



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

September 15, 2015

EA-14-158

Mr. Brian K. Taber
VP Nuclear Plant Site
Southern Nuclear Operating Co., Inc.
Vogtle Electric Generating Plant
7821 River Road
Waynesboro, GA 30830

**SUBJECT: VOGTLE ELECTRIC GENERATING PLANT – U.S. NUCLEAR REGULATORY
COMMISSION SUPPLEMENTAL INSPECTION REPORT 05000424/2015009;
05000425/2015009 AND ASSESSMENT FOLLOWUP LETTER**

Dear Mr. Taber:

On December 12, 2014, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Vogtle Electric Generating Plant (VEGP) Units 1 and 2. Based on the results of this inspection, documented in NRC Inspection Report (IR) 05000424/2014009; 05000425/2014009 on January 22, 2015, and the final significance determination letter dated March 30, 2015, the NRC assigned a White finding Action Matrix input to the Public Radiation Safety Cornerstone in the fourth quarter of 2014.

In response to this Action Matrix input, the NRC informed you that a supplemental inspection under inspection procedure (IP) 95001, "Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area," would be required. On June 1, 2015, you informed the NRC that VEGP was ready for the supplemental inspection.

On August 20, 2015, the NRC completed the supplemental inspection and discussed the results of this inspection, and implementation of your corrective actions, with you and other members of your staff. The inspection team documented the results of this inspection in the enclosed IR.

The NRC performed this supplemental inspection to determine if: (1) the root and contributing causes for the significant issues were understood, (2) the extent of condition and extent of cause for the identified issues were understood, and (3) your completed or planned corrective actions were sufficient to address, and prevent, repetition of the root and contributing causes.

The NRC determined that your staff's evaluation identified the primary root cause of the issue to be that there were less than adequate controls in place to ensure radioactive waste processing was properly documented, and verified during storage and shipping. The NRC determined that the root and apparent cause evaluations were conducted to a level of detail commensurate with the significance of the problems, and reached reasonable conclusions as to the root and contributing causes of the event. The NRC also concluded that you identified reasonable and

appropriate corrective actions for each root and contributing cause, and that the corrective actions appeared to be prioritized commensurate with the safety-significance of the issues. Based on the results of this inspection, no findings were identified.

After reviewing VEGP Unit 1 and Unit 2's performance in addressing the White finding, that was the subject of the IR, the NRC concluded that your actions met the objectives of IP 95001, "Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area." Therefore, in accordance with the guidance in Inspection Manual Chapter 0305, "Operating Reactor Assessment Program," the White finding will only be considered in assessing plant performance for a total of four quarters. As a result, the NRC determined the performance at VEGP Unit 1 and Unit 2 to be in the Licensee Response Column of the ROP Action Matrix as of October 1, 2015.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public inspections, exemptions, requests for withholding," of the NRC's "Agency Rules of Practice and Procedure," a copy of this letter, its Enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room, or from the Publicly Available Records component of the NRC's Agencywide Documents Access and Management System (ADAMS); accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Brian R. Bonser, Chief
Plant Support Branch 1
Division of Reactor Safety

Docket Nos. 50-424 and 50-425
License Nos. NPF-68 and NPF-81

Enclosure:
IR 05000424/2015009 and 05000425/2015009
w/Attachment: Supplementary Information

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/RA/
 Brian R. Bonser, Chief
 Plant Support Branch 1
 Division of Reactor Safety

Docket Nos. 50-424 and 50-425
 License Nos. NPF-68 and NPF-81

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 IR 05000424/2015009 and 05000425/2015009
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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 05000424 and 05000425

License Nos: NPF-68 and NPF-81

Report Nos: 05000424/2015009 and 05000425/2015009

Licensee: Southern Nuclear Operating Company, Inc.

Facility: Vogtle Electric Generating Plant, Units 1 and 2

Location: Waynesboro, GA

Dates: August 17 – 20, 2015

Inspectors: A. Nielsen, Senior Health Physicist
C. Dykes, Health Physicist

Approved by: Brian Bonser, Chief
Plant Support Branch 1
Division of Reactor Safety

Enclosure

SUMMARY

Inspection Report (IR) 05000424/2015009, 05000425/2015009; 8/17/2015 – 8/20/2015; Vogtle Electric Generating Plant Units 1 and 2; Supplemental Inspection – Inspection Procedure (IP) 95001

Two regional health physics inspectors performed this inspection. No findings were identified. The U.S. Nuclear Regulatory Commission (NRC)'s program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

Cornerstone: Public Radiation Safety

The NRC staff performed the supplemental inspection in accordance with IP 95001, "Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with the June 24, 2014, shipment of a Type B quantity of radioactive material in a Type A packaging. The NRC staff previously characterized this issue as having low to moderate safety-significance (White), as documented in NRC IR 05000424, 05000425/2014009.

