Official Transcript of Proceedings

NUCLEAR REGULATORY COMMISSION

Title: Predecisional Enforcement Conference
RE River Bend Station

Docket Number: (n/a)

Location: Teleconference

Date: Monday, August 16, 2021

Work Order No.: NRC-1612 Pages 1-173

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UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION

PREDECISIONAL ENFORCEMENT CONFERENCE

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IN THE MATTER OF

River Bend Station

_____

Monday, August 16, 2021

Via Video Teleconference

The above-entitled matter came on for predecisional enforcement conference at 8:30 a.m. CDT

From the Nuclear Regulatory Commission:

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DOUG DODSON, R-IV/ACES

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JOHN KRAMER, R-IV/ACES

PETE SNYDER, OE/EB

GAYLE WALKER, OI

[REDACTED], OI

[REDACTED], OI

REGINALD AUGUSTUS, OGC/GCHA/GCA

GREG PICK, R-IV/DRS/EB2

Also Present:

KENT SCOTT, Site Vice President, River Bend Station

TIM SCHENK, Manager Regulatory Assurance, Entergy

JEFF REYNOLDS, Senior Operations Manager, River Bend Station

KIMBERLY COOK-NELSON, Chief Operating Officer, Entergy

TIFFANY BABAN, Senior Manager, Fleet Inspection Services, Entergy

DANNY JAMES, Shift Operations Manager, River Bend Station

MARK FELTNER, Assistant Operations Manager, Entergy

MANDY HALTER, Vice President, Regulatory Assurance,

Entergy

BRIDGET JOHNS, Senior Licensing Specialist, Entergy

STEPHANIE PYLE, Director, Nuclear Licensing, Entergy

JOHN GIBBONS, Security Shift Supervisor, Entergy

ANNA JONES, Assistant General Counsel, Entergy

CHARLES THEBAUD, Counsel for Entergy

RON GASTON, Director Regulatory Compliance, Entergy

AGENDA

P R O C E E D I N G S

8:51 a.m.

MS. VOSSMAR: All right, welcome to the meeting, and sorry for the delay. So, I'll kick it off. As you know, today is August 16, 2021. We welcome you all to today's virtual predecisional enforcement conference for River Bend Station.

This conference is closed to public observation because it involves the findings of an NRC Office of Investigations report that has not been publicly disclosed.

My name is Patricia Vossmar. I'm a Senior Project Engineer in the Region IV office and I'm coordinating today's PEC.

Please allow me a moment to quickly go through some of the meeting logistics. I'll start by saying that this conference is being transcribed and we request that participants please speak loudly enough for the microphones to pick up your voice and identify yourself before speaking.

We do not normally release copies of the transcript outside of the NRC, but we will consider requests for the transcript made under the Freedom of

Information Act after we have completed our enforcement action in this case.

A couple of administrative type topics, today's presentation is run via Webex. We are using this platform for both video and audio participation in the conference. Using Webex, you should be able to view both the presenter's slide show presentations and hearing the presenters speaking, as well as see their video.

As you all know, the unfortunate COVID trends have driven us to hold this meeting virtually versus our initial plan of holding it in person. In order to try and --

(Telephonic interference.)

MS. VOSSMAR: -- as much of the in-person experience as possible, please keep your camera on if you are a conference presenter or key participant.

Note if you are purely here in an observer capacity, you may keep your camera off in order to allow us to spotlight the conference participants and to help us preserve bandwidth with the number of participants.

Please also note that if you'd like to

better see the other participants in the meeting, there is a sliding button in between the slide show image that you see on your screen and the videos toward the top of your screen. You can slide that up or down to expand or minimize the relative sizes of the presentation slides and the videos of the meeting participants which you can adjust to your liking.

Participants on the Webex meeting are not muted. Accordingly, we ask you to please mute yourselves when you are not speaking. I'd also like to ask everyone to please silence --

(Telephonic interference.)

MS. VOSSMAR: -- during this PEC. We will have one scheduled 15-minute break at approximately 10:30 a.m., so, if possible, please utilize that time to handle personal calls or business.

There will also be a schedule time toward the end of the meeting for the participants, NRC, and River Bend Station to caucus in their individual private spaces.

This is the agenda for today's meeting. The flow of this meeting will go as follows: we'll have opening remarks and introductions by John

Monninger. He'll offer an opportunity for Entergy to also introduce themselves.

Mike Hay will then go through the predecisional enforcement conference process. Doug Dodson will discuss the enforcement policy and process. Jason Kozal, and he's not mentioned here, but Nick Taylor as well, the two of them will go through the NRC summary of apparent violations. Then, we will provide an opportunity for Entergy to provide their presentation.

Then, we will go through questions and discussion. After that, we will have an NRC caucus and an associated break, and then we'll do one more question and answer discussion session. After that, we will move toward closing remarks.

Note that during the time labeled licensee presentation, we do plan to ask questions via a brief Q&A session after each apparent violation you discuss as you move through your presentation.

After you complete your presentation, we'll then open it up to that final additional Q&A session for the NRC participants to ask questions. Please note that copies of the agenda had been made

available to participants as part of our meeting notice.

At this time, I will now turn it over to Mr. John Monninger, the Region IV Deputy Regional Administrator, for opening remarks and introductions. Please note that following introductions, I will be locking the meeting to assure that no unexpected --

(Telephonic interference.)

MS. VOSSMAR: -- join the meeting. If you drop off during the meeting, you will be placed in the lobby and I'll admit you back into the meeting.

If an expected participant needs to join the meeting after we have begun, please help me out and indicate this in the Webex chat so that I'm prepared to admit them when they rejoin. The floor is yours, John.

MR. MONNINGER: All right, thanks, Trisha, and good morning to everyone, and thank you very much for joining us today. I'm John Monninger. I'm the NRC's Deputy Regional Administrator for our Region IV office based in Arlington, Texas, and I welcome you today.

As Trisha mentioned, we ask that all

conference participants please use the video. That will allow ourselves to ensure that we are more effectively communicating with each other.

Please make sure that if you are a conference participant, you turn your camera on at this time if you haven't already done so. First, we'll go through NRC introductions and then I'll turn it over to Entergy for your introduction.

Today's predecisional enforcement conference is being conducted at the request of the River Bend Station and is concerning several items identified during the NRC's review of Entergy's confidential corrective action program.

During this conference, we will discuss three apparent willful violations of NRC requirements that we're evaluating under the NRC's traditional enforcement process of our enforcement policy.

These apparent violations involve the administration of a training exam, performance of operator rounds, and the control of critical digital asset access keys.

The apparent violations were described in an NRC inspection report issued to River Bend Station

on July 1. That's inspection report 2021-090.

At this time, I would like to ask that other NRC scheduled presenters and key participants to please introduce themselves. I'll turn it over first to Mike.

MR. HAY: Great, thanks, John, and good morning, folks. My name is Mike Hay. I'm the Deputy Director of the Division of Reactor Projects in Region IV, and I'll turn it over to Doug Dodson. Thank you.

MR. MONNINGER: You're on mute, Doug. Doug, you were muted there.

MS. VOSSMAR: You're still muted.

MR. DODSON: Can you hear me now? Got it, all right. Thanks. Good morning. I'm Doug Dodson. I'm the Acting Team Leader for the Allegations, Coordination, and Enforcement staff, and next is Jason Kozal.

MR. KOZAL: Good morning, everyone. My name is Jason Kozal. I'm the Branch Chief in Projects Branch C, Division of Reactor Projects. I'm responsible for the River Bend Station. I'll turn it over to Nick.

MR. TAYLOR: Hello, I'm Nick Taylor. I'm

the Branch Chief for Engineering Branch II in Region IV, responsible for a number of functional areas, including in-service inspection and cybersecurity. Thank you.

MR. CYLKOWSKI: Hello and good morning, David Cylkowski. I'm a Regional Counsel in NRC Region IV, and I'll turn it to Ryan if he is still on the line.

MR. LANTZ: Yeah, this is Ryan Lantz. I'm the Director of the Division of Reactor Safety. I'm actually not a key participant today, just signing in as an interested party, and I will be signing off here fairly quickly, but have a good conference.

MR. MILLER: This is Geoff Miller, Deputy DRS. I'm going to be covering for Ryan while he's off.

MR. MONNINGER: All right, and again, these NRC folks will plan to leave their cameras on during the meeting. Now we'll take a moment or so to introduce other NRC personnel that we have on the line.

MR. KRAMER: Hi, it's John Kramer. I'm a Senior Enforcement Specialist in Region IV.

MS. VOSSMAR: Trisha Vossmar, Senior SPE, which I've already introduced myself.

MR. SNYDER: Pete Snyder, Headquarters Enforcement Specialist, NRC Headquarters.

MS. WALKER: Good morning, Gayle Walker. I'm a Special Agent in Charge, Office of Investigations. As well, other participants that's actually attending is Special Agent **[REDACTED]** and **[REDACTED]** who is a Senior Special Agent.

MR. AUGUSTUS: This is Reggie Augustus, General Counsel's Office, Headquarters, NRC.

MR. PICK: Greg Pick, Senior Reactor Inspector, Engineering Branch II.

MR. MONNINGER: Okay, it sounds like we probably have most NRC participants, so next I'll ask Entergy and the River Bend Station representatives to introduce themselves, and if you have any opening remarks, you may provide them at this time. The floor is yours, Mr. Kent Scott, and welcome.

MR. REYNOLDS: Hey, good morning. My name is Jeff Reynolds. I'm the Director of Regulatory Assurance and Performance Improvement at River Bend Station.

In the room with me, we have Bridget Johns, Bonnie Bryant, Tiffany Baban, Mark Feltner, Danny James, Mandy Halter, Stephanie Pyle, and John Gibbons. On the phone with us, we have Anna Jones, Chuck Thebaud, Ron Gaston, and Kimberly Cook-Nelson. That's all of the Entergy team.

MR. MONNINGER: Okay, is there --

MR. REYNOLDS: I'm sorry.

MR. MONNINGER: -- any opening remarks?

MR. REYNOLDS: I'm sorry, I left off at the table with me is Kent Scott, Site VP, and Tim Schenk, Reg Assurance Manager. So, we'll save our remarks for when our presentation starts. Thank you.

MR. MONNINGER: Okay, and thank you very much. And just a reminder to all conference participants, please state your name and, of course, your affiliation as the meeting is being transcribed.

So, we'll turn the meeting over to Mike Hay who will run us through the enforcement conference process.

MR. HAY: Great, thanks, John. As previously discussed, this conference is closed to public observation because it involves three

investigations that were performed by the NRC's Office of Investigations and the investigative reports have not been publicly disclosed.

Also, as a reminder, the meeting is being transcribed by a court reporter that's present in the meeting with us today.

While the discussions occurring during the conference today are not under oath, the transcript will allow us to have an official record of what was discussed should we need to refer back to it for any reason. Next slide, please?

I want to talk a little bit about the process that we'll be going through today. There's a few things, I think, that are important to note.

First of all, the NRC has not made a final decision yet. That's really the purpose of us getting together today to talk about the fact that we've had investigations performed.

We've reviewed the information that we got from those investigations. We've obviously come up with some preliminary conclusions. Today though is your opportunity to talk to us about your perspectives.

We'd really like to understand if you, first of all, agree with the violations or not. We'd like to understand any insights that you can provide us that pertain to the way in which the events were identified, and then any kind of corrective actions that you all may have taken.

I think it's real important today when we have these discussions, you know, we recognize there's an order that's in effect, and it's been in effect now for, you know, a couple, I think, three years now.

For my benefit, I'd like to understand kind of like a timeline, you know, when these events occurred. How were they identified? Was it a result of the actions you're taking from the order or was it from some other mechanism?

Because I think it's real important for us to understand from your perspectives how was River Bend doing with the culture at the site as far as willful activities? And I think kind of giving us an understanding on how these events occurred with respect to the order is going to help us a lot.

So, again, this is a closed meeting. Specific information that's associated with security-

related information can be discussed if needed, and please refrain from discussing safeguards information.

With that, I'd like to turn it over to Doug Dodson. He's going to discuss the enforcement policy process. Thanks.

MR. DODSON: All right, thanks, Mike. As noted earlier, I'm the Acting Team Leader for the Allegations, Coordination, and Enforcement staff in Region IV.

Following this conference, we'll make a decision based on the information we obtained in our inspection and investigation activities, and consider any new information you provide during today's meeting.

When we're ready to issue our decision, we'll notify you by phone and by letter, and this process can take up to several weeks, and for this case, will likely continue until the end of September.

Today, I'll quickly step through our process on traditional enforcement violation significance, civil penalty assessment, possible outcomes, and appeal rights.

First, after we identify a violation, the

NRC assesses the significance of the violation. For traditional enforcement violations, we use severity levels to classify the significance of each one, and as you see on the slide, there's four severity levels, severity level one being the most significant and Severity Level IV being the least significant.

We consider severity levels one, two, and three to be escalated enforcement actions, and those are candidates for civil penalties or monetary fines.

To make these determinations, we take four factors into consideration, actual consequences, potential consequences, potential for impact to the NRC's ability to complete its regulatory function, and any willful aspects of a violation.

If we determine a violation's categorized as escalated to severity levels one through three, we then assess whether the civil penalty or fine is warranted. Next slide?

The civil penalty assessment process is outlined in our enforcement policy section 2.3.4, and as you can see on the slide, considers the following elements: licensee enforcement history, identification of the violation, corrective actions, and then

discretion, and the NRC may choose to exercise enforcement discretion based on several factors which are described in the enforcement policy.

Although each case is different, there are three possible civil penalty outcomes in most violation cases absent the use of discretion. Those outcomes are no civil penalty, base civil penalty, and twice the base civil penalty.

Civil penalty assessment is normally dependent upon whether a licensee is deserving of identification and/or corrective action credit. So, during this conference, we'd very much like to hear your position on whether you believe River Bend Station is deserving of identification credit and whether you believe, for each of the violations, you're deserving of corrective action credit.

Base civil penalty amounts for licensee, reactor licensees like River Bend range from $150,000 for each Severity Level III three violation, $240,000 for each Severity Level II violation, all the way to $300,000 for each severity level one violation, and those are also outlined in our enforcement policy currently dated January 15, 2020.

For each of the three apparent violations that we discuss today, there's four possible outcomes from today's conference. We may take no enforcement action, a notice of violation may be issued, a notice of violation with a civil penalty may be issued, or we may issue an order.

Notices of violations are simply written notices that a violation's occurred and how the requirement was violated, and a written response may be required.

With respect to notices of violations with civil penalties, the intention of the penalty is to emphasize compliance in a way that further prevents future violations and focuses corrective actions and attention on significant violations.

And then, of course, for orders, they are written directives that can modify, suspend, or revoke a license, and can require specific actions by licensees or individuals.

I should note here that the NRC enforcement actions are generally public information, and as such, are published to our www.nrc.gov website.

If a civil penalty is imposed or an order

is issued, normally our Office of Public Affairs will issue a press release, and that will happen within a day or so of the final action being issued and received.

Finally, the NRC licensees have appeal rights and may challenge any NRC action. Instructions for challenging enforcement actions will be documented either in the action itself or in a transmittal letter. When civil penalties are issued, that particular action provides hearing rights.

A couple of final reminders, any security-related information discussed here today will not be included in any public material, and although transcribed conferences are not conducted under oath, when false statements are made on material matters, the person making the statement may be subject to civil and criminal prosecution. And next, I'll turn it over to Jason Kozal.

MS. VOSSMAR: I think you're muted again, Jason.

MR. KOZAL: Yeah, sorry about that. Good morning, everyone. I'm sorry, I just had a -- of course my computer did something squirrely just as

it's my turn. All right, thank you.

At this point, I'd like to transition into a discussion of the reasons why we're here today. Today, we are discussing three apparent violations that were identified during the NRC's review of Entergy's confidential corrective action program which occurred on August 13, 2018, September 1, 2019, and March 31, 2020 at River Bend Station.

For background, on January 27 --

(Telephonic interference.)

MR. HAY: Hey, Jason, we can't hear you. Something obviously happened.

MS. VOSSMAR: Yes, it looks like we've lost Jason.

(Pause.)

MS. VOSSMAR: We'll give the mic just a minute, Jay.

PARTICIPANT: You're back, Jason.

MR. KOZAL: Can you guys hear me?

MS. VOSSMAR: Yes.

MR. KOZAL: Okay, sorry about that, all set now. For background, on January 27, the NRC performed an inspection of Entergy's corrective

actions in response to a confirmatory order that was issued on March 12, 2018.

