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Director, Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, D. C. 20555-001
Attn: Document Control Desk

Subject: GEH VNC Written Follow-Up Report – NTR Control Room Staff

References: 1) NRC License R-33, Docket 50-73
2) GEH Event Report 53274, 3/20/18
3) Vallecitos Nuclear Center (VNC) Technical Specifications for the R-33 Nuclear Test Reactor (NTR), 5/15/07

Dear Sir or Madam:

In accordance with NTR Technical Specification Section 6.6.2(a)(2) Special Reports, GE-Hitachi Nuclear Energy Americas, LLC (GEH) hereby submits a written follow-up report for Event Notification 53274 that was provided to NRC on March 20, 2018 (Reference 2). As discussed in the initial event report, GEH reported a discovery that a licensed operator had not remained in the NTR facility control room for a brief time when the reactor was not secured.

Additional information is provided as follows:

Event Details and Safety Significance

At 11:30 am on March 19, 2018, a violation of NEDO 32765, NTR Technical Specification Section 6.1.3.1(a) occurred when a licensed operator was not present in the control room when the reactor was not secured.

The reactor had been operating at 100% power for over an hour with a Senior Reactor Operator (SRO) at the panel. Also present in the control room were: an RO trainee awaiting results of his NRC examination completed 5 weeks prior; an SRO trainee also awaiting NRC examination results; a senior radiation monitoring technician; a radiography technician who previously held an SRO license but was not current; and the NTR manager, also an SRO but working as the Nondestructive Testing (NDT) process film reviewer. These individuals were also trained and capable of carrying out the written posted emergency shutdown procedure to manually shut down the reactor if an unsafe or abnormal condition occurred and the automatic reactor protection action does not function.

The SRO became ill and hastily exited the control room. He informed the NTR manager he needed to leave and the manager acknowledged his departure. The NTR manager finished his discussion with the radiographer and turned and left the control room to continue reading film

approximately 24 feet down the hallway and still in line of sight with the control room. The NTR manager quickly realized he shouldn't have left and immediately returned to the control room.

As there were additional trained operators in the room and due to the very short duration of approximately 20 seconds, this event was considered as having minimal risk. During this time, the reactor remained stable with no issues.

Immediate Action Taken

1) The event was reported to NRC the following working day as required by NTR Technical Specification Section 6.6.2.

Probable Cause of Event

A preliminary investigation determined that the event was caused by a human performance error.

Short Term Corrective Actions

1) Condition Report # 28168 was initiated in the GEH Corrective Action Program to track additional investigation findings, causes, and corrective and preventive actions.

2) An independent review of the event by the cognizant Nuclear Safety Review group as required by NTR Technical Specification Section 6.2.3 is in progress.

Longer Term Corrective Action

1) Provide additional operator flexibility. Three additional operators have completed the NRC examination process and are awaiting the results to complete their qualification requirements.

If you have any questions regarding this matter, please contact me at (925) 918-6018.

Sincerely,

Matt Feyrer, Site Manager
Vallecitos Nuclear Center

Attachments: None

cc: NRC Region IV Administrator
D. Hardesty, NRC NRR/DPR
MJF 18-004