During this inspection, the inspectors determined that your staff performed an adequate evaluation of the cause of the White finding. Your staff's evaluation identified the root cause to be that there were less than adequate controls in place to ensure radioactive waste processing was properly documented, and verified, during storage and shipping. The inspectors found the extent of condition and extent of cause reviews were adequate, and the corrective actions implemented were adequate. All immediate and long term corrective actions have been completed, except for the action to verify the serial numbers on all liners currently in storage, which is due to be completed by December 2015.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 SUPPLEMENTAL INSPECTION (95001)

.01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with inspection procedure (IP) 95001 to assess the licensee's evaluation of a White finding that affected the public radiation safety cornerstone. The inspection objectives were to provide assurance that the:

- root causes and contributing causes of risk-significant performance issues were understood
- extent of condition and extent of cause of risk-significant performance issues were identified
- licensee's corrective actions for risk-significant performance issues were sufficient to address the root and contributing causes and prevent recurrence

The finding was characterized as having low to moderate safety-significance (White) as discussed in NRC IR 05000424, 05000425/2014009, and was associated with the June 24, 2014, shipment of the wrong waste container, which resulted in a Type B quantity of radioactive material (RAM) being transported in a Type A packaging.

The licensee informed the NRC staff on June 1, 2015, that they were ready for the supplemental inspection. In preparation for the inspection, the licensee performed a root cause investigation, documented in Root Cause Determination Report (RCDR) 255724, to identify weaknesses that existed in various organizations and processes, which resulted in the White finding.

The inspectors reviewed the licensee's RCDR and other assessments conducted in support of, and as a result of, the investigation. Corrective actions taken to address the identified root and contributing causes were also reviewed. Additionally, inspectors interviewed licensee personnel to ensure that the root and contributing causes, and the contribution of safety culture components were understood, and corrective actions were appropriate to address the causes and preclude repetition.

.02 Evaluation of Inspection Requirements

02.01 Problem Identification

- a. Determine that the evaluation identifies who identified the issue and under what conditions the issue was identified.

The licensee was informed of the shipping error when the consignee (Energy Solutions, Barnwell Processing Facility) discovered that the waste liner serial number did not match the number on the shipping paperwork. The consignee also performed receipt surveys of the unshielded waste liner, and discovered that the dose rates exceeded 1 R/hr at 3m, indicating that the shipment should have been transported in a Type B container. The licensee entered the issue into their corrective action program (CAP) and took

immediate actions, including submittal of a report to the NRC pursuant to 10 CFR 71.95(b) (report number NL-14-1308), and initiation of an apparent cause investigation. The inspectors verified that this information was documented in the licensee's evaluation.

- b. Determine that the evaluation documents how long the issue existed and prior opportunities for identification.

The licensee identified that several waste liners were removed from their storage locations, and returned to new locations, during a waste re-characterization campaign in June 2012. During this activity, the waste liner inventory was not accurately maintained; however, the licensee identified multiple opportunities to identify the discrepancies prior to shipment. These included a self-assessment performed in 2013 in preparation for an NRC baseline inspection in the areas of shipping and radwaste; and on the actual day of shipment, the liner numbers could have been visually verified, but were not.

The inspectors determined that the licensee's evaluation and assessments were adequate with respect to identifying how long the issue existed, and the prior opportunities for identification. The inspectors did not identify any additional missed opportunities.

- c. Determine that the evaluation documents the plant-specific risk consequences, as applicable, and compliance concerns associated with the issue.

The NRC determined this issue was a White finding, as documented in NRC IR 05000424, 05000425/2014009 dated January 22, 2015. The licensee's RCDR documented the consequences of the issue, including increased risk to the public if the shipment had been involved in an accident. The licensee also contracted an outside vendor to perform dose calculations for a hypothetical accident scenario in which the package contents were lost. The RCDR also documents all the violations (compliance concerns) that resulted from this shipping error.

