



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

September 14, 2021

EA-21-026

Robert Drayton Pitts  
Vice President  
Southern Nuclear Operating Company, Inc.  
Vogtle Electric Generating Plant  
7821 River Road  
Waynesboro, GA 30830

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC INVESTIGATION REPORT  
2-2020-014 AND NRC INSPECTION REPORT NO. 05000424/2021401 AND  
05000425/2021401

Dear Mr. Pitts:

This letter refers to the investigation initiated on May 21, 2020, by the 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 a (now-former) senior reactor operator (SRO) at Vogtle deliberately failed to report a change in medical condition. 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 50.9 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 SNC's failure to maintain complete and accurate information related to the SRO's medical history, in accordance with 10 CFR 50.9. Specifically, information maintained by SNC did not accurately reflect the prescribed medications or doses that the former SRO was actually taking while he was performing the functions of an SRO senior operator from approximately June 2015 through May 2020.

Since you identified the violation, and based on our understanding of your corrective action, a civil penalty may not be warranted in accordance with Section 2.3.4 of the Enforcement Policy. The final decision will be based on you confirming on the license docket that the corrective actions previously described to the NRC staff have been or are being taken.

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](mailto: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 in NRC Inspection Report 05000424/2021401 and 05000425/2021401, EA-21-026" 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 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 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.

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.

The AV will be administratively tracked under Inspection Report No. 0500424-425/2021401. 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](mailto:Eugene.Guthrie@nrc.gov).

Sincerely,

**Mark E.  
Franke**

 Digitally signed by Mark  
E. Franke  
Date: 2021.09.14  
09:40:11 -04'00'

Mark Franke, Director  
Division of Reactor Safety

Docket No. 50-424, 50-425  
License No. DPR-68, DPR-81

Enclosures:

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

cc w/encl: Distribution via ListServ

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 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 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 done it, 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. As a result, records maintained by SNC were inaccurate because they omitted several of SRO's medical conditions and medications. This inaccuracy is material to the NRC because the information is used by the Commission to evaluate individuals' medical qualifications to perform licensed activities.

### Apparent Violation

10 C.F.R. § 50.9(a), "Completeness and accuracy of information" states, in part, that information 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.

Contrary to the above, during the period from June 19, 2015 through May 5, 2020, the licensee failed to maintain complete and accurate medical qualification data for a senior licensed reactor operator in accordance with 10 CFR 50.9. 10 C.F.R. 55.27 requires facility licensees to document and maintain medical qualification information and provide the information to the NRC on request. Specifically, medical qualification records for a senior reactor operator failed to completely and accurately document the prescribed medications the senior operator was actually taking, including the doses. The medical qualification information is material to the NRC because the information directly influences the NRC's licensing decisions concerning medical qualification conditions imposed on the senior operator's license.