UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-4005

December 17, 2003

Paul D. Hinnenkamp
Vice President - Operations
River Bend Station
Entergy Operations, Inc.
P.O. Box 220
St. Francisville, LA 70775

SUBJECT: RIVER BEND STATION - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000458/2003-007

Dear Mr. Hinnenkamp:

On November 7, 2003, the NRC completed an inspection at your River Bend Station. The enclosed report documents the inspection findings, which were discussed on November 7, 2003, with you and other members of your staff.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, compliance with the Commission's rules and regulations, and the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures, representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, which included 207 condition reports, 22 audit reports, and 27 security incident reports, the team concluded that problems were properly identified, evaluated, and corrected. There was one green finding identified during this inspection associated with the failure to identify conditions that would have caused unexpected entry into Technical Specification Action Statements and had the potential to cause secondary containment to be inoperable. This finding was determined to be a violation of NRC requirements. However, because of its very low safety significance and because it has been entered into your corrective action program, the NRC is treating this finding as a noncited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this noncited violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001, with copies to the Regional Administrator, Region IV; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the resident Inspector at the River Bend Station facility. In addition, several examples of human performance errors were identified that were not entered into the corrective action program.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web-site at http://www.nrc.gov/NRC/Adams/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Anthony T. Gody, Chief
Operations Branch
Division of Reactor Safety

Docket: 50-458
License: NPF-47

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NRC Inspection Report
50-458/03-07

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Dockets:	50-458
Licenses:	NPF-47
Report No.:	05000458/2003-007
Licensee:	Entergy Operations, Inc.
Facility:	River Bend Station
Location:	5485 U.S. Highway 61 St. Francisville, Louisiana
Dates:	October 27 through November 7, 2003
Inspectors:	M. Murphy, Senior Operations Engineer, Operations Branch R. Azua, Project Engineer, Project Branch C B. Nicholas, Senior Health Physicist, Plant Support Branch P. Alter, Senior Resident Inspector, Projects Branch B
Approved By:	Anthony T. Gody, Chief Operations Branch Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000458-2003-007, Entergy Operations, Inc.; on 10/27-11/07/2003, River Bend Station; Baseline inspection of the identification and resolution of problems. A violation was identified in the area of effectiveness of problem identification.

The inspection was conducted by one senior operations engineer, one senior resident inspector, one project engineer, and one senior health physicist. One green finding of very low safety significance was identified during this inspection and was classified as a noncited violation. The finding was evaluated using NRC Inspection Manual Chapter 0609, "Significance Determination Process." The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

The team concluded that the licensee was effective at identifying problems and putting them into the corrective action program. The licensee's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. However, the team identified a repetitive failure on the part of the licensee to properly identify the inability of secondary containment doors to close and potential failures of secondary containment. The licensee effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. Corrective actions, when specified, were generally implemented in a timely manner. Licensee audits and assessments were found to be effective. On the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the problem identification and resolution program (4OA2).

Cornerstone: Barrier Integrity

Green: The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for failure to identify conditions that would have caused unexpected entry into Technical Specification Action Statements and had the potential to cause secondary containment to be inoperable.

The issue was more than minor because it affects the reactor safety/barrier integrity cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide release caused by accidents or events. The results of the phase one evaluation of the significance determination process was that the issue was of very low safety significance because the finding only represents a degradation of the radiological barrier function provided by the auxiliary building and the duration of each of the 9 incidents was less than 10 minutes.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

1. Effectiveness of Problem Identification

a. Inspection Scope

The team reviewed items selected across the seven cornerstones of safety to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. Specifically, the team selected 207 condition reports and 3 maintenance action items that had been issued between November 27, 2001 and September 29, 2003. The team also reviewed 22 licensee audit, surveillance and self-assessment reports, including several addressing various aspects of the problem identification and resolution program. The effectiveness of the audits and assessments was evaluated by comparing the audit and assessment results against self-revealing and NRC-identified findings. In addition, the team reviewed the licensee's response to 1 noncited violation, 1 licensee event report, 11 NRC information notices, 8 industry operating events, and 7 vendor 10 CFR Part 21 reports.

The team evaluated the condition reports and NRC findings to determine the licensee's threshold for identifying problems and entering them into the corrective action program. Also, the licensee's efforts in establishing the scope of problems were evaluated by reviewing pertinent control room logs, work requests, self-assessment results, system health reports, trending reports, and action plans. The industry experience information was reviewed to assess if issues applicable to River Bend Station were appropriately addressed. The condition reports and other documents listed in the attachment were used to facilitate the review.