The inspectors concluded that the licensee appropriately documented the risk consequences and compliance concerns associated with the finding.

- d. Findings

No findings were identified.

02.02 Root Cause and Extent of Condition Evaluation

- a. Determine that the problem was evaluated using a systematic methodology to identify the root and contributing causes.

The licensee's investigation was performed by a diverse qualified team of eight members using licensee procedure NMP-GM-002-GL03, "Cause Analysis and Corrective Action Guidelines." The following systematic methods and tools were used to perform the RCDR:

- TapRoot®
- Event and Causal Factor Chart Analysis

- Interviews
- Extent of Condition and Extent of Cause Evaluations
- Line of Sight Analysis
- Operating Experience (OE) Review
- Safety Culture Attributes Assessment
- Organization and Programmatic Review

The licensee also used an independent team to perform a mock inspection in June 2015 to determine their readiness for inspection, and the need for additional corrective actions.

The inspectors determined that the licensee adequately evaluated the issue using systematic methodologies to identify root and contributing causes.

- b. Determine that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.

The RCDR was detailed in the scope of investigation and licensee staff performed the following activities in support of the evaluation:

- conducted interviews with personnel involved with the issue
- created a timeline of relevant events
- reviewed radiological surveys and other records of waste liner processing
- performed reviews of industry OE and internal OE

The following represent a synopsis of the root cause and contributing causes:

- (1) The root cause of this issue was determined to be a lack of adequate controls to ensure radioactive waste processing was properly documented, and verified, during storage and shipment. Specifically, procedure 46111-C, "Storage of Radwaste in Outdoor Process Shields," did not provide adequate guidance for maintaining accurate inventory of radioactive waste liners; when they had to be moved to different storage locations. Also, the licensee displayed inadequate self-checking and error detection methods, because the waste liner numbers were not verified immediately prior to shipment.
- (2) A contributing cause was determined to be an inadequate self-assessment performed in June 2013. Although the assessment was conducted to evaluate readiness for a baseline NRC IP (71124.08, "Radioactive Solid Waste Processing and Radioactive Material Handling"), the licensee determined that it was not of sufficient scope because it did not identify inadequacies in procedure 46111-C, and did not discover errors in the waste liner inventory.
- (3) A second contributing cause was determined to be a lack of detail in the work orders (WOs) used to accomplish the re-characterization campaign in 2012. Specifically, the WOs did not contain inventory specifics such as liner numbers, and pre and post movement liner storage locations. The inspectors noted that the lack of detail began early in the planning process for the re-characterization campaign.

Based on a review of the RCDR and supporting documentation, the inspectors concluded that the evaluation was conducted to a level of detail commensurate with the significance of the problem.

- c. Determine that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

The RCDR included a review of plant corrective action databases and industry databases. The CAP review showed that there had been no prior occurrences of a similar shipping error at VEGP. Several recent and historical shipping issues throughout the industry were reviewed, but none were substantively similar to shipping a Type B quantity in a Type A container. None of the examples showed that use of industry OE would have prevented the shipping error.

Based on the licensee's detailed evaluation and conclusions, the inspectors determined that the licensee's root cause investigation included adequate consideration of prior occurrences of the problem, and knowledge of prior OE.

- d. Determine that the root cause evaluation addressed the extent of condition and the extent of cause of the problem.

The licensee performed an extent of condition review to assess the degree to which errors may currently exist in other radwaste storage locations, and in other Southern Nuclear Company (SNC) fleet waste procedures. This included verification of the liner serial numbers for radwaste currently stored in various locations, including the B/C pad, Solids Building, and Alternate Radwaste Building. No discrepancies were identified. However, one location on the B/C pad was not immediately verified due to worker dose concerns. The RCDR noted that other storage locations have more robust programmatic controls for liner movement and inventory than the B/C pad. The extent of condition review also considered whether there were prior instances of RAM control issues within the SNC fleet, and whether other departments had similar issues based on their potential to transport waste. The review found a small number of RAM control issues and one shipment documentation error. Also, one error was found in the Environmental Safety and Health (ESH) department where a shipment had exceeded its "ship by" date. All the discrepancies had been previously documented in condition reports (CRs).

The extent of cause was limited to the verification practices of various groups who must track the movement of materials that may have to be shipped as RAM in the future. Chemistry, Operations, and ESH protocols for tracking movement of items such as chemistry samples, and Special Nuclear Material (fuel), were evaluated. Across the SNC fleet, several instances of documentation and verification issues were evaluated in the RCDR. All the discrepancies had been previously documented in CRs.

