Actions
Reactor Actions
2011
2010
2009
2008
2007
Materials Actions
2011
2010
2009
2008
2007
Individual Actions
2011
2010
2009
2008
2007
Non-Licensee Actions
2011
2010
2009
2008
Fuel Cycle Facilities
2011
2010
2009
2008
2007

Home > About NRC > How We Regulate > Enforcement > Actions > 2009 Reactor Actions

2009 Reactor Actions

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Tennessee Valley Authority (Browns Ferry Nuclear Plant) EA-09-009; EA-09-203

On December 22, 2009, a Confirmatory Order (effective immediately) was issued to the Tennessee Valley Authority (TVA) to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) mediation session held on December 4, 2009. At issue were two apparent violations of the NRC's employee protection regulation (10CFR50.7) identified during two separate investigations conducted by the NRC Office of Investigations at the Browns Ferry Nuclear Plant (BFN). The NRC acknowledged that TVA, prior to the ADR session, had taken numerous actions which address the issues underlying the apparent violations. As part of the agreement, TVA agreed to take a number of additional actions. These actions include, implementing a process to review proposed adverse employment actions before they are taken to ensure compliance with 10CFR50.7 and to ensure the action could not negatively impact the Safety Conscious Work Environment (SCWE), issuing a fleet-wide written communication from TVA's executive management communicating TVA's policy and management expectations regarding the employee's right to raise concerns without fear of retaliation, performing two additional independent safety culture surveys before the end of calendar year 2013, and modifying contractor in-process training and new supervisor training to improve awareness of TVA's policy on SCWE. In recognition of these commitments, and the other actions already completed by TVA, the NRC agreed to refrain from issuing a civil penalty or Notice of Violation for these apparent violations.

Exelon Generating Company, LLC (Peach Bottom Atomic Power Station) EA-09-007, EA-09-059

On December 1, 2009, an immediately effective Confirmatory Order was issued to Exelon Generating Company, LLC (Exelon) to confirm commitments made as a result of an Alternative Dispute Resolution mediation session held on September 3, 2009. This enforcement action is based on two violations of NRC requirements at Exelon's Peach Bottom Atomic Power Station (Peach Bottom), including the deliberate failure of a former reactor operator to report an arrest in a timely manner and the deliberate failure of a former maintenance supervisor to provide complete and accurate information on a personal history questionnaire. Exelon agreed to take the following actions: (1) provide additional training on deliberate misconduct at Peach Bottom and other Exelon sites, for both employees and supervisors; (2) perform an assessment to verify the effectiveness of the deliberate misconduct training; (3) conduct training with licensed operators on the special obligations associated with holding an NRC license; (4) perform an assessment of Peach Bottom employee conduct, including trending; (5) conduct additional Exelon fleet-wide training on the Behavioral Observation Program, fitness for duty requirements, and the Employee Assistance Program; (6) submit a lessons-learned article to two professional organizations requesting publication in their respective newsletters; and (7) discuss with the Institute of Nuclear Power Operations the possibility of incorporating training on deliberate misconduct into its supervisor and operator development programs. In consideration of these commitments, and other actions already completed by Exelon, the NRC agreed to refrain from issuing a civil penalty or Notice of Violation for these violations.

Constellation Energy (Nine Mile Point Nuclear Station Unit 2) EA-09-262

On November 24, 2009, the NRC issued a parallel White finding to Constellation Energy as a result of inspections at Nine Mile Point Nuclear Station Unit 2. This parallel White finding was identified during a supplemental inspection to review the licensee's evaluation of the circumstances that led to the Mitigating Systems Performance Index for the cooling water system crossing the Green to White threshold. The performance indicator crossed the threshold because of service water pump unavailability for maintenance and reliability challenges caused by a November 4, 2008 event where the licensee failed to properly control diving operations

while cleaning the intake bays. The inspectors identified significant weaknesses in Constellation's causal analysis for the November 4, 2008 event. Specifically, Constellation failed to identify that the initial work controls put into place for the diving evolution, and subsequent changes made to the work scope, were inadequate and directly contributed to the event. In addition, Constellation failed to identify that governing diving procedures were not followed during the event. Based on these NRC-identified weaknesses, a parallel White inspection finding was opened to allow for the NRC's continued review of Constellation's actions to address the significant weaknesses identified during the supplemental inspection.