One of the licensee's corrective actions involved the creation of a confidential CAP focused on addressing allegations of wrongdoing at each of the Entergy sites.

During the NRC inspection, we discovered several instances where a wrongdoing investigation had been completed or were in progress for cases of alleged wrongdoing connected to NRC license activities that the NRC was previously unaware of.

The NRC performed a follow-up review in March 2020 and identified three cases associated with the River Bend Station that we are discussing today.

These cases involve potential willful violations of NRC requirements associated with administration of a training examination on August 13, 2018, performance of off-perimeter rounds on September 1, 2019, and control of critical digital asset keys on March 31 of 2020. Next slide, please?

The NRC's Office of Investigation launched investigations into the alleged wrongdoing in April and May of 2020. The Office of Investigation

substantiated that each of the three cases involved willful violations of NRC requirements.

Following further review under the enforcement process, the NRC determined that the associated violations had the potential to require escalated enforcement.

Accordingly, the NRC documented three apparent violations in River Bend inspection report 2021-090. The NRC issued inspection report 2021-090 and an associated choice letter to River Bend Station on July 1, 2021.

The choice letter provided the opportunity for River Bend Station to respond to the NRC's preliminary determination of the apparent violations at the predecisional enforcement conference, which brings us here today.

Next, we're going to get into the details of each of the three apparent violations and I'll turn this over to Nick Taylor to discuss this issue.

MR. TAYLOR: Good morning, everyone. The first issue that we'll be discussing today is associated with an exam proctoring violation which occurred on August 13, 2018.

Specifically, the NRC has preliminarily determined that after proctoring a nondestructive examination test, a level three NDE proctor apparently deliberately copied and recreated the test on behalf of an examinee and deliberately submitted the falsified test to the licensee for grading. Next slide.

And here we have the documented apparent violation associated with this case which was documented in the River Bend inspection report 2021-090. It's important that we're all on the same page with respect to the documented violation since it sets the stage for the rest of the discussions we're having today, so bear with me here as I read the preliminary citation from the slide.

Title 10, CFR Part 50, Appendix B, Criterion 5 requires in part that activities affecting quality shall be accomplished in accordance with documented procedures.

Licensee Procedure CEP-NDE-0100, administration and control of NDE, Provision 11, a quality-related procedure, Section 5.2.2.4 requires in part that unless administered directly by the

Principal Level III, exams shall be forwarded to an exam proctor.

Exams shall not be copied after issuance from the Principal Level III unless specifically requested. Additionally, Procedure CEP-NDE-0100, Section 5.2.2.3 requires in part that each written exam shall have a unique number and cover sheet.

Contrary to the above, on August 13, 2018, the exam proctor, who was not the Principal Level III, made an unauthorized copy of the exam with the same control number.

Specifically, following administration of the exam to the applicant, the Level III NDE exam proctor thought he had lost the original exam, so he printed a duplicate exam with the same control number without authorization from the Principal Level III, falsified the answers, and submitted the exam to the Principal Level III to prevent identification of a perceived error on his part. Next slide. To you, Jason.

MR. KOZAL: Yep, sorry about that. The second issue is associated with an exam proctor, excuse me, with non-licensed operator rounds that

happened on September 1, 2019.

The NRC preliminarily determined that an over-instruction NLO apparently failed to closely monitor the under-instruction during their operator rounds and deliberately failed to perform a tour of all required areas of the watch station.

Note that in addition to the apparent violation, the NRC documented a related violation of Severity Level IV NCV for inadequate log to report as a result of an apparent deliberate failure to perform rounds as well for this issue. Next slide, please?

So, apparently violation number two, Title 10 of 10 CFR Part 50, Appendix B, Criterion 5 requires in part that activities affecting quality shall be accomplished in accordance with documented procedures.

Entergy Procedure EN-OP-115-01, operator rounds, Revision 4, a quality-related procedure intended to meet this requirement for non-licensed operators performing watchstanding rounds, Step 5.1.8 requires in part that watchstanders tour all required areas of their watch station.

Section 5.1.27 states in part that if a trainee is taking logs as part of training, to ensure

the qualified watchstander is with the trainee to check each reading and perform a complete tour as the qualified watchstander.

Section 5.2.2 states in part that the operator assigned to an area, room, building, or group of buildings is responsible to complete rounds applicable to that area.

Contrary to the above, on September 1, 2019, a watchstander failed to tour all required areas of the watch station.

Specifically, a non-licensed operator assigned to the control building as over-instruction failed to properly observe the under-instruction, complete all panel checks, and failed to ensure a complete tour of all required areas of their watch station.

Back over to Nick for the third apparent violation.

MR. TAYLOR: Thank you. The third issue is associated with a critical digital asset access control violation which occurred on March 31, 2020.

Specifically, the NRC has preliminarily determined that a work week senior reactor operator

apparently checked out a critical digital asset access key and deliberately gave it to an individual who is not authorized to possess the key.

Note that in addition to the apparent violation, the NRC also documented an associated green finding to disposition the reactor oversight process aspects of the issue. Next slide.

Here, we have again documented the apparent violation associated with the third case, which again was documented in inspection report 2021-090. I'll go through the preliminary citation on this slide.

Title 10 CFR 73.54(b)(2) requires in part that the licensee establish, implement, and maintain a cybersecurity program for the protection of safety, security, and emergency preparedness assets from cyber attacks.

Renewed facility operating license NPF-47, License Condition 2.E requires in part that the licensee shall fully implement and maintain in effect all provisions of the Commission-approved cybersecurity plan, including changes made pursuant to the authority of 10 CFR 50.90 and 10 CFR 50.54(b).

Cyber Security Plan, Revision 2, Section 2.2.7 states in part that the performance-based requirements of the cybersecurity plan provide defense-in-depth through the integration of systems, technologies, programs, equipment, supporting processes, and implementing procedures as needed to ensure the effectiveness of the program.

Further, Section 3.1.6 states in part that defense-in-depth strategies are established by documenting and implementing the operational and management cybersecurity controls in Appendix E of NEI 08-09, Revision 6.

NEI 08-09, Revision 6, Appendix E, Control E 5.5 requires in part the cybersecurity control consist of controlling physical access points, including designated entry and exit points, to locations where critical digital assets reside, and verifies individual access authorization before granting access to these areas.

Licensee procedure EN-IT-103-07, cybersecurity physical access requirements for critical digital assets, Revision 8, an implementing procedure of the cybersecurity plan, Section 5.4,

Administrative Key Issue and Control Processes Step 1 requires in part the keys that are used to control access to a room which contains critical digital assets can only be issued by personnel who are members of the critical group to critical group members.

Contrary to the above, on March 31, 2020, a member of the critical group provided a key that is used to control access to a room that contains critical digital assets to a person who was not a critical group member.

Specifically, a senior reactor operator provided a critical digital asset key to a maintenance supervisor who was not a critical group member, and the supervisor accessed a room containing critical digital assets.

Now, I'll note here that in each of these three cases, for each of these three apparent violations, we're considering escalating the enforcement action due to the considerations surrounding willfulness involved with each violation. Next slide. Over to you, Jason.

MR. KOZAL: At this point, I'd like to turn the meeting over to Mr. Kent Scott so he and his

team can give a presentation. Can we transition over to the licensee's presentation, please?

As we previously discussed, during your presentation, we'd like to pause for an opportunity for us to ask questions after you present information on each apparent violation as we go. After your presentation is complete, we'll have an additional Q&A session to allow us to ask questions on the presentation as a whole. Thanks. Kent, over to you and your team. Thank you.

MR. SCOTT: All right, thanks, Jason. So, our presentation, we're going to start off with Jeff Reynolds to kick us off, and I'll follow with opening remarks and then the remainder of the team presentation, so, Jeff?

MR. REYNOLDS: All right, so I'm Jeff Reynolds. I'm the Director of Regulatory Assurance and Performance Improvement at River Bend Station. I've spent over 20 years in the nuclear industry, earning a reactor operator license and a senior reactor operator license. I've served in various capacities in maintenance and operations --

(Telephonic interference.)

MR. REYNOLDS: -- corporate functional area manager of operations for Entergy.

(Pause.)

MR. REYNOLDS: Okay, so I just, I started off with I've spent over 20 years in the nuclear industry, earning a reactor operator and a senior reactor operator license. I've served in various capacities in maintenance and ops, most notably as the River Bend operations senior manager and fleet operations corporate functional area manager.

In 2018, I became the regulatory assurance and performance improvement director here at River Bend. I was involved and present during the alternative dispute resolution for the confirmatory order, for the fleet confirmatory order.

I'd like to thank you for this opportunity for us to discuss these apparent violations. We appreciate the NRC's oversight of these issues and we embrace the high integrity standards required by our company, the industry, and rightly by the NRC.

Today, we will discuss the identification, corrective actions, and our enforcement perspective for each of the three issues. We appreciate the work

your team has put into coordinating this meeting so that we may provide our perspective on these apparent violations. Next slide, please.

So, this is our agenda for the meeting. We'll begin with Kent Scott, who is going to discuss his perspective on these issues and River Bend's recent regulatory history. I will talk about violations in the context of our confirmatory order.

Tim Schenk will explain how we came to identify each of the three issues, introduce the subject matter experts who will explain the issue, and then provide you with our enforcement perspective after each issue.

After we've gone over each issue in detail, Tim will provide you with our civil penalty assessment, and Kent will then provide closing comments.

We have planned for our presentation to take approximately three hours and we have left time for questions at the end of each section. At this time, I'll turn the meeting back over to Kent. Next slide.

MR. SCOTT: All right, good morning.

Again, my name is Kent Scott. I'm the Site Vice President here at River Bend Station. I'd also like to thank you for the opportunity to discuss the apparent violations with you today.

As Jeff said, we take integrity very seriously, and we do recognize and own the shortfalls in performance regarding the issues that we'll be discussing.

I want to emphasize that I understand, and we, as a team, understand the importance of ensuring the highest level of integrity when performing work at Entergy. It is unacceptable to me and my team that these issues occurred.

So, I recognize that the enforcement conference process calls for us to discuss the three specific issues that were the subject of your letter dated on the 1st of July, and we'll do that shortly, but I wanted to spend some time, that if we only focus on the specific issues, we'll miss the opportunity to understand the issues in a broader context.

So, before I turn over the presentation to my colleagues for a detailed discussion, I'd like to say a few words about where the issues fit into the

bigger picture and to talk about our ongoing approach to avoid future misconduct. Next slide, please.

So, this slide is an overview of our fleet's nuclear excellence model. This model establishes the fundamental values and principles by which we operate our fleet.

We're committed to operating all aspects of River Bend in accordance with these values. As you see on the model, integrity, developing strong ownership and accountability is one of our foundational values.

Now, it may be tempting for us to look at these issues, two of which we agree were willful, and dismiss them as relatively unimportant because they happened some time ago, or because there were no consequences, or because their individual safety significance was very low, or because we took timely corrective actions.

And we did those things, that's true, so that must be considered, but I want you to know that I and my management team are not brushing these issues aside for those reasons.

Rather, we're looking at these issues

collectively with clear eyes, acknowledging that as a plant and a fleet, we've been challenged with misconduct in years past.

So, from our assessment of these issues, I see several things from a broader perspective. I see that we are continuing to, on occasion, have issues with misconduct, poor performance, and integrity, and I understand that people make mistakes.

I mean, as humans, I expect that they will, but deliberate misconduct and integrity violations are in a separate category all together because they undermine our core values.

Simply put, we cannot succeed as an organization and we cannot safety operate our plant if our employees take matters into their own hands and deliberately violate the rules, and that's true regardless of the specific consequences or lack of consequences associated with the misconduct.

So, to be perfectly clear, let me restate my position. Willful violations of known requirements and breaches of personal integrity are not acceptable at River Bend or Entergy as a whole.

You might detect from my remarks and my

tone a little bit of emotion and perhaps some frustration, and if so, you're right.

My disappointment exists because of all of the efforts that we as a management team here at River Bend and as a fleet have put into preventing the very conduct that brings us here today.

I don't think I need to read you the list of the corrective actions we've taken since the issuance of the confirmatory order. Your recent inspections have focused on those actions even though these three issues occurred.

So, how do I explain the misconduct and performance that occurred here? Do the issues prove that the corrective actions didn't work? Did they prove that the company's values are merely slogans that look good on signs and placards, but have no real meaning or effect in the workplace?

I feel strongly that the answer to these questions is no. Let me explain why and let me tell you why, that even though I'm disappointed, I'm also optimistic.

So, from my experience, deliberate procedural violations and lapses in integrity most

often occur when individuals are under real or perceived stress and under difficult conditions choose the easier wrong instead of the harder proper action.

Two of the three issues that we'll talk about today, specifically the NDE proctor issue and the CDA key issue, fall into this category. The challenge for leadership is how do we stop this?

So, I see that meeting this challenge requires decisive management action in four major areas, first, effective communication of expectations, next, minimization of conditions that exacerbate a person's vulnerabilities, third, the development of employees of character, and lastly, regular checks and inspections to identify lapses and drive compliance.

The first most obvious action is to establish high standards and expectations, and to communicate them to the workers through periodic management communications and training, and we've done that. That's the easy part.

We're constantly emphasizing the importance of integrity and safe, ethical decision making. I'm not saying that we discuss these issues at every meeting or even every day. If we did, the

frequency would dilute the message, but we make a point of keeping these issues at the forefront of our discussions and our work.

As an example, the management team focuses its weekly message on one of the steps in our STAIR module, either safety, teamwork, always learning, integrity, or respect.

So, communications and training, however, are not enough. All the communications and training in the world will probably not cause an unethical or deceitful person to make an ethical decision, nor will training alone necessarily help a person lacking in character make that difficult decision to do the right thing when their instincts and personal interests are telling them to take the easy way out. To get our people through those tough times, we have to do more.

This leads me to the second major area of management attention, the minimization of conditions that breed or facilitate wrongdoing. In this area, I'm referring specifically to strengthening our nuclear safety culture. Doing so minimizes the times and circumstances when our workers face character challenging decisions.

For example, when we use well-written procedures, when we prudently plan our work, when we provide the right material and resources, when we develop reliable schedules, and when we work in an environment that is genuinely receptive to open, honest communication, we reduce the chances that someone will feel a need to deviate from our requirements or strike out on their own.

Based on the results of our nuclear safety culture monitoring panel, employees at River Bend are willing to bring forth issues to their supervisors, managers, or employee concerns, and are not concerned with retaliation.

The third area of management attention focuses on the moral development of our people. If we communicate high expectations and standards, and if we reduce or eliminate conditions that place people in unnecessarily challenging circumstances, we will still not be where we need to be. Our workers must be people of character.

Like all plants, we have people from different backgrounds who bring to work a variety of values, habits, and experiences. Some are good, some

are not. Our challenge as leaders is to filter out the bad and reinforce the good so that our ethical values control our workers' actions and decisions while they're at work.

Obviously, this is not easy task, and changing a person's values and character does not occur overnight. Strengthening and supporting character requires good leaders and good role models interacting constantly with their subordinates over time.

This puts a premium on the character and actions of the first line leaders because they, more than anyone else, create the conditions and environment in which individuals make decisions.

We recognize that our efforts to eliminate wrongdoing and integrity lapses will not be foolproof. That is why we are constantly checking our work and our workers through audits, assessments, observations, and inspections. That's our fourth area of management attention.

Importantly, the workers know that we're looking. They know that we're checking. So, even if a person lacks the character to make a good decision

on his own, the possibility of discovery may be enough to drive that person in the right direction.

The integrity audits that are being performed provide a trust but verify approach to prevention. The results of these audits are by process conveyed to those who were audited to reinforce the fact that we are independently reviewing actions and work that has been performed.

The fact that we are here today means that we still have work to do. Quite frankly, we knew this already. We did not need these three issues to tell us that we have unfinished business.

Even with our best efforts in the four focus areas I've described, I can't guarantee you that we'll never have another instance of individual misconduct. People are not machines that can be fixed with a new part, and there is no silver bullet corrective action that will preclude recurrence.

It will take time and persistence, and probably some disappointment along the way, before we embed our values in all our workers, and even when we get there, we have to avoid complacency and slippage.

As in all organizations, ingraining these

standards requires continuous reinforcement, and we will continue that reinforcement into the future. We are also firmly committed to success. By that, I mean we eradicate to the greatest extent possible instances of deliberate misconduct and integrity violations.

Although our meeting today will focus on our failures, there's no doubt that we're making progress. The three issues that we will be discussing today should be considered in that context.