The inspectors concluded that the licensee's root cause investigation adequately addressed the extent of condition, and the extent of cause of the issue.

- e. Determine that the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components as described in Inspection Manual Chapter 0305.

The licensee found weaknesses in the following crosscutting aspects:

- Human Performance component of Resources: This was related to inadequate procedural guidance to maintain inventory of waste liners during movement.
- Human Performance component of Work Practices: This was related to the ineffective error prevention techniques and self-checking prior to waste liner shipment.
- Problem Identification and Resolution component of Self and Independent Assessments: This was related to a radwaste self-assessment performed in 2013 that did not identify problems with the waste liner inventory.

The inspectors determined that the licensee's root cause investigation included a proper consideration of whether weaknesses in any safety culture component were root, or significant contributing causes of the issue.

f. Findings

No findings were identified.

02.03 Corrective Actions

- a. Determine that appropriate corrective actions are specified for each root and contributing cause, or that the licensee has an adequate evaluation for why no corrective actions are necessary.

The licensee created a matrix of the corrective actions and the corresponding causes in the RCDR. Immediately following the shipping incident the licensee implemented corrective actions that addressed the error prevention/self-checking aspects of the root cause. Specifically, the licensee halted all shipments until responsible health physics (HP) staff were retrained and completed oral boards. In addition, a stand-down occurred with the entire HP staff.

The licensee also created corrective actions that specifically addressed the inadequate procedural guidance aspects of the root cause.

- Revise procedure NMP-HP-415, "Storage of Radwaste in Outdoor Process Shields," to clarify inventory protocols by changing some data sheets and adding steps, including a requirement to create an electronic image of both the process shield number, and the liner serial number, every time a liner is inserted into a process shield. This procedure superseded 46111-C in December 2012.
- Revise procedure NMP-HP-405, "Shipment of Radioactive Waste and Radioactive Material," to require double verification of the liner serial number for all waste shipments.
- Purchase an add-on package to the shipping software suite that allows users to maintain inventory and location of packages. This program will be the official tracking method for waste liners.

Corrective actions were also created to address the two contributing causes of less than adequate self-assessments, and lack of detail in WOs.

- Revise NMP-HP-003, "Self-Assessment and Benchmark Procedure," to require that the team leader, for required self-assessments, cannot be the program or process owner.
- Revise NMP-HP-003 to require that the team lead complete a self-assessment pre-job brief and interview with the sponsoring manager and Performance Improvement Manager.
- Change the WO package detail instruction to include the liner number for informational purposes and as an additional barrier for verification.

The inspectors reviewed the matrix and evaluated and discussed the corrective actions with the licensee, and determined that appropriate corrective actions were established to address each root and contributing cause.

- b. Determine that corrective actions have been prioritized with consideration of risk-significance and regulatory compliance.

Immediate corrective actions consisted of a suspension of all radioactive waste shipments, and a requalification of the licensee's radioactive waste shippers and supervisors; allowing the licensee to operate within regulatory compliance. After the initial corrective actions were taken, an Apparent Cause Evaluation (ACE) was performed, and then later an RCDR was completed. The licensee based the corrective actions on the risk assessment of the possible hazards posed to members of the public under transportation accident conditions. A result of the evaluations were corrective actions commensurate with risk and regulatory compliance. The initial corrective actions addressed human performance errors and inadequate procedures. Additional corrective actions were completed to prevent reoccurrence by addressing a less than adequate process for storage and shipping of radioactive waste. The licensee also included worker-risk in its prioritization of corrective actions. Specifically, the serial number for one of the liners in storage was not verified during the immediate corrective actions phase, due to worker dose concerns.

The inspectors determined that the corrective actions for the event were properly prioritized and executed relative to the risk significance and regulatory compliance.

- c. Determine that a schedule has been established for implementing and completing the corrective actions.