The team reviewed 280 incident reports written by a contractor department during the period from November 1, 2002, to October 31, 2003, to assess the department's evaluation of and the scope of problems identified with equipment and personnel errors which resulted in the incidents. In addition, the team reviewed the department's multi-step corrective action program designed to reduce the number of violations caused by plant personnel. The team interviewed the superintendent and other members of the department to determine the effectiveness of the program.

b. Assessment

The team determined that the licensee was effective at identifying problems and entering them into the corrective action system. This was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee during the review period. Licensee audits and assessments were of good depth and identified issues similar to those that were self-revealing or raised during previous NRC inspections.

However, the team determined that although the contractor department's multi-step corrective action program was designed to reduce the number of violations caused by plant personnel, it failed to follow other licensee guidance and policies for the identification and correction of human performance errors. Program records did not sufficiently document the cause of the human errors, human performance traps encountered and human performance tools that could have been used to avoid repetition of the same error. Additionally, no condition reports were written for any of these human errors. Based on interviews with the site human performance coordinator, the team determined that this program was not monitored by the site human performance team and that the human errors identified met licensee guidance for documentation in the corrective action program.

Introduction

The team identified a repetitive failure on the part of the contractor department to properly identify the inability of secondary containment doors to close and potential failures of secondary containment. From January 30 through March 16, 2003, 9 such events occurred and were not reported to the main control room for evaluation against technical specification requirements. The team determined that the risk associated with this noncited violation of 10 CFR Part 50, Appendix B, Criteria XVI, was of very low safety significance (Green) because the duration of each failed open secondary containment door was less than 10 minutes.

Description

Based on a review of the incident reports written between January 30 and March 16, 2003, the inspectors determined that comtractor department personnel responded to door alarms 10 times when the doors in question were secondary containment doors between the turbine building and the auxiliary building. On 9 of those occasions, the doors were found in a condition where the door's locking mechanism latches were extended so that the door could not close if required. On 2 occasions there was no one present at the door. Although the person causing the alarm was present on each of the other 7 occasions, that person was not capable of correcting the problem to close the door. In each case, the secondary containment door was not capable of closing against its sealing surface, until the locking mechanism was released and the door closed by the responding department personnel.

On each occasion, contractor department personnel initiated an incident report, in accordance with Plant Security Procedure PSP-4-104, Administration (Reporting Events), Revision 19, or after March 3, 2003, the Department's Instruction SDI-005, Reporting Requirements and Matrix, Revision 0. Additionally, the person causing the problem was given a "Violation Notification" in accordance with the departments "Multi-Step Corrective Action Program." In none of these cases, did the department personnel or their shift supervision inform the main control room of the failed open secondary containment doors. Technical Specification 3.6.4.1 required that the auxiliary building shall be Operable in MODE 1. One requirement for "Operable" as stated in Technical Specification Basis 3.6.4.1. was that "At least one door in each access to the Auxiliary Building and Shield Building Annulus is closed, except for routine entry and exit of personnel and equipment." In each case, the door was incapable of closing against its

sealing surface until the condition was corrected by the responding department peraonnel 2 to 8 minutes after the alarm.

Although the contractor personnel routinely respond to door alarms there was no guidance given to their on-shift supervisors, who receive the alarms and dispatch personnel to unsecured doors, for reporting failed open secondary containment doors to the main control room. However, the licensee's corrective action program, as described in Policy LI-102, "Corrective Action Process," Revision 2, in effect at the time, listed in Attachment 9.2, any "unplanned entry or failure to enter a[n] LCO" as an example of an adverse condition required to be documented in a condition report. The inspectors determined that incident reports were reviewed each working day by the licensee security staff and that this incident report data was rolled up into a monthly report and quarterly memo that was sent to senior licensee management. The licensee's quality assurance department regularly performed a quarterly audit of the program. When interviewed, the licensee contractor superintendent and the quality assurance supervisor stated that they only evaluate the information based on the requirements, not in relation to other station requirements.

Analysis

The team determined that the 9 failures on the part of plant personnel to properly secure the secondary containment doors were potential failures of secondary containment. The issue was more than minor because it affects the reactor safety/barrier integrity cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide release caused by accidents or events. The results of the phase one evaluation of the significance determination process was that the issue was of very low safety significance because the finding only represents a degradation of the radiological barrier function provided by the auxiliary building and the duration of each of the 9 incidents was less than 10 minutes.