Thank you again for the opportunity to discuss these issues with you and your staff. I would like to emphasize that whatever the outcome, you can have confidence that we have taken each issue very seriously and are committed to maintaining the highest level of integrity at Entergy.

At this point, I'll turn the presentation back over to Jeff. Next slide, please.

MR. REYNOLDS: Thank you, Kent. I'd like to build on Kent's message and briefly provide Entergy's perspective on how the issues relate to Entergy's confirmatory order.

As a result of the confirmatory order, we implemented key process changes to detect and deter

willful misconduct. The changes include communications to all Entergy employees from our leadership about the importance of integrity in all we do, annual integrity training, elevation of willful misconduct behaviors using the corrective action program, implementations of the integrity audits, and the sharing of industry operating experience regarding willful violations of NRC regulations.

Each of these issues we are discussing today were identified by Entergy personnel in a timely manner and appropriately evaluated in a corrective action process to determine whether willful misconduct occurred.

Two of these instances involved willful misconduct. As Dan James will discuss later, our investigation concluded that the non-licensed operator did not engage in willful misconduct in the operator rounds issue.

For all three of these issues, Entergy did take meaningful personnel and programmatic corrective actions. Next slide, please.

Although we do not tolerate misconduct at any level, these issues demonstrate that we are doing

a better job at identifying and addressing misconduct at an earlier stage than we have historically.

Following implementation of the confirmatory order in 2018, Entergy personnel adopted a heightened sensitivity towards potential integrity issues. We also implemented oversight programs and processes to help us better spot and address potential integrity lapses. As a result, as you can see in this chart, we identified far more potential instances of willful misconduct per year than we had in the past.

Importantly, as we continued our efforts to detect and correct those issues, we also improved our ability to prevent future issues. The resulting decline in new cases is also shown on the graph.

As Kent talked about nuclear safety culture, I wanted to talk a little about that. We routinely assess the work environment here to ensure a strong nuclear safety culture exists.

We do that through meetings like the nuclear safety culture monitoring panel, which includes members from employee concerns, human resources, and the nuclear independent oversight.

Safety culture is also assessed as part of

our INPO evaluations and our annual OHI survey. All of these have concluded that River Bend Station has a healthy nuclear safety culture and we do not promote production over safety.

Recently, we received feedback during the NRC follow-up inspection for the confirmatory order that interviews of Station personnel confirm that there is no indication of schedule pressure over safety.

We also know this to be true. For example, two mechanics recently realized that they did not sign onto a tag out as a work order holder as required by our tagging process. They promptly reported that to their supervisor so that the condition could be corrected and evaluated for any lessons learned. Those individuals received positive recognition from me on owning that issue and displaying the value of integrity that we desire.

Effectiveness reviews for the confirmatory order have demonstrated fleet wide that Entergy personnel overall have exhibited a high level of integrity, and the actions from the confirmatory order have resulted in an improved ability to detect, deter,

and correct willful misconduct.

Entergy can now identify potential misconduct at an earlier stage and prevent more significant or widespread violations. The decline of willful misconduct issues confirms that since implementation of the confirmatory order, Entergy's actions taken to date have been effective.

I'll now turn it over to Tim Schenk, the Regulatory Assurance Manager, to introduce the three issues that are the subject of today's meeting. Next slide.

MR. SCHENK: Good morning. My name is Tim Schenk. I'm the Regulatory Assurance Manager at River Bend Station. I've been at River Bend for over 30 years, primarily in the operations department, where I was a reactor operator, a senior reactor operator, as well as a departmental manager.

Prior to coming to regulatory assurance, I was also the manager of emergency preparedness. I've been the regulatory assurance manager since August of 2016.

I'd like to step you through the identification of the issues to provide a complete

understanding of what transpired. Next slide.

River Bend workers identified and Entergy investigations confirmed the following instances when individuals violated Entergy's policies and procedures: first, the NDE proctor issue.

In September of 2018, an NDE proctor chose to deliberately circumvent the exam process by recreating a completed NDE exam that was originally administered in August of 2018.

The proctor was embarrassed because he mistakenly believed that he had lost the test taker's exam. The proctor admitted that he reprinted the entire exam, recreated what he thought was the test taker's answers, and then submitted the exam as though it was the test taker's original exam.

Second, the operator rounds issue, in September of 2019, two non-licensed operators failed to notice a yellow paper sign known as the golden ticket on a piece of equipment during rounds.

The golden ticket is periodically placed by operations department management on certain equipment to be inspected during the non-licensed operator rounds for self-auditing purposes.

Finally, the CDA key issue, in March of 2020, a work week SRO chose to not follow Entergy procedures, and instead provided a CDA key to a supervisor who was not part of the critical group. Next slide.

Having provided a brief overview of the issues that we're here to discuss, we will now have the three Entergy leaders discuss each of the issues in detail.

After each issue, I will discuss our enforcement perspective before moving on with the presentation. We will begin with Tiffany Baban who will discuss the NDE proctor issue. Next slide.

MS. BABAN: Good morning. I am Tiffany Baban. I am the Senior Manager of State Inspection Services. I have overall responsibility for non-destructive examination activities, including reactor head inspections and steam generator inspections. The NDE supervisors and their respective staff at River Bend Station, ANO, Grand Gulf, and Waterford report to me.

First, let me say that I take full responsibility of this issue and the actions of my

team. I was the manager at the time that the NDE proctor recreated the exam he thought he lost. Next slide.

In September 2018, Entergy identified that an NDE exam proctor falsified an exam. The NDE Principal Level III discovered that there were two exams apparently taken by the same person with the same examination number.

The first test was a passing score and the second test was a failure. It is important to note that the falsified exam was the second exam. The examinee's actual test was the first test which had a passing score.

The NDE Level III immediately reported the issue to me. I conducted some initial fact-finding interviews and then immediately referred the matter for a more formal investigation by corporate investigators to obtain a complete understanding of the issue.

During the investigation, the proctor admitted that he thought he lost the original test. He then reprinted another test and falsified the exam by retaking the test with the answers he thought the

test taker submitted. The test taker was unaware his exam was lost and unaware that the proctor had tried to recreate it.

I was both shocked and disappointed that this issue occurred, but I also knew that it was essential for me to understand how and why this issue had been so that I could take appropriate actions. Next slide.

The prompt actions taken upon discovery of the issue were that Entergy placed the proctor on leave and removed his access authorization pending investigation. Entergy withheld all certifications for all type of NDE methods for the test taker, and Entergy initiated a comprehensive internal investigation.

The root cause of this issue was that the proctor maintained loose standards of integrity and that he deliberately circumvented the NDE exam process. He understood the standard and made a choice to voluntarily and deliberately violate the standard. Next slide.

Entergy completed a fleet level extended condition review focusing on whether the proctor

falsified other exams, whether the proctor had other integrity lapses, whether other NDE proctors across the fleet falsified exams, and whether there were any indications of a widespread culture that NDE proctors were assisting newly hired NDE test takers in the fleet. In addition, we also looked into the overall proctoring issues that have occurred throughout the fleet.

Entergy identified that there were no other instances of exam falsification, willful misconduct, or systemic integrity issues among NDE proctors. The issue was isolated to the NDE exam proctor's decision to circumvent the exam process in this one instance. Next slide.

In addition to the corrective actions previously discussed, Entergy terminated the employment of the proctor and denied his unescorted access.

Entergy completed a root cause evaluation to delve into the organizational and programmatic aspects of the issue. Entergy issued fleet wide communications to discuss the operating conditions experienced. Entergy successfully retested and later

qualified the test taker.

Entergy completed a gap analysis of the NDE qualification program to identify potential process improvements as the NDE qualification program is not an accredited training program.

And lastly, we revised our implementing NDE procedures to institutionalize period management observations of the proctoring process, and a periodic self-assessment of the NDE qualification program.

The Entergy -- sorry, the individual that first identified the issue acted appropriately, as I would have expected him to, and so did all of those who helped us understand and correct the issue.

From the onset of this issue, Entergy self-identified the misconduct, took ownership of the integrity and behavior shortfalls, took timely actions to understand the facts, and took comprehensive corrective actions.

At this time, Tim will provide Entergy's enforcement perspective on this issue. Next slide.

MR. HAY: This is Mike. Can we ask questions before we go any further?

MS. BABAN: Sure.

MR. HAY: Thanks for all that, Tiffany. You know, something I'm interested in understanding is when I think about the order and the fact that you all did your root cause assessment -- and my recollection is the root cause was something along the lines of you all hadn't basically established the -- I hate to use the word discipline, but you didn't establish the fact that people need to understand that if they're involved in willful misconduct, they could get caught and there would be consequences, which led you all to develop these audits that you do to identify these behaviors.

What I recall is when you identify these events, you need to obviously learn from them. Others need to learn from them. It's not just fire the person or give them leave without pay for a while, but it's being able to communicate these events in a manner such that people realize there's consequences.

And I saw you mentioned that there was communications done on this event. But I'd be interested if you can share a little more detail and exactly what sort of communications occurred based on this event. And who received those communications?

What did those communications -- you know, what did they look like? Or when you put them out, was it by email? Was it by discussions? Was it a combination of things?

MR. REYNOLDS: So why don't we start that with -- Tiffany, could you explain how did you communicate that to your group specifically across the fleet? Let's just -- let's knock that one out first.

Yeah. Sorry about that. So what I was asking was we'll let Tiffany answer first on how the -- sorry. Jeff Reynolds, Regulation Assurance/Performance Improvement Director. Okay.

MS. BABAN: All right. We discussed this event with all Inspector Services personnel in the fleet and had them affirm with their signature that they understood the event and that the responsibility as it relates to examinations and proctoring and items such as testers -- sorry. Test Proctors are responsible for ensuring their Proctor-administered testing maintains testing standards and appropriate standard protocols.

All examinations shall be controlled to ensure that the confidentiality of the qualifications

materials, understanding the following requirements of our NDE procedures, specifically the CEP-NDE-100 that Nick mentioned, which is the administration and control of NDE -- we reinforced that in this event, the individual understood the standard and made the choice to voluntarily violate the standard.

We also discussed that mistakes and accidents happen, and the consequences of coming forward with an honest mistake is -- sorry. The consequences of coming forward with an honest mistake is much less than the consequence of trying to cover up the mistake. We also wanted to reinforce that we should never give away a signature, and maintaining a questioning attitude and honesty is the best policy.

MR. REYNOLDS: All right. This is Jeff Reynolds again.

Thank you for that, Tiffany.

Danny James, would you discuss how you communicated the issue of the operator rounds with the groups? We'll go ahead and just answer those questions now for all -- how all three issues were communicated.

(Off-microphone comment.)

MR. REYNOLDS: Yes, please.

MR. JAMES: This is Danny James, Senior Manager of Operations at River Bend.

After the operator rounds issue was discovered, the integrity audit for -- it was discovered during the integrity audit. So, at the end of each quarter, the integrity audit is communicated to all the crews and covered at their shift -- graded by their shift managers, is communicated to shift managers in the whole department by email, then discussed at beginning-of-shift brief. So that issue was discussed immediately after October 19th of 2019, covered on those briefs.

MR. REYNOLDS: All right. This is Jeff Reynolds again.

Thank you, Danny.

Now I would ask that Mark Feltner will discuss how the cyber -- the CDA key issue was discovered and investigated how that was communicated throughout the organization.

Mark?

MR. FELTNER: Thanks, Jeff.

Yeah, I'm Mark Feltner, System Operations

Manager at Entergy.

What we did there is we had the communication from -- directly from the Senior Manager of Operations, Tim Venable, to all the SROs in Operations, explaining to them the importance of criticality and of control of the CDA keys and access to CDAs. In that, he also expressed that the potential consequences would lead up to and including termination depending on the severity of the noncompliance.

MR. REYNOLDS: All right. This is Jeff Reynolds again.

Thank you, Mark.

MR. SCOTT: Any other questions?

MR. KOZAL: Yeah. This is Jason. Can you guys hear me real quick?

MR. REYNOLDS: Yeah. Go ahead, Jason.

MR. KOZAL: Hey. Just to follow up on what you guys covered, I heard a lot of communication inside the affected groups. Were there any station-wide or fleet-wide communications that went along with these types of items?

MR. REYNOLDS: This is Jeff Reynolds

again.

Jason, yes. There were communications sent. We would -- I'd have to take that as a look-up to go get you specifically when and what communications were made. I do recall we made more global communications. It wasn't just to the individual departments.

We'll take that as a follow-up and get all the communications that were made once the individual issues were done, and then if there was a roll-up communication after all three.

MR. KOZAL: Thank you very much. Thanks.

MR. SCHENK: All right. This is Tim Schenk, Regulatory Assurance Manager. I'm going to continue on with the NDE exam significance.

So we reviewed the NRC's Enforcement Policy and Enforcement Manual and understand that there are several considerations for the NRC to make when assessing significance. Those considerations include whether the issue resulted in actual or potential safety consequences, whether the issue affected the NRC's ability to perform its regulatory function, whether the issue was isolated or

repetitive, whether the issue was a result of individuals' actions or whether management was responsible, and whether Entergy identified the issues and took prompt and effective corrective actions.

So we'll refer back to these considerations as we discuss all three issues.

Next slide.

So Entergy concurs that the NDE Proctor violated written procedures. We discovered this during the exam verification process after the exam had been administered. We immediately placed the Proctor on leave and withheld the test taker's qualifications. We then entered the issues into our Protective Action Program and performed an internal investigation.

Once we understood what had happened and why, Entergy developed and implemented the corrective action described by Tiffany during her presentation. And throughout this process, we kept the NRC informed of our findings.

Next slide.

For each of the issues that we will discuss today, I will use a timeline to show how these

issues integrated into our confirmatory order and the actions that Entergy has taken to detect and deter willful violations of our integrity expectations.

Now, across the top of each of these timelines, you will see some of the milestones associated with the confirmatory order. They include the required communications to employees, effectiveness reviews, training, and inspection activities.

As you can tell by the bottom of the timeline information, the NDE Proctor issue occurred early in the implementation period of the confirmatory order. Now, subsequent to the NDE Proctor issue, just know that we did additional fleet Proctor root cause and ACA analysis.

Next slide.

Now, for several reasons, we believe this issue to be very low safety significance. First, there were no safety consequences, actual or potential. Second, no work was performed by an unqualified NDE individual. The exam the Proctor thought he lost was actual a passing exam. The circumstances would have, at the worst, resulted in a

knowledgeable individual being required to retake an exam.

Third, this issue did not impact the NRC's ability to perform its regulatory function. Finally, this issue was the result of an isolated action by a non-supervisory employee, which was not sanctioned by management and which was not the result of a lack of management oversight, as demonstrated by management's intrusiveness and the actions taken when the issue was identified.

Entergy agrees that the Exam Proctor acted inappropriately and violated Entergy's policies and procedures, but we have no evidence that the Proctor was trying to gain a specific advantage, economic or otherwise. We understand that he was embarrassed having lost the exam and was trying to eliminate the need for a peer to have to retake the test. Even so, Entergy management does not condone this behavior. To the contrary, when we identified the misconduct, we immediately remediated it by removing the Proctor and withheld the test taker's qualifications.

Entergy's perspective is that this issue was an isolated action of an employee failing to

follow written policies and procedures and should be assessed as a Licensee-identified traditional Level IV non-site violation.

Thank you, and are there any questions?

MR. TAYLOR: Thanks, everyone. This is Nick Taylor again, speaking for the court reporter. I had a few follow-up questions, and some of the questions I had, Tiffany and others have addressed in the slides. So I appreciate the discussion.

One of the purposes of this meeting is to make sure we have the right view of the facts, and we always learn something when we talk like this. One of the things Tiffany described was something outside of my knowledge of the facts in that there was a fleet extended condition review performed.

When we looked at the condition report for -- that was written for this occurrence -- the condition report number I have is CRHQN20182142. We went through all the actions in that condition report. I don't see anything in that condition report describing an extended condition review to the fleet.

Can you describe when that was performed and how it was documented?

(Pause.)

MR. TAYLOR: Did you all hear the question? I'm sorry.

MS. BABAN: The actions for the 20182142?

MR. TAYLOR: Yes, ma'am. So in your slides, I think on slide 12, you described that a fleet extended condition review was performed. And we were very interested in that. We looked for that and didn't find it.

Can you tell us where we can see the results of that fleet extended condition review?

MS. BABAN: Our fleet extended condition reviews for NDE Proctors specifically is what we're talking about, and that's in 2142. And I can provide a copy of that for you if you are specifically looking for that. It was specific to NDE Proctors, though.