After the event occurred, immediate corrective actions were implemented to ensure the licensee was operating within compliance. All shipments were put on hold until human performance errors were addressed through remedial instruction on human performance tools. After the immediate corrective actions had been determined an ACE was performed, later followed by a Root Cause Determination. Based on the results of those evaluations, additional corrective actions were created and assigned to responsible personnel for implementation. The licensee's schedule and implementation of the corrective actions were based on the results of the evaluations, and the priority assigned

to the corrective action. The licensee followed the criteria listed in procedure NMP-GM-002-001, "Corrective Action Program Instructions," to determine the priority level. The inspectors determined that a schedule had been established for implementing and completing the corrective actions, based on the licensee's priority assignment. Corrective actions to address the root cause and contributing causes were established and appropriately scheduled for implementation. The inspectors noted that all planned corrective actions have been completed, except for verification of one waste liner serial number. This liner is scheduled to be verified by December 2015.

- d. Determine that quantitative or qualitative measures of success have been developed for determining the effectiveness of the corrective actions to prevent recurrence.

The licensee developed an effectiveness review plan, that included quantitative and qualitative measures of success, to determine if the completed corrective actions are effective. It is a focused self-assessment of the HP Radwaste processes, shipping and procedures that will look at seven attributes. The effectiveness review defines success as no errors resulting in a Department of Transportation regulatory impact in at least five waste shipments of Low Specific Activity or higher waste. The seven attributes are listed as:

- A review of the Technical Evaluations (TEs) issued from the RCDR to ensure the actions were successfully implemented.
- Technical inconsistencies with shipping paperwork and manifests.
- Radiological survey data for material being shipped is correct.
- Review of shipping software documentation on package activity.
- A review of package and vehicle placarding to ensure it is correct.
- An audit of the site's process shield inventory. Ensure all waste liner movement documentation is complete.
- Management observation/oversight of all liner shipments and verification practices.

The effectiveness review for the RCDR is scheduled to be completed by October 2015, and a TE was written to make the reviews semi-annual.

The inspectors determined that the effectiveness review does include quantitative and qualitative measures of success.

- e. Determine that the corrective actions, planned or taken, adequately address a Notice of Violation that was the basis for the supplemental inspection, if applicable.

A Notice of Violation (NOV) was issued to the licensee on March 30, 2015. The licensee replied to the NOV in a letter received April 21, 2015, acknowledging the violation involved a Type B quantity of radioactive waste being shipped in a Type A shipping cask to the waste processing facility in Barnwell, SC.

The NRC listed failure to follow procedure 46111-C as required by Technical Specification 5.4.1, which requires written procedures as recommended by Regulatory Guide 1.33, as a violation. The licensee failed to maintain records of the contents of the waste liners in the process shields on the storage pad. Specifically, information

regarding the contents and location of the liner that was stored in process shield 10. In response the licensee enhanced procedures, inventory tools, and verification processes for waste liner handling and shipment. The licensee's corrective actions that directly addressed the reasons for the violation are listed.

- Revise procedure NMP-HP-415 to clarify inventory protocols by changing some data sheets and adding steps, including a requirement to create an electronic image of both the process shield number, and the liner serial number, every time a liner is inserted into a process shield.
- Revise procedure NMP-HP-405 to require double verification of the liner serial number for all waste shipments.
- Implement an onsite radioactive waste/material tracking software that allows users to maintain an inventory of packages.

After the RCDR, the licensee categorized all the corrective actions as (1) completed immediate/interim actions; (2) corrective actions to prevent reoccurrence; and (3) corrective actions to address cause. The corrective action that included the onsite radioactive waste/material tracking software addressed the issue of updating, and maintaining, the information about the waste liners as they were moved on, off, or around the storage pad for any reason; therefore, always maintaining the location of each liner. The corrective actions that revised the procedures addressed verification that the correct information, such as the serial number for the process liner, was always being maintained.

Inspectors determined that the corrective actions planned and taken adequately addressed the NOV associated with a White finding.

f. Findings

No findings were identified.

02.04 Evaluation of Inspection Manual Chapter 0305 Criteria for Treatment of Old Design Issues.

This issue did not meet the definition of an old design issue as described in Inspection Manual Chapter 0305.

40A6 Exit Meeting

- a. On August 20, 2015, the inspectors presented the inspection results to Mr. Taber and other members of the staff, who acknowledged the results. The inspectors asked the licensee if any of the material examined during the inspection should be considered proprietary. The licensee did not identify any proprietary information.
- b. Following the exit meeting, a Regulatory Performance Meeting was conducted to discuss corrective actions associated with the White finding.