NextEra Energy Seaboork, LLC (Seabrook Station) EA-09-145

On November 12, 2009, the NRC issued a Notice of Violation to NextEra Energy Seabrook, LLC, for a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," at Seabrook Station. The violation, which is associated with a White Significance Determination Process finding, involved the failure to assure that the design basis of the B emergency diesel generator (EDG) was correctly translated into work instructions and that measures were established for the selection of suitable parts and materials. Specifically, a design change to a flange on a jacket water cooling line to the B EDG turbocharger did not (1) control welding stresses, verify flange alignment, or evaluate vibration effects, (2) address suitability of gasket material, or (3) consider flange performance history. This resulted in failure of the flange during operation of the B EDG, leading to rapid loss of jacket cooling water and inoperability of the EDG.

Constellation Energy (R.E. Ginna Nuclear Power Plant) EA-09-249

On November 12, 2009, the NRC issued a Notice of Violation to Constellation Energy for a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," at the R.E. Ginna Nuclear Power Plant. The violation, which is associated with a White Significance Determination Process finding, involved the failure to identify the cause of a significant condition adverse to quality. Specifically, after identifying corrosion on the turbine-driven auxiliary feedwater pump governor control valve stem on April 11, 2005, the licensee did not take adequate measures to identify the cause or prevent recurrence. This led to additional corrosion and binding of the governor control valve, and resulted in failure of the turbine-driven auxiliary feedwater pump on July 2, 2009.

Northern States Power Company (Prairie Island Nuclear Generating Plant) EA-09-193

On October 27, 2009, the NRC issued a Notice of Violation for a Severity Level III violation to Northern States Power Company, Minnesota. The licensee violated 10 CFR 50.9 which requires, in part, that information provided to the Commission by an applicant shall be complete and accurate in all material respects. Specifically, on May 11, 2007, the licensee failed to report a medical condition, as required by 10 CFR 55.23 "Certification," of a senior reactor operator (SRO) on a license renewal form. This resulted in the NRC renewing the SRO's license without a restriction for the medical condition.

Exelon Generation Company, LLC (Dresden Nuclear Power Station Unit 3) EA-09-172

On October 26, 2009, a Notice of Violation was issued to Exelon Generation Company, LLC for a violations associated with a White Significance Determination Finding as a result of inspections at the Dresden Nuclear Power Station Unit 3. The White finding involved multiple violations including: (a) 10 CFR 50.54(j), in which non-licensed operators, during a maintenance activity, manipulated the control rod drive system hydraulic control unit insert riser isolation valves and the withdraw riser isolation valves, an action which affected the reactivity of the reactor in that the valve manipulations caused three control rods, D-7, E-7, and E-6 to move out of the core to positions 06, 18, and 16, respectively; (b) Technical Specification 3.1.1, in which the reactor was in Mode 4, the shutdown margin was not ≥ 0.38 Δk/k and the licensee failed to initiate immediate actions to insert control rods; (c) Technical Specification 5.4.1, in which maintenance that affected the performance of the control rods, which are safety–related equipment, was performed in accordance with a written procedure that was not appropriate to the circumstances; (d) Technical Specification 5.4.1, in which the control room operators failed to implement a section of a procedure in that they did not aggressively investigate annunciators and alarms and did not accept the alarms as correct until demonstrated otherwise; and (e) Technical Specification 5.4.1, in which the licensee failed to implement its written procedure which addressed the inability to drive control rods.

Northern States Power Company (Prairie Island Nuclear Generating Plant) EA-09-167

On September 3, 2009, a Notice of Violation was issued to Northern States Power Company - Minnesota for a violation associated with a White Significance Determination Finding involving a

violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" which requires, in part, that measures be established to assure that the design basis for safety related functions of structures, systems, and components are correctly translated into specifications, drawings, procedures, and instructions. Contrary to this requirement, Prairie Island Nuclear Generating Plant failed to implement design control measures to ensure that the design basis for the component cooling water system was correctly translated into specifications, drawings, procedures, and instructions. Specifically, the licensee failed to ensure that the safety-related function of the component cooling water system was maintained following a high energy line break, seismic, or tornado events in the turbine building.

Southern Nuclear Operating Company, Inc. (Joseph M. Farley Nuclear Plant) EA-09-103

On July 10, 2009, the NRC issued a Notice of Violation to Southern Nuclear Operating Company, Inc. (SNC) for a violation of 10 CFR 50.54(q) which states, in part, that the licensee shall follow and maintain emergency response plans which must meet planning standards in 10 CFR 50.47 (b). 10 CFR 50.47(b) requires, in part, that the licensee establish a means to provide early notification and clear instruction to the populace within the plume exposure pathway Emergency Planning Zone (EPZ). SNC emergency plan identifies both tone alert radios (TARs) and sirens as the means by which it provides alert and notification to the populace within the plume exposure pathway. This violation is associated with a White Significance Determination Process finding.

Specifically, in January 2008, the licensee identified that approximately 109 TARs had not been provided to residences that were outside the limits of the sirens but within the 10 mile EPZ of Farley Nuclear Plant. The licensee's subsequent review identified additional residences within the 10 mile EPZ which were required to have TARs in accordance with the Farley emergency plan, but were not provided TARs.

Nuclear Management Company, LLC (Point Beach Nuclear Generating Plant) EA-09-012

On June 26, 2009, the NRC issued a Notice of Violation to NextEra Energy Point Beach, LLC for a Severity Level III problem involving the failure to implement: (1) 10 CFR 50.74(c) which requires that each licensee notify the appropriate NRC Regional Administrator within 30 days of a permanent disability or illness, as described in 10 CFR 55.25, of a licensed operator or a senior licensed operator; (2) 10 CFR 50.9 which requires, 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; and (3) 10 CFR 55.23 requires, in part, that to certify the medical fitness of the applicant, an authorized representative of the facility licensee shall complete and sign NRC Form–396, "Certification of Medical Examination by Facility Licensee."

Specifically, the licensee was informed in February 1993 that the non-licensed operator was taking prescribed medication for hypertension, a permanent disability or illness. The non-licensed operator applied for an NRC operating license in May 1999. The NRC issued the operator a reactor operator license August 27, 1999 and a senior reactor operator license on February 22, 2002, with no restrictions. The licensee did not inform the NRC of the operator's medical condition until October 20, 2008.

Also, the licensee submitted an NRC Form 396 for renewal of a senior reactor operator's license and the NRC Form 396 certified that the applicant met the medical requirements of ANSI/ANS 3.4 1996 with no restrictions. However, in February 1993, the operator was prescribed medication to adequately compensate for a disqualifying medical condition. The certification by the senior licensee facility representative was material to the NRC because the NRC relied upon this certification to renew the senior reactor operator's license pursuant to 10 CFR Part 55 when the license should have been modified with a restriction that the senior reactor operator was required to take medication as prescribed to maintain his qualification.

Southern Nuclear Operating Company, Inc. (Edwin I. Hatch Nuclear Plant) EA-09-054

On June 9, 2009, a Notice of Violation was issued to Southern Nuclear Operating Company, Inc. for a violation associated with a White Significance Determination Finding involving a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions." Specifically, since 1988 the licensee had observed cracks in the glands of the emergency diesel generator (EDG) couplings, but did not recognize the cracking was an indication of coupling deterioration. This fact was not documented during routine maintenance inspections, therefore there was no condition report written to identify and correct the condition. Consequently, the 1B EDG coupling developed higher than normal vibration on July 12, 2008, during a routine surveillance test which prompted the licensee to declare the 1B EDG inoperable.

