Case Number	Licensee Name	Facility	Docket Number	Address	City	State	Zip	Type	Action	Penalty Proposed	Penalty Paid	Date	Case Summary
EA-2008-184	CAN USA Inc	AGREEMENT STATE-LOUISIANA	15000017					Radiographer	Order - Confirmatory			16-Apr-10	On April 16, 2010, the NRC issued a Confirmatory Order (effective immediately) to CAN USA, Inc. to formalize commitments made as a result of an ADR mediation session. The commitments were made by CAN USA, Inc. as part of a settlement agreement between CAN USA, Inc. and the NRC regarding apparent willful violations of NRC requirements by a radiographer and radiographer's assistant. The agreement resolves the apparent violations involving the CAN USA failures, which were identified during NRC inspection and investigation by the NRC Office of Investigations, and include the following areas: (1) failure to have a radiographer and at least one other individual qualified pursuant to 34.43(c), (2) failure to have a radiographer supervise and maintain direct observation of the assistant during use of a radiographic device, and (3) failure to control and maintain constant surveillance of licensed material that is in a controlled or unrestricted area and not in storage. CAN USA, Inc. agreed to a number of corrective actions, including the following: new and specific changes to operating procedures, activities related to training on new and/or revised operating procedures; interim training until the procedures are completed, unannounced audits; additional oversight of radiography crews; and specific written agreements with clients that address radiographic operations. In consideration of these commitments, the NRC agreed to limit the civil penalty amount to $7,000 and not to pursue any further enforcement action in connection with the inspection
EA-2008-204	B&W NOG, INC.	B&W NOG, INC.	07000027	P O. BOX 785	LYNCHBURG	VA	24505	Fuel Facility	Violation - SL III	$32,500		23-Feb-10	On October 12, 2010, the Atomic Safety and Licensing Board (Board) issued an Order approving a settlement agreement between Babcock and Wilcox Nuclear Operations Group, Inc. (B&W NOG) (formerly BWX Technologies (BWXT), Inc) and the NRC related to the failure by B&W NOG to adequately neutralize a spill of hydrofluoric acid (HF) which, on April 28, 2008, resulted in an operator receiving an ocular exposure requiring onsite and offsite emergency medical treatment. The original enforcement action associated with this incident, which was retracted and reissued on February 23, 2010, was issued on October 20, 2008 (ML082950026). In accordance with the Board Order, the NRC agreed (1) to withdraw the Order imposing a monetary civil penalty in the amount of $32,500 issued on June 15, 2010 (ML101580256), and, (2) to recategorize the violation issued on February 23, 2010 (ML100540701) from a Severity Level III violation to a violation with no severity level. In accordance with the Board Order, B&W agreed to (1) not challenge the existence of a violation of NRC requirements related to the HF spill and withdraw its request for a hearing, (2) pay a settlement fee of $32,500 in lieu of the withdrawn civil penalty; (3) perform one quarterly emergency drill within a twelve-month period related to a chemical exposure event, and, (4) give a presentation addressing lessons learned at the 2011 Fuel Cycle Information Exchange
EA-2009-018	Entergy Operations, Inc	Waterford	05000382	17265 River Road	KILLONA	LA	70057	Operating Reactor	Violation - White Significance			14-Jan-10	On January 14, 2010, the NRC issued a Notice of Violation to Entergy Operations, Inc. for a violation of Technical Specification 6.8.1.a, "Procedures and Programs," at Waterford Steam Electric Station Unit 3. The violation, which is associated with a White Significance Determination Process finding, involved the failure to properly follow all procedural steps during replacement of the safety-related Train B 125 Vdc battery in May 2008. Specifically, following replacement of the battery, the licensee did not: (1) adequately torque all of the affected intercell connections, (2) obtain the required quality control inspector verification that all affected connections were properly tightened, (3) ensure that all the necessary intercell resistance checks were performed, and (4) obtain quality control verification that the intercell resistance checks met Technical Specification limits. As a result, an intercell connection on the battery loosened over time and on September 2, 2008, the battery was found to be inoperable during testing.
EA-2009-038	V. A , DEPARTMENT OF	V. A , DEPARTMENT OF	03034325	2200 FORT ROOTS DRIVE	NORTH LITTLE RO	AR	72114	Hospital	Violation - SL II	$227,500	$275,000	17-Mar-10	On March 17, 2010, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $227,500 to the U.S. Department of Veterans Affairs for violations related to activities at the Philadelphia Veterans Affairs Medical Center (PVAMC). The following areas of violation were identified: (1) Severity Level III violations of 10 CFR 35.41(a)(2) for failure to develop, implement, and maintain written procedures to provide high confidence that each administration is in accordance with the written directive, resulting in a total of 74 prostate brachytherapy treatments where the administered radiation dose was not in accordance with the written directive, (2) a Severity Level II violation of 10 CFR 35.41(b)(2) for failure to have procedures that addressed verifying that the administration was in accordance with the applicable treatment plan and written directive , resulting the licensee administering at least 16 prostate brachytherapy treatments without performing post-treatment verifications until a prolonged period of time had passed, (3) a separate Severity Level III violation of 10 CFR 35.41(b)(2) related to the the licensee's failure to identify that the treatment plan for a brachytherapy treatment differed from the written directive, resulting in the wrong seeds being ordered and administered, (4) a Severity Level III problem involving violations of 10 CFR 35.27(a)(1) and 19.12(a)(4) for failing to instruct individuals about procedures, 10 CFR Part 35 and licensing requirements, and prompt reporting of conditions that resulted in two medical physicists not being instructed in the requirements for identifying and reporting medical events (10 CFR 35.2 and 35.3045) and an authorized user physician not being instructed of his responsibility to report to the licensee any condition that may lead to or cause a violation, (5) a Severity Level III violation of 10 CFR 35.3045(c) for failure to report to the NRC Operations Center no later than the next calendar day when they had information that medical events occurred, and (6) two Severity Level IV violations.
