


<b>United States Nuclear Regulatory Commission Official Hearing Exhibit</b>	
<b>In the Matter of:</b>	Charlissa C. Smith (Denial of Senior Reactor Operator License)
	<b>ASLBP #:</b> 13-925-01-SP-BD01
	<b>Docket #:</b> 05523694
	<b>Exhibit #:</b> CCS-040-00-BD01
	<b>Admitted:</b> 7/17/2013
	<b>Rejected:</b>
<b>Other:</b>	<b>Identified:</b> 7/17/2013
	<b>Withdrawn:</b>
	<b>Stricken:</b>

[REDACTED] **CCS-040**

April 26, 2013

UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

In the Matter of	)	
	)	
CHARLISSA C. SMITH	)	Docket No. 55-23694-SP
	)	
	)	
(Reactor Operator License for Vogtle Electric Generating Plant)	)	

AFFIDAVIT

Personally appeared before the undersigned attesting officer, duly authorized to administer oaths, the undersigned deponent signatory hereto, who, have been duly sworn, on oaths states and deposes as follows:

1.

I, ([REDACTED]), am 42 years old and I am a resident of Richmond County, Georgia living at [REDACTED].

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I have 10 years of Naval Nuclear Power experience both in the operation of nuclear power plants and training of personnel to operate nuclear power plants. I obtained an Electrical Engineering degree from The Citadel. I currently hold an SRO license position at Vogtle 1&2. I was a member of the crew assigned to perform two scenarios with Charlissa Smith. I was in direct observation of the actions that occurred.

This statement is to address the issue with regard to the comment about CharliSSa Smith's failure to maintain the temperature deviation less than 2F. This was scenario 7, Event 1. My position during this scenario was the Shift Supervisor. I provided a statement for CharliSSa to submit with her initial appeal request to the NRC. A copy of that statement can be viewed on page 12 of ML13080A128 (and below):

Fig. 13 response:

During the scenario CharliSSa (RO) kept me (SRO) informed of the TAVE/TREF Deviation and recommended several times to withdraw control rods beginning at a deviation of 1.7F. During those times there were failures present that I decided to prioritize over withdrawing control rods to maintain Tave in the established band. My responsibilities as Shift Supervisor require ensuring that there are no transients going on during reactivity manipulations and mitigating those transients prior to reactivity manipulations being performed, with the exception of maintaining Thermal Power within the licensed limit. CharliSSa (RO) was not allowed to make any positive reactivity manipulation without approval from me (SS), and met station expectations through keeping me informed of the deviation and its trend while recommending withdrawing control rods.

NMP-OS-001 (Reactivity Management Program):

6.3.4: Except when a Reactivity Management SRO is stationed per 6.4 of this procedure, the SS shall maintain direct supervisory oversight of reactivity manipulations. The SS will approve each reactivity manipulation, with the exceptions of transient conditions described in step 6.3.8 or when a Reactivity Management SRO is stationed per 6.4.



CharliSSa did not wait until the last moment to address the temp deviation and kept the crew updated on the temperature deviation. As the Shift Supervisor, I prioritized events and addressed the temperature deviation when the plant was in a stable condition; not during transient or fault conditions.

This statement is to address the RWST comment about how the crew spent the extended time looking for procedural guidance to close the valves. This was scenario 7, Event 6. My position during this scenario was the Shift Supervisor. I provided a statement for Charlissa to submit with her initial appeal request to the NRC. A copy of that statement can be viewed on page 20 of ML13080A128 (and below):

Pg. 20 response:

When ALB06-ED4 was received, Charlissa (RC) silenced and announced the alarm. I (SS) directed Charlissa to continue to monitor reactivity and directed [REDACTED] to pull the ARP for the alarm and investigate actions to be taken. [REDACTED] informed me, by name, not Charlissa of the automatic action that did not take place. There was never any confusion as to where the hand switches were located by either [REDACTED] or me. I made a conscious decision to isolate the sludge mixing system by use of the SOP 13105-1 Step 4.2.7.3. This decision was based on not isolating the system with the pump running. The delay of 19 minutes was incurred while reviewing the P&ID for the RWST and finding the correct procedure and step to isolate the sludge mixing system. My expectation for Charlissa was for her to monitor reactivity and critical parameters of the reactor. Charlissa getting involved with troubleshooting and diagnosis would have taken away from the duties I directed her to do.



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This statement is to address the issue with the comment about taking rods to manual and misdiagnosing that rods should have been automatically inserting. This was scenario 6, Event 6. My position during this scenario was the Reactor Operator. I notified Charlissa that I did not think rods were properly responding. At the time the temperature deviation (according to the computer point) was 1.5F and wanted to wait to see if instrument inaccuracies were why the rods were not stepping in. Charlissa eventually caught the error and I requested to return rods to manual and continued the rapid power reduction.

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This statement is to address the issue regarding the comment about TE130. This was scenario 7, Event 1. My position during this scenario was the Shift Supervisor. I provided a statement for Charlissa to submit with her initial appeal request to the NRC. A copy of that statement can be viewed on page 35 of ML13080A128 (and below):

Pg. 21 response:

Charlissa (RO) was the first to recognize that TE-0130 was the failed component. I directed [REDACTED] to pull and investigate the appropriate ARPs. The statement Charlissa made about contacting C&T was to reinforce the fact that there was no AOP entry to be made (for loss of letdown). This statement was not stand-alone and was taken out of context for the situation. When operating TIC-130 there was no consequential action in pressing the up arrow and the crew immediately self corrected as is the expectation of Operations Training and Operations for the control room team.

As Shift Supervisor, I assigned the Unit Operator to address the failure while ensuring that Charlissa (Reactor Operator) was monitoring reactivity. Charlissa did provide input to get maintenance to look at the failure but stayed in front of Charlie panel, as expected, to monitor reactivity.

This 26 day of April, 2013



Subscribed and sworn before me this 26 day of April, 2013.

Cynthia J. Barker

Notary Public

My Commission expires:

