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

March 18, 2021

Mr. Steven Vercelli, Site Vice President,
Entergy Operations, Inc.
5485 U.S. Highway 61N
St. Francisville, LA 70775

SUBJECT: RIVER BEND STATION – BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000458/2021010 AND NOTICE OF VIOLATION

Dear Mr. Vercelli:

On February 12, 2021, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at your River Bend Station and discussed the results of this inspection with you and other members of your staff. The results of this inspection are documented in the enclosed report.

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. However, the team identified weaknesses associated with categorization of issues documented in condition reports and with taking appropriate actions to address non-cited violations. Specifically, the team identified a finding associated with identifying and classifying adverse conditions in the corrective action program, a finding associated with corrective action of a previous non-cited violation, a finding associated with failing to restore compliance associated with a non-cited violation, and other observations that highlighted these performance gaps.

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 upon the interviews and document reviews, the team found that your organization appeared to have a safety conscious work environment where individuals felt free to raise concerns without fear of retaliation. Most expressed positive experiences after raising issues to their supervisors and documenting issues in condition reports, all individuals indicated that they would not hesitate to raise safety concerns. However, the team noted that some individuals did not always have positive experiences raising safety concerns by some methods

and assessed that additional focus is warranted to build trust within the radiation protection and instrumentation and control groups to ensure individuals continue to feel free to raise concerns.

The enclosed report discusses a violation associated with a finding of very low safety significance (Green). The NRC evaluated this violation in accordance Section 2.3.2 of the NRC Enforcement Policy, which can be found at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The violation is cited in Enclosure 1, Notice of Violation (Notice), and the circumstances surrounding it are described in detail in the subject inspection report (Enclosure 2). This violation is being cited in the Notice because it did not meet the criteria to be treated as a non-cited violation since your staff failed to restore compliance within a reasonable period of time after the violation was identified consistent with Section 2.3.2 of the Enforcement Policy. You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. If you have additional information that you believe the NRC should consider, you may provide it in 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.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. If you have additional information that you believe the NRC should consider, you may provide it in 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.

Additionally, two findings of very low safety significance (Green) are documented in this report. One of these findings involved a violation of NRC requirements. We are treating this violation as a non-cited violation consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violations or the significance or severity of the violations documented in this inspection report, 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 River Bend Station.

If you disagree with a cross-cutting aspect assignment or a finding not associated with a regulatory requirement 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 River Bend Station.

In accordance with 10 CFR 2.390 of the NRC's "Agency Rules of Practice and Procedure," a copy of this letter, its enclosures, and your response will be made available electronically for public inspection in the NRC Public Document Room or in the NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC website at http://www.nrc.gov/reading-rm/adams.html. To the extent possible, any response should not include any personal privacy or proprietary information so that it can be made available to the public without redaction.

If you have any questions regarding this matter, you may contact Mr. Douglas Dodson at 817-200-1436.

Sincerely,

Ami Agrawal

Digitally signed by Ami Agrawal
Date: 2021.03.19 08:50:12 -05'00'

Ami N. Agrawal, Team Leader
Inspection Program and Assessment Team
Division of Reactor Safety

Docket No. 05000458
License No. NPF-47

Enclosures:
1. Notice of Violation
2. Inspection Report 05000458/2021010

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RIVER BEND STATION – BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000458/2021010 AND NOTICE OF VIOLATION – DATED MARCH 18, 2021

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ADAMS ACCESSION NUMBER: **ML21064A220**
■ SUNSI Review ADAMS: ☐ Non-Publicly Available ■ Non-Sensitive Keyword:NRC-002
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NOTICE OF VIOLATION

Entergy Operations, Inc.
River Bend Station

Docket No. 05000458
License No. NPF-29

During an NRC inspection conducted from January 25 through February 12, 2021, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is listed below:

> Technical Specification 5.4.1.a, requires, in part, that procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Section 4.o of Appendix A to Regulatory Guide 1.33, Revision 2, requires instructions for the operation of the feedwater system.
>
> Contrary to the above, from June 1, 2019, to February 10, 2021, the licensee failed to establish, implement, and maintain applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, Section 4.o for the operation of the feedwater system. Specifically, the licensee established Procedures SOP-0009, “Reactor Feedwater System (SYS #107),” Revision 80 - 82, and OSP-0053, “Emergency and Transient Response Support Procedure,” Revision 27 and 28, to meet the Regulatory Guide 1.33 requirement, and the licensee failed to maintain these procedures for feedwater operation to include necessary precautions to prevent operation of the system in an improper lineup.

This violation is associated with a Green SDP finding.

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, TX 76011, and a copy to the NRC Resident Inspector at the River Bend Station, and email it to R4Enforcement@nrc.gov 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.

Because 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 website at http://www.nrc.gov/reading-rm/adams.html, to the extent possible, it should not include any personal privacy or proprietary 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).

Dated this 18th day of March 2021

U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Number:	05000458
License Number:	NPF-47
Report Number:	05000458/2021010
Enterprise Identifier:	I-2021-010-0005
Licensee:	Entergy Operations, Inc.
Facility:	River Bend Station
Location:	St. Francisville, LA
Inspection Dates:	January 25, 2021 to February 12, 2021
Inspectors:	D. Dodson, Senior Reactor Inspector R. Kumana, Senior Resident Inspector D. Reinert, Reactor Inspector A. Sanchez, Senior Project Engineer
Approved By:	Ami N. Agrawal, Team Leader Inspection Program and Assessment Team Division of Reactor Safety

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting a biennial problem identification and resolution inspection at River Bend Station, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to https://www.nrc.gov/reactors/operating/oversight.html for more information.

List of Findings and Violations

Failure to Follow Corrective Action Program Procedures			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Barrier Integrity	Green FIN 05000458/2021010-01 Open/Closed	[P.1] - Identification	71152B
The inspectors identified a Green finding associated with the licensee's failure to follow procedure EN-LI-102, "Corrective Action Program." Specifically, procedure EN-LI-102 requires the licensee to identify and classify adverse conditions in their corrective action program. On six occasions, the licensee failed to classify conditions adverse to quality associated with safety-related radiation monitors as adverse conditions in their corrective action program.			

