UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
245 PEACHTREE CENTER AVENUE N.E., SUITE 1200
ATLANTA, GEORGIA 30303-1200

February 4, 2021

EA-20-150

Mr. Don Moul
Executive Vice President, Nuclear Division
and Chief Nuclear Officer
Florida Power & Light Company
Mail Stop: EX/JB
700 Universe Blvd.
Juno Beach, FL 33408

SUBJECT: TURKEY POINT NUCLEAR GENERATING STATION - NRC INSPECTION REPORT 05000250/2021011 and 05000251/2021011, AND INVESTIGATION REPORT 2-2019-025; AND APPARENT VIOLATIONS

Dear Mr. Moul:

This letter refers to the investigation completed on November 10, 2020, by the Nuclear Regulatory Commission's (NRC) Office of Investigations (OI) regarding the Florida Power and Light Company's (FPL) Turkey Point Nuclear Generating Station (Turkey Point). The purpose of the investigation was to determine whether two instrumentation and control (I&C) technicians at Turkey Point deliberately provided incomplete or inaccurate information in maintenance records, and whether the I&C technicians, an I&C Supervisor, and the I&C Department Head deliberately failed to immediately notify the main control room of a mispositioned plant component as required by plant procedures. The incident under OI review occurred on July 10, 2019, when the two I&C technicians were assigned to perform a work order on a Unit 4 C charging pump oil pressure switch, but instead inadvertently performed work on the Unit 3 C charging pump oil pressure switch, causing the Unit 3 C charging pump to trip. Enclosure 1 to this report presents the results of this investigation. A Factual Summary of the OI Investigation is provided as Enclosure 2.

Based on the results of the NRC's review of the OI investigation report, two apparent violations (AVs) were identified and are being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC's Web site at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The AVs are more fully discussed in Enclosure 1.

The first AV being considered for escalated enforcement involves the failure to notify the main control room of mispositioned plant components in accordance with plant procedure OP-AA-100-1002, "Plant Status Control Management." Specifically, the I&C technicians, I&C Supervisor, and I&C Department Head failed to immediately notify the Operations Shift Manager of a component mispositioning that resulted in the inadvertent trip of the 3C charging pump. The NRC concluded the actions of the I&C Supervisor and the I&C Department head were apparently deliberate and caused FPL to be in violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

The second AV being considered for escalated enforcement involves the failure to maintain a complete and accurate record of maintenance performed on safety-related equipment. Specifically, I&C technicians assigned to work on the 4C charging pump recorded inaccurate information in work order (WO) 40632818. The NRC concluded that the actions of the mechanics were apparently deliberate and caused FPL to be in apparent violation of 10 CFR § 50.9(a).

Before the NRC makes its enforcement decision, we are providing you an opportunity to: (1) respond to the apparent violations addressed in this inspection report within 30 days of the date of this letter, (2) request a Pre-decisional Enforcement Conference (PEC), or (3) request Alternative Dispute Resolution (ADR). If a PEC is held, the NRC may issue a press release to announce the time and date of the conference; however, the PEC will be closed to public observation since information related to an Office of Investigations report will be discussed and the report has not been made public. Additionally, a PEC will be transcribed. If you decide to participate in a PEC or pursue ADR, please contact Booma Venkataraman at 301-415-2934 within 10 days of the date of this letter. A PEC should be held within 30 days and an ADR session within 45 days of the date of this letter.

If you choose to provide a written response, it should be clearly marked as a “Response to Apparent Violation in NRC Inspection Report 05000250,251/2021-011; EA-20-150” and should include for each apparent violation: (1) the reason for the apparent violation or, if contested, the basis for disputing the apparent violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved. Your response may reference or include previously docketed correspondence, if the correspondence adequately addresses the apparent violations. Additionally, your response should be sent to the NRC’s Document Control Center, with a copy mailed to Mark Miller, Director, Division of Reactor Projects, Region II, 245 Peachtree Center Avenue NE, Atlanta, GA 30303, within 30 days of the date of this letter. If a response is not received within the time specified or an extension of time has not been granted by the NRC, the NRC will proceed with its enforcement decision or schedule a PEC.

