Southern Nuclear

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U. S. Nuclear Regulatory Commission
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Vogtle Electric Generating Plant, Units 1 and 2
Response to Apparent Violation
Inspection Report 05000424/2021401 and 05000425/2021401,
EA-21-026

Dear Sir or Madam:

By letter dated September 14, 2021 the Nuclear Regulatory Commission (NRC) staff transmitted a factual summary of an NRC Office of Investigations (OI) investigation. The investigation evaluated whether a (now former) senior reactor operator (SRO) at Vogtle deliberately failed to report a change in medical condition. The factual summary concluded that the SRO deliberately failed to report changes in medical condition. As a result, records maintained by Southern Nuclear Operating Company (SNC) were inaccurate because they omitted several of the SRO's medical conditions and medications. This inaccuracy was material to the NRC because the information was used by the Commission to evaluate the individuals' medical qualifications to perform licensed activities.

As such the referenced letter notified SNC of one apparent violation (AV) of 10 CFR 50.9 which is being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. SNC agrees with the apparent violation of 10 CFR 50.9(a) and 10 CFR 55.27 as documented in Enclosure 2 of the referenced letter. Pursuant to the provisions of 10 CFR 2.201, SNC chooses to respond in writing to the AV and submits the response to the violation as an Enclosure to this letter. In addition to the factors required to be addressed in a written response as stated in the September 14, 2021 letter, SNC is providing additional information relative to the application of the Enforcement Policy in assessing this violation.

This letter contains no NRC commitments. If you have any questions, please contact Matt Euten at 205-992-7673.

Sincerely,

Cheryl A. Gayheart
Regulatory Affairs Director

CAG/tr

Enclosure: Response to Apparent Violation EA-21-026

cc: Regional Administrator
NRR Project Manager – Vogtle 1 & 2
Senior Resident Inspector – Vogtle 1 & 2
RType: CVC7000

Reference:

Vogtle Electric Generating Plant – NRC Investigation Report 2-2020-014 and NRC Inspection Report No. 05000424/2021401 and 05000425/2021401

Vogtle Electric Generating Plant - Units 1 & 2

Response to Apparent Violation EA-21-026

Enclosure 1

Response to Apparent Violation
050000424/2021401 and 050000425/2021401, EA-21-026

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 C.F.R. 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.

SNC does not contest the violation.

Reason for the Violation

The cause of the violation was the deliberate action of the individual to fail to disclose changes to his medical diagnoses and medications pursuant to SNC Procedure NMP-OS-026, “License Administration.” Specifically, the Senior Reactor Operator (SRO) failed to report a medical condition and new medication he had been taking for that condition since approximately 2015. Accordingly, the SRO’s medical qualifications were not accurately reflected. During interviews with NRC Office of Investigations, the SRO admitted that he knew he was required to report changes in medical conditions and medications. He also admitted that, while he initially forgot to report his prescription in 2015, once he realized he had not done so, he intentionally failed to report the change out of concern that it would jeopardize his employment. The actions of this SRO resulted in SNC maintaining inaccurate information (NRC Form 396, which the SRO signed as being accurate) which was material to the NRC.

Corrective Steps Taken and Results Achieved

The following actions were taken upon discovery of the violation:

1. Upon identification of the issue by Medical, Condition Report (CR) 10707108 was initiated requesting that the individual’s qualification for shift eligibility be removed. The individual’s qualification was removed on May 6, 2020.

2. The individual was placed in a “may not work” status pending a review by the Medical Review Officer. Following an internal investigation, the individual’s employment was terminated on June 4, 2020. Access records confirm the individual was last in the protected area on March 23, 2020.

3. SNC notified NRC via letter dated June 8, 2020 and requested the NRC terminate the individual’s license. The NRC terminated his license by letter date June 16, 2020, which stated his license was terminated effective June 8, 2020.

The following actions were taken to avoid further violations:

4. The shift managers reaffirmed with all licensed operators that the expectation to promptly report any change in medical status to their supervisor and site medical was a condition of maintaining their license.

5. The Operations Support Supervisor emailed NMP-OS-026, “License Administration,” and corresponding medical change form, NMP-OS-026-F04, to all licensed operators to reaffirm responsibilities.