Failure to Adequately Correct Radiation Monitor Calibration Frequencies			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Occupational Radiation Safety	Green NCV 05000458/2021010-02 Open/Closed	[H.13] - Consistent Process	71152B
The inspectors identified a Green finding and associated non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to correct calibration frequencies for area and airborne particulate process radiation monitors that were not being performed at the frequencies specified in the Updated Final Safety Analysis Report (UFSAR).			

Failure to Restore Compliance Associated with Technical Specification Required Procedures			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Initiating Events	Green NOV 05000458/2021010-03 Open	[P.3] - Resolution	71152B
The Inspectors identified a Green cited violation of Technical Specification 5.4.1.a for failure to maintain procedures required by Regulatory Guide 1.33, Revision 2, Appendix A. Specifically, the NRC issued a violation for failure to maintain adequate procedures for feedwater system operation on April 29, 2020, and the licensee failed to restore compliance within a reasonable amount of time.			

Additional Tracking Items

None.

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

Starting on March 20, 2020, in response to the National Emergency declared by the President of the United States on the public health risks of the coronavirus (COVID-19), inspectors were directed to begin telework. In addition, regional baseline inspections were evaluated to determine if all or portion of the objectives and requirements stated in the IP could be performed remotely. If the inspections could be performed remotely, they were conducted per the applicable IP. In some cases, portions of an IP were completed remotely and on site. The inspections documented below met the objectives and requirements for completion of the IP.

OTHER ACTIVITIES – BASELINE

71152B - Problem Identification and Resolution

Biennial Team Inspection (IP Section 02.04) (1 Sample)

(1) The inspectors performed a biennial assessment of the licensee's corrective action program, use of operating experience, self-assessments and audits, and safety conscious work environment.

- Corrective Action Program Effectiveness: The inspectors assessed the corrective action program's effectiveness in identifying, prioritizing, evaluating, and correcting problems. The team also evaluated the station's compliance with NRC regulations and licensee standards for corrective action programs. The inspectors sampled over 220 condition reports and their associated cause evaluations, if applicable. The inspectors also conducted five-year reviews of the recirculation system, the reactor core isolation cooling (RCIC) system, and the chilled water system, which included reviews of failures, maintenance issues, surveillances, corrective and preventive maintenance, reliability, and maintenance rule performance. Additionally, the inspectors reviewed all findings and violations issued during the biennial period.

- Operating Experience, Self-Assessments and Audits: The inspectors assessed the effectiveness of the station's processes for use of operating experience, audits and self-assessments. The sample included industry operating experience communications like 10 CFR Part 21 notifications and other vendor correspondence, NRC generic communications, publications from various industry groups, and site evaluations. The sample also included reviews of licensee self-assessments and internal audits.

- Safety Conscious Work Environment: The inspectors assessed the effectiveness of the station's programs to establish and maintain a safety-conscious work environment. The team interviewed 23 employees and contractors, observed interactions between licensee employees and management during routine meetings, reviewed employee concerns files, interviewed the Employee Concerns Program coordinator, and reviewed safety culture survey results.

INSPECTION RESULTS

Assessment	71152B

Corrective Action Program Effectiveness

Based on the samples reviewed, the team determined that the licensee's corrective action program complied with regulatory requirements and self-imposed standards. The licensee's performance in each of the areas of Problem Identification, Problem Prioritization and Evaluation, and Corrective Actions adequately supported nuclear safety. The team noted weaknesses associated with the licensee's categorization of issues documented in condition reports and with taking appropriate actions to address non-cited violations.

Problem Identification

The team found that the licensee was identifying and documenting problems at an appropriately low threshold that supported nuclear safety. During the 2-year assessment period, the licensee initiated over 12,000 conditions reports, including approximately 3,400 condition reports associated with conditions adverse to quality. However, the team noted in interviews that writing a condition report was not the default method for many when they raised safety concerns, and some individuals indicated that they had not or did not frequently write condition reports. All individuals indicated that they would be willing to write condition reports, but this could be impacting the size of the total population of condition reports and adverse conditions that are ultimately identified.

Problem Prioritization and Evaluation

In general, the team found that the licensee was adequately prioritizing and evaluating problems; however, the team identified a weakness associated with evaluating adverse conditions associated with safety-related equipment issues and quality related procedure compliance. Specifically, the team noted 12 examples (six associated with finding and other six associated with minor violation) of condition reports that were inappropriately categorized as non-adverse conditions. In each of these examples, the team determined that these conditions represented adverse conditions. Considering the sample size of approximately 75 condition reports categorized as non-conditions adverse to quality, the team determined that this represented a weakness. This report documents Green FIN 05000458/2021010-01, "Failure to Follow Corrective Action Program Procedures," and a minor performance deficiency associated with this weakness.

In addition to noting a weakness associated with evaluating adverse conditions associated with safety-related equipment issues and quality related procedure compliance, the team noted at least nine examples of issues where the licensee did not demonstrate a robust questioning attitude in its evaluations and chose not to evaluate, identify, and correct underlying programmatic or human performance related causes of issues. Examples

identified by the team included the following:

· On April 30, 2020, the NRC completed a special inspection (inspection report 05000458/202050) related to several issues with FLEX equipment, like diesel generators and other electrical components. The licensee took corrective actions to resolve these issues associated with failing to set up equipment according to approved design criteria. However, since the special inspection there have been four additional issues with the diesel generators that have prevented successful surveillance tests and rendered the equipment non-functional. In each case condition reports were written (CR-RBS-2020-0445, CR-RBS-2021-0344, CR-RBS-2021-0751, and CR-RBS-2021-0773), and the CRs were categorized as having category C significance, requiring broke-fix resolution in accordance with approved corrective action procedures. To date, the NRC has not identified any performance deficiencies with these equipment issues but continues to inspect these issues, as appropriate. The team also noted that none of these issues were evaluated with a root cause or adverse condition analysis to determine underlying causes. The inspectors noted that the issues are maintenance related (loose and worn cooling fan belts, wires not properly landed in wiring harnesses, a leaking cooling system nipple, and a damaged heater) and are adversely impacting the availability and reliability of the FLEX diesel generators. In each case, the component deficiencies were resolved, but the licensee has not classified these issues as a degrading trend or determined any underlying human performance or programmatic causes for the continued deficiencies.

