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

September 14, 2021

IA-21-050

Mr. Michael J. Giles
[Note: Home Address Deleted
Under 10 CFR 2.390]

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC INVESTIGATION REPORT 2-2020-014

Dear Mr. Giles:

This letter refers to the investigation initiated on May 21, 2020, by the Nuclear Regulatory Commission (NRC) Office of Investigations (OI) and conducted at Southern Nuclear Operating Company's (SNC) Vogtle Electric Generating Plant (Vogtle), Units 1 and 2. The investigation, which was completed on March 3, 2021, evaluated whether you deliberately failed to report a specific medication change while you held a Senior Reactor Operator (SRO) license at Vogtle from approximately 2015 - 2020. A factual summary of the OI investigation is included as Enclosure 1 to this letter.

Based on the investigation, the NRC identified one apparent violation (AV) of 10 CFR 50.5(a)(1), which is being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is available on the NRC's Web site at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The AV is provided in Enclosure 2 and involves your apparent deliberate failure to provide complete and accurate information to SNC regarding medications you were prescribed and taking while performing duties as an SRO at Vogtle from 2015-2020.

Before the NRC makes its enforcement decision, we are providing you an opportunity to: (1) respond to the apparent violation 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 will 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. If you decide to participate in a PEC or pursue ADR, please contact Eugene Guthrie, Branch Chief, Division of Reactor Safety, NRC Region II, at 404-997-4662, or via email at Eugene.Guthrie@nrc.gov 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 An Apparent Violation, IA-21-050" and should include for the 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 required response. Additionally, your response should be sent to the NRC's Document Control Center, with a copy mailed to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001 with a copy to the Regional Administrator, NRC Region II, Marquis One Tower, 245 Peachtree Center Avenue, NE, Suite 1200, Atlanta, GA 30303-1257 within 30 days of the date of this letter. If an adequate 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 ADR with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflicts using a third party neutral. 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 the apparent violation described in the enclosure 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.

A copy of this letter and its enclosures will not be made publicly available at this time. However, if the NRC subsequently issues an enforcement action to you, in accordance with 10 CFR 2.390, "Public inspections, exemptions, requests for withholding," 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 the NRC concludes that you deliberately caused or committed a violation of NRC requirements, the possible sanctions include a Notice of Violation, a civil penalty, or an Order. An Order may prohibit involvement in NRC-licensed activities, require notice to the NRC before resuming involvement in NRC-licensed activities, or require other action. Accordingly, you should be prepared to address why the NRC should not issue you an Order removing you from licensed activities.

Please note that final NRC investigation documents, such as the OI report described above, may be made available to the public under the Freedom of Information Act (FOIA), subject to redaction of information appropriate under the FOIA. Requests under the FOIA should be made in accordance with 10 CFR 9.23, "Requests for Records." Additional information is available on the NRC website at http://www.nrc.gov/reading-rm/foia/foia-privacy.html.

If you have any questions related to this matter, please contact Eugene Guthrie, Branch Chief, Division of Reactor Safety, NRC Region II, at 404-997-4662, or via email at Eugene.Guthrie@nrc.gov.

Sincerely,

Mark E. Franke

Digitally signed by Mark E. Franke
Date: 2021.09.14 09:42:40 -04'00'

Mark Franke, Director
Division of Reactor Safety

Enclosures:
1. Factual Summary of NRC OI Case No. 2-2020-014
2. Apparent Violation

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

FACTUAL SUMMARY
OFFICE OF INVESTIGATIONS REPORT NO. 2-2020-014

On March 3, 2021, the NRC's Office of Investigations (OI) completed an investigation to determine whether a Senior Reactor Operator (SRO) at Southern Nuclear Company's (SNC) Vogtle Electric Generating Plant (Vogtle, or licensee), Units 1 & 2, deliberately failed to report a change in medical condition.

On May 5, 2020, while reviewing personal medical records as part of the license renewal process for an individual who held an SRO license at Vogtle Unit 2, licensee officials determined that the SRO failed to report medical conditions and medication in accordance with the conditions of his license.

