



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

January 18, 2024

EA-23-055

Phil Hansett, Site Vice President  
Entergy Operations, Inc.  
River Bend Station  
5485 U.S. Highway 61N  
St. Francisville, LA 70775

**SUBJECT: RIVER BEND STATION – 95001 SUPPLEMENTAL INSPECTION  
REPORT 05000458/2023040 AND FOLLOW-UP ASSESSMENT LETTER**

Dear Phil Hansett:

On December 7, 2023, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection using Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 (Regulatory Response) Inputs," and discussed the results of this inspection with you and other members of your staff.

The NRC performed this inspection to review your station's actions in response to a White finding in the Mitigating Systems cornerstone which was documented and finalized in NRC Inspection Report 05000458/2023091 (Agencywide Documents Access and Management System (ADAMS) Accession No. ML23187A639) dated July 20, 2023. On October 5, 2023, you informed the NRC that your station was ready for the supplemental inspection.

The NRC determined that your staff's evaluation identified the cause of the White finding. Specifically, the NRC determined that your staff identified the root cause as the high-pressure core spray transformer low voltage bus bar connection was susceptible to degradation from routine maintenance. The extent of the problem was only applicable to the high-pressure core spray transformer due to the unique low voltage bus bar connection for the transformer. The staff's review of other safety and non-safety-related dry transformers on site did not identify any other unique low voltage bus bar connections. Corrective actions to address the root cause include (1) updating the transformer design specification to include that the transformer termination of connectors for leads be bolted and accessible for maintenance; and (2) complete the installation of a replacement transformer.

Overall, the inspectors determined that the licensee's problem identification, casual analysis, and corrective actions sufficiently addressed the notice of violation that led to the White finding. The final revision of the root cause evaluation documented in condition report CR--RBS--2023--00412 contains sufficient information such that all inspection objectives, as described in NRC inspection procedure 95001, were met.

The NRC determined that completed or planned corrective actions were sufficient to address the performance issue that led to the White finding. Therefore, the performance issue will be closed and no longer considered as an Action Matrix input as of the date of the exit meeting. Based on the results of this inspection and our Action Matrix assessment, the NRC has determined that River Bend Station will continue to be in the Regulatory Response Column of the Action Matrix due to a remaining White finding issued in NRC Inspection Report 05000458/2023092 (ML23201A132) dated August 15, 2023.

No findings or violations of more than minor significance were identified during this inspection.

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

Sincerely,



Signed by Josey, Jeffrey  
on 01/18/24

Jeffrey E. Josey, Chief  
Reactor Projects Branch C  
Division of Operating Reactor Safety

Docket No. 05000458  
License No. NPF-47

Enclosure:  
As stated

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RIVER BEND STATION – 95001 SUPPLEMENTAL INSPECTION SUPPLEMENTAL REPORT 05000458/2023040 DATED JANUARY 18, 2024

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DOCUMENT NAME: RIVER BEND STATION – 95001 SUPPLEMENTAL INSPECTION SUPPLEMENTAL REPORT 05000458/2023040 AND FOLLOW-UP ASSESSMENT LETTER  
**Non-Public Designation Category: MD 3.4 Non-Public \_\_\_\_\_ (A.3 - A.7 or B.1)**  
**ADAMS ACCESSION NUMBER: ML24014A045**

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**U.S. NUCLEAR REGULATORY COMMISSION  
Inspection Report**

Docket Number: 05000458

License Number: NPF-47

Report Number: 05000458/2023040

Enterprise Identifier: I-2023-040-0008

Licensee: Entergy Operations, Inc.

Facility: River Bend Station

Location: St. Francisville, Louisiana

Inspection Dates: December 4, 2023, to December 7, 2023

Inspectors: A. Saunders, Reactor Inspector  
W. Schaup, Senior Project Engineer

Approved By: Jeffrey E. Josey, Chief  
Reactor Projects Branch C  
Division of Operating Reactor Safety

Enclosure

## SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting a 95001 supplemental inspection at River Bend Station, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

### List of Findings and Violations

No findings or violations of more than minor significance were identified.

### Additional Tracking Items

Type	Issue Number	Title	Report Section	Status
NOV	05000458/2023090-01	Failure to Adequately Inspect High Pressure Core Spray (HPCS) Transformer Wiring Resulting in Transformer Failure and Inoperability of HPCS System EA-23-055	95001	Closed

## INSPECTION SCOPES

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

## OTHER ACTIVITIES – TEMPORARY INSTRUCTIONS, INFREQUENT AND ABNORMAL

### 95001 - Supplemental Inspection Response to Action Matrix Column 2 (Regulatory Response) Inputs

The inspectors reviewed and selectively challenged aspects of the licensee's problem identification, causal analysis, and corrective actions in response to the high-pressure core spray transformer failure on September 19, 2022, as documented in NRC Inspection Reports 05000458/2023090 (ML23165A102) dated June 26, 2023, and 05000458/2023091 (ML23187A639) dated July 20, 2023.

Objective: Ensure that the root and contributing causes of significant individual and collective White performance issues are understood.

Under this objective, the inspectors reviewed the root cause evaluation(s) the licensee conducted for the high-pressure core spray transformer failure on September 19, 2022, as documented in NRC Inspection Reports 05000458/2023090 (ML23165A102) dated June 26, 2023, and 05000458/2023091 (ML23187A639) dated July 20, 2023. Their review consisted of an evaluation of the following: the licensee's identification of the issue(s), when and how long the issue(s) existed, prior opportunities for identification, documentation of significant plant-specific consequences and compliance concerns, use of systematic methodology to identify causes with a sufficient level of supporting detail, consideration of prior occurrences, identification of extent of condition and extent of cause, and identification of any potential programmatic weaknesses in performance.

NRC Assessment: The inspectors concluded that this objective was Met. The inspectors determined that the licensee's root cause evaluation appropriately identified and documented the root cause, extent of condition, and extent of cause of the White performance issue.

The licensee's casual analysis determined that the root cause was the high-pressure core spray transformer has a cable to bus bar connection that is susceptible to degradation from routine maintenance. The transformer had a brazed stud connection in lieu of a bolted connection on the low voltage side of the transformer and the low voltage connections were not readily accessible, inspecting the entire connection could not be done without more intrusive methods than were being used prior to the transformer failure.

Two contributing causes were identified (1) maintenance electrical work processes did not require use of intrusive methods and testing methodology to identify degradation in wiring

and/or connections in the HPCS transformer; and (2) electrical maintenance workers and supervisors are not consistently demonstrating a Questioning Attitude during preparation for work activities that could assist in identifying potential latent conditions not identified prior to performance.

The licensee's extent of condition evaluated whether the identified condition exists within other River Bend Station high voltage electrical systems which require transformers to support safety-related functions where actual conditions exist or may exist which could result in a loss of safety function. The licensee did not identify any additional actual conditions.

The licensee's extent of cause evaluated whether the identified causes that created the condition exists in other areas at River Bend Station. The licensee identified that similar brazed connection degradation issues could lead to similar failures. The licensee has created actions to address similar issues including (1) reviewing and updating applicable preventive maintenance procedures and updating maintenance personnel training qualification cards.

- a. Identification. This issue was self-revealed when the division 3 high-pressure core spray transformer (E22-S003) failed during surveillance test STP-309-0203, "Division III Diesel Generator Operability Test."

However, the original condition was evaluated under an Adverse Condition Analysis performed under condition report CR-RBS-2022-05422. The operability review for CR-RBS--2022--05422 correctly identified the high-pressure core spray system as inoperable with a loss of safety function. Approximately 4 months later, it was determined to be a loss of safety function for HPCS, and condition report CR--RBS-2023--00412 was written to perform a Root Cause Evaluation (RCE).

The late identification for the need to conduct an RCE was addressed under condition report CR-RBS-2023-04984 and actions included briefing the Performance Improvement Review Group (PRG) and Department Performance Improvement Coordinators (DPICs) that condition reports related to loss of safety function require a Root Cause Evaluation.