· CR-RBS-2020-03056 and its evaluation documents that a non-safety-related relief valve was installed in a safety-related reactor core isolation cooling (RCIC) system application. The condition was evaluated; however, affirmation that current work management processes would not cause a similar incorrect installation in the future did not occur.

· CR-RBS-2017-07237 and its evaluation documents a failure to have adequate instructions from a vendor for RCIC testing. The licensee corrected this condition, but no effort was made to understand why the licensee had inadequate instructions from a vendor.

· CR-RBS-2019-03018 and its evaluation documents a loss of a safety related DC bus. Through interviews, the inspectors determined that the issue appeared to be caused by work planning issues during an outage. Although the bus condition was corrected, the condition report was categorized as a broke-fix, and correcting potential underlying causes was not prioritized.

· CR-RBS-2018-6018 and its evaluation document the station's identification that a corrective action to prevent recurrence associated with a bent turbine governor valve caused a 2018 trip. However, the condition report did not seek to understand why the 2012 corrective action to prevent recurrence was not completed.

· CR-RBS-2019-06990 documents an inadequately evaluated maintenance rule functional failure associated with a safety-related containment cooler failure. The cause evaluation associated with the inadequately evaluated maintenance rule functional failure determined that the issue was too old to determine a cause of the inadequate evaluation.

· CR-RBS-2019-07454 documents a feedwater pump oil pipe fatigue failure associated with a missing pipe clamp. The licensee corrected the condition and installed a new pipe clamp. However, no effort was made to understand why the pipe clamp was not installed.

· CR-RBS-2019-01976 documents a loss of normal service water and initiation of standby service water. The licensee's evaluation noted that there was some leak by from the normal service water system to the standby service water system. Though, no context (quantification or acceptability) was discussed in the evaluation, and the evaluation did not consider whether the leakage could have contributed to the event.

· CR-RBS-2020-02095 documents that the preventive maintenance frequency for a residual heat removal (RHR) train C room floor drain check valve was inappropriately moved to 40 years. Although the licensee corrected the preventive maintenance frequency, the underlying causes for the inadequate preventive maintenance frequency change were not considered in the licensee's evaluation.

The licensee's procedures provide a great deal of flexibility with respect to categorizing conditions and performing (or not performing) evaluations. The team determined that the flexibility was most frequently used by the licensee to justify lesser evaluations that did not identify underlying causes. In each of these cases, the inspectors did not identify any more-than-minor performance deficiencies, but the team assessed that a very strong corrective action program would have been more interested in the underlying causes of these safety-related and important issues and taken more action to evaluate and learn more from them.

Corrective Actions

The team concluded that River Bend Station generally developed effective corrective actions for the problems evaluated in the corrective action program. River Bend Station generally implemented these corrective actions in a timely manner, commensurate with their safety significance. However, the team identified a weakness associated with taking appropriate actions to address non-cited violations. Specifically, the team identified one non-cited violation for which the licensee failed to restore compliance, and for another non-cited violation the inspectors determined that the licensee did not take appropriate corrective actions to address the issue. As a result, this report documents Green NOV 05000458/2021010-03, "Failure to Restore Compliance Associated with Technical Specification Required Procedures," and Green NCV 05000458/2021010-02, "Failure to Adequately Correct Radiation Monitor Calibration Frequencies." These issues suggest to the inspection team that the station is not rigorously considering issues documented in findings and violations and adequately correcting the conditions.

Similarly, the team determined the licensee's response to the only identified significant condition adverse to quality and root cause evaluation was not timely. Specifically, the station performed a root cause evaluation in 2019 associated with a recirculation pump oil consumption issue that required a power reduction to add oil. This root cause evaluation was the only root cause evaluation performed over the last two years. Considering the station determined the issue was a significant condition adverse to quality, the inspectors expected the licensee would have promptly identified the root cause and corrected the condition. However, as of the inspection, the licensee had not identified a root cause, a planned temporary modification to mitigate the condition was not installed during two recent forced outages, and the final actions to correct the condition are not expected to be completed until June 2023. Although the inspectors did not identify any failures to follow procedures or other performance deficiencies associated with this issue, the inspectors assessed that in this example the licensee did not demonstrate timely corrective action and decision making.

Assessment	71152B

Use of Operating Experience

The team reviewed a variety of sources of operating experience including part 21 notifications and other vendor correspondence, NRC generic communications, publications from various industry groups. The team determined that River Bend Station is adequately screening and addressing issues identified through operational experience that apply to the station and that this information is evaluated in a timely manner once it is received.

Assessment	71152B

Use of Self-Assessment & Audits

The team reviewed a sample of River Bend's departmental self-assessments and audits to assess whether performance trends were regularly identified and effectively addressed. The team also reviewed audit reports to assess the effectiveness of assessments in specific areas. Overall, the team concluded that the licensee had an adequate departmental self-assessment and audit process.

The team noted two observations in this area. Specifically, the team noted that CR-HQN-2018-00153 evaluated gaseous and area radiation monitors to ensure the monitors complied with the licensing and design basis. However, this evaluation did not identify the issues documented by NCV 2019004-02, which was associated with the radiation monitor calibration discrepancies and alignment with the Updated Safety Analysis Report. The team determined this was a missed opportunity. Additionally, the team noted that the station may not be taking full advantage of Nuclear Independent Oversight (NIOS) and self-assessment insights. For example, the pre-problem identification and resolution self-assessment of the 2019 root cause evaluation associated with the recirculation pump oil consumption issue was similar to the NRC team's independent assessment. However, in response to the self-assessment, the licensee's evaluation determined that procedures were being followed and the self-assessment concerns were dismissed without additional actions being taken. Although the team did not identify any more-than-minor performance deficiencies in either case, the team views this as another missed opportunity for the station to holistically consider if the root cause evaluation was being treated with appropriate urgency.

Assessment	71152B

Safety Conscious Work Environment (SCWE)

The team conducted safety conscious work environment interviews with 23 employees and contractors from eight different disciplines (chemistry, engineering, electrical maintenance, instrumentation and controls, health physics, mechanical maintenance, operations, and security). The team also observed interactions between employees during routine condition report screening and management oversight meetings, and the team interviewed the Employee Concerns Program coordinator and reviewed the results of the latest safety culture surveys and any case files that may relate to safety conscious work environment.