EA-2009-040	CHIPPENHAM & JOHNSTON-WILLIS HOSP., IN	CHIPPENHAM & JOHNSTON-WILLIS HOS	03005805	1401 JOHNSTON-WILLIS DRIVE	RICHMOND	VA	23235	Physician (M)	Violation - SL III			21-Jan-10	On January 21, 2010, the NRC issued a Notice of Violation to CJW Medical Center - Johnston-Willis Campus for a violation of 10 CFR 35.41(a)(2) associated with a Severity Level III violation involving the failure to develop, implement, and maintain written procedures to provide high confidence that each administration is in accordance with written directives. Specifically, as of December 16, 2008, the licensee's procedures did not require verification of the treatment site nor resolution of any inconsistencies in the written directive prior to administration of the dose. This resulted in a patient receiving treatment to the left trigeminal nerve instead of to the originally-intended site (right trigeminal nerve)
EA-2009-082	TROXLER ELECTRONIC LABORATORIES INC	TROXLER ELECTRONIC LABORATORIE	03005595	P. O. BOX 12057	RESEARCH TRI P	NC	27709	Gauge	Violation - SL III			09-Mar-10	On March 9, 2010, the NRC issued a Notice of Violation for a Severity Level III violation involving the failure to implement 10 CFR 110.20(a)(2) and 10 CFR 110.41(a)(9). Specifically, on November 21, 2008, Troxler Electronic Laboratories, Inc., failed to apply for a specific license and exported byproduct material listed in Appendix L (a moisture density gauge containing Am-241) to an embargoed country listed in 10 CFR 110.28 (Iraq). Further, this failure to apply for a specific export license prevented an Executive Branch review of the export activity as required by 10 CFR 110.41(a)(9).
EA-2009-142	COMMERCE, DEPARTMENT OF	COMMERCE, DEPARTMENT OF	03003732	325 BROADWAY, MC 104.02	BOULDER	CO	80305	Other	Order - Confirmatory	$10,000	$10,000	01-Mar-10	On March 1, 2010, the NRC issued an Immediately Effective Confirmatory Order to the U.S. Department of Commerce's National Institute of Standards and Technology (NIST or licensee) to confirm commitments made as a result of an Alternate Dispute Resolution mediation session held on January 5, 2010. This enforcement action is based on ten apparent violations of NRC requirements at NIST's facility in Boulder, Colorado, which were identified during NRC inspection and investigation activities conducted in response to a June 9, 2008 plutonium spill. The apparent violations involved the licensee's failure to conduct the radiation safety program at NIST-Boulder in accordance with NRC requirements and the conditions of the NIST-Boulder license. The licensee agreed to take the following actions: (1) complete an independent assessment of the radiation safety program at NIST-Boulder; (2) submit copies of the required annual radiation safety audit to the NRC; (3) develop and implement a procedure for training new employees on radiation safety policies and procedures; (4) upgrade initial and refresher training for employees who work with radioactive materials, including a review of lessons learned from the plutonium spill and the associated apparent violations; (5) submit a license amendment request for deletion of the radionuclides on the NIST-Boulder license that NIST no longer plans to use; (6) develop a formal radiation hazards analysis process; (7) revise the NIST Ionizing Radiation Safety Committee charter to require additional review of NRC submittals; (8) revise the NIST radiation safety program policy to indicate that all individuals interacting with the NRC are required to provide complete and accurate information; (9) develop a clearly defined process for acquiring radioactive materials; and (10) pay a civil penalty of $10,000. In consideration of these commitments, and other actions already completed by NIST, the NRC agreed not to pursue any additional enforcement actions for the apparent violations or count this matter as previous enforcement for the purposes of assessing potential future enforcement actions in accordance with Section VI.C of the Enforcement Policy.
EA-2009-147	BETA GAMMA NUCLEAR RADIOLOGY, INC	BETA GAMMA NUCLEAR RADIOLOGY,	03035572	P.O. BOX 7891, PMB 372	GUAYNABO	PR	00970	Hospital	Order - Confirmatory & Violation SL III	$5,000	$5,000	21-Jan-10	On January 21, 2010, the NRC issued a Notice of Violation (NOV) and Immediately Effective Confirmatory Order to Beta Gamma Nuclear Radiology, Inc., (BGNR) to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) mediation session held on October 27, 2009. This enforcement action is based on a violation of 10 CFR 30.9 which requires, in part, that information provided to the Commission by a licensee, or information required by the Commission's regulations to be maintained by the licensee shall be complete and accurate in all material respects. Contrary to this requirement, in a May 5, 2008 response contesting a Severity Level IV Notice of Violation, BGNR maintained, and provided to the NRC, information that was not complete and accurate in all material respects. Specifically, the BGNR response stated that three written directives, administered on September 14, 2005, and February 19 and 26, 2008, were written prior to the administrations, when in fact, the written directives were signed and dated after the administrations. The written directives were required to be maintained by 10 CFR 35.40(a), and were therefore, material to the NRC. BGNR agreed to: (1) perform quarterly comprehensive radiation safety audits and (2) authorize a new RSO for a two year period. In recognition of these commitments, the NRC agreed to issue to BGNR a civil penalty in the amount of $5,000 and also issue an NOV containing a SL III violation of 10 CFR 30.9.
EA-2009-248	PPL Susquehanna, LLC	Susquehanna	05000388	2 NORTH NINTH STREET	ALLENTOWN	PA	18101	Operating Reactor	Violation - SL III			28-Jan-10	On January 28, 2010, a Notice of Violation for a Severity Level III violation was issued to PPL Susquehanna, LLC. This finding involved a violation of 10 CFR Part 55.21 which requires, in part, that the licensed operator receives a medical examination by a physician every two years and meets the requirements of 10 CFR 55.33(a)(1). 10 CFR 55.33(a)(1) states, in part, the medical condition of the applicant will not adversely affect the performance of assigned duties or cause operational errors endangering public health and safety. 10 CFR 55.33(b) states, in part, if an applicant's general medical condition does not meet the minimum standards under 10 CFR 55.33(a)(1), the Commission may approve the application and include conditions in the license to accommodate the medical defect. 10 CFR 55.23 requires, in part, that a facility licensee shall certify the medical fitness of an applicant. PPL certified that it used the guidance of ANSI/ANS 3.4-1983 which describes the health requirements.