Enforcement

The team determined that the repetitive failure of the contractor personnel to report failed open secondary containment doors to the main control room was a violation of 10 CFR Part 50, Appendix B, Criterion XVI, for failure to identify conditions adverse to quality. In addition, the incident reports written to track these incidents were reviewed by licensee contractor supervision and the quality assurance department, yet no condition reports were issued identifying the missed entry into a required technical specification action statement. Because this problem identification and resolution problem was of very low safety significance and has been entered into the corrective action program as Condition Report CR-RBS-2003-3515, this violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy.

2. Prioritization and Evaluation of Issues

a. Inspection Scope

The team reviewed approximately 218 condition reports and supporting documentation, including root cause evaluations, to ascertain whether the licensee identified and considered the full extent of conditions, generic implications, common causes, and previous occurrences. The team also reviewed the other documents cited in Section 4OA2.1.a to evaluate whether issues applicable to River Bend Station were properly prioritized and evaluated.

The team attended corrective action review board meetings, which reviewed the root-cause analyses for two significant condition reports. The team evaluated the corrective action review board input into the root-cause analyses and suggestions for improvement of the corrective actions recommended by the root-cause analyses teams. The team also evaluated the revised root-cause analyses and final corrective actions presented to the corrective action review board chairman for his approval. Finally, the team ensured that the revised corrective actions were included in the condition report program for resolution.

b. Assessment

Based on a review of the licensee's records, the team concluded that it effectively prioritized and evaluated issues.

3. Effectiveness of Corrective Actions

a. Inspection Scope

The team reviewed the condition reports, audits, assessments, and trending reports described in Section 4OA2.1.a above to verify that corrective actions related to the issues were identified and implemented in a timely manner commensurate with safety, including corrective actions to address common cause or generic concerns. A listing of specific documents reviewed during the inspection is included in the attachment to this report.

The team evaluated the timeliness and adequacy of operability determinations and evaluations. The team reviewed corrective actions planned and implemented by the licensee and sampled specific technical issues to determine whether adequate decisions related to structure, system, and component operability were made.

b. Assessment

The team concluded that implemented corrective actions for those conditions reviewed were effective.

4. Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The team interviewed 28 individuals from the licensee's staff, which represented a cross-section of functional organizations and supervisory and non-supervisory personnel. These interviews assessed whether conditions existed that would challenge the establishment of a safety-conscience work environment. The team also sampled safety-related concerns placed into the licensee's employee concerns program to ascertain that the licensee had provided appropriate responses. The employee concerns program provided an alternate method to the corrective action program for employees to raise safety concerns, with the option of remaining anonymous.

b. Assessment

The team identified no findings related to the safety-conscience work environment at the facility. The team concluded, based on information collected and reviewed from the interviews, that employee's were willing to identify safety issues and enter them into a corrective action system.

4OA6 Exit Meeting

The team discussed the findings with Mr. Paul Hinnenkamp and other members of the licensee's staff on November 7, 2003. Licensee management acknowledged that proprietary materials examined during the inspection had been returned. No proprietary information is discussed in this report.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

L. Ballard, Supervisor, Quality
R. Biggs, Coordinator, Nuclear Safety Assurance
M. Boyles, Manager, Radiation Protection
J. Clark, Admin. Support, Operations
J. Fowler, Manager, Quality Assurance
R. Godwin, Manager, Training
J. Heckenberger, Manager,
P. Hinnenkamp, Vice President, River Bend Station
K. Huffstatler, Technical Specialist, Licensing
A. James, Superintendent, Security
R. King, Director, Nuclear Safety Assurance
D. Lorfing, Acting Manager, Licensing
T. Lynch, Manager, Operations
J. McGhee, Manager, Maintenance
P. Page, ALARA Supervisor, Radiation Protection
K. Talbot, Supervisor, Instuments and Controls
W. Trudell, Manager, Corrective Actions and Assessment

DOCUMENTS REVIEWED

PLANT PROCEDURES

PL-162	Human Performance Program	R01
PSP-4-104	Administration (Reporting Security Events)	R19
RBNP-006	Plant Security Requirements and Responsibilities	R13
RBNP-078	Operability Determinations	R07
SDI-005	Security Reporting Requirements and Matrix	R00
API-06	Alarm Station Supervisor	R40
EP-02-018	Technical Support Center	R26
EP-305	10 CFR 50.54(q) Review Program	R00
EP-401	Public Use of Emergency Preparedness Owner Controlled Area	R00
EIP-2-002	Classification Actions	R22