If you choose to request a PEC, the conference will afford you the opportunity to provide your perspective on these matters and any other information that you believe the NRC should take into consideration before making an enforcement decision. The decision to hold a predecisional enforcement conference does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference would be conducted to obtain information to assist the NRC in making an enforcement decision. The topics discussed during the conference may include information to determine whether a violation occurred, information to determine the significance of a violation, information related to the identification of a violation, and information related to any corrective actions taken or planned.

In lieu of a PEC, you may also request Alternative Dispute Resolution (ADR) with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflicts using a neutral third party. The technique that the NRC has decided to employ is mediation. Mediation is a voluntary, informal process in which a trained neutral (the “mediator”) works with parties to help them reach resolution. If the parties agree to use ADR, they select a mutually agreeable neutral mediator who has no stake in the outcome and no power to make decisions. Mediation gives parties an opportunity to discuss issues, clear up misunderstandings, be creative, find areas of agreement, and reach a final resolution of the issues. Additional information concerning the NRC's program can be obtained at http://www.nrc.gov/about-nrc/regulatory/enforcement/adr.html. The Institute on Conflict

Resolution (ICR) at Cornell University has agreed to facilitate the NRC's program as a neutral third party. Please contact ICR at 877-733-9415 within 10 days of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

In addition, please be advised that the number and characterization of apparent violations described in the enclosed inspection report may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

Additionally, one finding of very low safety significance (Green) was self-revealed for the failure to correctly verify the correct component as specified in work order 40632818. This finding involved a violation of NRC requirements. This violation did not involve deliberate misconduct and was screened using the reactor oversight process significance determination process. This violation is not being considered for escalated enforcement and will be documented in separate correspondence.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice and Procedure," a copy of this letter, its enclosures, and your response, if you choose to provide one, will be made available electronically for public inspection in the NRC Public Document Room or from 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. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

If you have any questions concerning this matter, please contact Booma Venkataraman of my staff at 301-415-2934.

Sincerely,

/RA/

Mark S. Miller, Director
Division of Reactor Projects

Docket Nos.: 05000250, 05000251
License Nos.: DPR-31, DPR-41

Enclosures:
1. Inspection Report 05000250/2021011 and 05000251/2021011
2. Factual Summary

cc w/ encl: Distribution via ListServ

SUBJECT: TURKEY POINT NUCLEAR GENERATING STATION - NRC INSPECTION REPORT 05000250/2021011 and 05000251/2021011, AND INVESTIGATION REPORT 2-2019-025; AND APPARENT VIOLATIONS DATED FEBRUARY 4, 2021

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U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Number:	05000250 and 05000251
License Number:	DPR-31 and DPR-41
Report Number:	05000250/2021011 and 05000251/2021011
Enterprise Identifier:	I-2021-011-0012
Licensee:	Florida Power & Light Company
Facility:	Turkey Point Nuclear Generating Station
Location:	Homestead, FL 33035
Approved By:	Booma Venkataraman, Chief (Acting) Reactor Projects Branch 3 Division of Reactor Projects

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance of the Turkey Point Nuclear Generating 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

Failure to Report Mispositioned Plant Component that Caused Charging Pump Trip			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Not Applicable	AV 05000250, 05000251/2021011-01 Open EA-20-150	Not Applicable	71152
An apparent violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for the failure to immediately notify the main control room of mispositioned plant components in accordance with plant procedure OP-AA-100-1002, Plant Status Control Management.			

Incomplete and Inaccurate Information Associated with Charging Pump Maintenance			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Not Applicable	AV 05000250, 05000251/2021011-02 Open EA-20-150	Not Applicable	71152
An apparent violation of 10 CFR § 50.9(a) was identified for not maintaining a complete and accurate record of maintenance of safety-related equipment. Specifically, Instrumentation and Control (I&C) technicians assigned to work on the 4C charging pump recorded inaccurate information in work order (WO) 40632818.			