EA-2009-252	Duke Energy, Carolinas, LLC	William B McGuire Nuclear Station						Operating Reactor	Order - Confirmatory			02-Jun-10	On June 2, 2010, an immediately effective Confirmatory Order was issued to Duke Energy Carolinas, LLC (Duke Energy), to confirm commitments made as a result of an Alternative Dispute Resolution mediation session held on March 29, 2010. This enforcement action is based on two violations of NRC requirements at the McGuire Nuclear Station, which included a contract employee introducing and using marijuana inside the Protected Area and a contract employee failing to immediately report the event to Duke Energy management. Duke Energy agreed to take the following actions: (1) develop a summary of lessons learned from the facts and circumstances surrounding the apparent violations and communicate this summary to its fleet wide employees, (2) perform a self-assessment of the adequacy of the programs and processes in place to detect and deter the introduction of illegal drugs and alcohol into the Protected Area of Duke Energy's nuclear stations and implement appropriate enhancements in accordance with Duke Energy's corrective action program, and (3) prior to December 31, 2010, perform an effectiveness review of the corrective actions identified in (1) and (2) above. This is in addition to several other corrective actions already completed by Duke Energy. In consideration of these commitments, and the corrective actions already completed by Duke Energy, the NRC agreed that the non-compliances will be characterized as a violation of 10 CFR Part 26, with a significance of Severity Level IV.
EA-2009-258	BASIN ELECTRIC POWER COOPERATIVE	BASIN ELECTRIC POWER COOPERATI	03014682	1717 E. INTERSTATE AVENUE	BISMARCK	ND	58501	Gauge	Violation - SL II Violation - SL III Violation - SL III	$11,200 $7,000 $6,500		26-Aug-10	On August 26, 2010, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $24,700 to Basin Electric Power Cooperative. The violations involved: (1) Severity Level (SL) II violation of 10 CFR 20.1301(a)(1) for failure to limit radiation exposure to members of the public to less than 100 millirem in a year, resulting in six members of the public received doses in excess of 100 millirem, (2) SL III violation of 10 CFR 20.1902(e) for failure to conspicuously post caution signs with the words "CAUTION, RADIOACTIVE MATERIAL(S)" or "DANGER RADIOACTIVE MATERIAL(S)" in areas where nuclear gauges were used; (3) SL III violation of 10 CFR 30.50(b)(4) for failure to notify the NRC within 24 hours after the discovery of an unplanned fire on March 8, 2007, that damaged the integrity of a licensed device; and (4) SL III violation of License Condition 21 of Amendment 10 to NRC Materials License 33-18224-01 for failure to close and lock the nuclear gauge shutters after plant operations had stopped and prior to allowing welders to begin work, resulting in welders exposed to the direct radiation beam from these nuclear gauges.

EA-2009-259	Exelon Generation Co , LLC	Braidwood	05000456	4300 Winfield Road	WARRENVILLE	IL	60555	Operating Reactor	Violation - White Significance			25-Feb-10	On February 25, 2010, a Notice of Violation was issued to Exelon Generation Company, LLC, for a violation associated with a White Significance Determination Finding as a result of inspections at the Braidwood Nuclear Power Station This finding involved a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which requires, in part, that measures be established for the selection and review for suitability of application of materials, parts, equipment, and processes that are essential to the safety-related functions of the structures, systems, and components.
EA-2009-263	B&W NOG, INC	B&W NOG, INC	07000027	P O BOX 785	LYNCHBURG	VA	24505	Fuel Facility	Violation - SL III	$35,000	$35,000	11-Jan-10	On January 11, 2010, a Notice of Violation and Proposed Imposition of a Civil Penalty in the amount of $35,000 was issued, to Babcock and Wilcox Nuclear Operations Group, Inc. (B&W -NOG). This action was based on a Severity Level III violation involving the failure of the licensee to declare an Alert in a timely manner as required by Appendix G to their Emergency Plan Specifically, on July 15, 2009, the licensee failed to declare an Alert for more than 2 hours even though employees were cognizant that during that time, criticality controls associated with a sand saw reservoir did not exist and that the lost controls could not be immediately reestablished. Although the failure to declare an Alert in a timely manner did not result in any actual consequences in this case, the potential consequences of an untimely emergency declaration could have been significant under different circumstances.