EIP-2-026	Evacuation, Personnel, Accountability, Search and Rescue	R15
EPP-2-201	River Bend Station Emergency Preparedness Organization and Responsibilities	R18
SOP-0113	Liquid Radwaste Processing/Recovery Sample Tank System (SYS #603)	R10
FPP-0010	Fire Fighting Procedure	R10
ADM-0009	Station Fire Protection Program	R08
RBNP-052	RBS Trending System	R08
LI-102	Corrective Action Process	R03
OE-100	Operating Experience Program	R01
EDG-AA-115	Engineering Request-Response Development	R04
ADM-0009	Station Fire Protection Program	R08
SOP-0071	Rod Control and Information System	R12

MAINTENANCE ACTION ITEM

MAI 350059 - Seal Internal Conduit Seal for 1CX958NA on Elevation 137’ - 10"

MAI 350060 - Seal Internal Conduit Seal for 1CX958NB on Elevation 137’ - 10"

MAI 350061 - Seal Internal Conduit Seal for 1CK600NE2 on Elevation 137’ - 10"

CONDITION REPORTS

CR-RBS-2003-00336	CR-RBS-2003-00685	CR-RBS-2003-01260
CR-RBS-2002-00366	CR-RBS-2002-00450	CR-RBS-2002-00114
CR-RBS-2002-00088	CR-RBS-2002-00012	CR-RBS-2001-01617
CR-RBS-2001-01523	CR-RBS-2001-01158	CR-RBS-2001-00438
CR-RBS-2001-00355	CR-RBS-2001-02177	CR-RBS-2000-01600
CR-RBS-1999-01634	CR-RBS-2003-03176	CR-RBS-2003-03248
CR-RBS-2003-03202	CR-RBS-2003-01328	CR-RBS-2002-00079
CR-RBS-2003-00523	CR-RBS-2001-01713	CR-RBS-2002-00183
CR-RBS-2002-00369	CR-RBS-2002-00372	CR-RBS-2002-00502
CR-RBS-2002-00542	CR-RBS-2002-00573	CR-RBS-2002-00603