MR. TAYLOR: That would be useful. And I'll go back and review it again, I guess. Perhaps we missed it the first time around, but we didn't see it in the CR when we looked at it. So I'll look again, but if you have something that could help target us to the right part of that document, that would be greatly appreciated.

MS. BABAN: Yes. We can do that.

MR. REYNOLDS: Yeah, Nick. We'll look at a -- this is Jeff Reynolds again. We'll look at an apparent cause from headquarters where it was a global look at proctoring issues as well. So we'll take that as a follow-up to get you that information as well.

MR. TAYLOR: Great. We're aware of the look that was done in response to some issues at Grand Gulf, but we didn't see one related specifically to this issue. But we'll look forward to seeing that if it's out there.

MR. REYNOLDS: Okay. Yeah. Let us get that information.

MR. TAYLOR: For this particular issue, I'm looking at the root cause evaluation that was performed, and it was a -- you know, it looked like it was an expansive root cause evaluation. We saw the direct cause. The NDE Inspector decided to deliberately circumvent the exam process by recreating the completed exam. And then there were two contributing causes identified, first being that NDE management has not provided adequate oversight of the qualification activities -- and I'm paraphrasing a

little bit -- and the second, that NDE management has not consistently or adequately assessed the qualification process.

We did receive a written response back from the individual. And one of the things the individual stated in his written response as a causal factor was his inability to manage a work overload by performing both supervisory and NDE Level 3 responsibilities as well as preparing for a refueling outage. And he stated that those things contributed to poor judgment.

Did you all look at those organizational factors as potential contributing causes? We don't see them discussed in the root cause evaluation.

MS. BABAN: Yes, we looked at that as far -- I'm sorry. There's an echo. We did look at that as far as the root cause, but we felt that the individual action was the main factor, specifically that there was an opportunity to go ahead and retest that individual or have the Principal Level 3 re-create the exam and redo it. And he decided otherwise. He decided to take a test with answers from someone else and then take it to be his own or

say that it was the other individual's test. We thought that that was the main factor.

MR. TAYLOR: So I appreciate that. And obviously the individual has the ultimate responsibility for his or her actions. We totally understand that.

Could you describe what you did to perhaps -- you know, the individual is talking about just being overloaded with the multiple responsibilities that he had and an upcoming refueling outage. Did you determine that that just wasn't a contributor to his decision-making or that it wasn't relevant somehow?

MS. BABAN: Oh, I wouldn't say that it wasn't a factor. I just don't think it was the main factor. We did -- as we discussed, we did take the individual and he was placed on leave, so others stepped up, such as myself, to take in those supervisory activities for him and then other Level 3s within the fleet to support his Level 3 activities at River Bend Station.

MR. TAYLOR: Great. Did you take any actions in the Corrective Action Program or otherwise to see if there is a workload issue that might be

setting people up for making poor choices?

MS. BABAN: I do not believe we took an action -- that we put a corrective action to look at workload issues specifically.

MR. TAYLOR: Okay. Thank you.

Separate question. Obviously, there's been a lot of good communication with the station and a lot of actions taken coming out of the confirmatory order. In providing the perspective on whether or not there is an indication here that the actions for that confirmatory order might not have been successful in changing this individual's behaviors, a lot of those actions had already been taken and were in place before this individual made the error that he made.

MR. REYNOLDS: Yeah, Nick. This is Jeff. So, just looking at that timeline, so this was pretty early on. The confirmatory order issued in March of 2018, and then this test issue occurred in early '18 as well.

So I wouldn't say that the actions weren't effective or would not have deterred him from doing this. I would just say early in the timeline -- and I wouldn't consider that, that it wasn't effective or

wasn't a factor in why he did this.

MR. TAYLOR: Thank you for that. So, as I understand the timeline, the confirmatory order was issued in March of 2018, and there were some early actions, communications with the station and some front-end corrective actions or some longer term things. This error occurred, I think, in August of 2018, so yeah, I guess within about six months of the order.

Was there a time where people such as this individual just weren't quite on board yet or didn't understand what was going on in the station? Is there a knowledge gap there that we need to understand?

MR. TAYLOR: This is Jeff again. I don't believe so. I don't believe that was a gap. When the early communications came out about the confirmatory order, about the importance of integrity, employees were knowledgeable of this. And we had -- with this -- and you'll hear this in the cyber key as well. But this individual in the investigation made a poor choice.

Tim stated he wasn't gaining any advantage. He submitted a failed test. It wasn't

even -- wasn't cheating. It wasn't a passing test to help the other individual out. He just -- and faced in a decision of managing his workload -- which Tiffany assessed that it wasn't necessarily high, higher than anyone else's workload -- the individual chose to take a road that in his mind seemed easier to him and would then cover up his embarrassment of losing the test.

So I wouldn't -- you know, I don't believe the timing of the order really would have made a difference here in how he viewed this.

MR. TAYLOR: Okay. Thank you.

Kind of a separate question, in looking at some of the outcomes of the root cause evaluation, the root cause evaluation included an analysis of extended cause. And in that analysis, the writers basically credited that the actions from a 2017 root cause evaluation that came out of the Grand Gulf issues as being sufficient (audio interference) concerns that other NDE Inspectors don't have similar integrity gaps.

But those 2017 actions, of course, were in place before this individual made his or her choice.

Can you help us understand why you viewed that 2017 -- the actions taken for that 2017 root cause as founding for this issue when it didn't prevent this individual from making the poor choice that he made?

MS. BABAN: I would say that for the extended cause, the root cause focused on the NDE Proctors. And for extended cause, it took credit for, like you said, the Grand Gulf root cause as well as the headquarters cause as far as trying to extend it further than just NDE. For this root cause, we wanted to lend it to NDE versus trying to limit all Proctor issues.

MR. TAYLOR: Okay. Thank you.

Also, in the root cause evaluation, the team documented that the root cause team is confident that even if personnel have low standards of integrity for a given process or activity, the trust to verify assessments while changing perception of risk will dissuade personnel from violating standards of integrity.

And just from the perspective of someone who hasn't been involved in all of this for the past few years, will you please describe what a trust to

verify assessment is and why you believe that will dissuade people from having similar integrity lapses?

MR. REYNOLDS: So, Nick, I believe you're asking us about the integrity audits. And the integrity --

(Simultaneous speaking.)

MR. REYNOLDS: Go ahead. Sorry.

MR. TAYLOR: I'm sorry. I didn't mean to interrupt you. I'm just using the language out of the root cause evaluation, so I guess perhaps that's -- perhaps the same thing. You would know better than I.

MR. REYNOLDS: Yeah. So just -- this is Jeff Reynolds again. So the integrity audits that we perform on a -- so they're procedurally required on a routine frequency and performed in multiple different organizations. They're performed at all the sites. And those are intended to -- in the original root cause, that was one of the primary corrective actions was we did not have a method in place to really detect if misconduct was occurring.

So the audits were put into place. All the different departments and organizations have theirs that are specific to them. And then employees

are -- they're knowledgeable that those are occurring, and the results are -- whether they're all positive and favorable, either way, they're all communicated at the end of the audit to the employees.

So what that audit does is it takes a sample, and we'll talk about ops and the golden ticket in a minute. But those golden tickets get placed on various points in the plant unbeknownst to the operators that are going to take the rounds. They find that golden ticket, bring it back to the ops manager, and say, hey, I found this out there.

So that's a satisfactory integrity audit. So all of the operators know that at any given point in time, there could be this golden ticket placed throughout the plant, and they could be audited. And then you just -- each -- I won't go through each different department, but everyone has their method of how they're monitoring and assessing integrity and ensuring that the employees know that's being done.

Does that answer your question?

MR. TAYLOR: I think that gets me at least part of the way there.

And perhaps, for Tiffany, maybe you can

help me understand. For your group in which this individual worked, has there been -- was there an integrity assessment done prior to this individual making this error, and he just didn't get it? Or was this an action that kind of came together some time after this event where that individual didn't have, say, the benefit of that feedback loop?

MS. BABAN: It was after.

MR. TAYLOR: Okay.

MR. REYNOLDS: Okay. So, Nick, I just -- I do want to elaborate on that a little bit. So feedback on the audit portion, but this individual was receiving the integrity training and the integrity communications that all Entergy employees receive and are required to take. So --

MS. BABAN: That's correct.

MR. REYNOLDS: -- not necessarily part of the audits, the integrity audits that were being done. But the individual was knowledgeable of the confirmatory order and was given the communications and training on the importance of integrity.

MR. TAYLOR: Thank you. And so that helps me kind of understand. It sounds like the trust-to-

verify language in the root cause has maybe been overcome by the integrity assessment process that's in place. So appreciate that clarification.

MR. REYNOLDS: Okay.

MR. TAYLOR: In looking at the contributing causes, again -- I appreciate you enduring all the specific questions. One of the things that's really important for us to have some assurance that this is a -- the station has come through this and is on the other side of this is to understand the right causes, contributing causes, have been identified and actions taken to help give us that confidence.

So, in looking at the root cause evaluation, again, there was a lot of discussion about one of the contributing causes, that there was a failure to perform self-assessments in the NDE program for the previous three years. And as a corrective action, self-assessment was done, and now there's a programmatic requirement to do that, which sounds like a very useful corrective action.

And I did appreciate Mr. Scott's discussion about management priorities including that

auditing and assessing role. We understand the importance of that for self-governance at the station.

But in looking at the extended cause discussion and the root cause for that contributor, the failure to perform self-assessments, it doesn't look like there was any extended cause performed to look for a similar gap in any other program at the station. It was really just focused entirely on the NDE area.

Can you discuss whether or not you considered looking in to see if other important programs at the station lacked similar self-governance?

MS. BABAN: Yes. For extended cause, the focus is on the root cause, but we did look at other training programs, whether or not they were doing self-assessments, and we looked at maintenance and technical training and engineering support personnel training. They were providing self-assessments, as well as the operations training programs.

MR. TAYLOR: Okay. Thank you for that.

And then last question for me, and there may be others that have relevant questions. And I'll

yield the floor here in a second.

In the root cause evaluation, the team also documented that there was no indication of this nuclear safety culture aspect, lack of integrity, being systematic and that it appears to be limited, only NDE Inspector Number 1.

What would a systematic lack of integrity look like at the station? Have you thought about what an indicator would be of that? I'll just note that we're having a meeting here to talk about at least three integrity issues from different departments and different processes on the heels of a confirmatory order that was written for that purpose. What would it look like to have a systematic lack of integrity at the station?

MS. BABAN: For this specific one, we were looking at the NDE Proctor. And for that, we were looking at, as we discussed earlier, whether or not we were -- if other Proctors had integrity issues or whether or not that one specific one had integrity lapses.

Do you want to focus on the other site things?

MR. REYNOLDS: So hey. This is Jeff again. So, if we had a systemic integrity issue at the site, we would be noticing and finding more issues. And our integrity audits are designed to go find those. And that's one method.

When we talk about these other issues today -- the one we're talking about now, the NDE exam, that was not caught in an audit. It was caught in another mechanism by an individual receiving two exams, knowing that that was incorrect, and brought that to the attention of management so that it could get identified and get a condition report written.

With the cyber key issue, that was not done as part of an integrity audit. That was done as a key audit where an individual -- the cyber audit where one of the individuals in IT was reviewing footage, saw that a key was used, realized and questioned whether that individual should have had that key or not, got an investigation going, and got a condition report written.

So, when you talk about nuclear safety culture, in that monitoring panel, we bring multiple different documents and discussions in to assess --

the main thing we assess is do we have a production over safety environment?

So we would know if there was a systemic issue because more issues and other avenues would detect that we have integrity lapses. And we're not seeing those. I know we're talking about three issues here. If you look at it, it's about one a year, 2018, 2019, and 2020, for the three issues we're talking about now.

But I just felt it was important to say that only one was found through the integrity audit. And all the integrity audits, when they get rolled up, the SFAM or the Department Manager reviews them, submits them. The Corporate Functional Area Manager has a review of them, and then they all roll up to myself for -- I look at what was identified in there. Were there anomalies that were misclassified and could potentially be willful? If something was willfully identified in the audit, I know about it long before the audit was ever sent to me and finalized.

But I review all of those to see, are we having other issues? And our method is meant to

detect integrity lapses, and we're not seeing those. So I'm answering your question with, if it was systemic, we would have more issues identified in various other avenues.

MR. TAYLOR: Okay. Thank you for that.

I don't have any other questions. Anyone else at NRC have questions to offer?

MR. HAY: This is Mike Hay. I've got a question regarding the third bullet on the slide that we're looking at. It talks about there was no impact to the NRC's ability to perform its regulatory function.

So I guess I need to understand that bullet a little better. When I think about willful misconduct, I think those sorts of activities inherently impact the ability of us to perform our function, falsified records that we would review, potentially books that shouldn't be qualified would be qualified -- I mean, I can just think of a number of scenarios where willful behaviors can result in things that will affect the ability of us to do our regulatory function if that information or those activities aren't done correctly.

So is that bullet just trying to say that for this particular (audio interference) no impact?

MR. SCHENK: Hey. This is Tim Schenk. So, yeah, that's exactly what it's trying to say. There was no impact, no outcome of it. I mean, this is something that was internally identified and rectified, and it didn't exist for an extended period of time that would allow someone to go do something that would have impacted NRC's regulatory function.

So yeah. That's exactly what it's saying. It's zero outcome because our process internally identified it. Does that answer your question, Mike?

MR. HAY: It does. It does. Thank you. I just -- I wanted to share at least my perspectives also. I do recognize this time it was identified, so there was no real impact. But I think, from my perspective, it's the behaviors that are the important thing to think about here. But yeah. I do understand. Thank you.

MR. DODSON: Hi. This is Doug Dodson. Perhaps the answers are similar, but related to your first bullet there on slide 17, you noted that there were no potential safety consequences. Can you talk

about how you came to that conclusion?

MR. SCHENK: First of all, the individual passed the exam that was falsified. So the exam that was re-created only stopped an individual from actually having qualifications to do anything. So, again, nothing took place after this falsification. And the potential of it was not there because we had a requisite knowledgeable individual who was just denied a qualification because of this falsification.

MR. DODSON: Okay. Thank you.

MS. HALTER: This is Mandy --

(Simultaneous speaking.)

MS. HALTER: This is Mandy Halter. I'm the Vice President of Regulatory Assurance.

Nick, I heard your question, your line of questioning around the timing of this Proctor issue. And, candidly, we expect to get the same kind of questions for the other issues that we're going to talk about today.

And I think it's important to acknowledge that they actually gave us a confirmatory order that lasted over the course of multiple years. And that was by design because we recognized, the NRC

recognized, that changing behaviors, changing culture, it does take some time.

And last year, at the end of 2020 -- September of 2020 -- we received an escalated enforcement action, and now it was EA20018. And in that enforcement action, the NRC seemed to acknowledge that these things take time. Specifically, it said the NRC also noted that the corrective actions required by the confirmatory order remain in effect at ANO through the remainder of 2020. This order was issued as a result of a successful ADR mediation session, resulting in a settlement agreement related to the apparent violations involving deliberate misconduct that occurred at a different Entergy (audio interference).

The order confirmed Licensee commitments made by Licensee to deter and detect deliberate misconduct at all power reactor Licensees owned and operated by Entergy, which included ANO. The NRC determined that the corrective actions required that a confirmatory order were in the implementation phase during the October 10th, 2018, event involving the prohibited items and would provide a high likelihood

of deterring a similar event.

So, John Monninger, we appreciate that he wrote those words to us, and we just ask you to, as we talk this morning, think about the fact that this confirmatory order was multiple years.

Thanks.

MR. TAYLOR: So I appreciate that perspective. And just so you understand the reason for the question, there's something -- we're really just trying to make sure we get the information we need to make the right kind of decision in the enforcement process.

And our enforcement policy aks us, when concerning corrective action credit, to specifically look for licensed operator -- or the NRC, considering the comprehensiveness of corrective action, will consider whether or not the Licensee applied the corrective actions to all its similarity licensed operations since they could be susceptible to the same (audio interference) for Licensees having more than one facility or location.

So, for example, in the CDA key issue -- we'll talk about it later -- there was specifically a

fleet extended condition review performed for that issue, and the results of it are in the Corrective Action Program. They're easy to see and read.

And I'm looking through the root cause right now for this issue. There were eight actions taken that are attached to the root cause evaluation, none of which, as near as I can tell, describe any extended condition that was done to the fleet, contrary to the apparent cause that was performed for the CDA key issue.