EA-2009-266	ALLEGIANCE HEALTH	ALLEGIANCE HEALTH	03001990	205 N EAST AVENUE	JACKSON	MI	49201	Hospital	Violation - SL III			06-Jan-10	On January 6, 2010, the NRC issued a Notice of Violation to Allegiance Health for a Severity Level III violation involving the failure to develop written procedures to provide high confidence that the administration was in accordance with the written directive as required by Title 10 of the Code of Federal Regulations (CFR), Section 35.41. Specifically, on April 16, 2009, the licensee's procedures did not contain any steps to ensure that no changes had occurred in the patients' prostate volume between the time the treatment plan was prepared and the administration of the treatment and no other method was provided to ensure that the administration was in accordance with the written directive
EA-2009-268	GLOBAL NUCLEAR FUEL - AMERICAS, LLC	GLOBAL NUCLEAR FUEL - AMERICAS	07001113	P. O BOX 780	WILMINGTON	NC	28402	Fuel Facility	Problem - SL III			09-Jun-10	On June 9, 2010, a Notice of Violation and Exercise of Enforcement Discretion (Notice) was issued to Global Nuclear Fuels – Americas, LLC (GNF-A). This action was based on a Severity Level III problem involving three violations of regulatory requirements. Specifically, the licensee failed to (1) identify credible accident scenarios as required by the license, (2) characterize criticality accident scenarios in the integrated safety analysis (ISA) as high consequence events as required by the license, and (3) designate engineered or administrative controls as items relied on for safety (IROFS) when necessary to comply with the performance requirements of 10 CFR 70.61(b) – (d), as required by 10 CFR 70.61(e). Because, in part, the NRC staff and the licensee did not share a common understanding of GNF-A's application of its ISA methodology to scenario evaluation and IROFS identification during the ISA summary review and related inspection activities, the NRC concluded that enforcement discretion to forego proposing a civil penalty was appropriate in this case. No actual consequences resulted from these violations because there were no incidents and no existing safety controls were identified as degraded
EA-2009-269	Energy Nuclear Operations, Inc	Palisades	05000255	700 First St	HUDSON	WI	54016	Operating Reactor	Violation - White Significance			20-Jan-10	On January 20, 2010, a Notice of Violation was issued to Entergy Nuclear Operations, Inc. for a violation associated with a White Significance Determination Finding as a result of inspections at the Palisades Nuclear Plant. This White finding involved the licensee's failure to meet the requirements of Technical Specification (TS) for fuel storage in the spent fuel pool (SFP). Specifically, the Region I spent fuel pool storage rack neutron absorber had deteriorated over the life of the plant and was less than required by TS. Corrective actions are currently in place for additional controls of the spent fuel pool
EA-2009-272	AREVA NP, INC (RICHLAND)	AREVA NP, INC (RICHLAND)	07001257	2101 HORN RAPIDS ROAD	RICHLAND	WA	99354	Fuel Facility	Order - Confirmatory			26-Apr-10	On April 26, 2010, a Confirmatory Order (effective immediately) was issued to AREVA NP – Richland, Inc (AREVA) to formalize commitments reached as part of an alternative dispute resolution (ADR) mediation session involving a violation of a facility procedure by an employee who willfully defeated the function of an Item Relied On For Safety (IROFS) on April 21, 2009. Specifically, an electronic eye sensor known as the vacuum wand interlock was deliberately bypassed by an employee and made to work by using tape. As a result, IROFS 1111 was not available and reliable as required by 10 CFR 70.61(e). Although the vacuum wand interlock was disabled, sufficient system IROFS remained in service to perform the intended safety function for identified accident scenarios and protect the health and safety of the public. As part of the settlement agreement, AREVA agreed to take a number of actions in addition to those already completed These additional actions include: (1) incorporating lessons learned from this incident, including enhanced safety conscious work environment (SCWE) training, into General Employee training for new employees and annual refresher training for all Richland employees. (2) implementing a management observation program for the purpose of reinforcing task performance standards and work practices; (3) performing a survey to determine the results of efforts to increase supervisor availability in the work area; and (4) developing a presentation on the incident and lessons learned with regard to work practices for a future industry forum. In recognition of these actions, the NRC agreed to refrain from proposing a civil penalty and issuing a Notice of Violation or other enforcement action
EA-2009-283	FirstEnergy Nuclear Operating Co	Davis-Besse	05000346	76 South Main St.	AKRON	OH	44308	Operating Reactor	Violation - White Significance			25-Feb-10	On February 25, 2010, a Notice of Violation was issued to FirstEnergy Nuclear Operating Company for a violation associated with a White Significance Determination Finding as a result of inspections at the Davis-Besse Nuclear Power Station This finding involved a violation of 10 CFR 50 54(q) which requires, in part, that a holder of an operating license shall follow emergency plans which meet the standards in 10 CFR 50 47(b). 10 CFR 50 47(b) requires, in part, that the licensee have a standard emergency classification and action level scheme in use The Davis-Besse Emergency Plan requires, in part, that the Shift Manager shall verify the indication of an off-normal event and classify the situation
EA-2009-289	GAMMA KNIFE CENTER OF THE PACIFIC	GAMMA KNIFE CENTER OF THE PACI	03034629	2226 LILIHA STREET, B1 LEVEL	HONOLULU	HI	96817	Hospital	Violation - SL III			23-Feb-10	On February 23, 2010, the NRC issued a Notice of Violation for a SLIII violation to Gamma Knife Center of the Pacific for a failure to implement 10 CFR 35 41(b) Specifically, as of July 2, 2009, the licensee failed to develop, implement, and maintain written procedures to provide high confidence that each medical administration is in accordance with the written directive in that the procedures did not require explicit verification that the administration was in accordance with the treatment plan and written directive Consequently, the treatment plan and written directive were not followed to ensure that the collimator was used in the treatment of a patient
EA-2009-290	GREAT FALLS CLINIC	GREAT FALLS CLINIC	03035944	3000 15TH AVENUE SOUTH	GREAT FALLS	MT	59404	Hospital	Problem - SL III			21-Jan-10	On January 21, 2010, the NRC issued a Notice of Violation to Great Falls Clinic for violations associated with a Severity Level III problem involving the failure to: (1) secure from unauthorized removal or access licensed materials that are stored in controlled or unrestricted areas, in violation of 10 CFR 20 1801 and (2) secure the unit, console, console keys and the treatment room when not in use or unattended, in violation of 10 CFR 35.610 (a)(1) Specifically, the licensee stored a high dose-rate remote afterloader unit in a designated controlled area and did not secure the radioactive material from unauthorized removal or access. The console and unit were found in the unattended and not secured, designated controlled area The console was found with its key inserted
EA-2009-307	Tennessee Valley Authority	Browns Ferry	05000259	400 W Summit Hill Dr ET 12A	KNOXVILLE	TN	37902	Operating Reactor	Violations - Yellow & White Significance			19-Apr-10	On April 19, 2010, a Notice of Violations was issued to Tennessee Valley Authority (TVA) for violations associated with Yellow and White Significance Determination Findings as a result of inspections at the Browns Ferry Nuclear Plant. The Yellow finding involved the licensee's failure to meet the requirements of 10 CFR 50, Appendix R, III G, fire protection of safe shutdown capability. There were multiple examples of the licensee not providing fire protection features capable of limiting fire damage and failing to ensure one train of systems or components was free of fire damage by approved methods. Compensatory measures are currently in place and long term corrective actions will be implemented. The White finding involved the licensee's failure to meet the requirements of a Technical Specification. This involved the inappropriate revision to a procedure which could have delayed proper operator response to a major disabling fire event. The procedure has been revised to prevent such an issue from occurring
EA-2009-312	Kanawha Scales & Systems, Inc	AGREEMENT STATE-OHIO	15000034					Gauge	Violation - SL III			18-Feb-10	On February 18, 2010, the NRC issued a Notice of Violation to Kanawha Scales & Systems, Inc , a licensee of the State of Ohio, for a Severity Level III violation involving 10 CFR 150 20. Specifically, on November 2, 2009, Kanawha Scales & Systems, Inc , used sealed sources in a non-agreement state without filing an NRC Form 241 at least three days prior to engaging in licensed activities in areas of exclusive Federal jurisdiction.
EA-2009-321	Florida Power & Light Co	Saint Lucie	05000335	P. O Box 14000	JUNO BEACH	FL	33408-0420	Operating Reactor	Violation - Yellow Significance			19-Apr-10	On April 19, 2010, a Notice of Violation was issued to Florida Power & Light Company for a violation associated with a Yellow Significance Determination Finding as a result of inspections at the St. Lucie Nuclear Plant. The Yellow finding involved the licensee's failure to meet the requirements of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." In 2008, the licensee experienced an air in-leakage event into the closed cooling water (CCW) system which affected the system's ability to supply adequate cooling to essential equipment. Their troubleshooting and corrective actions failed to identify the source of the air in-leakage, which resulted in a similar event in 2009
EA-2009-332	FirstEnergy Nuclear Operating Co	Davis-Besse	05000346	76 South Main St	AKRON	OH	44308	Operating Reactor	Problem - SL III			30-Apr-10	On April 30, 2010, a Notice of Violation (NOV) was issued to FirstEnergy Nuclear Operating Company for a Severity Level III problem for the failure to implement. (1) 10 CFR 50.71 "Maintenance of records, making of reports" and (2) 10 CFR 50, Appendix B, Criterion III, "Design control." In July 1999, the licensee submitted a license amendment request to eliminate as found leaking criteria by using the past data for double O ring data and was approved by the NRC. However, the licensee staff did not update this fact in their updated final safety analysis report. The licensee also changed from the double O ring design to a flat gasket design which did not have the same reliable history as the double O ring and failed to translate this fact into the licensing basis at time of installation.
EA-2009-335	NANTICOKE MEMORIAL HOSPITAL	NANTICOKE MEMORIAL HOSPITAL	03013060	801 MIDDLEFORD ROAD	SEAFORD	DE	19973	Hospital	Violation - SL III			02-Feb-10	On February 2, 2010, the NRC issued a Notice of Violation to Nanticoke Memorial Hospital for a Severity Level III violation involving the failure to notify the NRC Operations Center by telephone no later than the next calendar day after discovery of the medical event as required by 10 CFR 35.3045(c). Specifically, Nanticoke Memorial Hospital became aware that a medical event had occurred on June 26, 2009, but the NRC was not notified until July 15, 2009
EA-2010-009	Southern Nuclear Operating Co , Inc	Hatch	05000321	P O BOX 1295	BIRMINGHAM	AL	35201	Operating Reactor	Violation - White Significance			12-May-10	On May 12, 2010, a Notice of Violation (NOV) was issued to Southern Nuclear Operating Company, Inc for a violation associated with a White Significance Determination Finding as a result of inspections at the Edwin I Hatch Nuclear Plant. The White finding involved the licensee's failure to meet Technical Specifications From 1988 to 2009 the licensee failed to establish and perform preventative maintenance activities on components having a specific lifetime. This resulted in a capacitor failure on a circuit card, during a surveillance test of an emergency diesel generator (EDG) and caused the EDG to be declared inoperable.
EA-2010-014	SOUTH BEND, CITY OF	SOUTH BEND, CITY OF	03018412	227 WEST JEFFERSON BOULEVARD	SOUTH BEND	IN	46601	Gauge	Violation - SL III			10-Mar-10	On March 10, 2010, a Notice of Violation was issued to the City of South Bend for a Severity Level III violation involving Condition 11 B of the facility's license which authorized a specifically named individual to fulfill the responsibilities of the Radiation Protection Officer. Specifically, as of January 19, 2010, the named individual was no longer employed by the company. The licensee failed to appoint a new Radiation Protection Officer and had not amended the license.
EA-2010-023	V A , DEPARTMENT OF	V A , DEPARTMENT OF	03034325	2200 FORT ROOTS DRIVE	NORTH LITTLE RO	AR	72114	Hospital	Violation - SL III Violation - SL III	$7,000 $7,000	$7,000	02-Jun-10	On June 2, 2010, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $14,000 to the Department of Veterans Affairs for two Severity Level III violations identified as a result of a medical event that occurred at the San Diego Healthcare System facility. The medical event resulted when Iodine-131 was injected into the wrong port of the gastrostomy feeding tube (g-tube) resulting in an underdose to the patient's thyroid and an unintended dose to the patient's stomach. Specifically, the licensee's written procedures did not include directions for administering byproduct material through a g-tube to ensure that the administered dose was in accordance with the written directive as required by 10 CFR 35 41(a)(2). Additionally, two nuclear medicine technologists had not been instructed on administering byproduct material through a g-tube prior to performing the administration in order to ensure that the administered dose was in accordance with the written directive. The second Severity Level III violation involved the licensee's failure to notify the NRC Operations Center no later than the next calendar day after discovery of a medical event as required by 10 CFR 35 3045(c). Specifically, on September 23, 2009, the licensee had sufficient information, based on patient survey data and the image from the nuclear medicine department, to report the medical event and did not notify the NRC until September 28, 2009

EA-2010-025	SSM ST CLARE HEALTH CENTER	SSM ST CLARE HEALTH CENTER	03002368	1015 BOWLES AVENUE	FENTON	MO	63026	Hospital	Violation - SL III			19-Apr-10	On April 19, 2010, the NRC issued a Notice of Violation to SSM St. Clare Health Center for a Seventy Level III violation involving the failure to implement written procedures to provide high confidence that each administration was in accordance with the written directive as required by Title 10 of the Code of Federal Regulations (CFR), Section 35.41. Specifically, between November 19, 2008, and September 23, 2009, the licensee failed to follow its procedures which required the preparation of final computerized treatment plans for two patients whose prostates had been implanted with radioactive seeds. The seeds were implanted on October 22, 2008, and their computed tomography (CT) studies were performed on November 19, 2008. However, the licensee still had not prepared the final treatment plans for these patients at the time of the inspection.