This issue was dispositioned during a problem identification and resolution inspection completed on November 2, 2023, as a minor violation. The evaluation of this minor violation can be reviewed in NRC Inspection Report 05000458/2023010 (ML23334A081), dated December 12, 2023, in the assessment of Corrective Action Program Effectiveness, Problem Prioritization and Evaluation section.

The inspectors have determined that the licensee's root cause and associated causal products adequately identified and resolved the issue by elevating the causal product to a root cause evaluation and evaluating why the identification was late.

- b. Exposure Time. The issue was assumed to have existed for one-half of the time period since the last successful functional operation of the transformer plus the repair time totaling 26 days.

However, the NRC determined the issue had existed right after the last successful functional operation of the transformer plus the repair time totaling 40 days. Since both exposure times resulted in ultimately meeting the criteria of a White finding, the licensee's evaluation assessed the exposure time.

- c. Identification Opportunities. The licensee had few opportunities to identify the conditions leading to the division 3 high-pressure core spray transformer failure primarily due to the clean and inspect preventive maintenance being performed on an every 8-year frequency and only performed a total of five times during the operation of the transformer (1986-2022).
- d. Risk and Compliance. The licensee's evaluation demonstrated an appropriate understanding of the risk and compliance aspects of the issue. Specifically, not being able to detect degrading conditions on the division 3 high-pressure core spray transformer caused the transformer to fail resulting in the high-pressure core spray system becoming inoperable and removing a primary system used to mitigate the consequences of an accident by providing inventory makeup to the reactor vessel.
- e. Methodology. The licensee's evaluation employed a systematic evidence based causal analysis to reliably and scrutable determine the root and contributing causes of the White performance issue including: Barrier Analysis, Event and Causal Factor Charting, Performance Analysis, Failure Mode Analysis, Vendor Failure Mode Analysis, Equipment Failure Evaluation, Organizational and Programmatic Evaluation.
- f. Level of Detail. The inspectors determined that the root cause evaluation was conducted and documented in sufficient detail commensurate with the significance and complexity of the issue and regulatory requirements.

However, due to multiple revisions to the root cause evaluation the final root cause determination language was not consistently utilized throughout the document. The licensee has documented this in the corrective action program as condition report CR--RBS--2023--08965. The staff has updated the document to reflect consistent language throughout the document.

- g. Operating Experience. For the root cause evaluation, the licensee conducted reviews of internal and external operating experience. The reviews looked for occurrences of same or similar performance issues where knowledge gained could be used to improve the evaluation. Some of the reviews may have benefited from a broader scope into areas outside of just transformer issues. There are numerous events where degraded electrical connections have resulted in failures in safety-related components. Looking into events not associated with just transformers may have provided some additional insights. The inspectors determined that the operating experience was appropriately considered to identify and prevent similar occurrences.
- h. Extent of Condition and Cause. The extent of condition evaluation considered whether the identified condition currently exists within other station high voltage electrical systems which require transformers to support safety-related functions where actual conditions exist or may exist which could result in a loss of safety function. The extent of cause evaluation considered whether the identified cause that created the condition exist currently in other areas at the site. The inspectors determined that the licensee appropriately identified the extent of condition and extent of cause.



- i. Common Cause. Although not required because the two White finding inputs were not in the same cornerstone (one White finding in the Mitigating Systems cornerstone and one White Finding in the Emergency Preparedness cornerstone), the licensee elected to perform a common cause analysis for the two White finding inputs to further analyze for potential programmatic weakness in performance. The NRC has not performed the supplemental inspection on the White finding input for the Emergency Preparedness cornerstone; therefore, the common cause analysis will be discussed in the supplemental report for the White finding input for the Emergency Preparedness cornerstone with input from the lead inspector for this report.

Objective: Ensure that completed corrective actions to address and preclude repetition of White performance issues are timely and effective.