Based upon the interviews and document reviews, the team found that the licensee had a

safety conscious work environment where individuals felt free to raise concerns without fear of retaliation. Most expressed positive experiences after raising issues to their supervisors and after documenting issues in condition reports, and all individuals indicated that they would not hesitate to raise safety concerns.

However, the inspectors noted that some individuals did not have positive experiences raising safety concerns to the outage control center at the end of outages; some individuals indicated that they were not sure that their concerns mattered; one individual indicated he/she would not use the Employee Concerns Program again; and some individuals indicated some issues could have been addressed more promptly. Though, all individuals were still willing to raise safety concerns through their chain of command or in a condition report.

Additionally, the inspectors noted that the station's pre-PI&R self-assessment noted that the radiation protection group "is an outlier in the area of morale and leader/work relationships." Considering this self-assessment input and many other inputs, including interviews, Employee Concerns Program input, safety culture surveys, and other insights, the inspectors independently assessed that additional focus is warranted to build trust within the radiation protection and instrumentation and control groups to ensure that individuals continue to feel free to raise concerns.

Failure to Follow Corrective Action Program Procedures			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Barrier Integrity	Green FIN 05000458/2021010-01 Open/Closed	[P.1] – Identification	71152B

The inspectors identified a Green finding associated with the licensee's failure to follow procedure EN-LI-102, "Corrective Action Program." Specifically, procedure EN-LI-102, Revision 42, requires the licensee to identify and classify adverse conditions in the corrective action program. On six occasions, the licensee failed to classify conditions adverse to quality associated with safety-related radiation monitors as adverse conditions in the corrective action program.

Description: During a review of selected condition reports, the inspectors identified six condition reports that were classified as "non adverse" by the licensee. The inspectors reviewed the associated conditions and found that six condition reports issued between November 12, 2019, and November 29, 2020, documented failures, malfunctions, and non-conformances of safety-related components that affected their safety-related function. Procedure EN-LI-102 defines an adverse condition to include a condition adverse to quality. The procedure further defines a "condition adverse to quality" as, "a failure, malfunction, deficiency, deviation, defect, or nonconformance associated with the performance of an activity affecting the safety-related function of a structure, system or component [(SSC)]."

The six condition reports (CR-RBS-2019-07312; CR-RBS-2020-01861; CR-RBS-2020-02301; CR-RBS-2020-05053; CR-RBS-2020-04607; and CR-RBS-2019-07281) were associated with the containment atmosphere gaseous and particulate radiation monitor (RE-111), one of two reactor building annulus monitors (RE-11B), and one of two residual heat removal heat exchanger radiation monitors (RE-15A). Each of these monitors is safety-related. The inspectors noted that the impact on the safety function was not described in the associated

condition reports. Of the six condition reports, the inspectors determined that the most significant impact was the failure of the reactor building annulus monitor RE-11B data transfer signal documented in CR-RBS-2020-04607. This failure resulted in one of two instruments being incapable of performing its design and safety functions of alerting operators in the control room of high radiation in the reactor building annulus and automatic actuation of one train of the standby gas treatment system on a high reactor building annulus radiation signal.

Section 5.4 of procedure EN-LI-102 provides instructions on screening of condition reports. In particular, Step 8 describes the required actions of the Performance Improvement Review Group (PRG). Specifically, Step 8.c states that the PRG, "Classifies the [condition report] based on risk significance as identified in Attachment 1." EN-LI-102 Attachment 1, "Condition Report Classification Guidance," specifies that adverse conditions are to be given a classification of A, B, C or D, depending on the significance. The six condition reports identified by the inspectors were classified as "N," or non-adverse. The inspectors noted that a classification of "non-adverse" would result in allowing the condition to be given a lower priority, to not be tracked to completion, or to not be corrected. In addition, none of these conditions were evaluated for functionality to ensure that the affected safety-related functions described in the Updated Final Safety Analysis Report were still met.

Corrective Actions: The licensee entered this issue into its corrective action program and verified that the associated conditions in the condition reports had ultimately been corrected.

Corrective Action References: CR-RBS-2021-00794

Performance Assessment:

Performance Deficiency: The licensee failed to follow corrective action program procedures and appropriately classify six condition reports associated with safety-related radiation monitors. Specifically, the licensee inappropriately classified the condition reports as non-adverse and failed to determine whether the affected safety-related radiation monitors could perform their safety and design basis functions.

Screening: The inspectors determined the performance deficiency was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern and impacted the SSC and barrier performance attribute of the Barrier Integrity Cornerstone objective. Specifically, continuing to fail to treat conditions associated with these SSCs as adverse conditions has resulted in and will continue to result in these SSCs not being evaluated for functionality when equipment degradation occurs, and could result in these radiation monitors not being able to perform their safety-related functions during design basis events. In the case of the failure of the reactor building annulus monitor RE-11B (CR-RBS-2020-04607), this failure resulted in one of two instruments being incapable of performing its design and safety functions of alerting operators in the control room of high radiation in the reactor building annulus and automatic actuation of one train of the standby gas treatment system on a high reactor building annulus radiation signal, and the issue was not given the appropriate priority within the corrective action program.

Significance: The inspectors assessed the significance of the finding using Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." The inspectors determined that the performance deficiency was Green because it affected the SSC and barrier performance attribute of the Barrier Integrity Cornerstone objective and only represents a degradation of the radiological barrier function for the auxiliary building and standby gas treatment system.

Cross-Cutting Aspect: P.1 - Identification: The organization implements a corrective action program with a low threshold for identifying issues. Individuals identify issues completely, accurately, and in a timely manner in accordance with the program. Specifically, individuals did not describe the issues entered in the corrective action program in sufficient detail to ensure they can be appropriately prioritized, trended, and assigned for resolution, which resulted in the licensee failing to follow corrective action program procedures.

Enforcement: Inspectors did not identify a violation of regulatory requirements associated with this finding.

Failure to Adequately Correct Radiation Monitor Calibration Frequencies			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Occupational Radiation Safety	Green NCV 05000458/2021010-02 Open/Closed	[H.13] - Consistent Process	71152B

The inspectors identified a Green finding and associated non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to correct calibration frequencies for area and airborne particulate process radiation monitors that were not being performed at the frequencies specified in the Updated Final Safety Analysis Report (UFSAR).