Now, maybe that fleet extended condition is located elsewhere, or maybe I have an outdated version of the document. Both could be possible. So I'm really just seeking clarification as to where we can see the results of the fleet extended condition review that was described during the conference. Thank you.

MR. SCHENK: Any additional questions of any Proctor?

MR. MONNINGER: Yes. This is John Monninger from the NRC.

So you talked about putting in place a good safety culture, good procedures, expectations, to

potentially avoid setting individuals up but recognizing that human errors will occur, and then the distinction between a human error becoming a willfulness issue is really the issue of integrity.

So, in terms of this individual, he believed he had lost the test. I guess he didn't actually lose the test. It was in the envelope, the file, whatever. What would have been the consequences -- can you elaborate on how do you come forward with believing that he had just loss the test? What would have been the consequences to him, and then what would have been the potential consequences he believed would have occurred to him? The barrier between taking it to the willfuless. What would he have believed would have occurred to him if he had come forward saying that he had lost that exam?

MS. BABAN: There's absolutely no consequence for him telling us that he lost the exam. For -- the best is he would have had Principal Level 3 re-create another test, which is no consequence, and then the test taker would've had to redo the test, which is also of no consequence. There's no consequence to the Proctor to identify the issue.

MR. MONNINGER: This is John Monninger. So, to follow up on that, then, I guess his response talked about workload, ability to complete workload, et cetera. So, I mean, could there be a view that in him not -- in losing the test, he wasn't completing all the work assign -- what would have been the consequences of him not completing all the work assigned to him? Is there a delta between the test and a view that he is unable to handle his work?

MS. BABAN: When I asked him specifically why didn't he ask to have the Principal Level 3 retake it, he said it did not cross his mind. So it just wasn't part of what he thought of. His focus was trying to cover up the -- what he thought was a mistake.

MR. MONNINGER: Whether it was pride or -- you know, to me, this case and then the CDA, you have individuals with -- this individual had 30-something years of experience. So it's just a tremendous waste of history and resources. Anyway, thank you.

MR. SCHENK: Thanks, John.

Anything else for the NDE Proctor?

MS. VOSSMAR: This is Tricia Vossmar, I

think if there's no more questions on our side -- I'll give one last opportunity for our folks.

(Pause.)

MS. VOSSMAR: All right. With no more questions, I'd like to offer an approximate ten-minute break. We planned for this in the schedule. I have 10:35 here right now, so let's plan to be back at 10:45 where we can reconvene.

(Whereupon, the above-entitled matter went off the record at 10:35 a.m. and resumed at 10:45 a.m.)

MS. VOSSMAR: All right, everyone. I have 10:45 a.m. here. I'd like to go ahead and reconvene the meeting.

I put a note over in the chat with respect to viewing the licensee's presentation. We've better uploaded the presentation into Webex so that you can see it a little bit more closely.

So, in order to best see and best view their presentation, please go up to your menu at the top of Webex, select view and then fit to viewer. That should allow you to see the presentation as a whole rather than just a piece of it. Note, if you

have any trouble with that, I did put those instructions in the chat.

And with that, I think we have everyone back that we need. I will turn it back over to River Bend Station. Thank you.

MR. REYNOLDS: All right. Thank you, Trish. At this time, I'm going to turn it over to Dan James so we can discuss the operator rounds issue. So next slide.

MR. JAMES: Good morning. I'm Dan James, currently senior manager of operations at River Bend Station. At the time of the issue, I was the station senior license holder and assistant ops manager of shift responsible for the overall performance of licensed operators and non-licensed operators. I held both senior reactor operator licenses, thank you, held both senior reactor operator licenses and reactor operator license at River Bend Station.

The overall responsibility for the shift crew's performance issue was disappointing to me. And I wanted to take immediate action to ensure the behaviors were addressed in a timely manner.

Personally, I do take full responsibility

for the failure of the operators in this case. And River Bend continues to ensure this lesson is communicated in both initial and requal training so we never experience failure like this again. Next slide, please.

In September of 2019, two non-licensed operators failed to inspect certain panels during rounds in the control building.

As part of Entergy's self-auditing process, operations management periodically placed a yellow piece of paper, referred to as a golden ticket, on a specific piece of equipment, in this case, it was a non-safety related alarm panel, to require to be inspected as part of routine operator rounds.

When found on a panel, the operator is supposed to retrieve that golden ticket and return it with the completed rounds. Entergy discovered the potentially missed inspection when the two NLOs did not return that golden ticket to operations management as instructed.

A subsequent independent investigation into the matter concluded that each operator incorrectly assumed the other completed that

inspection. While the over-instruction watch has the overall responsibility for the watch station, both the operators were culpable.

A gap in communication caused this miss since neither validated their assumption that the other had completed that inspection.

The following slides will detail the issue and the findings of our investigation. Next slide, please.

This picture shows the position of the sign as placed prior to the control building operator rounds. These components are alarm panels for non-safety related services building ventilation.

This equipment if an alarm does display both audible and visible annunciation. These panels remained available and functional to provide alarms as evidenced by the satisfactory inspection the previous shift and the following day. Next slide, please.

Prior to arriving at the panels with the golden ticket, the NLOs completed the inspection of the area pictured. The operators paused in the area of the red circle for a discussion on the filter train for training purposes.

When the discussion concluded, they agreed to postpone additional discussions till the end of the round to prevent an unusually long rounds tour.

The over-instruction led the way in the direction of the arrow indicated to the next inspection point, which was the golden ticket panel, believing the under-instruction was directly behind him.

In fact, the under-instruction was looking down at his handheld waiting for it to wake up following a period of inactivity. Next slide, please.

When the over-instruction passed by the panels UA 250, 425, and 650 located in the yellow box on the picture, he called out these panels to the under-instruction, who was still behind at the discussion point.

The over-instruction did not look at the panels and, therefore, did not see the golden ticket hiding in the lamps of the 650 panel.

Although the over-instruction called out the panel numbers as a reminder to the under-instruction to perform the inspections, the under-instruction mistakenly believed the over-instruction

called out the panel numbers because he had completed the inspections.

The under-instruction then rapidly made entries into the handheld signifying satisfactory inspection results when it woke up.

After he completed those entries, the under-instruction noticed that the over-instruction had moved on toward the next inspection point without him. Under-instruction then quickly walked by the three panels without looking at them, also not noticing the golden ticket. Next slide, please.

MR. HAY: Can I ask a quick question?

MR. JAMES: Sure.

MR. HAY: This is Mike Hay. I'm trying in my mind to I guess understand how they each mistakenly thought the other one did it.

You know, I was an operator. And I obviously was once trained, and I was a trainer also. And, you know, typically what I'm used to is you have a system set up that you follow.

And if what you're telling me is the system is the upon-watch person calls out the panels and then the under-instruction watch assumes that that

means he did those activities so the under-instruction didn't have to do that, is that the way that those folks learn how to do the job there?

MR. JAMES: Absolutely not. And we are not excusing the performance of these operators. This was extremely poor performance, poor attention to detail, poor decision making by the over-instruction watch. We are not excusing that at all.

Where we're going is that it was not a willful issue. And I actually address that in the next slide. If this doesn't answer your question, we can get to it again in just a second.

We engaged an investigator, who was independent, at River Bend Station and Entergy to investigate this issue. The investigation found there was a breakdown in communication between the two operators and that each incorrectly believed without validation that the other performed the inspection.

The operators did exhibit poor performance and poor attention to detail, but neither operator deliberately violated Entergy procedures nor acted with careless indifference to the inspection. They certainly did not intend to miss the panel inspections

or violate procedures.

Deliberate violation requires a worker make a conscious decision to violate a known requirement. The enforcement manual also requires that an accused employee knew at the time that his actions violated the applicable requirement and that he did so anyway. That is not the case here.

The over-instruction acknowledged that he knew the requirement to be with the under-instruction during the round. But he did not make a conscious decision to violate the requirements associated with his responsibilities as over-instruction as he approached the panels.

It's clear the over-instruction honestly believed he was with the trainee as required by the governance at the time. Obviously, he was mistaken.

As he passed the panels, he did not hear an audible alarm. And he personally believed he knew the panels were in satisfactory condition. He also believed the under-instruction was right behind him and that that under-instruction was confirming his understanding of the panels' satisfactory condition.

As we know, the two operators were

together immediately before the panel checks. And the over-instruction did not learn until after he passed by the panels that the under-instruction was not right behind him.

Nevertheless, based on the over-instruction passing presence at the panels, the absence of an audible alarm, and his direction to the under-instruction, he believed he had a clear personal understanding of the equipment status.

The behaviors exhibited were not representative of excellent standards that we expect. However, we determined the investigation was not a willful issue. Next slide, please.

MR. KOZAL: Hey, real quick, I have a question on that. What does your procedure say or what are the expectations in the over-instruction watch as it pertains to actually completing the rounds?

For instance, would it be okay if the over-instruction watch did not look at the panels but, you know, watched the under-instruction watch look at the panels and get the readings and indications there, or is there a requirement for the over-instruction

watch to also ensure that the readings are appropriate and appropriately logged? Thanks.

MR. JAMES: There is a requirement for the over-instruction watch to ensure the readings are correct and that there are entered correctly into the handheld. And that's what --

MR. KOZAL: All right. Thank you.

MR. JAMES: Corrective actions taken to remove the non-licensed operator qualifications pending investigation of both operators. Each operator was formally disciplined with a written warning for violation of Entergy procedures and poor performance.

In addition to the direct actions for the individuals, we recognized the opportunity to enhance the behaviors of other personnel to ensure over-instruction and under-instruction conduct is in line with expectations of excellence and integrity.

With that in mind, we updated all non-licensed qualification cards with a section to ensure that understanding of over-instruction and under-instruction responsibilities.

Each crew also held a stand-down to brief

the responsibilities and ensure understandings of what rounds integrity meant.

We're confident the remedial action taken to formally discipline the operators with a written warning was commensurate with the circumstances and that neither operator deliberately violated the requirements or acted with careless disregard.

During our recent calls of product (phonetic) for the Severity Level IV received in July, we did identify additional corrective actions that will help strengthen the over-instruction and under-instruction controls and standards.

These actions include a brief by operations management on operating experience for each rounds issue for each new class of operators, a brief by each shift manager to new trainees on their crew for conduct and integrity during rounds.

And we will now require management observation be added to the first set of rounds of all qualification cards to ensure over-instruction and under-instruction conduct is understood and practiced correctly and observed by management.

Since this incident occurred, golden

ticket audits have been successfully completed over 30 times at River Bend. And key card audits of over 60 different rounds inspections on site have found no other issues.

To close, I want to emphasize I do understand and my team understands the importance of ensuring the highest level of integrity when performing work at Entergy. My team continues to challenge our operators with methods to ensure they have the right mindset and disposition to ensure integrity in all aspects.

From the time of this issue, we took ownership of the identified behavior gaps. We self-identified the issue with an existing internal integrity audit and reported the issue immediately upon discovery.

At this time, I'll turn it over to Tim to provide our enforcement perspectives if there are any questions.

MR. KOZAL: Yeah, I have a couple of questions if you don't mind stopping right here. And then we can talk about the enforcement perspective. Is that all right with everybody?

MR. JAMES: Yep.

MR. KOZAL: Hey, thanks. So, first of all, did you guys as you looked at this, have you, did you do any type of causal product associated with this issue?

MR. JAMES: We did not. At the time, it was, the CR was graded as a non-adverse address and went into confidential CAP, which was the process at that time.

We have now done an apparent cause. With the severity level poor we got last month was where additional actions came out.

MR. KOZAL: Okay. Thanks. Secondly, just under a year ago, we issued a violation to River Bend Station for specifically not completing rounds and in the context of over-instruction and under-instruction watch control.

Those examples are a little different than that one, this one in some cases. But they're, at the root of the base of the violation, they're effectively in our perspective kind of the same thing.

Could you describe your corrective actions that were related to those that were implemented I

think it was about September of last year and why those weren't effective in preventing this from happening?

MR. JAMES: Well, this incident happened a year before that violation came out. This was September of 2019. That violation we got was September of 2020.

The corrective actions that we took there was revising of the EN-OP-115-01, which required the operator, the over-instruction operator to be with the under-instruction operator during all rounds.

What makes this not willful but poor performance is that operator believed he was in compliance with that, that he believed he was with the operator by being in the area with him.

So we took actions to strengthen that understanding for everyone to be able to know that with the trainee is not in the same area. It's actually validating the readings with the operator and validating those readings are input correctly.

MR. KOZAL: And, no, I appreciate that. Thanks. You're right about the 2019. I got my time crossed on this. I appreciate it.

All right. I think I -- that's the end of my questions right now. If you guys want to go ahead, that's fine. Thanks.

MR. MONNINGER: Hey, Danny, this is John Monninger. Could I just ask a brief question? I'm not sure. You know, for the under operator, I assume it wasn't their first time, you know, at those three or four panels, whatever.

But you had talked about the over operator walking by and not hearing any audible alarms. I assume it's more than just listening for the audible alarm. It's taking data, et cetera.

What's the typical time duration that someone would stand, you know, a rookie standing by the panel taking, you know, the readings versus, you know, a qualified individual? Is it a five-second thing or is it a minute thing? I'm just -- the delta --

MR. JAMES: Probably about, yeah, two seconds per panel.

MR. MONNINGER: Okay.

MR. JAMES: And this was the, the under-instruction watch, this was his last watch station

qualification. He was qualified for previous watch stations. So he did have a knowledge of how to do panel checks.

MR. MONNINGER: Okay.

MR. JAMES: And the, not hearing the audible alarm was not the inspection. That triggered the operator's mind that the panel was still satisfactory with no out of spec conditions for the system. They did require a test push button to be depressed to test the lamp function and the bell function on the panel.

MR. MONNINGER: But it's not a 30-second thing of taking down 15 different measurements or anything like that.

MR. JAMES: That's correct. It tests silence immediately, and they reset on their rounds.

MR. MONNINGER: Okay. Thank you.

MR. JAMES: Any other --

MR. KOZAL: Yeah, one more, Mr. James. Did the, the under-instruction watch, was he aware of the requirements as well?

MR. JAMES: The requirements of EN-OP-115-01?

MR. KOZAL: That's right.

MR. JAMES: Yes, he was also aware of the requirements and believed the same as the other operator, that they were together.

MR. KOZAL: And is that individual, at the time, was he qualified at other watch stations?

MR. JAMES: He was qualified at other watch stations, yes.

MR. KOZAL: All right. Hey, thanks a lot. Appreciate it.

MR. SCHENK: All right. Thanks, Dan. You should be on the next slide that has enforcement perspectives.

All right. Entergy recognizes that the operators made a mistake that resulted in a non-compliance of operator rounds procedures.

We identified this non-compliance through our self-auditing process, which is the use of the golden tickets. We initiated an internal investigation. And we took corrective actions described by Danny during his presentation.

During this process, we kept the NRC informed of our findings. However, the facts

discovered during our internal investigation do not support a finding of willfulness.

The operators miscommunicated with one another and neither operator intentionally failed to complete the control building round. Next slide.

Now, prior to the issuance of the confirmatory order, Entergy had issues with willful violations of operations personnel. And that's a historical fact.

Entergy performed root cause evaluations dealing with these issues. And we believe that the ultimate corrective actions were effective.

Entergy continues to hold that the non-licensed operator rounds issue that we're here discussing today was not the result of ineffective corrective actions from the confirmatory order. Instead, it was a miscommunication between the individuals that led to the violation of procedures.

The actions that we have taken as a result of the issue are effective in keeping this type of miscommunication and mistake from happening again. Next slide.

Entergy believes that this issue was not

willful and has very low safety significance. Based on our thorough internal investigation, Entergy found no indications of willfulness associated with the incomplete operator rounds.

At the time the operators were conducting the rounds, both operators mistakenly thought the other had inspected the panel that was obscured by the golden ticket.

We simply have no evidence that the over-instruction operator acted with reckless indifference to the inspection, let alone that he intentionally skipped it.

As for the safety significance, the inadvertently missed panels remain fully operational and actively monitored. The equipment would have provided both an audible and a visual annunciation had an abnormal condition existed. In other words, if there had been a problem with the equipment, the operators would have recognized it despite their miscommunication.

This missed panel check of non-safety related annunciator did not result in any safety consequences or impact the NRC's ability to perform

their oversight function.

In addition, Entergy has already received a licensee-identify Severity Level IV non-site violation on this issue.