Under this objective, the inspectors assessed the appropriateness and timeliness of the licensee's corrective actions.

NRC Assessment: The inspectors concluded that this objective was Met. The inspectors determined that the corrective actions reviewed under this section were implemented appropriately and in a timely manner as discussed in detail below.

Root cause: The high-pressure core spray transformer has a cable to bus bar connection that is susceptible to degradation from routine maintenance.

Corrective actions are documented and tracked in the licensee's corrective action program under condition report CR-RBS-2023-00412.

- a. Completed Corrective Actions to Prevent Recurrence
  - (1) No completed corrective actions to prevent recurrence existed. Two planned corrective actions to prevent recurrence are discussed in the next section of the report.
- b. Other Completed Corrective Actions
  - (1) CA 65 - Document installation of the temporary modification under work order (WO) 586001-and engineering change (EC) 93841. This corrective action installed a temporary transformer to restore high-pressure core spray system operability until the licensee could procure and install a new transformer that met all design specifications. The inspectors determined that this corrective action was implemented appropriate and was completed in a timely manner.

However, during the review of engineering change EC 93841, the inspectors noted that the licensee had not performed an evaluation as required by Title 10 CFR 50.59, "Changes, Tests and Experiments," for installation of the temporary transformer. The temporary transformer, when powered from the grid, would under certain grid conditions, supply higher than allowed voltages to the low side of the transformer. This was an adverse impact to the equipment and components supplied by the low side of the transformer. The licensee documented in the process applicability determination form for the EC that no 50.59 evaluation would be required because the proposed activity did not adversely affect the design function. The licensee made this determination based on having developed compensatory measures when grid conditions occurred that would cause the low voltage side of the transformer to

supply higher voltage and that the adverse effect of the higher voltages was minimal to the supplied equipment and components.

The inspectors reviewed NEI 96-07, "Guidelines for 10 CFR 50.59 Implementation," revision 1, which states the following in Section 4.2.1, "Screening for Adverse Effects:"

The screening process is not concerned with the magnitude of adverse effects that are identified. Any change that adversely affects a UFSAR-described design function, method of performing or controlling design functions, or evaluation that demonstrates that intended design functions will be accomplished is screened in. The magnitude of the adverse effect (e.g., is the minimal increase standard met?) is the focus of the 10 CFR 50.59 evaluation process.

The inspectors determined that a 50.59 evaluation was required to be performed and that this was a violation of 10 CFR 50.59(d)(1), which requires the licensee to maintain records of changes in the facility, of changes in procedures, and of tests and experiments made pursuant 10 CFR 50.59(c). These records must include a written evaluation which provides the bases for the determination that the change, test, or experiment does not require a license amendment pursuant to paragraph (c)(2) of this section. The inspectors determined that the violation was minor because sufficient information was reviewed that when the evaluation is completed the licensee will not have to submit a license amendment and the licensee has documented this violation in the corrective action program as condition report CR-RBS-2023-08986. This minor violation is not subject to enforcement action in accordance with the NRC's Enforcement Policy.

- (2) CA 58 - Document the results of the engineering study performed by Engineering for LCM-23-0139. This corrective action provides input for completion of CA 62 which is a planned CAPR. The inspectors determined that this corrective action was implemented appropriate and was completed in a timely manner.
- (3) CA 59 - Based on the X/R values, % Z values and other parameters obtained from the engineering study, update/revise the original specification for the new transformer purchase. This corrective action provides input for completion of CA 62 which is a planned CAPR. The inspectors determined that this corrective action was implemented appropriate and was completed in a timely manner.
- (4) CA 60 - Release the purchase order for the new transformers. Three new transformers to be purchased. This corrective action provides input for completion of CA 62 which is a planned CAPR. The inspectors determined that this corrective action was implemented appropriate and was completed in a timely manner.
- (5) CA 61 - Initiate an LCM for the purchase of new transformers and obtain ECRG/MPRC approval. This corrective action provides input for completion of CA 62 which is a planned CAPR. The inspectors determined that this corrective action was implemented appropriate and was completed in a timely manner.

