



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

July 23, 2020

EA-20-043

Mr. Don Moul
Vice President, Nuclear Division and Chief Nuclear Officer
Florida Power & Light Company
Mail Stop: NT3/JW
15430 Endeavor Drive
Jupiter, FL 33478

SUBJECT: TURKEY POINT NUCLEAR GENERATING STATION - NRC INSPECTION
REPORT 05000250/2020011 and 05000251/2020011, AND INVESTIGATION
REPORT 2-2019-011; AND APPARENT VIOLATION

Dear Mr. Moul:

This letter refers to the investigation completed on March 10, 2020, by the Nuclear Regulatory Commission's (NRC) Office of Investigations (OI) at the Florida Power and Light Company (FPL) Turkey Point Nuclear Generating Station. The purpose of the investigation was to determine if three mechanics at Turkey Point deliberately falsified information in a work order package associated with required inspection and maintenance of a safety-related check valve. 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 this investigation, an apparent violation (AV) was identified and is 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 AV is more fully discussed in Enclosure 1.

The AV being considered for escalated enforcement involves the recording of inaccurate/incomplete information associated with maintenance and inspection of a safety-related valve, contrary to the requirements of 10 CFR § 50.9(a), Completeness and Accuracy of Information. Specifically, on January 23, 2019, mechanics assigned to work on auxiliary feedwater check valve AFWU-3-017 recorded inaccurate information in work order 40542353. The NRC concluded that the actions of the mechanics were apparently deliberate as discussed in the enclosed Factual Summary 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 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 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 Randy Musser at 404-997-4603 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 05000250,251/2020-011; EA-20-043" 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 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.

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 Randy Musser of my staff at 404-997-4603.

Sincerely,

/RA/

Mark S. Miller, Director
Division of Reactor Projects

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

Enclosures:

1. Inspection Report 05000250/2020011 and 05000251/2020011
2. Factual Summary

cc w/ encl: Distribution via ListServ

SUBJECT: TURKEY POINT NUCLEAR GENERATING STATION - NRC INSPECTION
REPORT 05000250/2020011 and 05000251/2020011, AND INVESTIGATION
REPORT 2-2019-011; AND APPARENT VIOLATION DATED JULY 23, 2020

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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: 05000250/2020011 and 05000251/2020011

Enterprise Identifier: I-2020-011-0043

Licensee: Florida Power & Light Company

Facility: Turkey Point Nuclear Generating Station

Location: Homestead, FL 33035

Approved By: Randall A. Musser, Chief
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

Incomplete and Inaccurate Information Associated with Auxiliary Feedwater Maintenance			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Not Applicable	Apparent Violation AV 05000250/2020011-01 Open EA-20-043	Not Applicable	Not Applicable
An apparent violation of 10 CFR § 50.9(a) was identified for not maintaining a complete and accurate record of inspections of safety-related equipment. Specifically, mechanics assigned to work on auxiliary feedwater check valve AFWU-3-017 recorded inaccurate information in work order (WO) 40542353.			

INSPECTION RESULTS

Incomplete and Inaccurate Information Associated with Auxiliary Feedwater Maintenance			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Not Applicable	Apparent Violation AV 05000250/2020011-01 Open EA-20-043	Not Applicable	Not Applicable
<p>An apparent violation of 10 CFR § 50.9(a) was identified for not maintaining a complete and accurate record of inspections of safety-related equipment. Specifically, mechanics assigned to work on auxiliary feedwater check valve AFWU-3-017 recorded inaccurate information in work order (WO) 40542353.</p> <p><u>Description:</u> Safety related check valve AFWU-3-017 on Unit 3 provides a flow path for cooling from the auxiliary feedwater pump lube oil cooler to the condensate storage tank. This valve is located within the auxiliary feedwater system cage (auxfeed cage) which has only one entrance/exit and requires badge access. The valve is disassembled and inspected on a three-year frequency per the Check Valve Monitoring program which was required by the American Society of Mechanical Engineers (ASME) Operation and Maintenance (OM) Code. In 1986 the Institute of Nuclear Power Operations (INPO) issued SOER 86-03, "Check Valve Failures or Degradation," which utilities responded to by developing programs to verify that check valves are monitored for degradation. Inspection and maintenance of AFWU-3-017 was scheduled per WO 40542353 on January 23, 2019. The work required completion of three documents: a Work Order Task Description (WOTD), an "SOER 86-03" Check Valve Data Sheet (CVDS), and a Journeyman Work Report (JWR).</p> <p>The inspectors went to the auxfeed cage several times on January 23, 2019, to witness the work on AFWU-3-017 and inspect the work activities. Based on visual observations, it appeared that valve was never disassembled despite that each step of the work order, including final completion, being signed as completed.</p> <p>Based on questioning by the inspectors, the licensee investigated the activities associated with WO 40542353. The licensee's investigation indicated that the subject valve was disassembled and some of the steps were completed. However, a significant time discrepancy was discovered between (i) the Badge Access Transaction Report (BATR) for badge swipes at the only entrance/exit from the auxfeed cage on January 23, 2019 and (ii) the Measuring & Testing Equipment (M&TE) Issues & Returns by User ID log on January 23, 2019 (M&TE Log) used to track precision tool usage during work processes. The M&TE Log indicated that three (3) of four (4) required precision tools were not checked out until after the individuals, who were assigned to perform the work, exited from the auxfeed cage for the final time on January 23. This time discrepancy clearly indicated that those precision tools could not have been used to conduct the precision measurements required by the CVDS.</p> <p>According to Step 4.6 of the WO, the mechanics were to "PERFORM SOER 86-03 check valve inspection using attached SOER 86-03 check valve data sheet (Type: LIFT CHECK)." The CVDS provides space for the mechanic to record three measurements: disc diameter, disc weight, and body bore diameter.</p>			

This step was marked as completed, however, the three mechanics admitted they did not have the CVDS with them while the valve was disassembled for inspection despite knowing that the procedure required them to perform the work with the CVDS. Therefore, the information in the WO indicating the step had been completed was inaccurate.