Entergy's perspective is that this issue was adequately addressed through the licensee-identified Severity Level IV non-site violation which was issued and the previous screening of the event as minor under the ROP process.

Thank you. And are there any questions on this issue? All right. Hearing none, at this time Mark Feltner will discuss the CDA key issues. Next slide.

MR. FELTNER: Good morning. I'm Mark Feltner. I'm the assistant operations manager at River Bend Station. I've worked in the nuclear power industry for over 37 years and was previously licensed as the senior reactor operator at River Bend.

I have recently been assigned to lead a station initiative to improve plant equipment performance.

At the time of this issue, I was responsible for operations and involvement in the work

management process both online and (audio interference). In this role, the workweek SROs, senior reactor operators, reported to me.

I was disappointed by this issue and take full responsibility for its occurrence. Next slide, please.

~~**[N/SRI]**~~ In April 2020, Entergy cyber security performed an audit and identified that eight days earlier on the last day of March a maintenance supervisor had opened the door and entered the **[REDACTED]** for no more than 30 seconds.~~**[N/SRI]**~~

The equipment in this building is considered and classified as a critical digital asset, a CDA, and requires a specific CDA key to access the building.

CDA keys can only be issued to members of the critical group. The supervisor who entered the building was not a member of the critical group.

The auditor reported this discovery to the cyber security manager, who promptly directed the initiation of a condition report, which led to a causal evaluation. Next slide.

~~**[N/SRI]**~~ On March 31, 2020, a mechanical

maintenance supervisor discussed with an operations workweek SRO the performance of scheduled maintenance on the **[REDACTED]**. ~~**[N/SRI]**~~

During their discussion, the supervisor requested a CDA key from the SRO. Both individuals were uncertain if a CDA key was required to perform the scheduled work.

Using the key control database, the SRO verified that the supervisor was not in the critical group and explained that he could not issue him a CDA key.

He also checked the qualifications of other members of mechanical maintenance and determined that no one in that department was in the critical group. Additionally, he verified no non-licensed operators were available to escort the supervisor.

The SRO then chose to issue the key to himself and gave the key to the supervisor. The SRO requested the supervisor to check with other maintenance departments to see if they had members of the critical group that could be available as an escort. The SRO explained that he would transfer the key responsibility to the critical group member if one

were located.

~~**[N/SRI]**~~ The SRO also told the supervisor that if he were unable to locate an escort and he required entry into the **[REDACTED]** the supervisor needed to contact the work management center and he himself would be the escort. ~~**[N/SRI]**~~

~~**[N/SRI]**~~ Upon arrival at the **[REDACTED],** the supervisor and his crew determined that a CDA key was not required to enter the **[REDACTED].**~~**[N/SRI]**~~

~~**[N/SRI]**~~ While at the **[REDACTED],** the supervisor used the CDA key to open the door to the **[REDACTED].** He entered the room for no more than 30 seconds. And then he exited and closed the door. ~~**[N/SRI]**~~

Based on confirmation following the audit, no cyber security controls were manipulated or altered.

The actions of these individuals in no way reflects the standards or expectations that either I or Entergy have regarding the performance of work at River Bend Station. Next slide.

Entergy completed an adverse condition analysis of the cyber security program protocols and

Entergy personnel involved in the issue to understand the issue and determine the relevant causes.

The ACA identified that the SRO knowingly violated the CDA key control requirements due to self-imposed schedule pressure. Recent interviews of station personnel confirmed that there is no indication that schedule pressure at River Bend is anything but self-imposed.

River Bend's nuclear safety culture of monitoring panel monitors for potential transfer concerns. Their focus is on production over safety and has found no issues of concern.

Finally, River Bend Station management has repeatedly focused on reinforcing with our workforce the need to stop when unsure, ask questions to ensure a thorough understanding, and to not proceed in the face of uncertainty.

~~**[N/SRI]**~~ Additionally, the SRO worked under his own assumptions. He assumed that the supervisor would not access the **[REDACTED]** as they had discussed without first ensuring that he had a qualified escort. ~~**[N/SRI]**~~

The SRO, by providing the key to an

unqualified supervisor, failed to question how he could ensure the security of the CDA without maintaining control of the key.

The actions of this individual failed to meet station procedural requirements and standards of conduct. However, no cyber security equipment was manipulated or altered. Next slide.

Entergy conducted an extended condition that focused on similar instances of CDA keys or media being issued to or in possession of non-critical group members across the Entergy fleet. No examples other than the incident before us were identified.

Since October 2019, there have been no other instances at River Bend where CDA keys were issued or possessed incorrectly or inappropriately.

Again, I would like to reiterate that none of the issues resulted in any cyber security issues or tampering. Next slide.

Entergy took several corrective actions in response to this issue. River Bend disciplined both individuals, issuing time off without pay and a written warning to the SRO and the maintenance supervisor.

We believe these actions demonstrate the seriousness of the violation to other employees and will deter others from deviating from requirements.

River Bend operations management reinforced with SROs the importance and criticality of verifying critical group status prior to issuing CDA keys. Robust changes were made to the software requiring verification of critical group status prior to issuing CDA keys.

River Bend operations management focused, excuse me, River Bend operations management employed direct communication and coaching of behaviors related to issuance of keys with a focus on CDA keys.

The signage on doors that require a CDA key was updated to alert individuals of the procedure requirements before opening the door.

River Bend also installed a new key control system that uses fingerprint identification protocol that verifies critical group status prior to the issuance of CDA keys to qualified individuals.

I again would like to express that I'm accountable for this issue and was disappointed in the actions taken by personnel working directly for me.

At this time, Tim will provide Entergy's enforcement perspective on this issue. Next slide.

MR. SCHENK: All right. Entergy agrees that the workweek SRO's actions were in violation of Entergy's procedures.

We identified the issue during a cyber security audit and found no evidence that an error occurred that resulted in equipment or cyber security controls being manipulated or altered.

We conducted an adverse causal analysis to understand what had happened and why. And we developed and implemented the corrective actions that Mark described during his presentation.

During this entire process, we kept the NRC informed of our findings. And I know this because I've been the regulatory assurance manager since, again, 2016. And anything that potentially could be a willful issue I inform our senior resident, our resident inspector. So it's been my practice for keeping the NRC informed of these kind of issues.

But it should be noted that when this occurred it was after the 2020 NRC confirmatory auditor inspection. And by this time, Entergy had

began notifications of the senior allegations coordinator directly as soon as we had a potentially significant willful issue. Next slide.

Prior to 2020, Entergy had issues involving CDA control. Some buildings were found unlocked. Other locks were installed incorrectly, and some improper classification of CDA keys.

While these all involve CDAs, this is the only issue involving a willful violation of procedures by an individual properly issuing a CDA key to himself but choosing to give the key to an employee that was not part of the critical group.

As Mark just described, the significance of proceduralized key control now is much higher and appropriate sensitivity than it once was. Next slide.

For at least four reasons, this incident has very low safety significance.

~~**[N/SRI]**~~ First, there were no actual safety consequences. The result of the SRO's misconduct was that an unauthorized individual entered the **[REDACTED].** And it was confirmed that no equipment or critical digital asset was manipulated or altered. ~~**[N/SRI]**~~

Second, this issue did not impact the NRC's ability to perform its regulatory function. Third, the SRO's actions were isolated and not recurring.

And fourth, the SRO's actions were the result of self-imposed schedule pressure and poor decision making and were not the product of management action.

~~**[N/SRI]**~~ Although the SRO gave the key to someone outside the critical group, he did not intend for that person to access the **[REDACTED]** without a member of the critical group present. ~~**[N/SRI]**~~

The SRO did not intend to gain a specific advantage, economic or otherwise. He acted solely to facilitate scheduled maintenance.

This issue was an isolated action of an employee failing to follow written procedures and policies.

Because of the position of the individual in the organization, Entergy's perspective is that this, is that the safety significance is low and should be assessed as a Severity Level III violation.

Thank you. And are there any questions on

this issue?

MR. TAYLOR: Yes, this is Nick Taylor. I'd like to talk a little bit about corrective actions. And you brought in a nice slide, a few slides back, that kind of summed up those corrective actions.

In looking at those corrective actions, and the others there were in the record, can you describe which, if any of those, would have prevented this occurrence and therefore the SRO knowingly checked out the key to himself and handed it to somebody else?

Is there anything they've done that will mitigate that in the future?

MR. REYNOLDS: Yes, Nick, this is Jeff. Just, the sharing of this operating experience. And we're not able to disclose to the site that we gave an individual time off. But as you know, things like that aren't necessarily kept a secret.

People will know that we took this serious. People know just through the talk around the station that individuals were given time off without pay for this misconduct.

So the corrective actions that will help to prevent someone from just willing making a personal choice to do something, circumventing a process. The corrective actions are communicating what happened to those individuals and continuing to reinforce that we value integrity over getting a scheduled item done.

Or, if you have anything else --

MR. SCHENK: Yes. And in addition to that, and Kent stated it earlier, that we realize our efforts are not going to be full proof in this area and that we're going to have to constantly check and observe our workers, like we are doing with operating rounds to reinforce our standards and ensure that our workers understand the station's expectations.

MR. TAYLOR: So thank you, that's a good discussion. And we also recognize, we've done some follow-up inspection and had some discussion with the station owner in the past six months or so about some of the substantial improvements that have been made in the way in which these keys are controlled. So we recognize all of that.

What challenges us, and I know challenges you as well, is having someone in a position, like a

work week SRO who has all the access and control for all of the processes at this site, making this kind of call, really hard to design corrective actions to prevent that. I think we recognize the reality.

One of the things that we noted, the time line described that this was the only occurrence of this nature, maybe since October 2019. But you would have to go back that far to find many other examples of this.

In fact, you're probably aware that there was QA findings and an audit done in preparation for an NCR inspection that identified many other examples of this. And there was a causal evaluation done back in 2018, going into 2019, that resulted in a similar communication to the SROs.

Sent from Mr. Venable to all the SROs explaining this standard. And the discipline was awaiting anyone who got it wrong.

And when we talk to this SRO he actually was confident that that communication was sent but he didn't remember that it had been lost to his memory. Probably in the fog of everything else. Can you explain how you reinforce this behavior in a way that

might stick a little better than the email from Mr. Venable in 2019?

MR. FELTNER: Yes, I can. Go ahead.

(Off microphone comments.)

MR. FELTNER: Oh, yes. So through, just like we talked about, just through observations, another person had done observations at the work management center of the work week SROs, we had actions for every shift manager to perform at least a one-hour observation of key control of his crew to ensure that we were reinforcing with those SROs the significance and importance of criticality of issuing keys. And so, those actions were taken and were addressed.

And again, reinforced with our folks the importance of this matter based on the importance that the management team placed on the observations thereof.

(Off microphone comments.)

MR. FELTNER: This was Mark Feltner, I'm sorry.

MR. TAYLOR: Thank you, Mr. Feltner. You know, kind of along those lines, the causal effect, or

number one, is that the SRO violated this process to do a self-imposed pressure to encompass scheduled activities.

And again, it challenges us, when we have someone in this position, that makes this kind of a choice. Just because we know these people, they have a relationship with the NRC individually. And that's not the behavior we expect, right.

So that really makes us go back and scratch our heads as to why an individual in this position would feel self-imposed schedule pressure to violate a security standard like this.

We did note, again, that he had received communication that was clear communication, we think, in February of 2019 that this was not to be tolerated and that he could expect discipline for making this kind of a choice. So we tried to do our best to understand why, and with that knowledge, he would make such a choice.

We did not note that a few weeks prior to this error, this individual specifically counseled, and I'm reading something directly from his record. He received feedback from the online superintendent,

and myself, about the need to pursue completion of work.

I coached him that as a work week SRO, he should never accept all work scheduled end of work week not being completed. Can you describe that meeting, who was there and whether or not that was considered as a possible contributor to this and that the conclusion was that the schedule pressure was entirely self-imposed?

MR. FELTNER: Yes, I recall, this is Mark Feltner, I did recall that meeting, that discussion. The work week SRO, the work week superintendent and myself were present. It was after a schedule accountability meeting at the end of the day.

The context of that was, I don't remember the specific activity, but Rich had reported out on operations activity that an activity they did not complete on that day. And his comment was basically, it's okay that we didn't finish this job today without any explanation as to what happened and why it occurred.

And so the coaching that we provided to him was, we needed to understand why something didn't

occur, why it didn't happen, why didn't it complete as expected so that in the future we can explain that and we can improve our processes going forward.

It wasn't to tell him that we have to finish everything at all costs. That was never the message. The message was, you put activities on the schedule, we finish the work, and it's not okay that we didn't do that, we have to have some type of action in place to address the short numbers for not finishing those activities.

So it was more his behavior toward not finishing the work as opposed to not finishing the work. And that was very clearly communicated too.

MR. TAYLOR: Thank you. And of course you were there, we weren't. And you have firsthand knowledge of the conversation.

And I take it the statement that he should never accept all work scheduled administration not being completed, that's an overstatement from what was actually communicated in your mind?

MR. FELTNER: In my opinion, yes.

MR. TAYLOR: Okay. Do you know if the apparent cause team that looked at this was aware of

that conversation as a potential contributor?

MR. FELTNER: I do not believe they did but I don't know that. I would have to go back to check. I can take that as a look up.

MR. TAYLOR: Okay. Again, we're trying to make sure we understand the causal factors and what's been done to kind of close the gap on each.

The second causal factor that was identified described that the first line supervisor failed to maintain a questioning attitude. The ACA documents that the first line supervisor noticed he was not in the critical group, accepted a key that he knew was checked out to someone else.

We also noted that the 2018 causal evaluation done after the QA finding identified a similar issue at the station and that first line supervisors were receiving keys with the knowledge that they shouldn't be receiving them and not writing CRs and not mentioning about that either.

And at the time, the fleet causal analysis expert documented that there is a missing causal factor. And again, that workers are giving keys not in accordance, and the program knew they were not

complying with the program but didn't write CRs.

Has anything been done in the corrective action space to react to the fact that the first line supervisor knew that he should not get the key yet didn't do anything in the corrective action space or anywhere else to make that, to bring that to the attention of the station?

MR. FELTNER: No, we did not. When the station considered this action we considered it to be an individual issue. And discipline was the only action we took to address the causal factor too at that time.

MR. TAYLOR: Okay. So the station didn't view this as sufficiently similar to the 2018 occurrences to view that as an ongoing issue with first line supervisors?

MR. FELTNER: No, we didn't because in this instance the supervisor knew he was not in the critical group and he still accepted the key. For the situations you were referring to earlier, were supervisors were not aware, or believed that they were in a critical group, and requested a key and were issued those keys.

And at the time, our system, in our process, that EN-IT-103-07, allowed for verbal communication to the SRO that they were in the critical group. To be sufficient to issue them a key. And we've since strengthened that issue within our process.

MR. TAYLOR: Okay, thank you. We ought to look at the fact finding somewhere that the station performed in April of 2020. And there was something in there that the, part of what we're doing here is just a procedure to the facts to make sure we have actual facts and that we don't surmise anything.

One of the things that was documented in the fact-finding summary for this case was that Mr. Eldeson has had performance issues in the past related to placing great importance on facilitating work in lieu of process and procedure compliance.

We've looked everywhere we can think to look, between talking to the individual, for the underpinning of that statement. Can you provide any perspective on what the basis for that statement and the fact finding was?

Were there indeed previous examples of Mr.

Eldeson placing more importance on facilitating work in lieu of process and procedure compliance?

MR. FELTNER: Yes, I can. During a review of his working file, during RF-20, which was in early 2019, while working in the work management center, Mr. Eldeson authorized a temporary lift of an administrative tag out at the Fancy Point switchyard.

The activity allowed the removal of certain tags from a tag out on a temporary basis. This is specifically not allowed by Entergy's procedures, specifically EN-LI-102.

In this case he was acting in knowledge space as he was not aware of the requirement. However, during my discussions with him expressed several times that he did not look at the procedure nor did he involve other more experienced SROs to assist in the evaluation.

He stated that he understood that removing the tags would have no impact on the safety of the workers, and of the tagging boundary, and was trying to allow maintenance technicians to get their work accomplished.

MR. TAYLOR: Okay, thank you for that.

Was it just that one relevant example that you could think of or was there a trend of this?

MR. FELTNER: That was the only example that I could think of off the, you know, looking at this working file that I saw directly tied to the execution of work or the importance of the procedural violation kind of thing.

MR. TAYLOR: Okay, thank you. One of the things that looked like it was a significant topic of discussion between the work week SRO and the first line supervisor was whether or not a cybersecurity key was really required for this work.

