant.

Conclusions

The August 10, 2020, event at Duane Arnold was potentially risk significant and warranted consideration for chartering a reactive inspection. The performance of a risk assessment was appropriate to risk inform the decision-making process. The response determination and inspection activities conducted by Region III were also appropriate given the facts and circumstances surrounding the event; however, the MD 8.3 evaluation should be revised to clarify the answers to the deterministic questions and the basis for the reactive inspection response.

In addition, the reviewer identified the deterministic questions in MD 8.3 are subject to interpretation and appear to have been inconsistently applied across regions and over time. Further, the structure of MD 8.3 to consider risk only after a deterministic criterion is met is inconsistent with Commission guidance and with the Agency's vision of becoming a more modern risk-informed regulator. MD 8.3 should be revised to direct risk consideration at the start of the decision-making process, with clarifying guidance in the form of deterministic criteria should the risk of the event warrant additional inspection consideration.

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Date
10/5/2020

10. Signature and Date of NCP Coordinator

Geoffrey B. Miller

 Digitally signed by Geoffrey B. Miller
Date: 2020.11.16 15:49:29 -06'00'

11. Signature and Date of NCP Approver

Kenneth G. O'Brien

 Digitally signed by Kenneth G. O'Brien
Date: 2021.01.22 07:45:26 -06'00'