EA-2010-037	Florida Power & Light Co	Turkey Point	05000250	P. O. Box 14000	JUNO BEACH	FL	334080420	Operating Reactor	Violation - SL III Violation - White Significance	$70,000	$70,000	21-Jun-10	On June 21, 2010, the NRC issued a White finding with two associated violations to Florida Power and Light Company (FP&L) as a result of inspections at Turkey Point Nuclear Plant Unit 3. This White finding involves the licensee's failure to adequately address degradation of Boraflex, a fixed neutron absorber material used in the Turkey Point Unit 3 spent fuel pool. Boraflex degradation resulted in a reduction in the Boron-10 areal density of the spent fuel storage racks such that, when considering the biases and uncertainties identified in Chapter 9 of the Updated Final Safety Analysis Report, the effective neutron multiplication factor would not have been maintained less than 1.0 if the spent fuel pool had been flooded with unborated water. The NRC identified that FP&L had violated 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," which requires that conditions adverse to quality be promptly identified and corrected, and Technical Specification 5.5.1.1.a, which requires that the spent fuel storage racks be maintained with an effective neutron multiplication factor less than 1.0 if flooded with unborated water, when considering the biases and uncertainties described in the Updated Final Safety Analysis Report. The NRC also issued FP&L a Severity Level III Notice of Violation with a proposed $70,000 civil penalty for failure to comply with 10 CFR 50.73, which requires, in part, that licensees report any condition prohibited by the plant's Technical Specifications. As discussed, Boraflex degradation led to a condition prohibited by Turkey Point Unit 3 Technical Specifications, but this condition was not reported to the NRC as required by 10 CFR 50.73.
EA-2010-041	AREVA NP, INC (LYNCHBURG)	AREVA NP, INC (LYNCHBURG)	07001201	P.O. BOX 11646	LYNCHBURG	VA	24506	Fuel Facility	Order - Confirmatory			02-Dec-10	On December 2, 2010, the NRC issued a Notice of Violation and a Confirmatory Order to AREVA NP, Inc., as a result of an Alternate Dispute Resolution settlement for a violation of 10 CFR 71.5(a) and 49 CFR 172.204(a) involving inaccurate transportation records for several export shipments of special nuclear material (SNM). Specifically, on December 9, 2009, and March 11 and 18, 2009, an AREVA employee deliberately altered (falsified) the reference and date stamp on three documents entitled "Approval to Transit a UK [United Kingdom] Port" associated with the export of SNM from the United States to Germany by Areva NP, Inc.
EA-2010-044	ARCELORMITTAL USA, INC.	ARCELORMITTAL USA, INC	03004353	3210 WATLING STREET	EAST CHICAGO	IN	46312	Gauge	Violation - SL III			02-Jun-10	On June 2, 2010, the NRC issued a Notice of Violation to ArcelorMittal USA, Inc., for a Severity Level III violation involving the failure to ensure that only persons who have completed the licensee's training program, the gauge manufacturer's training course, or those persons specifically authorized by the Commission or an Agreement State remove gauges from service as required by license condition, Item 9. Specifically, on November 20, 2009, two individuals removed a gauge from service and neither individual had completed the licensee's training program or the gauge manufacturer's training course. In addition, on April 15, 2009, two other individuals removed a gauge from service, and one of those two individuals was not trained. None of the three individuals was authorized by the Commission or an Agreement State to remove gauges from service.
EA-2010-054	Stone and Webster Construction Inc	Stone and Webster Construction Inc		4171 Essen Lane	Baton Rouge	LA	70809	Other	Order - Confirmatory			10-Sep-10	On September 10, 2010, a Confirmatory Order (effective immediately) was issued against Stone & Webster Construction, Inc. (S&W) to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) mediation session held on August 24, 2010. By letter dated June 2, 2010, the NRC identified an apparent violation of 10 CFR 50.7 based on the United States Department of Labor (DOL) Administrative Review Board's (ARB) September 24, 2009 Final Decision and Order of Remand (ARB Case No. 06-041). That ARB decision reversed a January 9, 2008 DOL Administrative Law Judge's (ALJ) recommended decision where the ALJ issued a Proposed Decision and Order (ALJ Case No. 2005-ERA-6), concluding that S&W had not retaliated against a former painter foreman at the Browns Ferry Nuclear Power Plant.
EA-2010-062	EARTH ENGINEERS, INC.	EARTH ENGINEERS, INC	03037119	380 MAPLE AVENUE	CHESHIRE	CT	06410	Gauge	Problem - SL III			28-Jun-10	On June 28, 2010, the NRC issued a Notice of Violation to Earth Engineers, Inc., d.b.a. Haynen Engineers (EEI) for a Severity Level III problem involving two violations. The first violation involved a failure to comply with the conditions of the NRC Order Revoking License, issued on June 4, 2009. Specifically, the licensee did not pay fees within 30 days or transfer the licensed material to an authorized recipient within 60 days from the date of the Order. The second violation involved a failure to afford the NRC an opportunity to inspect the EEI facility, as required by 10 CFR 19.14(a). Specifically, on October 7, 2009, the licensee did not provide access to the nuclear portable gauge to inspect the condition of the gauge; and, between November 2, 2009 and January 27, 2010, the NRC made several attempts to contact the licensee, but the licensee did not provide access to the EEI facility.