Description: The inspectors reviewed the licensee's response to NCV 2019004-02. The NCV stated the licensee had not maintained process, effluent, and area radiation monitors calibrated periodically, annually, or per the 2-year refueling frequency as stated in the UFSAR. In response to the NCV, the licensee initiated condition report CR-RBS-2019-07493 in November 2019 to evaluate and adjust the calibration frequencies. The licensee evaluated the calibration frequencies for all 55 UFSAR radiation monitors listed in UFSAR Tables 11.5 and 12.3 (this group did not include Technical Specification radiation monitors) and adjusted the calibration frequency for all 55 monitors to four years. Of these 55 monitors, 39 have still not been calibrated since 2019. Three of the eight airborne particulate continuous radiation monitors, which are a subset of the radiation monitors listed in Table 12.3-2, "Airborne Process and Effluent Radiation Monitors," have not been calibrated since 2005 or 2006; these radiation monitors fall under UFSAR Section 12.3.4.2.5, which states that these radiation monitors are calibrated annually.

The inspectors reviewed the adjusted frequencies and noted that UFSAR Section 12.3.4.1.5 states the following regarding area radiation monitors, "In-plant calibration, using a standard radioactive point source traceable to NIST, is done at each refueling or whenever maintenance work is performed on the detectors or in accordance with the Technical Specifications/Requirements." Similarly, the inspectors identified that UFSAR Section 12.3.4.5.2 states that for airborne particulate process radiation monitors, "Each continuous monitor is calibrated annually using the secondary radionuclide standards."

The inspectors questioned why the licensee's new strategy of calibrating detectors every four years did not match the refueling outage and annual frequencies described in UFSAR Sections 12.3.4.1.5 and 12.3.4.2.5, respectively. The licensee informed the inspectors that they had considered the UFSAR frequency descriptions but had interpreted the descriptions to mean the calibration frequency could be set at the licensee's discretion in accordance with the licensee's preventative maintenance strategy. The inspectors noted that the UFSAR

Sections 12.3.4.1.5 and 12.3.4.2.5 had not been changed or specifically evaluated for change.

The inspectors also noted the licensee used its preventative maintenance change process checklist, Attachment 9.1 to Procedure EN-DC-324, "Preventative Maintenance Program," Revision 22, to justify the change to the four-year frequency. Along with other factors, the checklist has the change evaluator consider any licensing or regulatory commitments and any design bases documents that could affect the proposed change. The checklist forms that were completed for the calibration frequency change noted "a non-cited violation for failure to maintain an adequate calibration frequency of the [UFSAR] radiation monitors," but the checklist neither identified the specific frequencies described in Sections 12.3.4.1.5 and 12.3.4.2.5 of the UFSAR (and as discussed in the NCV), nor evaluated these discrepancies. The inspectors learned through interviews that these discrepancies should have been specifically identified and evaluated before proceeding with the change. The inspectors determined that the licensee's preventative maintenance change process did not appropriately consider all design bases documents prior to adjusting the calibration frequencies for all 55 UFSAR radiation monitors to four years.

Corrective Actions: The licensee entered this issue in the corrective action program to re-evaluate and align the UFSAR and preventative maintenance calibration frequencies. For those detectors that had not been recently calibrated in accordance with the UFSAR specified frequencies the licensee reviewed historic data and observed no adverse performance trends.

Corrective Action References: CR-RBS-2021-00482 and CR-RBS-2021-00744

Performance Assessment:

Performance Deficiency: The failure to properly calibrate radiation monitors in accordance with UFSAR specified frequencies and adequately correct the conditions identified in NCV 2019004-02 is a performance deficiency.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the Plant Facilities/Equipment and Instrumentation attribute of the Occupational Radiation Safety cornerstone and adversely affected the cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Specifically, the failure to properly calibrate radiation monitors impacts the ability to mitigate radiation dose to workers and the public from radioactive material during routine civilian nuclear reactor operation. Consequently, the failure to calibrate or verify the calibration of these plant radiation monitors impacts the licensee's ability to ensure accurate radiation measurements; three of the 55 UFSAR monitors, which the UFSAR states are calibrated annually, have not been calibrated since 2005 or 2006.

Significance: The inspectors assessed the significance of the finding using Appendix C, "Occupational Radiation Safety SDP." The inspectors determined the finding to be of very low safety significance (Green) because it was not an as low as reasonably achievable (ALARA) issue, there was no overexposure or substantial potential for overexposure, and the licensee's ability to assess dose was not compromised.

Cross-Cutting Aspect: H.13 - Consistent Process: Individuals use a consistent, systematic approach to make decisions. Risk insights are incorporated as appropriate. Specifically,

individuals did not demonstrate an understanding of the decision-making process and use it consistently in 2019 when making changes to the preventive maintenance frequencies utilizing Procedure EN-DC-324, “Preventive Maintenance Program.”

Enforcement:

Violation: Title 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” 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.

Contrary to the above, from October 22, 2019, until February 12, 2021, the licensee failed to establish measures to assure that a condition adverse to quality was promptly identified and corrected. Specifically, the licensee failed to adequately correct the conditions outlined in NCV 2019004-02 and ensure calibration frequencies for area radiation monitors that were not being calibrated at the specific frequencies described in UFSAR section 12.3.4.1.5, and airborne particulate process continuous radiation monitors that were not being calibrated on an annual frequency as described in in UFSAR section 12.3.4.2.5 matched design basis information.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

Failure to Restore Compliance Associated with Technical Specification Required Procedures			
Cornerstone	Significance/Severity	Cross-Cutting Aspect	Report Section
Initiating Events	Green NOV 05000458/2021010-03 Open	[P.3] – Resolution	71152B

The Inspectors identified a Green cited violation of Technical Specification 5.4.1.a for failure to maintain procedures required by Regulatory Guide 1.33, Revision 2, Appendix A. Specifically, the NRC issued a violation for failure to maintain adequate procedures for feedwater system operation on April 29, 2020, and the licensee failed to restore compliance within a reasonable amount of time.