6. Licensed Operator Initial Training (LOIT) covers this expectation as part of license maintenance in Operations Transition Training for current and future LOIT classes.

Actions 4-6 were documented in SNC Technical Evaluation (TE) 1084709, “Reaffirmation of Expectations for [Licensed Operators].”

Corrective Steps That Will Be Taken

Upon receipt of the Apparent Violation, SNC initiated CR 10831723. In accordance with SNC Procedure NMP-GM-002-001, Corrective Action Program Instructions, a causal product will be required. The CR spawned a causal product, a Corrective Action Report (CAR), that will be associated with the given CR number.

Date When Full Compliance Will Be Achieved

Full compliance was achieved when the individual’s license was officially terminated on June 8, 2020.

Additional Information for Consideration

Several aspects of the NRC’s Enforcement Policy are relevant in this case. Section 2.3.4 provides factors for the NRC to consider when determining whether to issue a civil penalty, including whether credit is warranted for the licensee identifying the violation and implementing corrective actions. In determining whether self-identification credit should be given, the NRC will consider whether a licensee had prior opportunities to identify the problem. In determining whether corrective action credit should be given, the NRC will

consider the timeliness and comprehensiveness of the corrective actions taken.

Additionally, in section 2.3.11 of the Enforcement Policy, NRC states:

> When a licensee or applicant has corrected inaccurate or incomplete information, the decision to issue an enforcement action for the initial inaccurate or incomplete information normally will depend on the circumstances, including the ease of detection of the error, the timeliness of the correction, whether the NRC or the licensee or applicant identified the problem with the communication, and whether the NRC relied on the information prior to the correction. *Generally, if the matter was promptly identified and corrected by the licensee or applicant before the NRC relies on the information, or before the NRC raises a question about the information, no enforcement action will be taken for the initial inaccurate or incomplete information*.

(emphasis supplied).

As described above and recognized in NRC's letter, SNC identified the condition leading to this apparent violation at the earliest opportunity and took immediate corrective action. As noted in the NRC's inspection report, SNC's procedure requires licensed operators to notify their Supervisor and Medical Services of any change in medical condition. Absent such notification, the earliest time SNC could have reasonably identified a violation would be during a review of medical records as part of the SRO's 6-year license renewal process, which is exactly when SNC discovered the issue in this case. *See* 10 C.F.R. § 55.55(a). SNC promptly notified the NRC upon discovering the SRO's omission. SNC also promptly implemented corrective actions by immediately developing a CR to remove the SRO's qualifications for shift eligibility, placing the employee in a "may not work" status, conducting an internal investigation, and ultimately terminating the SRO's employment and access authorization and requesting that the NRC revoke the SRO's operator license. SNC took additional comprehensive corrective actions to reaffirm medical reporting obligations with all licensed operators, including communicating the importance of this obligation to all licensed operators and ensuring this requirement is incorporated in all current and future initial operator training classes. These actions were documented by SNC in a Technical Evaluation. SNC also initiated an additional CR to create a causal product upon receipt of the apparent violation. Accordingly, credit is warranted for self-identification and corrective action and, therefore, to the extent the NRC considers escalated enforcement action, a civil penalty is not warranted in this case.

Additionally, the NRC should consider NRC Enforcement Policy Section 2.3.2.a.4, which provides a list of circumstances indicating when escalated enforcement action is not appropriate for a willful violation. These include circumstances where: the licensee identified the violation and promptly notified the NRC; the violation was an isolated action of an employee without management involvement and not caused by lack of management oversight; and the licensee took significant remedial action commensurate with the circumstances that will deter future violations.

SNC recognizes that the SRO deliberately provided the inaccurate information; however, the guidance in Section 2.3.2.a.4 is applicable in this case. As noted above, the violation was self-identified by SNC and promptly reported to the NRC. SNC had limited opportunity to foresee or correct the inaccurate Form 396 because the medical conditions and

medication were never disclosed by the SRO and SNC was not aware of the omission until it discovered the discrepancy itself. The SRO admits he was aware of and failed to follow SNC medical reporting procedures. Finally, SNC's actions taken to terminate the SRO's employment, access, and license, and communications and training reaffirming medical reporting obligations should deter other SNC employees from engaging in the same behavior.