EA-2010-063	YALE-NEW HAVEN HOSPITAL	YALE-NEW HAVEN HOSPITAL	03034705	40 TEMPLE STREET	NEW HAVEN	CT	06510	Hospital	Violation - SL III			21-May-10	On May 21, 2010, the NRC issued a Notice of Violation to Yale-New Haven Hospital (YNHH) for a Severity Level III violation involving the failure to develop and maintain written procedures to provide high confidence that each administration requiring a written directive was performed in accordance with the written directive as required by 10 CFR 35.41. Specifically, YNHH's written procedures did not require a physical verification of the automatic position system coordinates against the electronic coordinates prior to initiation of gamma stereotactic radiosurgery (GSR) treatment and did not specify how hospital personnel should respond to unexpected GSR treatment console errors. These procedural inadequacies resulted in a medical event, when YNHH personnel did not verify that the automatic position system coordinates were in accordance with the written directive, during the treatment of a patient undergoing GSR on August 5, 2009.
EA-2010-066	BRYAN LGH MEDICAL CENTER	BRYAN LGH MEDICAL CENTER	03037263	2300 SOUTH 16TH ST	LINCOLN	NE	68502	Other	Violation - SL III			18-Aug-10	On August 18, 2010, the NRC issued a Notice of Violation to Bryan LGH Medical Center dba Bryan LGH Heart Institute (Bryan Heart), for a Severity Level III violation involving the failure to file NRC Form 241 "Report of Proposed Activities in Non-Agreement States," at least three days prior to engaging in licensed activities within NRC jurisdiction, as required by 10 CFR 150.20. Specifically, as of December 16, 2009, Bryan Heart, a holder of Nebraska State license, provided mobile nuclear medicine services at a temporary job site in the State of Missouri, a non-Agreement State, without filing a reciprocity submittal for calendar year 2009 with the NRC.
EA-2010-068	ANTHONY AND EDWARD CONSULTANTS	ANTHONY AND EDWARD CONSULTANTS	03036857	5 PENCE ROAD	MANALAPAN	NJ	07726	Gauge	Problem - SL III			25-Jun-10	On June 25, 2010, the NRC issued a Notice of Violation to Anthony & Edwards Consultants (A&E) for a Severity Level III problem involving three violations. The first violation involved a failure to comply with the conditions of the NRC Order Revoking License, issued on July 28, 2009. Specifically, the licensee did not pay fees within 30 days or transfer the licensed material to an authorized recipient within 60 days from the date of the Order. The second violation involved a failure to afford the NRC an opportunity to inspect the A&E facility, as required by 10 CFR 19.14(a). Specifically between February 18, 2009 and September 17, 2009, the NRC made several attempts to contact the licensee to visit the facility and to schedule an inspection of licensed activities, but the licensee did not respond to these requests. And the third violation involved a failure to confine storage of licensed material to a location specified on the license, as required by 10 CFR 30.34(c). Specifically, from September 5, 2008 through at least September 30, 2009, the licensee stored the licensed material at a location not authorized by the license.
EA-2010-069	LABORATORY TESTING SERVICES LLC	LABORATORY TESTING SERVICES LL	03037345	36 RIVER STREET	BRIDGEPORT	CT	06604	Gauge	Problem - SL III			06-Jul-10	On July 6, 2010, the NRC issued a Notice of Violation to Laboratory Testing Services, LLC (LTS) for a Seventy Level III problem involving three violations. The first violation involved a failure to confine possession and use of byproduct material to the location authorized by the license, as required by 10 CFR 30.34(c). Specifically, the licensee possessed and used portable gauges at a location not authorized by the license. The second violation involved a failure to have an individual named on the license as a Radiation Safety Officer (RSO), as required by the license. Specially, the RSO named on the license left the company in June 2008, and the licensee failed to have an RSO approved by the NRC. The third violation involved a failure to obtain written consent from the NRC before transferring ownership of LTS to HAKS Material Testing Company (HAKS), as required by 10 CFR 30.34(b). Specifically, on January 14, 2010, LTS transferred ownership control of the license to HAKS without the Commission's written consent.
EA-2010-076	NUCLEAR FUEL SERVICES, INC.	NUCLEAR FUEL SERVICES, INC	07000143	P. O. BOX 337, MS 123	ERWIN	TN	37650	Fuel Facility	Order - Confirmatory			18-Nov-10	On November 16, 2010, a Confirmatory Order (effective immediately) and a Notice of Violation (NOV) were issued to Nuclear Fuel Services, Inc. (NFS) to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) mediation sessions held on October 4, 2010. This enforcement action is based on the failure of NFS to provide complete and accurate information to the NRC, as required by 10CFR70.9(a), on two occasions. Specifically, (1) on November 25, 2008, NFS submitted a response to a previously issued NOV stating that all fire dampers in Procedure NFS-GH-22 were inspected in September 2008 and all passed the inspection, when 12 of the fire dampers had not been inspected, and (2) in August 2009, during an inspection to verify the corrective actions as documented in the response to the previously issued NOV, a former NFS employee created and provided a document to an NRC inspector that indicated that all but one of the dampers had been fully inspected in 2008, when in fact more than one of the dampers had not been fully inspected. The NRC concluded that these actions were willful and associated with the same former employee. As a result of the ADR agreement, the licensee agreed to a number of actions, including, (1) issuance of a NOV as part of the Confirmatory Order, (2) conducting an effectiveness review within one year of each corrective action to the NOV, (3) performing an assessment of the effectiveness of its corrective actions by an independent group to assure adequacy and accuracy of information submitted to the NRC, (4) developing and implementing an appropriate safety culture improvement plan and conducting periodic integrated safety culture assessments, and (5) assessing its current corrective action program (CAP) against NQA-1-2008 and submitting a license amendment request within nine months incorporating the CAP into its license. In recognition of these actions, the NRC agreed to refrain from proposing a civil penalty for this matter.