They obviously had a substantial discussion about this that involved the, I think a trip back to the work center for the first line supervisor to figure out why a key was needed. Is there somebody else in the group that can get it.

And they appeared to not reach an understanding of why a CDA key would be required for the work that they were doing. Can you describe whether or not any actions had been taken to look at whether the work orders require something that shouldn't be there or why the individuals didn't

proceed in the face of uncertainty and just issued the key as opposed to trying to resolve that question?

MR. FELTNER: Well, to address the first part of your question, this is Mark Feltner again. To address the first part of your question, I did review the work order. I've reviewed it multiple times. I had a colleague review it.

And could find no reference to the use of or the requirement for a CDA key for the job. The work instructions did note that workers needed to contact security and operations to gain access to the area.

The only thing I can surmise or, and figure out what happened here is the supervisor may have realized that the key was needed. And when they were discussing the need for the key, they went to the key log to look at what key would be needed.

~~**[N/SRI]**~~ And they noted that there was a CDA key that was needed to get into **[REDACTED]**. And I can only, again, surmise that when they had that discussion it was, well, let me give you the key. Don't use it unless you need to kind of comment. And that's where we ended up issuing the CDA key to

himself and then providing that willing to the supervisor. ~~[N/SRI]~~

MR. TAYLOR: Thank you. That's actually a little clearer view of the facts than I think I had relative to the work order.

Has any action been taken to reinforce the right behaviors as far as proceeding in the face of uncertainly?

Because it sounded like there really wasn't a clear signal that a key was required yet the work, we would expect the work week SRO has all the authority in the world to change the work order or to get the clarification needed. So it challenges our thinking that he felt the need to proceed with uncertainty in that decision.

MR. FELTNER: Yes, and as we've discussed --

MR. JAMES: If you want, I can actually speak for that.

MR. FELTNER: All right. Thanks, Dan. Sure.

MR. JAMES: This is Dan James, senior officer at River Bend. We do have an operations core

business in the behaviors document that has been in place for about a year and a half now.

We call it a, don't answer your own question campaign. It's actually to stop work criteria guidance that requires one step removal for answering your own question. That is in place for operations now.

Whether it would have stopped this instance I can't answer that. We do have a process in place for that kind, we still have behavior review.

MR. TAYLOR: Thank you, Dan. Moving on to a little bit different topic. The fleet extent of condition review.

And again, this is something we look for in cases like this to make sure we understand what the utility has done to look around the fleet for similar problems. And the good news is, it's pretty well documented in the apparent cause evaluations, so that was pretty easy to follow.

But it looked like the extended condition effort conducted by the other stations in the Entergy fleet looked at basically two things. It asked the other stations to look for evidence of similar

problems by looking at the key control log and to look for evidence of problems in PCRS. That condition reporting system.

Would this error have been apparent in either of those processes at River Bend?

MR. FELTNER: This is Mark Feltner. So, I believe that it would have. The extended condition that we asked the folks to perform, we were looking for instances where key or media had been issued to somebody that wasn't qualified. And there were none of those that were identified.

So they went back and did audits of the people that received the keys and verified they were in the critical group. So we didn't have those instances.

Then we also looked at were there any instances of an SRO or other group providing they keys, and we couldn't find that.

MR. TAYLOR: Thank you for that.

MR. FELTNER: I think it would have been. I think it would have been effective.

MR. TAYLOR: But in this example though the SRO --

MR. FELTNER: And it wasn't.

MR. TAYLOR: -- checked the key out to themself. Would that have appeared as a violation?

Had you looked at your own key control log, would that have raised an alarm with anyone?

MR. FELTNER: I don't think that it would have because we would have identified that he wasn't a member of the critical group. And I don't think the issue at hand was that he checked the key out for himself, the issue is that he may have exercised poor judgment and then took the key that he checked to himself and handed it to an individual that he had just verified was not in the critical group.

MR. TAYLOR: That totally makes sense, so thank you for that. So, how would this extended condition review have identified his similar behavior in other station of the Entergy fleet?

MR. FELTNER: By not showing that it could have it there was an individual who chose not to follow our rules and processes and went ahead and provided a key to other individuals.

MR. TAYLOR: Okay. And given that the first line supervisor knew he received a key that he

shouldn't have but didn't write a CR, would a search of PCRS reveal this type of issue at another station?

MR. FELTNER: Probably not. I don't know for certain but I would say probably not.

MR. REYNOLDS: No, it wouldn't reveal that an individual did not go write an additional report. I think that is a question you asked us, so I will just note, if an individual willingly took the key and proceeded to go do the work, at that point he's not thinking he needs to write a condition report and he goes on about his business to perform the work.

So, if we have someone who inappropriately receives a key and does not see the need to write that, offered the key or actually receives the key, if they don't go write a condition report for that then no, a PCRS search is not going to help us there.

(Off microphone comments.)

MR. REYNOLDS: Yes, it was Jeff Reynolds.

MR. TAYLOR: Thank you. So, last question. And again, it's very important to us that we understand your understanding of causal factors because that drives everything in a corrective action space, right?

So, again, there's two causal factors identified here. Just to paraphrase, the work week SRO had self-imposed schedule pressure that caused him to violate the procedure. And that the first line supervisor operated under his own assumptions and performed work that was contrary to the procedure.

But we see other factors that were involved. This SRO apparently was not working in his work week, per say. He had been called in, I think due to COVID losses, to operate someone else's work week, so he wasn't familiar with the work that was in the schedule.

The COVID conditions had clearly reduced the number of staff available. And we understand that challenge completely. But the normal resource that the work week SRO had at his disposal to help go out to the field with craft was diminished.

We have learned through discussion with the individual and follow-up that there really hasn't been any training procedure on the control of cybersecurity keys at the station, have been trending on key control but not on the unique aspects of the cybersecurity key control program and the physical

requirements for CDAs.

Also aware of some looseness in the manner in which CDA keys were controlled. And at the time of this incident they were basically loose in a cabinet mixed with other keys. And the SRO viewed the looseness of the controls and the manner with which craft had apparently been left alone in CDA areas historically as conveying that this program was somewhat less important.

There was clear indication that the work week SRO and the first line supervisor proceeded in the face of uncertainty, not understanding why a CDA key was needed. And not resolving that before they went to the field to go do work contrary to the procedure.

And then there was clearly some communication of schedule importance to the work week SRO that he clearly recalled, more so than he recalled the message from station manager about proper compliance with the key control procedure.

So we see those other factors in the record. But then we noted in the apparent cause that the organizational programmatic screen determined

there were no organizational programmatic causes for the actions taken by the individual.

Can you explain that, you know, how you came to the point of view that there were no organizational programmatic causes that contributed to this and no actions taken along those lines?

MR. FELTNER: Yes, sir. Yes. So to address, by the way, you brought up a lot of points there, I'll try to make sure we address all of them.

First off, I did go back and look at the shift roster for the day in question and verified that we had our normal complement of non-licensed operators. So there may have been some COVID issues, yes, but we did have the normal complement of seven to, I can't remember if it was seven or eight, non-licensed operators available on that day. Which is the normal complement for that shift.

There was an illness and Dan Rich was filling in that day at the work management desk. There were other SROs, and the work week SRO, work week manager also there to assist. And also myself available to assist if needed.

Going down and looking at the bigger

question you asked, I'm trying to, I've lost my train of thought I'm sorry. You were really looking for --

MR. TAYLOR: Organizational and programmatic.

MR. FELTNER: O&P. Yes, right, the O&P. When we looked at this, we did a human performance evaluation. And that human performance evaluation led us to the point of, this was an individual accountability issue and an individual willing provided that key that he knew didn't, should not be issued to the supervisor but he issued, handed it to him and provided it to him anyway.

And so when we got into the O&P aspects of that, and we looked at those areas, that did not come up as evaluated those issues. Those did not arise in our evaluation.

And the overriding factor there was the individuals choice to provide that key to the supervisor.

MR. REYNOLDS: So I want to add a little bit to that. This is Jeff Reynolds again.

So, we don't have a causal product in front of us right here to go look at how we answered

the organizational and programmatic screening, but I am familiar with the fact-finding of these individuals because I sat in on both of the interviews with the maintenance manager and the operations manager, and we interviewed them separately.

So, we're specifically talking about the SRO at this time. So I get the fact that he was brought in for overtime and he was filling in for a different SRO. Well, that happens. We bring different people in all the time to stand watches for unforseen circumstances.

That does allow that person to not follow rules and it doesn't put schedule pressure on that person to get a schedule done just because you're filling in for the work week SRO. I've done all those jobs. A work week SRO as a CRS, a shift manager. That's not the message that you get sent when you get called in on overtime, you're still expected to abide by the rules and follow them.

When we talked to this individual, he spent a lot of time trying to find someone that could possess the key. So a lot of time spent, well, can I get this operator to do it, can I get you an I&C tech

or an electrician, somebody I can check it out.

Ultimately in the end, the individual said, well, I'll just sign this key out to myself and I'll give it to you. We don't know we're going to need it, but if you get out there and you do need it, I will then come out and be your escort.

So I just think it's important to talk about the individual and put into perspective, he's a little more of a pleaser. So he choose to go do this, to try to get this work done.

Spent a lot of time turning trying to find a way, or someone who could officially have the key. So the fact that he was called in additionally, to me it's irrelevant because he clearly stated he knew the rules and trying to find different ways to follow the rule, couldn't find it, ultimately made his choice to do what he did.

So, that's why I don't want to answer directly to the O&P and why here weren't any gaps there, but I would offer that through the fact-finding that would lend you to, why weren't there organizational and programmatic gaps.

One question you ask when you get into

these is, would others act the same, and that answer was no, we did not find other SROs that would inappropriately, knowingly sign a key out to someone else and then try to accommodate that work.

So, I hope that helps in the O&P gaps. And tried to give you just a little more detail on the individual and his specific performance and the things that he told us in the fact-finding that I sat in on.

MR. TAYLOR: I appreciate that additional perspective. And I guess it just, this is a little bit of a challenge for us because we know that there is knowledge at the station that this is a more widespread behavior. Even a year or so before this that actually resulted in a direct communication from Mr. Venable to all the SROs that basically stopped doing this.

So that's a challenge for us, I think, to put that recent history --

MR. REYNOLDS: Yes.

MR. TAYLOR: -- and understand that there is no one else at the station that might feel this way.

MR. REYNOLDS: Yes. So this is Jeff

again. So just want to make sure that we talk about those as they're a little different.

A little more of a complex process. There was some issues, we had cyber key issues. People not necessarily understanding the process and proceeding in uncertainty.

Some process changes and a communication from the senior ops manager, which was Tim Venable, on, I expect you to follow these rules, and if you don't know, you ask questions. Now we have an individual who clearly knew the rules. They weren't hard to follow and he willing chose not to follow the rules.

So I would say those issues are, I wouldn't say they're totally separate. I don't, I'm not saying that. But they are different issues with different causes. And also different corrective actions. So I hope that helps.

MR. TAYLOR: Thank you. No other questions. It's open to any other NRC questions.

MR. REYNOLDS: Okay.

MR. HAY: This is Mike Hay. I think, Jeff, you were talking about the enforcement

perspective. And I think at the end, well, I know at the end, you broke up on my phone.

And I heard you say something about, Severity Level III. And I'm assuming what you said is, you all were making an argument that based on those factors you thought that it should not be a Severity Level III, that it basically is a very low safety significance. Which would be dispositioned as a Level IV. Is that what you were saying at the end?

MR. SCHENK: Hey, Mike, this is Tim Schenk, and that was not correct. I'll say it again. What we said is because, because of the position of this individual within the organization, introduced perspective is that the safety significance is very low and should, should be assessed a Severity Level III violation.

MR. HAY: Oh, okay. Okay. Then I have no further questions. Thank you. Appreciate it.

MR. SCHENK: Any other questions on the CDA key issue? All right, thanks, Mark.

We should be on the civil penalty assessment slide. All right. We'll go ahead and move it forward, one more slide please.

All right. For each of these three issues that we have discussed today, it is Entergy's perspective a civil penalty is not warranted. Although these three issues are not the same, there are mitigating factors that appropriately characterize these issues under the enforcement policy and manual.

The three issues were the result of an individual's actions and were not recurring or condoned by management. All three issues had very low safety significance.

And we believe the operator rounds case was not willful. In these three cases Entergy identified and remediated the issue. We reported the issue, and we took prompt and effective corrective actions to prevent recurrence.

We restored compliance as soon as possible after identification. We conducted our investigations, our causal evaluations, and placed the issues in Entergy's corrective action program. And we also kept the NRC informed.

Finally, there have been no previous escalated enforcement at River Bend attributed to events occurring within the last two years.

Next slide. Entergy has reviewed Section 232 of the enforcement policy and contends these facts are pertinent.

Entergy identified the issues, reported them to the NRC and promptly restored compliance. Entergy placed the issues in the corrective action program to restore compliance and prevent reoccurrence.

The issues were not repetitive. The violations were the result of actions by single individuals and were not condoned by management or the result of an inadequate management oversight.

Entergy took appropriate remedial actions with respect to the individuals involved. And these issues did not result in any actual safety consequences nor did they negatively impact the regulatory process.

Entergy contends that the NDE proctor issues should be treated as a licensee identified Severity Level IV non-cited violation. Entergy concedes that the CDA key issue should be assessed as a Severity Level III violation. But due to the low safety significance and the proctor comprehensive

corrective actions taken by Entergy, no civil penalty should be assessed.

Further, with respect to the apparent violations for failing to complete operator rounds, circumstances do not support the finding of a willful violation. Entergy contends the existing licensee identified Severity Level IV non-cited violation, which was issued, and the previous screening of these event as minor under the ROP process is sufficient.

Entergy's perspective is that no civil penalty should be imposed for any of these issues. Are there any questions?

All right, Kent Scott will now provide Entergy's closing remarks. Next slide.

MR. SCOTT: So I'd like to thank you for your time and attention during our presentation. And the questions and open discussion, it is appreciated.

We do appreciate the opportunity to share what we've learned and what we've done in response to these apparent violations. And to present our position that these issues are of very little safety significance.

As our team indicated several times during

our presentation we recognize and we take full responsibility to make sure these types of issues do not recur in the future. I'm confident in the team at River Bend to hold each other to the highest standards and integrity in accordance with our nuclear excellence model.

So from what we've learned from this experience we've been able to demonstrate the strength in our existing processes, to self-identify potential integrity issues and take swift and appropriate corrective actions. Not just at River Bend but across the fleet.

We know and respect that it's the NRC's decision to do what is most appropriate. As such, we appreciate the opportunity to share with our position that the most appropriate assessment for the NDE proctor issue is licensee identified Severity Level IV, non-cited violation. And the CDA key issue assessed as a Severity Level III violation with no-civil penalty.

Thank you again for your time and attention.

MS. VOSSMAR: All right, thank you very

much for that presentation. I am transitioning back to the NRC's slides.

And at this point I would like to step forward and open it up to NRC and Entergy conference participants to ask any clarifying questions from information that was presented today. In order to best facilitate dialog for this portion of the meeting, I'm going to stop sharing the presentation so the meeting participants can better see each other.

If you'd like to see more of the meeting participants on your screen, I can invite you to the layout button on your Webex meeting screen, and select preview.

When the question and answer section is concluded, Staff will depart to caucus, I'm sorry, the NRC Staff will depart to caucus. The purpose of the caucus is to determine if any additional questions need to be asked to clarify our understanding of the issues or to get, or to identify any additional information needed to arrive (technical difficulties.)

NRC Staff will then return to the Webex meeting to continue the meeting. So at this point, again, I'm turning it over for NRC questions

associated with what River Bend has presented.

MR. HAY: This is Mike Hay. And I'm not sure if I have a, I guess I do have a question but I wanted to, I guess, first talk about the fact that we recognize the efforts that you and Entergy have taken dealing with willful activities at the sites.

And Cale Young and Fred Sanchez were at the site just a couple of weeks ago taking a look specifically at River Bend's actions. And the feedback we got was favorable, that River Bend, the actions that you all have taken appear to be working.

And one of the questions that I had was, with our inspectors, was, what's River Bend seeing with respect to the number of items that you all are investigating if you think back to where you first started the audits as compared to today?

When we start talking about, this is isolated but we keep talking about all of these events are isolated, well, when do you get to the point that we're talking about so many isolated cases that it doesn't seem to be isolated. And that's something, in my mind, that I was trying to grasp.

And that's why I think it's important, and

I kind of like you to share, where are you at today with what you're seeing versus where you were at when you began the process?