The SRO's actions are similar to other willful violations the NRC has concluded were not subject to escalated enforcement action. For example, the NRC determined a Severity Level IV violation occurred in another case involving an operator's willful submission of inaccurate information. *See* River Bend Station – NRC Inspection Report 05000458/2020012, Investigation Report 4-2019-013 and Notice of Violation (Sep. 29, 2020) (ADAMS Accession No. ML 20273A235) (concluding Severity Level IV violation occurred after operators falsified completion of on-the-job training records for trainees). The NRC also issued a Severity Level IV non-cited violation after a licensee employee lied about an arrest on his unescorted access application. *See* Seabrook Station, Unit No. 1 – Integrated Inspection Report 05000443/2019002 (Aug. 5, 2019) (ADAMS Accession No. ML19217A286). In concluding that Severity Level IV was appropriate, the NRC considered (1) that the violation was an isolated occurrence that did not call into question the licensee's ability to meet the overall performance objectives of the access authorization program, (2) that criminal history is only one part of access authorization requirements and an arrest, on its own, is not necessarily a disqualifying occurrence, and (3) while the individual was onsite he remained under the licensee's continual behavioral observation program (BOP), was not involved in any operational errors affecting plant safety, and did not pose a security concern. *Id*. at 12.

The NRC should consider the same factors in this case. The SRO acted entirely on his own and the violation does not indicate that SNC is failing to implement any operator licensing requirements. The SRO's medical conditions and medications are only one part of operator licensing requirements, which also include a written examination, operating test, and biennial physicals. *See* 10 C.F.R. §§ 55.21, 55.43, 55.45. Nor does the mere fact that an individual has a medical condition or takes medication automatically disqualify him from becoming a licensed operator. The SRO also remained under the Vogtle 1 & 2 Behavioral Observation Program (BOP) the entire time he was performing licensed duties, and a review of his performance records did not identify any disciplinary, significant human performance, or safety challenges.

Finally, the apparent violation is similar to the examples of Severity Level IV violations related to inaccurate information described in the NRC Enforcement Policy, which further indicates this apparent violation should not be subject to escalated enforcement action. NRC Enforcement Policy Section 6.4, "Violation Examples," provides guidance for the Severity Level of licensed operators submitting inaccurate information. Section 6.4.d.1.(d) provides:

> *SL IV* violations involve, for example:
>
> 1. A nonwillful compromise (see 10 CFR 55.49) of an application, test, or examination required by 10 CFR Part 55. For example . . . .
>
> (d) an individual operator who met ANSI/ANS 3.4, Section 5, as certified on NRC Form 396, required by 10 CFR 55.23, but failed to report a

> condition that would have required a license restriction to establish or maintain medical qualification based on having the undisclosed medical condition.

The actions of the SRO in this case are similar to those described in this example. The NRC has found submittal of inaccurate Form 396 information to be a Severity Level IV violation in numerous other instances. *See, e.g.,* Fort Calhoun Station – NRC Licensed Operator Requalification Inspection 05000285/2015010 and Notice of Violation (Mar. 30, 2015) (ADAMS Accession No. ML15089A393) (omission of olfactory testing requirements); Indian Point Nuclear Generating Unit 3 – NRC Integrated Inspection Report 05000286/2009005 and Notice of Violation (Feb. 9, 2010) (ADAMS Accession No. ML100400200) (omission of tactile testing requirements); D.C. Cook Nuclear Plant, Units 1 and 2 – NRC Integrated Inspection Report 05000315/2012005 and 05000316/2012005 (Feb. 11, 2013) (ADAMS Accession No. ML13042A356) (SRO failed to report prescribed therapeutic device for sleep apnea).

Accordingly, consistent with NRC Enforcement Policy guidance and past enforcement determinations, the NRC should refrain from issuing a civil penalty or escalated enforcement action. NRC should consider SNC's self-identification and notification to the NRC; the fact the violation was caused by the SRO's independent behavior and does not indicate lack of oversight or failure by management to implement operator licensing requirements; and SNC's prompt and comprehensive corrective actions.