Description: Following a review of a reactor scram that occurred on May 31, 2019, the inspectors identified that the procedures governing operation of the feedwater system during normal and abnormal conditions, SOP-0009, “Reactor Feedwater System (SYS #107),” and OSP-0053, “Emergency and Transient Response Support Procedure,” did not contain precautions to ensure that a heater string was in service prior to feedwater pump operation. Consequently, following the scram on May 31, 2019, the licensee started a feedwater pump with no heater string in service, resulting in a second loss of feedwater, loss of reactor water level, and a second scram actuation on low water level following the initial reactor scram. Technical Specification 5.4.1.a requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, dated February 1978. Regulatory Guide 1.33, Revision 2, Appendix A, Section 4.o identifies procedures governing the operation of the feedwater system as recommended procedures. The inspectors determined that the failure to include necessary precautions in the two procedures was a failure to maintain them in accordance with TS 5.4.1.a. In inspection report 05000458/2020001 the NRC issued a Green NCV of Technical Specification 5.4.1.a for

failure to maintain required procedures.

The licensee documented this violation in condition report CR-RBS-2020-00965. This condition report was closed to two actions taken under condition report CR-RBS-2019-03891. Corrective action CA-2 developed interim guidance for operation, and corrective action CA-13 reviewed all procedures for accurate technical data. These actions had already been closed at the time CR-RBS-2020-00965 was issued to document the violation. Neither of the actions addressed the inadequate procedural guidance on preventing operation of a feedwater pump with no feedwater heater string in service.

The inspectors noted that EN-LI-102, "Corrective Action Program," Step 5.6.2.l requires, "Corrective action descriptions must be worded to ensure the Adverse Condition or cause/factor is addressed and the corrective action is tracked to completion." However, the inspectors determined that none of the corrective actions developed were worded to ensure the adverse condition was addressed, and all condition reports addressing the issue were closed. As a result, the inadequate procedures were not corrected.

Corrective Actions: The licensee initiated the required changes to the affected procedures through their procedure change process.

Corrective Action References: CR-RBS-2021-00644

Performance Assessment:

Performance Deficiency: The failure to restore compliance by correcting procedure inadequacies identified in NCV 2020001-03 was a performance deficiency. Specifically, the licensee failed to correct inadequate procedures SOP-0009 and OSP-0053 for operation of the feedwater system, as described in NCV 2020001-03.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the Procedure Quality attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, station procedures for reactor feedwater system operation, SOP-0009 and OSP-0053, do not contain sufficient precautions or guidance to ensure that a heater string is in service prior to feedwater pump operation, which has been shown to be necessary to prevent an unplanned loss of feedwater, loss of reactor water level control, and scram actuation.

Significance: The inspectors assessed the significance of the finding using Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." The inspectors determined that the finding was of very low safety significance (Green) 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.

Cross-Cutting Aspect: P.3 - Resolution: The organization takes effective corrective actions to address issues in a timely manner commensurate with their safety significance. Specifically, corrective actions did not resolve and correct the identified issues described in NCV 2020001-03, which resulted in the licensee failing to restore compliance.

Enforcement:

Violation: Technical Specification 5.4.1.a, requires, in part, that procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Section 4.o of Appendix A to Regulatory Guide 1.33, Revision 2, requires instructions for the operation of the feedwater system.

Contrary to the above, between June 1, 2019, until February 10, 2021, the licensee failed to establish, implement, and maintain applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Specifically, the licensee established procedures SOP-0009, "Reactor Feedwater System (SYS #107)," Revision 82, and OSP-0053, "Emergency and Transient Response Support Procedure," Revision 28, to meet the Regulatory Guide 1.33 requirement, and the licensee failed to maintain these procedures for feedwater operation to include necessary precautions to prevent operation of the system in an improper lineup.

Enforcement Action: This violation is being cited because the licensee failed to restore compliance within a reasonable period of time after the violation was identified consistent with Section 2.3.2 of the Enforcement Policy.

Minor Performance Deficiency	71152B

Minor Performance Deficiency: The inspectors identified six examples of a minor performance deficiency associated with the licensee failing to follow corrective action program procedures and appropriately classify six condition reports, which included issues with a safety-related containment cooler failing to start, a minor NRC identified violation, and other failures to follow quality-related procedures. Specifically, EN-LI-102, "Corrective Action Program," Revision 42, Section 5.4, Step 8, requires, in part, that, "The Performance Improvement Review Group (PRG) performs the following: Determines if the condition is [a] significant condition adverse to quality, a condition adverse to quality, or non-adverse." EN-LI-102 defines an adverse condition to include a condition adverse to quality, and the licensee inappropriately classified condition reports CR-RBS-2013-1901; CR-RBS-2019-05538; CR-RBS-2019-5724; CR-RBS-2019-6383; CR-RBS-2020-00100; and CR-RBS-2020-2326 as non-adverse conditions. These classification issues were entered into the corrective action program as CR-RBS-2021-00466, CR-RBS-2021-00688, CR-RBS-2021-00782.