Objective: Ensure that pending corrective action plans direct prompt and effective actions to address and preclude repetition of White performance issues.

Under this objective, the inspectors assessed the appropriateness and timeliness of the licensee's planned corrective actions.

NRC Assessment: The inspectors concluded that this objective was Met. The inspectors determined that the licensee implemented appropriate and timely corrective actions to prevent recurrence as discussed in detail below. When the planned corrective actions to prevent recurrence are complete, the NRC plans to inspect and assess the corrective actions to prevent recurrence through inspection samples from the baseline inspection.

Root cause: The high-pressure core spray transformer has a cable to bus bar connection that is susceptible to degradation from routine maintenance.

Corrective actions are documented and tracked in the licensee's corrective action program under condition report CR-RBS-2023-00412.

a. Planned Corrective Actions to Prevent Recurrence

- (1) CA 62 - Update the Design Specification to include that transformer's termination of connectors for leads on low and high voltage sides should be bolted and accessible for maintenance. The licensee is utilizing their engineering change process to develop an engineering change (EC) that will install the replacement transformer. Part of this process includes updating the Design Specification. The licensee has determined that this action will be complete with the final approval of the EC which is planned to be completed by September 30, 2024. The inspectors reviewed the timeline provided by the licensee and determined that the corrective action is appropriate and will be timely to support installation of the new transformer in the next refueling outage.
- (2) CA 66 - Complete the installation of the replacement high-pressure core spray transformer. No replacement transformer could be found by the licensee that met the design specifications of the failed transformer; therefore, the licensee will have a vendor manufacture a new transformer. The licensee is utilizing their engineering change process to develop the EC that will install the replacement transformer. This process includes developing the EC, placing a purchase order with the vendor, the vendor completing the manufacturing of the transformer, design verification of the transformer, final approval of the EC, shake testing of the transformer, dedication process for the transformer, the installation of the transformer and any required testing after installation to demonstrate the transformer functions satisfactorily to the design specifications. The expected completion date is at the completion of the next refueling outage May 31, 2025. The inspectors reviewed the timeline provided by the licensee and determined that the corrective action is appropriate and will be timely if completed in the next refueling outage.

b. Other Planned Corrective Actions

- (1) No planned corrective actions existed.

## Conclusion

Overall, the inspectors determined that the licensee's problem identification, casual analysis, and corrective actions sufficiently addressed the notice of violation that led to the White finding. The final revision of the root cause evaluation documented in condition report CR--RBS--2023--00412 contains sufficient information such that all inspection objectives, as described in NRC inspection procedure 95001 were met. Therefore, this inspection is closed.

## **INSPECTION RESULTS**

No findings were identified.

## **EXIT MEETINGS AND DEBRIEFS**

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

- On December 7, 2023, the inspectors presented the 95001 supplemental inspection results to Phil Hansett, Site Vice President, and other members of the licensee staff.

## DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
95001	Calculations	E-222-E22-S002	480 Vac Standby Motor Control Center Load Tabulation Including Cable Verification	0
	Corrective Action Documents	CR-RBS-2022-05470	Condition Report	0
		CR-RBS-2023-04984	Condition Report	06/08/2023
		CR-RBS-2023-04998	Condition Report	06/08/2023
		CR-RBS-2023-05437	Condition Report	06/26/2023
		CR-RBS-2023-06051	Condition Report	07/25/2023
		CR-RBS-2023-06490	Condition Report	08/14/2023
		CR-RBS-2023-08172	Condition Report	11/01/2023
		CR-RBS-2023-08256	Condition Report	11/03/2023
		CR-RBS-2023-7177	Condition Report	09/14/2023
		CR-RBS-202300412	Condition Report	
		Corrective Action Documents Resulting from Inspection	50037101-01	PM Change Request Form
	CR-RBS-2023-08942		Condition Report	12/06/2023
	CR-RBS-2023-08956		Condition Report	12/06/2023
	CR-RBS-2023-08986		Condition Report	12/08/2023
	CR-RBS-2023-08987		Condition Report	12/08/2023
	CR-RBS-2023-		Condition Report	12/08/2023