Because to me there are ought to be less things being investigated. There ought to be less things that are substantiated.

To me that would demonstrate that things are becoming more isolated. I think that was a long-winded question, but I would appreciate some discussion.

MR. SCHENK: Jeff, do you want to take that?

MR. REYNOLDS: Yes. So, this is Jeff Reynolds again. I'll refer back to the graph we had early in the presentation where it shows the time line of where the confirmatory order was issued.

And then we see, so this is an Entergy graph, it's not just River Bend specific. But we look at where our sensitivity to identify potential integrity issues, get them into the process, get them evaluated. You can see there is a pretty significant spike there.

And then the NDE proctor issue was during

that time. And then you see the flat plateau area where the operator rounds.

And then you see the three arrows there as the downward trend. That's where we're saying that we are changing the culture of people and that the issues are becoming less and less.

And early in that slope of decline, which is where the CDA key issue falls in. And talking about the example in my presentation about the mechanics coming forward with their mistake in not signing on to the tag out as a work order holder and bringing that in, there were no consequences for them to bring that in.

There was not necessarily a definitive way to detect that. Those individuals just know the right thing to do was to come in and discuss their mistake. Ensure that we can learn from that. If there are any learnings from it.

So, not only are we seeing a graphical representation that the cases are going down, we have an example of where someone has brought forward an issue and disclosed that that made a mistake.

And I know I can go find other places

where people have brought forward I have made mistakes, but that one is just really relevant to me because of the importance of tagging and then two individual contributors displaying that level of integrity. Does that help answer your question, Mike?

MR. HAY: It does. It does, thanks. Thanks very much. I appreciate it.

MR. REYNOLDS: You're welcome.

MR. KOZAL: Hey, Jeff, this is Jason Kozal. Hey, just a real quick question.

I heard you talk about, with the communications, that you guys do not communicate the disciplinary action to the staff to understand what the consequences were? Did I hear that correctly? Just trying to clarify.

MR. REYNOLDS: You did hear me correctly, Jason. I've got to go validate what we do and don't communicate.

I don't know that we specifically say we gave individuals time off without pay. I've got to validate that.

(Off microphone comments.)

MR. REYNOLDS: We do? Okay. Let me

validate in the forms of communication along how that goes out.

Typically we say disciplinary action was given and don't go to that level, but I'll get those communications and get them back to you.

MR. KOZAL: Okay. I appreciate that. And the reason why I ask is, we had many conversations, especially early in the order, on what the approach was to changing the behaviors on the site fleet.

And the approach was, detect and deal with these things in discipline space. And then communicate that to the staff so they understood what the consequences were going to be of willful violations of the rule.

So we're just trying to confirm that that's the case and that's still the approach you guys are using. I appreciate that.

MR. REYNOLDS: Yes, I'll validate that.

MR. KOZAL: All right, thanks, Jeff.

MR. TAYLOR: This is Nick. Kind of a follow-up to the previous discussion. The human element here is hard. And you know, any station that doesn't think they have an integrity issue at some

level is probably being myopic. You know that.

But the trend at River Bend, at least in the recent years, appears to have been a little different than what we experienced elsewhere. And it looks like you've got a program for monitoring and assessing that. And hopefully discovering those things in a reasonable way.

We've also seen stations go through kind of cyclic performance on these types of things. Where there is a lot of focus and improvement for a while but these things have a way of coming back.

You can set up any kind of, for lack of a better term, assigned posts that would tell you that your actions are losing their effectiveness or something else has shifted underneath you such that you don't recognize when a systemic issue might be on its way back at the station.

MR. REYNOLDS: So, Nick, I would say yes to the question. And one of those methods is the nuclear safety culture monitoring panel and the data that we reviewed.

That gets rolled up, there's multiple members that are required forum that come to that

meeting. The reg assurance manager is one, HR business partner, employee concerns, nuclear independent oversight, myself, the performance improvement manager and the security manager, all on that team.

All of them, except myself, well, I bring cognitive discussion usually. The others all have required documentation that's trend able, actual data that comes into the meeting. And we evaluate that for any, that's one of the things we look at is, is there any potential willful misconduct issues.

I forgot to mention the integrity audits as an aggregate also go to the safety culture monitoring panel where we assess if there is any commonalities.

So when you look at all that data you look to see is there, not only is there an integrity issue you look for, is there a nuclear safety culture issue. And then you look through the ten traits of the safety culture and assess each of those to see if there is an area for improvement or strength in those.

So that is a method where it's looked at to see if, are we having increased potential integrity

issues, are we having misconduct or are we creating a culture to where we're starting to push production over safety or production over following the rules. So that's the method that's used.

And then that rolls to a safety culture lead team, which is a higher level of individuals from a site. And then all of these roll to the nuclear safety culture executive team, which is an even higher level of individuals. And then they're looking across at fleet wide.

So, I'll give you the yes, that is one method to detect it. We don't have a specific additional assessment, that I'm aware that, that we go do, other than that. Which is our process to look at that. Does that answer your question, Nick?

MR. TAYLOR: Yes. Thank you for that response.

MR. REYNOLDS: Okay.

MR. MONNINGER: This is John Monninger. So, the three different cases, the three different individuals, in terms of your follow-up investigation, did you see any difference in terms of the forced rightfulness of the three individuals or the

willingness to take ownership responsibility versus potential, I don't want to call it dodginess, but was there any difference in the three individuals that you witnessed?

MR. REYNOLDS: I'll let the owners, we'll talk to them specifically. I mean, when we talk about the NDE proctor, that individual was terminated. So, when we talk about the work week SRO and then the first line supervisor, I'll just, before I turn it over to Mark to talk about their follow-up behaviors, both of those, in their interview, took ownership of the issue.

Especially the work week SRO. He admitted, I knew what I was doing was wrong, I should not have done this and explained why he went down the path he did.

But I'll let Mark talk about after the fact and how, you know, how his behaviors were afterwards. Mark.

MR. FELTNER: Yes. So, what that did was it spurred additional discussions when those types of issues came up with Rich, is what I recall.

Is he was more willing to engage with

others and ask questions when he was unsure. And kind of, it allowed him to recognize what that vulnerability for him. And be able to engage with others when making critical decisions.

MR. REYNOLDS: Okay. All right. This is Jeff Reynolds again. Thank you, Mark Feltner.

Danny James, would you speak on what you saw in operator behavior changes?

MR. JAMES: Yes. So, the operators involved in this, actually, at first in belief because they could not fathom that they missed an inspection once we showed the evidence they were very contrite and surprised.

But took it to heart. Both changed their behaviors. We still have one shift who is a very good operator and knows what integrity means, knows what his rounds means when he signs his papers. And he's carried that message throughout all the groups. Does that answer your question?

MR. MONNINGER: Yes, thank you very much. I appreciate it.

MR. DODSON: Back to the nuclear safety culture monitoring panel discussion. I guess the

issues that are being discussed today, could you talk about whether those have already gone through that evaluation and whether those were considered collectively or individually?

MR. REYNOLDS: So, this is Jeff Reynolds again. So they were brought to the nuclear safety culture monitoring panel.

The panel meets three times a year. So if you look back on these, we've had multiple meetings since these events. So we're talking 2018, 2019, 2020.

I'll answer your question directly that we have not taken all three of those over a three year period and looked to see if that resulted in a trend. You assess the previous period in the meeting. What did I have in the previous period, what did I see and then how does that relate to the current nuclear safety culture ratings.

If they were closer together, if I have over a one year period and I had these incidents all happening close together, then I would call a, you have the option to call a special meeting together. And that's what I would, as I've been the RAPID since

2018. So fairly familiar with the process.

If I were to see these things coming up as a trend, I wouldn't wait for a meeting to call the people together, we would have an emergency safety culture monitoring panel meeting just specifically to go over them.

So, just, I didn't want to answer your question first and just say no, I wanted to give a little bit of an explanation on how the meetings work and how they're assessed. But no, we did not take all three of those and look over that period. It's just assessed in a different manner, if that makes sense to you.

MR. DODSON: Okay, thanks.

MR. HAY: This is Mike Hay. I've got one last question. And your presentation might have covered it, I just didn't pick up on it.

But when we got down to going through here is where you're at with your analysis of all this, you talked about the individual involved with issuing the CDA key. And his actions you thought reflected a Severity Level III violation, but yet the proctor that was involved with basically falsifying, completing

take a test for a student, (audio interference) student but a person that's being qualified to do that activity, and you thought for whatever reasons that the proffer endorsed for that would be a Severity Level IV.

I'm just trying to, in my mind, compare the two and understand, what is the difference between those two events that would dictate the severity level being different?

MR. SCHENK: Hey, Mike, this is Tim Schenk. I think the primary difference between the two is the position in the organization.

You're looking at a licensed senior reactor operator versus essentially an individual contributor. And as we look through the enforcement policy, that was the defining difference between those two issues.

MR. HAY: Okay. That's what I thought, I just wanted to make sure. Thank you.

MR. SCHENK: Yes, sir.

MS. VOSSMAR: All right, are there any other questions coming from the NRC side? Okay. The NRC will move forward.

And please note that the agenda now provides for a 15 minute break. Immediately following that break we are going to have the NRC caucus separately. This allow the NRC to briefly review what has been presented this afternoon and determine whether there is any additional information we need to consider before we conclude the conference.

NRC Staff will recess in a separate Team's meeting channel, as sent out to NRC Staff conference participants. If we have any follow-up questions, we will present them to the Entergy Staff as we reconvene in the meeting presentation.

We encourage the Entergy Staff to use that same recess time to determine if you have any additional information you would like to present. Following those final discussions we will then proceed to our concluding remarks.

All conference participants will now take the scheduled recess. And all other attendees may hold on mute until we return.

(Whereupon, the above-entitled matter went off the record at 12:14 p.m. and resumed at 1:04 p.m.)

MS. VOSSMAR: All right, so we are

reconvening the meeting at this point. I'm going to ask, before I get too far into this, if we have James, our court reporter? Okay, perfect.

All right. We did, the NRC did have a discussion of additional questions or items of interests, items for follow-up. And we did come up with one, two, three, four, five, six items for follow-up. So whenever you're ready for them, I will go through those items.

MR. SCHENK: We're ready whenever the NRC team is.

MS. VOSSMAR: Okay, very good. Thank you. For the first one, it's related to the NDE proctor case.

And we want information on the fleet extent of condition performed for the NDE proctor issue.

MR. SCHENK: Okay. Yes, we've got that as a follow-up actually, Trisha.

MS. VOSSMAR: That's our understanding as well.

MR. SCHENK: Okay.

MS. VOSSMAR: All right. The second item

that we would like to request is related to the CDA case. We would like to get a copy of the completed work order that was used to obtain the key for the CDA case.

MR. SCHENK: Okay, understand. A copy of the completed work order used to obtain the key for the critical digital asset issue.

MS. VOSSMAR: That's correct.

MR. SCHENK: Got it.

MS. VOSSMAR: All right. The next item is associated with the CDA case. We understand that there have been, in the last week, questions surrounding the additional maintenance supervisor associated with this case and whether or not he was engaged with willful actions linked to the case. And whether or not he possibly provided inaccurate info, information, during his interviews.

We wanted to request a copy of the licensee investigation that you ultimately complete for that individual.

MR. SCHENK: Yes, understand. We'll get you a copy of the completed licensee investigation regarding the maintenance supervisor and access to the

CDA area.

MS. VOSSMAR: That's correct. My understanding is that that investigation is not complete yet, is that correct?

MR. SCHENK: That's correct.

MS. VOSSMAR: Okay. For that one we just request that you provide it once it is complete. Do you have a timeline for when you expect it to be done? You might not have that offhand.

(Off microphone comments.)

MR. REYNOLDS: Yes, so this is Jeff again. I spoke with the ethics investigator at the end of last week. I expect that I have a final report in my email, but I haven't checked today. And assuming that it is final, I'll get it to you by tomorrow, if we can compile it by then.

If it's not complete, at the latest it would be the end of this week, Friday. But I do believe it is fully complete, and we'll get it to you soon.

MS. VOSSMAR: Thank you very much.

MR. REYNOLDS: You're welcome.

MS. VOSSMAR: We'll discuss timelines for

all of the rest of these items that are on here shortly.

MR. REYNOLDS: Very good.

MS. VOSSMAR: Okay. All right. The next item, and this should be, I think item number four on your list.

It's linked to the CDA key case. And it's associated with schedule pressure. So the question that we have is, how was scheduled pressure considered as a causal factor for this case?

So that's the question we have. And I think you guys have that as a follow-up action. But we'd like to expand that question to address whether or not scheduled pressure was considered for either of the two additional cases.

So all three cases, how did you address scheduled pressure?

And for a little bit of context, for the other two cases we received via interviews or discussions with the individuals involved in those other two cases that they felt that there was scheduled pressure involved but want to try to understand what information you have relative to that,

and how much you considered that for all three cases to be a causal factor.

MR. SCHENK: Okay. So, just so I've got that right, you would like to understand for all three cases to what extent did our investigations and causal analyses consider scheduled pressure as a factor, as a contributing factor, into those events?

MS. VOSSMAR: That's correct.

MR. SCHENK: Okay.

MS. VOSSMAR: All right. And then the next item, and I believe you may have taken this as a follow-up item as well.

We want you to let us know how you guys communicate, or have been communicating, disciplinary actions associated with willfulness to site personnel?

This was brought up during the non-licensed operator case.

MR. SCHENK: Yes, understand. We'll follow-up with how communications to site personnel on willful violations are made here at the station.

MS. VOSSMAR: Yes, that's correct. And then the last item that I have here is linked to the non-licensed operator rounds issue.

And we'd like to request a copy of the apparent case evaluation that you are performing, or have performed, for that issue.

MR. SCHENK: Okay, understand. For the operator rounds issue you'd like a copy of the apparent cause evaluation.

MS. VOSSMAR: That's correct. All right. And you should have six items there on your list, is that consistent?

MR. SCHENK: Yes.

MS. VOSSMAR: Okay. All right. In terms of timelines, we already discussed for the investigation sometime this week. The investigation regarding the maintenance supervisor and the CDA key issue. And that works.

For timelines for the other items, I believe we would like to see that information this week. If you have any issue with that or any challenges, Jason Kozal is available for you to work with him to work through any timelines that are different than that. Does that sound reasonable to you?

MR. SCHENK: Yes. Trisha, we'll work

through a response on those questions by the end of this week. If we have any issues with completing the requests by the end of this week, then Tim will reach out to Jason and have conversations about the specific exceptions and come to a consensus on timelines for any that can't be done by the end of this week.

MS. VOSSMAR: Perfect, that sounds great. Thank you very much.

All right, if there are no additional questions or comments by the NRC then I think we'll be moving into closing remarks. And I'll start by turning it over to Entergy for their closing remarks.

MR. SCHENK: Yes, I'd just like to reiterate my closing remarks earlier from our presentation that we do appreciate the opportunity to get together and talk and provide our perspectives on this. And it was apparent with the open dialogue that we've had that it provided value for us to get together and have these conversations. So thank you for that opportunity. That's all I've got, Trisha.

MS. VOSSMAR: All right, thank you very much. And with that I'll turn it over to Mr. John Monninger for his remarks.

MR. MONNINGER: Okay. So in closing our predecisional enforcement conference, on behalf of the NRC team I just want to extend our thanks to both the River Bend and the expanded Entergy team for the information and discussions. There were both informative and productive.

I note that we, the NRC, will consider the information gained today, making any decisions on the safety significance and/or any enforcement actions. And we'll notify you by telephone and in writing when we are ready to announce our final decision.

So what's next in the process? Well one is, I guess you guys will supplement, submit responses to the six different requests that we had. And then we'll make final determinations on whether apparent violations constitute actual violations. And any potential severity levels. We'll communicate that, as I mentioned, both in writing. And it will also be made publicly available.

So in closing this conference, I'll remind everyone that the apparent violations discussed at the conference today are subject to further review based on the information. They may be revised pertaining

resulting enforcement action.

And that the statements or expressions or opinions made by NRC Staff at this conference, or lack thereof, are not intended to represent any type of final agency position or determination.

And as I mentioned, we'll consider all the information we did gain today. And then we'll be in further communications with you.

Our goal is to complete our review and communicate the decisions within 45 days. Or approximately the end of September. September 30th.

So, with that, unless there is any other comments, the meeting is concluded and adjourned. So thank you very much.

(Whereupon, the above-entitled matter went off the record at 1:16 p.m. CDT)