Screening: The inspectors determined the performance deficiency was minor. The inspectors determined the performance deficiency did not adversely affect a cornerstone objective, would not lead to a more significant safety concern if left uncorrected, and could not reasonably be viewed as a precursor to a significant event.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On February 12, 2021, the inspectors presented the biennial problem identification and resolution inspection results to Steven Vercelli and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Calculations	PN-317	MELC - Max Flood Elevations for Moderate Energy Line Cracks in CAT 1 Structures	Revision 2
71152B	Corrective Action Documents	Condition Reports (CR)-HQN-YYYY-NNNNN	2018-00153; 2019-01617; 2020-00201; 2020-01416	
71152B	Corrective Action Documents	Condition Reports (CR)-RBS-YYYY-NNNNN	2010-01587; 2013-01053; 2013-01901; 2013-02068; 2015-03983; 2015-08476; 2016-04353; 2017-01151; 2017-01511; 2017-07237; 2017-07710; 2017-07728; 2017-08377; 2018-00780; 2018-01917; 2018-02524; 2018-02592; 2018-02739; 2018-03804; 2018-03866; 2018-03938; 2018-03965; 2018-04134; 2018-04419; 2018-04625; 2018-05213; 2018-05816; 2018-06018; 2018-06363; 2019-00399; 2019-01220; 2019-01258; 2019-01613; 2019-01723; 2019-01740; 2019-01787; 2019-01796; 2019-01805; 2019-01825; 2019-01895; 2019-01976; 2019-02067; 2019-02260; 2019-02342; 2019-02496; 2019-02589; 2019-02643; 2019-02665; 2019-02799; 2019-02861; 2019-02928; 2019-02985; 2019-02992; 2019-03014; 2019-03018; 2019-03019; 2019-03114; 2019-03118; 2019-03271; 2019-03391; 2019-03599; 2019-03600; 2019-03649; 2019-03727; 2019-03853; 2019-03871; 2019-03891; 2019-03904; 2019-03961; 2019-04039; 2019-04087; 2019-04135; 2019-04139; 2019-04203; 2019-04386; 2019-04480; 2019-04541; 2019-04715; 2019-04936; 2019-05021; 2019-05056; 2019-05128; 2019-05199; 2019-05416; 2019-05652; 2019-05709; 2019-05724; 2019-05861; 2019-06380; 2019-06383; 2019-06513; 2019-06521; 2019-06523; 2019-06525; 2019-06526; 2019-06836; 2019-06871; 2019-06941; 2019-06990; 2019-07025; 2019-07040; 2019-07137; 2019-07281; 2019-07312; 2019-07343; 2019-07454; 2019-07493; 2019-07531; 2019-07566; 2019-07844; 2019-07993; 2020-00100; 2020-00136; 2020-00295; 2020-00470; 2020-00530; 2020-00724; 2020-00748; 2020-00964; 2020-00965; 2020-01049; 2020-	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			01264; 2020-01292; 2020-01311; 2020-01344; 2020-01548; 2020-01535; 2020-01660; 2020-01712; 2020-01723; 2020-01826; 2020-01861; 2020-01907; 2020-01928; 2020-02002; 2020-02081; 2020-02095; 2020-02109; 2020-02301; 2020-02326; 2020-02336; 2020-02385; 2020-02491; 2020-02502; 2020-02689; 2020-02764; 2020-02858; 2020-02884; 2020-03002; 2020-03014; 2020-03049; 2020-03050; 2020-03056; 2020-03110; 2020-03196; 2020-03199; 2020-03272; 2020-03276; 2020-03309; 2020-03375; 2020-03445; 2020-03450; 2020-03494; 2020-03497; 2020-03573; 2020-03599; 2020-03601; 2020-03625; 2020-03649; 2020-03687; 2020-03729; 2020-03746; 2020-03783; 2020-03785; 2020-03800; 2020-03811; 2020-03817; 2020-03858; 2020-03886; 2020-03889; 2020-03908; 2020-03929; 2020-03939; 2020-03950; 2020-04019; 2020-04025; 2020-04031; 2020-04057; 2020-04063; 2020-04064; 2020-04065; 2020-04105; 2020-04107; 2020-04232; 2020-04313; 2020-04400; 2020-04401; 2020-04415; 2020-04446; 2020-04607; 2020-04773; 2020-05053; 2020-05263; 2020-05302; 2021-00268; 2021-00327; 2021-00329; 2021-00334; 2021-00344; 2021-00350; 2021-00353; 2021-00357; 2021-00376; 2021-00377; 2021-00378; 2021-00379; 2021-00380; 2021-00392; 2021-00411; 2021-03599	
71152B	Corrective Action Documents Resulting from Inspection	Condition Reports (CR)-RBS-YYYY-NNNNN	2021-00403; 2021-00466; 2021-00482; 2021-00610; 2021-00644; 2021-00688; 2021-00744; 2021-00782	
71152B	Engineering Changes	EC-84539	Connect Stainless Steel Tubing to B33-PC001A Bearing Oilers Vent	Revision 0
71152B	Engineering Changes	EC-84735	Temporary Modification to Install Backup SVV Compressor	Revision 0
71152B	Miscellaneous		Site MRM River Bend	October 5, 2020
71152B	Miscellaneous		OSRC 2019-009 Meeting Minutes	
71152B	Miscellaneous		OSRC 2019-013 Meeting Minutes	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Miscellaneous		OSRC 2020-001 Meeting Minutes	
71152B	Miscellaneous		OSRC 2020-010 Meeting Minutes	
71152B	Miscellaneous	2019-07	July 2019 DPRM-Maintenance	
71152B	Miscellaneous	2019-10	October 2019 DPRM-Maintenance	
71152B	Miscellaneous	2019-11	November RBS APRM	
71152B	Miscellaneous	2020-01	January 2020 DPRM-Maintenance	
71152B	Miscellaneous	2020-04	April 2020 DPRM-Maintenance	
71152B	Miscellaneous	2020-04	April Operations DPRM	
71152B	Miscellaneous	2020-04	April RP DPRM	
71152B	Miscellaneous	2020-04	April Training DPRM	
71152B	Miscellaneous	2020-07	July SPMS DPRM	
71152B	Miscellaneous	2020-10	October 2020 DPRM-Maintenance	
71152B	Miscellaneous	Amendment No. 199	Issuance of Amendments to Adopt TSTF-529, "Clarify Use and Application Rules"	09/11/2019
71152B	Miscellaneous	ECP Case Files		
71152B	Miscellaneous	EN-NE-G-026	Engineering Guide Probabilistic Safety Assessment	
71152B	Miscellaneous	EN-PL-161	Zero Tolerance for Unanticipated Equipment Issues	Revision 0
71152B	Miscellaneous	EN-PL-161	Zero Tolerance for Unanticipated Equipment Issues	Revision 1
71152B	Miscellaneous	EN-PL-161	Zero Tolerance for Unanticipated Equipment Issues	Revision 2
71152B	Miscellaneous	Operating Experience (OE)-NOE-YYYY-NNNNN	2019-00130; 2019-00142; 2019-00147; 2019-00194; 2019-00206; 2019-00209; 2019-00221; 2019-00222; 2019-00238; 2020-00016; 2020-00041; 2020-00067; 2020-00087; 2020-00093; 2020-00099; 2020-00142; 2020-00144; 2020-00154; 2020-00180; 2020-00190; 2020-00199	
71152B	Miscellaneous	QA-12-18-2019-RBS-1	Technical Specification Audit Report	
71152B	Miscellaneous	QA-16-2020-RBS-1	Security Audit Report	
71152B	Miscellaneous	QA-4-2020-RBS-1	Engineering Design Control Audit	
71152B	Miscellaneous	QA-7-2019-RBS-1	Emergency Preparedness Audit Report	
71152B	Miscellaneous	QA-7-2020-RBS-	QA-7-2020-RBS-1	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		1		
71152B	Miscellaneous	RLP-STM-0108-LO	Moisture Separator Reheaters, Feedwater Heaters, Extraction Steam, and Drains	Revision 1
71152B	Miscellaneous	SDC-402/410	Control Building Chilled Water System/Ventilation Chilled Water System Design Criteria System Numbers 402 & 410	Revision 5
71152B	Miscellaneous	WT-WTRBS-2019-00578		
71152B	Miscellaneous	WTRBS-2019-0032		
71152B	Procedures	AOP-0006	Condensate/Feedwater Failures	Revision 26
71152B	Procedures	AOP-0007	Loss of Feedwater Heating	Revision 34
71152B	Procedures	EN-DC-115	Engineering Change Process	Revision 30
71152B	Procedures	EN-DC-136	Temporary Modifications	Revision 20
71152B	Procedures	EN-DC-144	System Health Reporting	Revision 2
71152B	Procedures	EN-DC-153	Preventive Maintenance Component Classification	Revision 19
71152B	Procedures	EN-DC-153	Preventive Maintenance Component Classification	Revision 20
71152B	Procedures	EN-DC-153	Preventive Maintenance Component Classification	Revision 21
71152B	Procedures	EN-DC-167	Classification of Structures, Systems, and Components	Revision 11
71152B	Procedures	EN-DC-175	Single Point Vulnerability Process Review	Revision 10
71152B	Procedures	EN-DC-204	Maintenance Rule Scope and Basis	Revision 4
71152B	Procedures	EN-DC-205	Maintenance Rule Monitoring	Revision 4
71152B	Procedures	EN-DC-324	Preventive Maintenance Program	Revision 22
71152B	Procedures	EN-LI-102	Corrective Action Program	Revision 37
71152B	Procedures	EN-LI-102	Corrective Action Program	Revision 42
71152B	Procedures	EN-LI-113	Licensing Basis Document Change Process	Revision 20
71152B	Procedures	EN-LI-118	Causal Analysis Process	Revision 33
71152B	Procedures	EN-NS-231	Protected Area Search	Revision 3
71152B	Procedures	EN-OP-104	Operability Determination Process	Revision 15
71152B	Procedures	EN-OP-104	Operability Determination Process	Revision 16
71152B	Procedures	EN-OP-115-01	Operator Watchstation Logs and Rounds	Revision 4
71152B	Procedures	EN-OP-125	Fire Brigade Drills	Revision 0
71152B	Procedures	EN-TQ-104	Engineering Support Personnel Training Program	Revision 27
71152B	Procedures	EN-TQ-125	Fire Brigade Drills	Revision 10