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		08988		
	Drawings	0221.418-000-022	HPCS One Line Drawing	K
		3-221-418-000-001A	Installation Instructions-HPCS XFMR	12/03/1979
		828E537AA	Breaker Schematic	028
		BE-230D	4.16KV Bus 1E22*S004 Relay Settings	013
		EE-008BF	4160 V Wiring Diagram	014
		GEK-5697	General Electric Dry-Type Transformer	000
		IB-317-SPI	HPCS Storage and Installation Instructions	000
		Engineering Changes	EC 93841	E22-S003 Transformer Replacement
	EC 93841 RBS-2022-05422		Process Applicability Determination Form	000
	Engineering Evaluations	RBS	High-Pressure Core Spray Transformer Failure Analysis	02/10/2023
		RBS	High-Pressure Core Spray Mode Analysis	Final
	Miscellaneous	2020	System 203 Health report	09/29/2020
		2021	System 203 Health Report	02/17/2022
		2022	System 203 Health Report	06/31/2023
	Procedures	ARP-P808-86	P808-86 Alarm Response	27
		ARP-P808-86	P808-86 Alarm Response	28
		ARP-P808-86	P808-86 Alarm Response	29
		EN-DC-114	System Health Management	4
		EN-DC-136	Temporary Modifications	22
		EN-DC-144	System Health Management	4
		EN-DC-153	Preventative Maintenance Component Classification	23
		EN-DC-322	Inservice Testing Duties and Responsibilities	4
		EN-DC-324	Preventative Maintenance Program	29
		EN-FAP-LI-001	Performance Improvement Review Group Process	22
		EN-LI-100	Process Applicability Determination	34
		EN-LI-101	10 CFR 50.59 Evaluations	22
		EN-LI-102	Corrective Action Program	50
		EN-LI-118	Causal Analysis Process	37
		EN-LI-121	Trending and Performance Review Process	31

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		EN-OP-104	Operability Determination Process	18
		SDC-203	High-Pressure Core Spray System Design Criteria System Number 203	11/22/2011
		SDC-308	Safety-Related 480 V Electrical Distribution System Design Criteria System Number 303	22
		STP-302-0102	Power Distribution Operability Check	17
	Self-Assessments	QA-3-2-23RBS-1	Quality Assurance Audit Report	07/25/2023
	Work Orders	WO 00586001-007	FIN Test E22-S004-ACB3-50/51-1 Protective Relay	09/19/2022
		WO 00586001-09	FIN Test E22-S004 ACB3-50/51-3 Protective Relay	0
		WO 50348709	Preventative Maintenance Template E22-S-003 Transformer	0
		WO 52760782	Thermography	0
		WO 52813509	Thermography	0
		WO 52863773	E22-0003 Clean, test, E22-S003 transformer	0
		WO 5289977	Thermography	0
		WO 52922470	Thermography	0
		WO 52950661	E22-S004- Major Clean, Inspect E22-S004 ACB03	06/29/2022
		WO 52959369	Thermography	0
		WO 52959640	Thermography	0
		WO 53003640	Clean, Test, E22-S003 Transformer	0
		WO 53003640	Clean, Test, E22-S003 Transformer	06/21/2022
		WO 53012112	STP-302-0203: (Division 3) Diesel Generator Operability	08/23/2022
		WO 53016329	STP-302-0102 Weekly Power Distribution System Operability	09/19/2022
		WO 586001-032	PMT EC 93841	0
		WO 586001-08	FIN Test- ACB3-50/51-2 Protective Relay	09/19/2022
		WO 586001-27	E22-S003 Transformer Replacement EC-93841 AWA-04	0
		WO 586001-30	Install Transformer E22-S003	0
		WO 586001-31	Prefab Mounting Plate E22-S003 EC 93841	0
		WO 596001-32	FIN Troubleshoot E22-S003 Failure CR22-5422	0