INSPECTION RESULTS

<table>
<tr><td colspan="4">Failure to Report Mispositioned Plant Component that Caused Charging Pump Trip</td></tr>
<tr><td>Cornerstone</td><td>Significance/Severity</td><td>Cross-Cutting Aspect</td><td>Report Section</td></tr>
<tr><td>Not Applicable</td><td>Apparent Violation
AV 05000250, 05000251/2021011-01
Open
EA-20-150</td><td>N/A</td><td>71152</td></tr>
<tr><td colspan="4">An apparent violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified for the failure to immediately notify the main control room of mispositioned plant components in accordance with plant procedure OP-AA-100-1002, Plant Status Control Management.</td></tr>
<tr><td colspan="4">Description: On July 10, 2019, Unit 4 plant conditions were established to facilitate maintenance on the 4C charging pump. Instrumentation and Control (I&C) technicians were authorized to complete work order (WO) 40632818 and calibrate pressure switch PS-4-201C, which provides a low oil pressure trip signal to the 4C charging pump. The I&C technicians did not follow the proper verification steps and incorrectly conducted work on the 3C charging pump. The Unit 3 chemical volume and control system was in a normal alignment with a single, 3C charging pump, operating to maintain programmed reactor coolant system (RCS) pressurizer level and reactor coolant pump (RCP) seal injection. The I&C technicians manipulated an isolation valve for pressure switch PS-3-201C and loosened the test cap causing oil to flow out on the 3C charging pump. The pump tripped on low oil pressure at 10:09 a.m. This result caused the I&C technicians to review the WO and to recognize that they were working on Unit 3 and not Unit 4.

Rather than immediately call the Unit 3 main control room, as required by plant procedure OP-AA-100-1002, the I&C technicians restored the oil low pressure switch to its normal alignment, exited the room and informed the I&C Supervisor and I&C Department Head of the human performance error via a phone call. The two I&C technicians admitted to manipulating the pressure switch on the incorrect unit and reported that they had heard the pump change sounds, but they were unsure if the pump had tripped. The I&C technicians were directed to remove all shop tools and equipment from the 3C charging pump, and then return to the I&C shop.

After receipt of the phone call from the I&C technicians, the Supervisor and Department Head checked a plant computer to determine the operating status of the 3C charging pump. Based on review of the plant computer indications, they could not conclude with certainty that the pump had tripped. The Supervisor and the Department Head also checked the narrative logs as input from the control room and saw no entries related to a 3C charging pump trip. The I&C technicians, the shop steward, the Supervisor, and the Department Head then met in the shop’s conference room to discuss the issue. At the conclusion of the meeting, the I&C Department Head advised the attendees that he had decided they would keep this matter “in house.” The Department Head then went to the control room. The Supervisor returned to his office and checked the operating logs, where he learned the 3C charging pump had tripped.

Upon arriving in the main control room, the I&C Department Head was advised by the Shift Manager that the 3C charging pump had tripped. However, the Department Head did not disclose that two of his technicians had incorrectly worked on that pump and probably caused the trip. The I&C Department Head returned to the maintenance shop and advised the I&C</td></tr>
</table>

Supervisor that the main control room was aware of the 3C charging pump trip. He also told the two I&C technicians to forget about the prior meeting in the conference room as if it had never happened. The I&C Department Head then proceeded to the Outage Control Center (OCC) where he informed plant management that the 3C charging pump trip was the result of a human performance error. To that end, FPL conducted a prompt review of the issues. Action Request (AR) 2320534 was initiated, and FPL promptly initiated a human performance incident investigation.

On July 11, 2019, FPL management was subsequently informed by a Turkey Point individual that the I&C Supervisor and Department Head, when informed of the 3C charging pump trip, initially intended to keep the mispositioning event "in-house." Upon learning of the intent to keep the mispositioning event "in-house," FPL immediately initiated an investigation regarding the behaviors of each of the individuals involved in the 3C charging pump trip. The licensee's investigation concluded that the parties involved intended not to report that the wrong pressure switch was manipulated unless they could confirm the 3C charging pump had tripped.

Corrective Actions: The licensee completed an internal investigation into the matter. The site issued disciplinary corrective actions to the four individuals involved in the issue, including denial of site access and termination of employment. On August 22, 2019, FPL chartered a common cause evaluation (CCE) to investigate a trend of unacceptable behavior events including this event and its associated investigative report. The CCE was documented in AR 2323787 and approved by the FPL management sponsor on December 12, 2019. Corrective actions, in the form of site communications, were implemented to address the importance of a strong nuclear safety culture and requirement for complete and accurate work and truthfulness. Additionally, FPL implemented a procedure (fleet procedure AD-AA-103, Nuclear Safety Culture Program) to require semiannual verification of randomly selected work activities. The purpose of these reviews is to determine whether workers were in the correct location to perform assigned work in a manner consistent with applicable procedures.