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Procedures	LO-RLO-2018-0124	Maintenance and Technical Training Self-Assessment	12/18/2019
71152B	Procedures	OSP-0053	Emergency and Transient Response Procedure	Revision 28
71152B	Procedures	RLO-2018-0154	Integrity Willful Misconduct Audit - DCRM	04/11/2019
71152B	Procedures	SOP-0007	Condensate System (Sys#104)	Revision 311
71152B	Procedures	SOP-0007	Condensate System (Sys#104)	Revision 313
71152B	Procedures	SOP-0009	Reactor Feedwater System (Sys#107)	Revision 82
71152B	Procedures	STP-209-6310	RCIC Quarterly Pump and Valve Operability Test	Revision 41
71152B	Self-Assessments	HQN-LO-2020-0013	Integrity Audit Report	07/22/2020
71152B	Self-Assessments	HQN-LO-2020-0014	Integrity Audit Report	10/17/2020
71152B	Self-Assessments	LAR-2019-0170	Integrity Audit Report	01/21/2020
71152B	Self-Assessments	LO-HQNLO-2020-00005	Integrity Audit Report	08/19/2019
71152B	Self-Assessments	LO-RLO-2017-013	CR-RBS-2015-07532 Effectiveness Review	02/17/2017
71152B	Self-Assessments	LO-RLO-2018-0100	CR-RBS-2018-3969 Effectiveness Review	12/18/2018
71152B	Self-Assessments	LO-RLO-2018-0138	Equipment Reliability Operating Experience Assessment	02/15/2019
71152B	Self-Assessments	LO-RLO-2019-0153	Assessment of RBS Monthly Status Report Dashboard	11/12/2019
71152B	Self-Assessments	QS-2020-RBS-010		
71152B	Self-Assessments	RLO-2018-0056	Operating Experience Self-Assessment	12/23/2018
71152B	Self-Assessments	RLO-2018-0108	2019 Pre-NRC Emergency Planning Program Inspection Assessment	03/18/2019
71152B	Self-Assessments	RLO-2018-0112	Pre-NRC Self-Assessment: Radioactive Gaseous and Liquid Effluent Treatment IP 71124.06 Radioactive Environmental Monitoring Program IP 71124.07	04/04/2019
71152B	Self-Assessments	RLO-2018-0169	Equipment Database Assessment	06/11/2019
71152B	Self-Assessments	RLO-2018-0175	Operations Leadership Informal Self-Assessment	12/22/2019
71152B	Self-Assessments	RLO-2018-0186	Operations Field Verification Assessment	01/09/2020

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Self-Assessments	RLO-2019-0115	B1 Operating Experience Review Self-Assessment	08/13/2020
71152B	Self-Assessments	RLO-2019-0132	Focused Crew Assessment - E Crew	08/05/2020
71152B	Self-Assessments	RLO-2019-0152	2020 Maintenance and Technical Training OJT/TPE Self-Assessment	09/10/2020
71152B	Self-Assessments	RLO-2020-0017	2020 PI&R Readiness Assessment	09/24/2020
71152B	Self-Assessments	RLO-2020-0036	Annual Safeguards Self-Assessment per EN-NS-204, Protection of Unclassified Safeguards Info (Rev 17)	10/20/2020
71152B	Work Orders	366982; 521918; 527439; 527440; 527446; 527447; 527447; 527448; 527449; 527450; 527451; 532550; 541999; 542000; 19019054; 52613219; 200000683		