In February of 2020, the SRO had used the change in medical status process to report a [redacted] and the use of a new medication to treat the condition, but failed to mention medication that he had been prescribed and was taking for another medical condition since approximately 2015. The licensee medical staff also determined that the SRO was taking a higher dose of medication than would be expected for his diagnosed condition.

The SRO's license contained two conditions in addition to those specifically listed in 10 CFR 55.53: that he shall use therapeutic device(s) as prescribed to maintain medical qualifications; and that he shall take medication as prescribed to maintain medical qualification.

Additionally, the SRO's license contained the condition that "[w]hile performing licensed duties, you shall observe the operating procedures and other conditions specified in the facility license authorizing operation of the facility."

10 C.F.R. § 50.9, ‘‘Completeness and Accuracy of Information,’’ states that "[i]nformation provided to the Commission by an applicant for a license or by a licensee or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the applicant or the licensee shall be complete and accurate in all material respects."

10 C.F.R. § 55.27, "Documentation" states that the facility licensee shall document and maintain the results of medical qualifications data, test results, and each operator's or senior operator's medical history for the current license period and provide the documentation to the Commission upon request. The facility licensee shall retain this documentation while an individual performs the functions of an operator or senior operator.

SNC Operating procedure NMP-OS-026, Version 1.1 dated 11/8/2019, Section 3.8, "Licensed Operator" states that "[t]he licensed operator SHALL be responsible for the following: Notifying their Supervisor and Medical Services of any change in medical condition, by completing NMP-OS-026-F04, Notification to Supervisor and Medical Services of Changes in Medical Condition for a Licensed Operator."

The evidence demonstrates that the SRO performed licensed reactor operator duties consistently (at least 6 days/month) during the period from May 14, 2017 to October 28, 2019.

The SRO's medical records demonstrate that during this period, he was prescribed and was taking numerous medications. However, the SRO failed to report to the facility licensee (SNC) the medical diagnoses for which these medications had been prescribed. Additionally, the SRO

failed to report to SNC that he was taking higher doses of certain medications than he had reported in any of his annual questionnaires.

During transcribed interviews with NRC:OI, the SRO admitted that he knew he was required to report the change in medical condition and any new medication he was prescribed. The SRO also admitted that, while he initially forgot to report his additional prescriptions, once he realized he had not reported this information to SNC, he intentionally failed to report his change in medical condition to licensee officials because he did not want to jeopardize his employment. Specifically, he stated that he knew at the time he signed the medical history questionnaire that it was not correct, saying that he “screwed up.”

Based on the evidence, it appears that the SRO deliberately failed to report changes in medical condition, causing SNC to be in violation of 10 C.F.R. § 50.9, “Completeness and Accuracy of Information.” This constitutes a violation of 10 C.F.R. 50.5(a)(1), “Deliberate Misconduct.”

Apparent Violation:

10 C.F.R. § 50.5(a)(1), “Deliberate Misconduct” states, in part, that any employee of a licensee may not engage in deliberate misconduct that causes (or would have caused, if not detected) a licensee to be in violation of any regulation issued by the Commission.

Contrary to the above, during the period from June 19, 2015 through May 5, 2020, Mr. Michael J. Giles, at the time a licensed senior reactor operator at Southern Nuclear Operating Company’s (SNC) Vogtle Electric Generating Plant (Vogtle), Units 1 and 2 (an NRC facility licensee), caused the facility licensee to be in violation of 10 C.F.R. § 50.9(a) “Completeness and accuracy of information”, which states, in part, that information provided to the Commission by a facility licensee or information required by statute or by the Commission’s regulations, orders, or license conditions to be maintained by the facility licensee shall be complete and accurate in all material respects.

Specifically, during this time you deliberately failed to report the prescribed medications you were actually taking, including the doses, in accordance with NMP-OS-026, License Administration, which caused the facility licensee to maintain incomplete and inaccurate medical records as required by NRC regulations. The information is material to the NRC because it directly influences the NRC’s licensing decisions concerning medical qualification conditions imposed on the senior operator’s license.