Constellation Energy (R. E. Ginna Nuclear Power Plant) EA-09-045

On June 8, 2009, the NRC issued a Notice of Violation to Constellation Energy for a violation of Technical Specification 5.4.1.a, "Procedures" at the R.E. Ginna Nuclear Power Plant. The violation, which is associated with a White Significance Determination Process finding, involved the failure to implement a Technical Specification-required procedure. Specifically, in March 2008, the licensee did not implement steps for cleaning and lubricating the turbine-driven auxiliary feedwater pump's governor linkage assembly, as required. Failure to conduct this preventative maintenance led to the turbine-driven auxiliary feedwater pump being declared inoperable when the governor linkage became stuck, preventing the pump from obtaining the required discharge pressure and flow during surveillance testing in December 2008.

Florida Power and Light Energy (Duane Arnold Energy Center) EA-09-083

On June 6, 2009 a Notice of Violation was issued to Florida Power and Light Energy Duane Arnold, LLC for a violation associated with a White Significance Determination Finding involving a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions." Specifically, the licensee initially identified and corrected a condition adverse to quality regarding overspeed trip alarms on the Train B emergency diesel generator (B EDG), a safety–related component covered under 10 CFR Part 50, Appendix B, in February and March 2008. However, when spurious overspeed trip alarms began recurring in June 2008, the licensee did not perform any additional evaluation to identify the cause for the new condition adverse to quality and did not correct the recurring spurious overspeed trip alarms. This allowed the overspeed switch degradation to continue, resulting in the failure of the B EDG during the monthly surveillance test conducted in November 2008.

Northern States Power Company (Monticello Nuclear Generating Plant) EA-09-010

On May 27, 2009, a Notice of Violation was issued for a Severity Level III problem involving incomplete and inaccurate information in the renewal application for a Senior Reactor Operator's (SRO) license. Specifically, on September 11, 2008, Monticello Nuclear Generating Plant submitted NRC Form 396 for renewal of an SRO license certifying that the individual met the medical requirements. The NRC renewed the SRO license based on NRC Form 396, which only requested a corrective lenses license restriction. Later in November 2008, the NRC received a license restriction change request for the same SRO to add a "Must Take Medication as Prescribed to Maintain Medical Qualifications" license restriction. During the review of the licensing action, the NRC discovered that the SRO both started taking medication and notified the Monticello medical staff in July 2004. The licensee failed to notify the NRC of this change in medical condition. This is a violation of 10 CFR 50.74(c), which requires the licensee to notify the appropriate Regional Administrator within 30 days of a permanent disability or illness of a licensed operator. As a result of the inaccurate information contained in the renewal request, the NRC renewed the SRO license. This is a violation of both 10 CFR 50.9 and 10 CFR 55.23. Title 10 CFR 50.9, states, in part, "Information provided to the Commission…shall be complete and accurate in all material respects" and 10 CFR 55.23, states, in part, that to certify the medical fitness of the applicant, an authorized representative of the facility licensee shall complete and sign NRC Form 396, "Certification of Medical Examination by Facility Licensee."

Northern States Power Company (Prairie Island Nuclear Generating Plant) EA-08-349

On May 6, 2009, a Notice of Violation was issued to Northern States Power Company for a violation associated with a White Significance Determination Process finding at Prairie Island. Specifically, the licensee failed to meet the requirements of 49 CFR 173.441(a), which requires shipments of radioactive material to be packaged such that under conditions normally incident to transportation, dose rates on all external surfaces of the package are less than 200 mrem per hour, and 49 CFR 172.704, which requires training for personnel involved in packaging and shipping radioactive materials. Specifically, on October 31, 2008, a shipment of radioactive material sent from Prairie Island to a Westinghouse facility in Pennsylvania was found to have a dose rate on an external surface in excess of 200 mrem per hour. Subsequent investigation identified that a number of the personnel involved in preparing this shipment had not been properly trained, as required.