Corrective Action References: AR 2323787, AR 2320534

Performance Assessment: The ROP's significance determination process does not specifically consider willfulness in its assessment of licensee performance. Therefore, it is necessary to address this violation which involves willfulness using traditional enforcement to adequately deter non-compliance.

Enforcement:

Violation: 10 CFR Part 50 Appendix B, Criterion V, states that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

Procedure OP-AA-100-1002, "Plant Status Control Management" (an FPL implemented safety-related procedure), Step 3.6.7, states, in part, that site personnel are to immediately notify the Operations Shift Manager of any inadvertent bumping or mispositioning of plant components.

Contrary to the above, on July 10, 2019, the reporting of a mispositioned plant component, an activity affecting quality, was not accomplished in accordance with procedure OP-AA-100-

1002. Specifically, site personnel failed to immediately notify the Operations Shift Manager that I&C technicians assigned to work on the 4C charging pump inadvertently manipulated a pressure switch on the 3C charging pump. The I&C technicians, I&C Supervisor and I&C Department Head had several opportunities to report the human performance error to the control room and failed to do so.

Enforcement Action: This violation is being treated as an apparent violation pending a final significance (enforcement) determination.

Incomplete and Inaccurate Information Associated with Charging Pump Maintenance			
Cornerstone	Severity	Cross-Cutting Aspect	Report Section
Not Applicable	Apparent Violation AV 05000250, 05000251/2021011-02 Open EA-20-150	Not Applicable	71152
An apparent violation of 10 CFR § 50.9(a) was identified for failure to maintain a complete and accurate record of maintenance of safety-related equipment. Specifically, Instrumentation and Control (I&C) technicians assigned to work on the 4C charging pump recorded inaccurate information in work order (WO) 40632818.			

Description: On July 10, 2019, Unit 4 plant conditions were established to facilitate maintenance on the 4C charging pump. I&C technicians were authorized to calibrate pressure switch PS-4-201C in accordance with the instructions in the work order task description (WOTD) for PS-4-201C associated with WO Package 40632818-01. Pressure switch PS-4-201C provides a low oil pressure trip signal to the 4C charging pump. The I&C technicians did not follow the proper verification steps, proceeded to the wrong unit, and incorrectly began work on the 3C charging pump. The I&C technicians manipulated an isolation valve for pressure switch PS-3-201C and loosened the test cap causing oil to flow out on the 3C charging pump. The pump tripped on low oil pressure at 10:09 a.m. This result caused the I&C technicians to review the WO and to recognize that they were working on Unit 3 and not Unit 4.

Rather than immediately call the Unit 3 main control room, as required by plant procedure OP-AA-100-1002, the I&C technicians restored the oil low pressure switch to its normal alignment, exited the room and informed the I&C Supervisor and I&C Department Head of the human performance error via a phone call. The I&C technicians admitted to manipulating the pressure switch on the wrong unit and reported that they had heard the pump change sounds, but they were unsure if the pump had tripped. The I&C technicians were directed to remove all shop tools and equipment from the 3C charging pump and then return to the I&C shop

Despite not completing any WO steps associated with the 4C charging pump, the I&C technicians marked several steps as completed in the PS-4-201C WOTD using the “circle-slash” method. According to time stamps in the electronic version of the WOTD, steps 1.1 – 2.1, and 3.1 were marked complete between 10:15 and 10:16, several minutes after the 3C charging pump had tripped. At 10:17, steps 4.0 – 4.2 were marked complete and step 4.1 was initialed. All of these entries were made after the two I&C technicians realized they were

working on the wrong pump. The I&C technicians also filled out and initialed Steps 10 through 12 on Form 747 (Breaker/Switch/Valve Manipulation Form), indicating that the valve and the switch associated the 4C charging pump were restored. Based on timestamps, these actions also occurred after the technicians realized they had worked on the wrong pump. There was no indication on the form that the steps had been performed on the valve and switch associated with the 3C charging pump instead of 4C charging pump. The evidence indicates that the I&C technicians realized their mistake of working on the wrong component and then falsified the work order.