ATTACHMENT: SUPPLEMENTARY INFORMATION

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

NRC

M. Cain, Senior Resident Inspector
A. Alen, Resident Inspector
B. Bonser, Chief, Plant Support Branch 1

Licensee

B. Taber, Site Vice-President
K. Morrow, Licensing Engineer
G. Gunn, Regulatory Affairs Manager
M. Johnson, Radiation Protection
J. Dixon, Radiation Protection Manager
R. Wheeler, Senior Health Physicist
J. Griffis, Health Physicist
T. Reeves III, Health Physicist
T. Mattson, Cause Analyst

LIST OF ITEMS OPENED, CLOSED, DISCUSSED, AND UPDATED

Opened

None

Closed

05000424, 425/2014009-01	VIO	EA-14-158; Shipment of a Type B Quantity of RAM in a Type A Container
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DOCUMENTS REVIEWED

Plans and Procedures

46111-C, Storage of Radwaste in Outdoor Process Shields, Revision 6.1
NMP-GM-002-GL03, Cause Analysis and Corrective Actions Guideline, Version 25.0
NMP-HP-415, Storage of Radwaste in Outdoor Process Shields, Version 2.0, 2.1
NMP-HP-405, Shipment of Radioactive Waste and Radioactive Material, Version 1.3, 2.3
NMP-GM-003, Self-Assessment and Benchmark Procedure, Version 21.1
NMP-GM-002-F09, Root Cause Determination Report: Vogtle 1 & 2, CAR 255724, 4/30/2015
NMP-GM-002-F02, Apparent Cause Determination Report: Vogtle 1 & 2, CAR 255724,
9/22/2014
NMP-GM-020-001-F01, IRT Activation Checklist Attachment 1, CAR 210987

Corrective Action Documents

CR 831652 Incorrect Waste Liner Shipped
CAR 210987 Incorrect Waste Liner Shipped
CR 832198 Request to Perform a Performance Gap/Training Needs Analysis
TE 915606 Perform a Training Gap/Needs Analysis in Response to Shipping the Incorrect Liner
TE 834311 IRT Action From Incorrect Radwaste Liner Shipped

TE 921374 CAPR Implement an Onsite Radioactive Waste /Material Tracking Software
TE 834320 Corrective Action to Revise NMP-HP-405 from Incorrect Radwaste Liner Shipped
TE 921375 Require an Electronic Image of Both the Process Shield Number and the Liner
Serial Number
TE 921687 Require the Team Leader Required for the FASA Cannot Be the Program Process
Owner
TE 921688 Require the Team Leader Review with PI a Pre-Job Brief or Familiarization Sheet
TE 921690 Require Section 5.3.5 and Data Sheet 2 as Continuous Use
CR 10041251 Verification is Needed for Liners Stored in Process Shields
TE 834312 IRT Action from incorrect Radwaste Liner Shipped- Perform Detailed Review with
Radwaste HP
TE 834313 IRT Action from Incorrect Radwaste Liner Shipped- Perform Oral Board with
Radwaste HP
TE 862064 Action to Revise NMP-HP-415
TE 844721 Corrective Action to Revise NMP-HP-405 Data Sheet 8
TE 917208 Semi-Annual Review of Shipping Activities

Miscellaneous Documents

Event & Causal Factor Chart for Liner 003698-19
Event & Causal Factor Chart for Liner 605163-02
46111-C Data Sheet 2, Container Information Sheet, 1/31/2011
Radiological Survey 149144, RPF Resin Vault #4
Duty Foreman's Checklist – Daily Report Items - Dayshift, 6/14/12, 6/15/2012
ALARA Briefing Record, RWP 12-0126, 6/14/2012, 6/15/1202, 7/25/2012
Mock NRC Inspection Procedure 95001 Supplemental Inspection, 6/25/2015
Focused Area Self-Assessment, Health Physics, 3/27/2012
Focused Area Self-Assessment, Radiological Hazards Analysis and Transportation, 5/12/2013
CR 441296
WO SNC#646048- Verification is needed for liners stored in process shields

LIST OF ACRONYMS

ACE	Apparent Cause Evaluation
CAP	Corrective Action Program
CRs	Condition Reports
ESH	Environmental Safety and Health
HP	Health Physics
IP	Inspection Procedure
NOV	Notice of Violation
OE	Operating Experience
RAM	Radioactive Material
RCDR	Root Cause Determination Report
SNC	Southern Nuclear Company
TEs	Technical Evaluations
VEGP	Vogtle Electric Generating Plant
WOs	Work Orders