CR-RBS-2002-00606	CR-RBS-2002-00653	CR-RBS-2003-00043
CR-RBS-2003-00044	CR-RBS-2003-00274	CR-RBS-2003-00571
CR-RBS-2003-00576	CR-RBS-2003-00577	CR-RBS-2003-00624
CR-RBS-2003-00652	CR-RBS-2003-00697	CR-RBS-2003-00947
CR-RBS-2003-01949	CR-RBS-2003-01950	CR-RBS-2003-01992
CR-RBS-2003-01993	CR-RBS-2003-02094	CR-RBS-2003-02095
CR-RBS-2002-00291	CR-RBS-2002-00351	CR-RBS-2002-01840
CR-RBS-2003-00730	CR-RBS-2003-00774	CR-RBS-2003-00850
CR-RBS-2003-00866	CR-RBS-2003-00868	CR-RBS-2003-00899
CR-RBS-2003-01729	CR-RBS-2003-02141	CR-RBS-2003-02529
CR-RBS-2003-02909	CR-RBS-2003-03094	CR-RBS-2003-03199
CR-RBS-2002-00199	CR-RBS-2002-00326	CR-RBS-2002-00352
CR-RBS-2002-00582	CR-RBS-2002-00924	CR-RBS-2002-01069
CR-RBS-2002-01079	CR-RBS-2002-01080	CR-RBS-2002-01081
CR-RBS-2002-01090	CR-RBS-2002-01113	CR-RBS-2002-01190
CR-RBS-2002-01193	CR-RBS-2002-01219	CR-RBS-2002-01331
CR-RBS-2002-01380	CR-RBS-2002-01714	CR-RBS-2002-01769
CR-RBS-2002-01814	CR-RBS-2002-01859	CR-RBS-2002-01871
CR-RBS-2002-01889	CR-RBS-2002-01896	CR-RBS-2002-02043
CR-RBS-2003-00110	CR-RBS-2003-00228	CR-RBS-2003-00229
CR-RBS-2003-00295	CR-RBS-2003-00234	CR-RBS-2003-00235
CR-RBS-2003-00433	CR-RBS-2003-00467	CR-RBS-2003-00508
CR-RBS-2003-00520	CR-RBS-2003-00566	CR-RBS-2003-00881
CR-RBS-2003-01016	CR-RBS-2003-01052	CR-RBS-2003-01099
CR-RBS-2003-01111	CR-RBS-2003-01115	CR-RBS-2003-01132
CR-RBS-2003-011780	CR-RBS- 2003-01189	CR-RBS-2003-01205
CR-RBS-2003-01213	CR-RBS-2003-01391	CR-RBS-2003-01442
CR-RBS-2003-01507	CR-RBS-2003-01540	CR-RBS-2003-01602
CR-RBS-2003-01779	CR-RBS-2003-01982	CR-RBS-2003-02290
CR-RBS-2003-02685	CR-RBS-2003-02783	CR-RBS-2003-02804
CR-RBS-2003-02809	CR-RBS-2003-02811	CR-RBS-2003-02847
CR-RBS-2003-02881	CR-RBS-2003-02925	CR-RBS-2003-03005
CR-RBS-2003-03006	CR-RBS-2003-03007	CR-RBS-2003-03008
CR-RBS-2002-00159	CR-RBS-2002-00517	CR-RBS-2002-00531
CR-RBS-2002-01573	CR-RBS-2003-00055	CR-RBS-2003-00284
CR-RBS-2003-00321	CR-RBS-2003-00383	CR-RBS-2003-02804
CR-RBS-1998-0794	CR-RBS-1999-1914	CR-RBS-1999-1915
CR-RBS-2000-0865	CR-RBS-2000-1395	CR-RBS-2002-0684
CR-RBS-2002-0688	CR-RBS-2002-1372	CR-RBS-2002-1704
CR-RBS-2002-1911	CR-RBS-2003-2054	CR-RBS-2003-2437
CR-RBS-2003-2955	CR-RBS-2003-3203	CR-RBS-2003-3409
CR-RBS-2003-3462	CR-RBS-2003-3501	CR-RBS-2003-3515
CR-RBS-2002-0397	CR-RBS-2002-0893	CR-RBS-2002-1523
CR-RBS-2003-275	CR-RBS-2003-02082	CR-RBS-2003-02621
CR-RBS-2003-3071	CR-RBS-2003-03072	CR-RBS-2003-03073
CR-RBS-2003-03074	CR-RBS-2003-03075	CR-RBS-2003-03076
CR-RBS-2003-03078	CR-RBS-2003-03079	CR-RBS-2003-03080
CR-RBS-2003-03081	CR-RBS-2003-03082	CR-RBS-2003-03083
CR-RBS-2003-03084	CR-RBS-2003-03085	CR-RBS-2003-03086

CR-RBS-2003-03087	CR-RBS-2003-03088	CR-RBS-2003-03089
CR-RBS-2003-03090	CR-RBS-2003-03091	CR-RBS-2003-03092
CR-RBS-2003-03093	CR-RBS-2003-03094	CR-RBS-2003-03095
CR-RBS-2003-03096	CR-RBS-2003-03097	CR-RBS-2003-03098
CR-RBS-2003-03099	CR-RBS-2003-03100	CR-RBS-2003-030101
CR-RBS-2003-02379	CR-RBS-2002-00761	CR-RBS-2002-01000
CR-RBS-2002-02275	CR-RBS-2002-00684	CR-RBS-1998-0384
CR-RBS-2003-01754	CR-RBS-2003-01438	CR-RBS-2003-00388
CR-RBS-2002-02000	CR-RBS-1999-01522	CR-RBS-2002-01547
CR-RBS-2002-01550	CR-RBS-2003-02685	

Security Incident Reports

SIR-2003-018	SIR-2003-053	SIR-2003-062	SIR-2003-084
SIR-2003-019	SIR-2003-054	SIR-2003-065	SIR-2003-090
SIR-2003-039	SIR-2003-056	SIR-2003-067	SIR-2003-092
SIR-2003-043	SIR-2003-057	SIR-2003-069	SIR-2003-093
SIR-2003-045	SIR-2003-058	SIR-2003-072	SIR-2003-185
SIR-2003-048	SIR-2003-059	SIR-2003-076	SIR-2003-210
SIR-2003-052	SIR-2003-061	SIR-2003-082	

AUDITS AND ASSESSMENTS

QA-16-2001-W3-1-Multi-Site, Multi-Site Security Audit Report, November 5 - 29, 2001

QA-16-2002-GGNS-1-Multi-Site, Multi-Site Security Audit Report, November 2 - December 10, 2002

QA-7-2002-RBS-1, “Emergency Plan,” April 8 - May 6, 2002

QA-7-2003-RBS-1, “Emergency Plan,” April 21 - May 9, 2003

QS-2002-RBS-001, “Emergency Preparedness Owner Controlled Area Evacuations,” January 16-24, 2002

QS-2002-RBS-006, “Emergency Plan Team “A” Training Drill,” February 4-6, 2002

QS-2002-RBS-027, “Followup to Corrective Actions Associated with Emergency Preparedness White Finding,” October 15 - November 4, 2002

QA-14-2003-RBS-1, “Radiation Protection,” January 13 - February 28, 2003

QS-2002-RBS-015, “ALARA Planning and Controls,” June 24 - July 3, 2002

QS-2002-RBS-018, “ALARA Program,” August 2-6, 2002

QS-2002-RBS-021, “Access Control to Radiologically Significant Areas,” August 19 - September 11, 2002

QS-2003-RBS-004, “Evaluation of Radiation Work Permit Justification for Dose Estimate Revision,” February 10-14, 2003

QS-2003-RBS-012, “Radiation Work Permit Dose Extensions,” July 28-30, 2003

“ALARA Planning and Controls Focus Area Self-Assessment,” January 7-24, 2002

QA-2-2002-RBS-1, “Chemistry Program,” September 23 - October 21, 2002

QS-2003-RBS-013, “Followup to Corrective Actions Associated with 2002 Quality Assurance Chemistry Audit,” July 7-28, 2003

QA-15-2001-RBS-1, "Radwaste"

QA-4-2002-RBS-1, "Design Control (Engineering)"

QA-9-2002-RBS-1, "Fire Protection"

QA-1-2002-RBS-1, "FFD/AA"

QA-18-2002-RBS-1. "Tech. Specs."

OPERATING EXPERIENCE REPORTS

Industry Operational Event OE17170, “Turbine Lube Oil Interface Valve Oil Leak,” dated October 28, 2003

Industry Operational Event OE17169, “Defective Vendor Equipment Releases Oil into River,” dated October 28, 2003

Industry Operational Event OE17107, “Control Rod Movement Not Recognized During Plant Startup Rod Withdrawal,” dated October 16, 2003

Industry Operational Event OE12866, “Automatic Scram During Turbine Testing,” Dated October 26, 2003

Industry Operational Event OE17169, “Defective Vendor Equipment Releases Oil into River,” dated August 5, 2003

Industry Operational Event OE17173, “Grid Instabilities Cause Turbine Generator Trip with Reactor Scram,” dated August 14, 2003

Industry Operational Event OE17171, “Auxiliary Feedwater Train 1 Inoperability Due to Response Time,” dated September 23, 2003

Industry Operational Event OE17172, “Ineffective Implementation of the Procedure Governing Oversight of Contractors,” dated August 2, 2003

IN 03018 - General Electric Type SBM Control Switches With Defective Cam Followers

IN 03014 - Potential Vulnerability of Plant Computer Network to Worm Infection

IN 03008 - Potential Flooding Through Unsealed Concrete Floor Cracks

IN 03003 - Part 21: Inadequate Staked Capscrew Renders RHR Pump Inoperable

IN 03001 - Failure of a Boiling Water Reactor Target Rock Main Steam Safety/Relief Valve

IN 02036 - Incomplete or Inaccurate Information Provided to Licensee and/or NRC by Any Contractor or Subcontractor Employee

IN 02006 - Design Vulnerability in BWR Reactor Vessel

IN 01013 - Inadequate Standby Liquid Control System Relief Valve Margin

IN 01012 - (er) Hydrogen Fire at a Nuclear Power Station

Part 21s:

2002-18: Air Start System Pressure Reducing Valve, Norgen R18 Relieving

2002-23: Failures of Capacitors in Damping Circuits of Certain Models 1153 and 1154

2002-35: Broken Solder joints (Crack in Solder Joint) on Some Pins on the Tap Blocks of Power Shield Trip Devices

2003-36: Premature Gellation or Significant Thickening Prior to the End of the 12-Month Shelf Life Expiration Date of Carbonize 11 SG