Step 4.11 of the WO required the mechanics to "RECORD findings in the JWR and attached SOER 86-03 data sheet." The CVDS requires the mechanic to record three measurements: disc diameter, disc weight, and body bore diameter. Due to the nature of this inspection these measurements must be taken using precision measuring tools in order to obtain the recordings which require a high degree of accuracy. However, as noted above, three of the four required precision tools were not checked out on the M&TE log until after the mechanics had made their final entry into the auxfeed cage on January 23. Therefore, these tools could not have been used to take measurements required by the CVDS. Despite this discrepancy, the mechanics logged in the JWR that precision tools had been used to inspect the valve. Therefore, the information in the JWR regarding precision tool use was inaccurate. Additionally, the measurement values recorded in the CVDS were identical to measurements that had been recorded in 2015, which brought into question the accuracy of the values in the CVDS.

Corrective Actions: The licensee completed an internal investigation into the matter. The site issued disciplinary corrective actions to the individual mechanics involved in the issue, including denial of site access and termination of employment. 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, the site implemented a semi-annual random audit of a portion of work orders at Turkey Point to determine whether personnel completed assigned duties by comparing work to the BATR and other validating information, such as M&TE Logs.

Corrective Action References: AR 2299601

Performance Assessment: The inspectors determined this apparent violation was associated with a minor performance deficiency when addressed in the NRC's reactor oversight process (ROP).

Enforcement:

Violation: 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 apparent willfulness using traditional enforcement to adequately deter noncompliance.

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 January 23, 2019, the licensee maintained information recorded in steps 4.6 and 4.11 of WO 40542353, which was not complete and accurate in all material respects. Specifically, step 4.6 was marked complete, yet the work was not performed using the CVDS.

Additionally, for step 4.11, inaccurate information was recorded regarding the tools used in the JWR and inaccurate measurement values were recorded in the CVDS. Records of inspections 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.

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

FACTUAL SUMMARY
OFFICE OF INVESTIGATIONS REPORT NO. 2-2019-011

On March 10, 2020, the NRC's Office of Investigations completed an investigation into the circumstances of a potentially falsified work order package associated with required inspection and maintenance of a safety-related check valve at Turkey Point Nuclear Plant, Unit 3.

On January 23, 2019, two mechanics were assigned to perform a required inspection and maintenance on Valve AFWU-3-017, a safety-related check valve at Turkey Point Unit 3. A third licensee employee was assigned as a temporary General Maintenance Leader (GML) for this inspection. The responsibilities of the GML included assigning the work, conducting a "tailboard" (briefing), performing required visual inspections while the work was being done, and reviewing and closing out the work package. The valve is located in the Auxiliary Feedwater System Cage (AuxFeed Cage), which has only one entrance/exit point and requires badge access.

The inspection was conducted using Work Order (WO) 40542353, which required completion of three documents: a Work Order Task Description (WOTD), an "SOER 86-03" Check Valve Data Sheet (CVDS), and a Journeyman Work Report (JWR). According to Step 4.6 of the WOTD, the mechanics were to "**PERFORM SOER 86-03** check valve inspection using attached **SOER 86-03** check valve data sheet (Type: LIFT CHECK)." The SOER data sheet provides space for the mechanic to record three measurements: disc diameter, disc weight, and body bore diameter. Step 4.11 of the WOTD required the mechanics to "**RECORD** findings in the JWR and attached **SOER 86-03** data sheet." All three individuals (the two mechanics and the temporary GML) signed the last page of the WOTD indicating they had completed the valve inspection work using the SOER data sheet.

Per Step 4.6 of the WOTD, the mechanics were required to perform an SOER 86-03 check valve inspection "using attached SOER 86-03 check valve data sheet." One of the mechanics marked that step with a circle and slash indicating that it had been performed on the morning of January 23, 2019, while he and the second mechanic were in the AuxFeed Cage. However, evidence obtained by NRC OI indicated that all three workers (the two mechanics and the temporary GML) admitted that they did not have the SOER data sheet with them while the valve was disassembled for inspection.

The JWR indicated that the work was performed "[in accordance with the] task description and procedure" and that four precision tools were used during the inspection. Turkey Point tracks usage of precision tools at the plant in a log of Measuring and Testing Equipment (MTE) Issues and Returns (MTE Log). The MTE Log for January 23, 2019 indicated that one mechanic checked out a torque wrench at 11:10 a.m. and returned it at 11:28 a.m. The MTE Log also indicates that the mechanic checked out a micrometer, a scale, and a "Starrett Gage" at 1:30 p.m. and returned those items at 1:55 p.m. According to badge access records for the AuxFeed Cage entry/exit, the mechanics and the temporary GML did not enter the AuxFeed Cage after 12:00 p.m.

The mechanic who recorded the measurements on the SOER data sheet on January 23, 2019, stated that he used a standard measuring tape and a scale located in another building to perform the required measurements. The measurements he recorded were identical to measurements that had been recorded in 2015.

The preponderance of evidence gathered during the investigation appears to indicate that the employees willfully falsified the measurements recorded in the CVDS. By falsifying information associated with WO 40542353 for the check valve inspection, this appears to have caused FPL to be in violation of 10 CFR § 50.9(a).

Records of inspections 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.