Constellation Generation Group, LLC (Calvert Cliffs Nuclear Power Plant) EA-08-351

On April 3, 2009, a Notice of Violation was issued to Constellation Energy for a violation associated with a White Significance Determination Process finding at Calvert Cliffs. Specifically, the licensee failed to maintain in effect Emergency Plans that met the requirements of 10 CFR 50.47(b)(4) and 10 CFR 50, Appendix E. An emergency action level table used by operators to assess the functionality of the containment barrier during an accident contained an inaccurate

threshold for identifying a potential loss of the containment barrier. This error could have adversely impacted the licensee's ability to accurately classify an emergency condition.

Duke Power Company, LLC (Oconee Nuclear Station) EA-08-324

On February 19, 2009, Duke Power Company, LLC was issued a White Significance Determination Finding which involved the performance of a maintenance procedure that was inadequate. Specifically, the maintenance procedure failed to identify and electrically isolate all main generator automatic voltage regulator trip outputs to the main generator lockout relay. This deficiency caused a main generator lockout which resulted in a loss of power event to the site which ultimately led to a loss of reactor coolant inventory while the reactor was shutdown.

Entergy Nuclear Operations, Inc. (Palisades Nuclear Plant) EA-08-322

On January 30, 2009, a Notice of Violation was issued for a violation associated with a White Significance Determination finding involving a violation of 10 CFR 20.1501 which requires the performance of surveys (evaluations) necessary for the licensee to comply with the regulations in Part 20. The violation involved the failure to evaluate radiological hazards and assess dose to workers that handled tools used for reconstituting failed fuel during work on the refueling floor in October 2007, as required by 10 CFR 20.1501 to demonstrate compliance with the dose limits of 20.1201.

Northern States Power Company (Prairie Island Nuclear Generating Plant) EA-08-272

On January 27, 2009, a Notice of Violation was issued to Northern States Power Company for a violation of Technical Specifications associated with a White Significance Determination finding at Prairie Island Nuclear Generating Plant. Specifically, the licensee failed to adequately control the position of a normally open pressure switch block valve for the Unit 1 turbine-driven auxiliary feedwater pump. The valve was inadvertently left closed, causing the turbine-driven auxiliary feedwater pump to fail to operate as required following a July 31, 2008, Unit 1 reactor trip. The pump was subsequently determined to have been inoperable for 138 days, a time period that significantly exceeded that allowed by the Technical Specifications.

Tennessee Valley Authority (Sequoyah Nuclear Plant) EA-08-211

On January 5, 2009 a Confirmatory Order (effective immediately) was issued to Tennessee Valley Authority to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) settlement agreement, regarding violation of site security procedures caused by the deliberate actions of one contract security supervisor at the Sequoyah Nuclear Plant, who falsified an inventory form to conceal the supervisor's failure to verify inventory as required by licensee procedures.

Exelon Generation Company, LLC (Peach Bottom Atomic Power Station) EA-08-298

On January 6, 2009, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $65,000 was issued for a Severity Level III problem involving inattentive security officers at Exelon's Peach Bottom Atomic Power Station. An investigation conducted by the NRC Office of Investigations determined that multiple security officers at Peach Bottom were deliberately inattentive on multiple occasions. In addition, multiple security officers deliberately failed to report observations of inattentiveness to their supervision. These security officers put Exelon in violation of 10 CFR 73.55, which requires armed responders to maintain continuous communication with each alarm station and be available to immediately respond to threats, and Peach Bottom License Condition 2.C(3), which requires, in part, reporting of aberrant behavior.

All significant enforcement actions issued to reactor licensees

TOP

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Wednesday, October 20, 2010