2003-01: Unstaked Capscrews Renders Residual Heat Removal Pump Inoperable

2003-05: Main Steam Isolation Valve Disc Separated from its Stem Allowing the Disc/Piston Assembly to Drop into the Valve Seat

2003-17: Condition Reported with an EMD Electric Start Motor at Oyster Creek Generating Station

OTHER

OSRC Meeting RBS-2001-042 Minutes, August 30, 2001

OSRC Meeting RBS-2001-061 Minutes, November 15, 2001

SEC-2003-012, Security Monthly Report - June 2003, July 24, 2003

"River Bend Station RF-11 Reactor Reassembly Radiological Work Plan," 4/04/03

"River Bend Station RF-11 Reactor Vessel Reassembly Cavity Decontamination Job Guide," 4/04/03

Significant Event Response Team (SERT) Root Cause Analysis Report, "Containment Contamination During Reactor Disassembly," 5/22/03

Root Cause Analysis Report, "Reactor Core Isolation Cooling (RCIC) Locked High Radiation Entry," 12/12/02

Root Cause Analysis Report, "Refuel Floor Commenced Core Alterations Prior to Required Postings Being Established," 4/29/03

"Technical Requirements Manual," Revision 83

"Offsite Dose Calculation Manual," Revision 12

RBS Quarterly Trend Report, "3rd Quarter 2003"

Entergy Operations, Inc., "Problem Trending Guide," Revision 2

Nuclear Management Manual OE-100, "Operating Experience Program," Revision 1

Engineering Department Guide EDG-AA-115, "Engineering Request-Response Development," Revision 4

Information Request 1 - July 2003
River Bend PIR Inspection (IP 71152; Inspection Report 50-458/03-07)

The inspection will cover the period of November 27, 2001 to September 29, 2003. All requested information should be limited to this period unless otherwise specified. The information may be provided in either electronic or paper media or a combination of these. Information provided in electronic media may be in the form of e-mail attachment(s), CDs, or 3 ½ inch floppy disks.

Please provide the following information to Michael Murphy in the NRC Region IV Arlington office by October 6, 2003:

1. Summary list of all condition reports of significant conditions adverse to quality opened or closed during the period

2. Summary list of all open condition reports which were generated during the period

3. Summary list of all open condition reports which were generated prior to the latest refueling outage

4. Summary list of all condition reports closed during the specified period

5. A list of all corrective action documents that subsume or "roll-up" one or more smaller issues for the period

6. List of all root cause analyses completed during the period

7. List of root cause analyses planned, but not complete at end of the period

8. List of plant safety issues raised or addressed by the employee concerns program during the period

9. List of action items generated or addressed by the plant safety review committees during the period

10. All quality assurance audits and surveillances of corrective action activities completed during the period

11. A list of all quality assurance audits and surveillances scheduled for completion during the period, but which were not completed

12. All corrective action activity reports, functional area self-assessments, and non-NRC third party assessments completed during the period

13. Corrective action performance trending/tracking information generated during the period and broken down by functional organization

14. Current revision of the following procedures:

ADM-022, "Conduct of Operations"

ADM-0023, "Conduct of Maintenance"
CPN LI-102, "Corrective Action Process"
EDG-PR-001, "Maintenance Rule Program"
EDG-PE-002, "Guidline for Performing 10 CFR Part 21 Applicability Reviews"
ENG-3-033, "Modification Design Control Plan"
ENG-3-037, "Engineering Request Process"
LI-102, "Corrective Action Process"
OE-100, "Operating Experience Program"
PEP-0219, "Reliability Monitoring Program"
RBNP-002, "Root Cause Determination Guidance"
RBNP-010, "Configuration Management"
RBNP-030, "Initiation and Processing of Condition Reports"
RBNP-062, "River Bend Industry Events and Analysis Program"
RBNP-069, "Significant Event Evaluation"
RBNP-078, "Operability Determinations"

15. Any additional governing procedures/policies/guidelines for:
    a. Condition Reporting
    b. Corrective Action Program
    c. Root Cause Evaluation/Determination

16. A listing of all external events evaluated for applicability at River Bend during the period

17. Condition Reports or other actions generated for each of the items below:

    a. All LERs issued by River Bend during the period

    b. NCVs and Violations issued to River Bend during the period

    c. Part 21s reviewed during the period.

18. Safeguards event logs for the period (will review onsite)

19. Radiation protection event logs

20. Current system health reports or similar information

21. Current predictive performance summary reports or similar information

22. Corrective action effectiveness review reports generated during the period