Corrective Actions: The licensee completed an internal investigation into the matter. The site issued disciplinary corrective actions to the two I&C technicians involved in the issue, including denial of site access and termination of employment. On August 22, 2019, FPL chartered a common cause evaluation (CCE) to investigate a trend of unacceptable behavior events including this event and its associated investigative report. The CCE was documented in AR 2323787 and approved by the FPL management sponsor on December 12, 2019. Corrective actions, in the form of site communications, were implemented to address the importance of a strong nuclear safety culture and requirement for complete and accurate work and truthfulness. Additionally, FPL implemented a procedure (fleet procedure AD-AA-103, Nuclear Safety Culture Program) to require semiannual verification of randomly selected work activities. The purpose of these reviews is to determine whether workers were in the correct location to perform assigned work in a manner consistent with applicable procedures.

Corrective Action References: AR 2323787

Performance Assessment: The ROP's significance determination process does not specifically consider willfulness in its assessment of licensee performance. Therefore, it is necessary to address this violation which involves willfulness using traditional enforcement to adequately deter non-compliance.

Enforcement:

Violation: 10 CFR 50.9(a) states, in part, that information required by the Commission's regulations, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

Contrary to the above, on July 10, 2019, the licensee maintained information recorded in the in the PS-4-201C WOTD and Breaker/Switch/Valve Manipulation Form (Form 747) associated with WO Package 40632818-01 that was not complete and accurate in all material respects. Specifically, information recorded on both documents was inaccurate because it reflected work performed on the unit 4C charging pump pressure switch (PS-4-201C), when in fact no work was performed on PS-4-201C. Additionally, the WO contained no documentation or notes explaining that the steps were completed on the wrong component. Records of maintenance of safety-related equipment are material to the NRC because they indicate whether the licensee is performing quality, safety-related activities in accordance with its operating procedures and NRC regulations. Documents associated with WO Package 40632818-01 for the safety-related unit 4C charging pump, are records that the licensee is required to maintain pursuant to 10 CFR Part 50, Appendix B, Criterion XVII.

Enforcement Action: This violation is being treated as an apparent violation pending a final significance (enforcement) determination.

FACTUAL SUMMARY
OFFICE OF INVESTIGATIONS REPORT NO. 2-2019-025

On November 10, 2020, the NRC's Office of Investigations (OI) completed an investigation into the circumstances of whether two former instrument and control (I&C) technicians (Technician 1 and Technician 2) at the Turkey Point Nuclear Generating Station (Turkey Point) deliberately falsified a work order related to the Unit 4C (U4C) charging pump after they incorrectly performed the work on the Unit 3C (U3C) charging pump. Additionally, OI investigated whether an I&C supervisor (Supervisor) and the I&C department head (Department Head) at Turkey Point engaged in deliberate misconduct by concealing the human performance error, thereby failing to follow a site procedure that required immediate notification to the control room.

Turkey Point is owned and operated by Florida Power and Light (FPL). Technician 1 was employed at Turkey Point since September 2010. Technician 2 was employed at Turkey Point since August 2009. The I&C Supervisor was a Maintenance Section Supervisor and was originally hired by Turkey Point in December 1988. The I&C Department Head was an I&C Department Supervisor at Turkey Point and was originally hired in March 1988.

FPL procedure OP-AA-100-1002, Rev. 20, Plant Status Control Management, in part establishes requirements for standardized response to mispositioned plant equipment. Section 3.6, paragraph 7, states that site personnel are to immediately notify the Operations Shift Manager of any inadvertent bumping or mispositioning of plant components."

On July 10, 2019, the two I&C technicians were assigned to perform maintenance tasks on the safety-related Unit 4 charging pump C (U4C). Prior to going to the field to perform the work, the technicians obtained Work Order Package 40632818-01 and received a pre-job brief from the Supervisor. The I&C technicians passed through the radiation protection (RP) checkpoint area and proceeded to the Unit 3 room (instead of the Unit 4 room) and began work on the Unit 3 charging pump C (U3C) oil low pressure switch.

Technician 1 closed the pressure switch isolation valve and then loosened the test cap valve, which resulted in a steady release of oil. Both technicians heard a change in the pump sound, and Technician 2 observed that the pump hesitated, and the piston slowed and stopped. Technician 1 then retightened the cap and re-opened the isolation valve, and the pump "came back." At that point Technician 1 checked the paperwork and confirmed they were working on the wrong pump.

Later, after they realized they had worked on the incorrect pump (U3C), Technician 1 and Technician 2 marked several steps on the U4C Work Order Package as completed using the "circle-slash" method. However, no work was actually performed on the U4C charging pump. The technicians did not indicate in the Work Order Package that the steps had been performed on U3C instead of U4C. During the licensee's internal investigation, Technicians 1 and 2 initially claimed they filled out the paperwork before starting the maintenance work, and only admitted to doing so after the fact when confronted with the timestamp data from the electronic Work Order Package.

The I&C technicians gathered their tools, left the pump room, and proceeded to the RP checkpoint, where Technician 2 called the Supervisor. The Supervisor put the call on speakerphone where it was heard by other technicians who were present and the Department Head. Technician 2 informed the Supervisor that they had worked on the wrong pump.

Technician 2 went on to explain that when they began to isolate the pump, the sound had changed, so they stopped and returned the valve to the open position. Technician 2 stated they did not fully isolate the pump but did not state that Technician 1 loosened the cap or that oil spilled out. Technician 2 also did not indicate that the pump had slowed and then stopped. There was no indication or discussion as to whether the technicians had called the main control room. At this time, the Supervisor told the technicians to return to the shop. After ending the call, the Supervisor and Department Head, in the presence of several others, reviewed the equipment data for U3C in a site database called PI in an attempt to determine if U3C had tripped. They also checked the narrative logs from the control room and saw no entries related to a U3C trip.

About 10 minutes later, when the two I&C technicians arrived back at the shop, the Department Head called them, along with the Supervisor and shop steward, into a conference room called the “Green Room.” The Department Head asked what happened, and at this point Technician 1 explained that he had isolated the pressure switch and loosened the cap, causing oil to flow from the pump. When the Supervisor heard this, he realized the pump had tripped. Technician 2 did not say anything related to whether the pump stopped. At some point before or during the meeting, the Department Head said he had spoken to the team and they would keep it “in house.”

After the meeting, the Supervisor returned to his office, reviewed the PI and narrative logs a second time and saw there were several log entries indicating U3C had tripped. In parallel, the Department Head went to the main control room and spoke with the shift manager, who stated the U3C charging pump had tripped. The Department Head did not say anything to the Shift Manager about his technicians working on the incorrect pump and causing the trip. The Department Head left the control room and returned to the shop where he informed the two technicians the pump had tripped, and he would have to report the incident. The Department Head also informed the two I&C technicians to forget the Green Room meeting ever took place.

The Department Head went to the outage control center where he informed the maintenance director, the shift manager, and others that the two I&C technicians’ incorrect manipulation of U3C may have caused the pump trip. The four individuals involved were terminated after an internal licensee investigation in August 2019.

During the licensee’s internal investigation, the Supervisor and the Department Head admitted that they should have contacted the control room immediately after receiving the call from Technician 2, but they did not do so because they were unsure whether the pump had tripped. The Supervisor told FPL investigators that he did not advise anyone after learning that the pump had tripped. The Department Head told OI that the control room should be notified first “no matter what” in a situation like this. When asked if he had training on contacting the Control Room when a component is mispositioned, the Department Head told OI that part of initial training and reinforcement is to notify the Control Room right away, and that was the discussion the times he went through training. The Turkey Point Site Director told OI that the requirement to immediately notify the Control Room if you inadvertently manipulate equipment in error has been in place for many years and is clearly memorialized in site procedures.

The information in Work Order Package 40632818-01 is material to the NRC because these documents are records of maintenance that was performed on a safety-related component.

Based on the evidence gathered during the OI investigation, including the results of the licensee’s internal investigation, it appears that on July 10, 2019, Technicians 1 and 2

deliberately provided incomplete and inaccurate information on the Work Order associated with maintenance of charging pump U4C, in violation of 10 CFR 50.5(a)(2).

Additionally, it appears that the I&C Supervisor and Department Head engaged in deliberate misconduct, in violation of 10 CFR 50.5(a)(1), by deliberately failing to immediately notify the control room of the technicians' mispositioning of charging pump U3C as required by Procedure OP-AA-100-1002, "Plant Status Control Management." The actions of the Supervisor and Department Head appear to have caused the licensee to be in violation of 10 CFR Part 50, Appendix B, Criterion V.