EA-2010-077	SUPERIOR WELL SERVICES, LTD	SUPERIOR WELL SERVICES, LTD	03034542	1380 ROUTE 286 EAST, SUITE 121	INDIANA	PA	15701	Well Logger	Problem - SL III	$34,000		21-Oct-10	On October 21, 2010, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $34,000 to the Superior Well Services, Ltd (SWS), for two Severity Level III problems. The violations involved the licensee's failure to: (1) secure a shipment of radioactive materials on a public highway to prevent shifting during normal transportation conditions in accordance with 10 CFR 71.5(a); control and maintain constant surveillance of the licensed material in an unrestricted area as required by 10 CFR 20.1802 and notify the NRC of the missing licensed material in accordance with 10 CFR 20.2201(a), (2) conduct required radiological surveys of vehicles before transporting licensed material in accordance with10 CFR 39.67, and the deliberate falsification of survey records for the vehicles. Specifically, on September 20, 2008, while transporting licensed material on a public highway, SWS did not secure a shipment of radioactive materials, and failed to control and maintain constant surveillance of the licensed material for at least ninety minutes, until SWS located and retrieved the sources, and also failed to notify the NRC of the missing licensed material until July 23, 2009, ten months after identifying the event. In addition, on an unspecified number of occasions prior to July 22, 2010, before transporting licensed materials, SWS did not make radiation surveys of the position occupied by each individual in the vehicle and of the exterior of the vehicle used to transport the licensed materials and recorded survey results that were obtained by copying from previous survey records.
EA-2010-080	Calvert Cliffs Nuclear Power Plant, Inc	Calvert Cliffs	05000318	250 West Pratt St. 24th Fl.	BALTIMORE	MD	21201	Operating Reactor	Violation - White Significance			03-Aug-10	On August 3, 2010, the NRC issued a White Significance Determination finding with an associated violation to Calvert Cliffs Nuclear Power Plant (Calvert Cliffs). This White finding involved the licensee's failure to develop and implement scheduled preventive maintenance for Agastat E7000 series time delay relays, as required by Technical Specification 5.4.1. Specifically, subsequent to the approval of Engineering Change Package No. ES200100067, issued in March 2001, the licensee did not replace the relays within the vendor recommended 10-year lifetime, nor establish a performance monitoring program. Consequently, on February 18, 2010, an Agastat E7000 series time delay relay that had a lifetime in excess of 10 years, used in the 2B emergency diesel generator (EDG) protective logic, timed out early and failed to support a demand fast start and run of the 2B EDG. This resulted in the EDG becoming inoperable with the resultant loss of alternating current to the 24 safeguards bus during the dual unit trip that occurred on February 18, 2010.

EA-2010-081	V. A , DEPARTMENT OF	V A , DEPARTMENT OF	03034325	2200 FORT ROOTS DRIVE	NORTH LITTLE RO	AR	72114	Hospital	Violation - SL III Violation - SL III	$39,000			On August 23, 2010, the NRC issued a Notice of Violation (Notice) and Proposed Imposition of Civil Penalty in the amount of $39,000 to the Department of Veteran Affairs (VA) for two Severity Level III violations involving: (1) the failure to implement 10 CFR 35 41(a)(2) and 10 CFR 35 41(b)(2) requirements for verifying medical treatments, and (2) the failure to implement 10 CFR 35 3045(c) requirements to report a medical event. Additionally, the Notice issued a Severity Level III violation for three examples of both 10 CFR 35 41(a)(2) and 35 41(b)(2) violations involving five patients at the VA Boston Healthcare System during 2005, which is also beyond the statute of limitations time period such that a civil penalty was not assessed. Specifically, for the first set of violations assessed a civil penalty, several facilities are identified and involve multiple examples of the licensee's failure to verify that the administration of permanent prostate brachytherapy implants was in accordance with the written directives: (i) the VA Sierra Nevada Health Care System in Reno, Nevada, between September 29, 2005 and October 12, 2008; (ii) the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi, between May 2007 and February 2008, and, (iii) the VA Boston Healthcare System in Boston, Massachusetts on September 27, 2005. Further, the Notice identifies that the second violation assessed a civil penalty occurred on October 10, 2008, at the VA New York Harbor Healthcare System in Brooklyn, New York, where the licensee failed to make a timely medical event report regarding a permanent prostate brachytherapy implant when the data available at the time indicated otherwise, with the actual treatment dose less than 69 percent of the prescribed dose.
EA-2010-084	Omaha Public Power Distrct	Fort Calhoun	05000285	444 South 16th St Mall	OMAHA	NE	68102	Operating Reactor	Violation - Yellow Significance			06-Oct-10	On October 6, 2010, the NRC issued a Notice of Violation to Omaha Public Power District for a violation of Technical Specification 5.8.1.a, "Procedures," at Fort Calhoun Station. This violation, which is associated with a Yellow Significance Determination Process finding, involved the licensee's failure to develop an adequate procedure for protecting vital facilities and equipment from external flooding events to the level described in the Updated Final Safety Analysis Report. Specifically, the inspectors identified that the licensee's strategy of using sandbags stacked on top of floodgates would not be effective in protecting the auxiliary building, intake structure, and turbine building basement because the tops of the floodgates were too small to support the necessary number of sandbags. This could have resulted in flooding impacting multiple, redundant trains of equipment required for safe shutdown of the plant.
EA-2010-085	ST. LOUIS TESTING LABORATORIES, INC	ST. LOUIS TESTING LABORATORIES	03005064	2810 CLARK AVENUE	ST. LOUIS	MO	63103	Radiographer	Violation - SL III			31-Aug-10	On August 31, 2010, the NRC issued a Notice of Violation to St. Louis Testing Laboratories, Inc., for a Severity Level III violation involving the failure to ensure each individual who acts as a radiographer or a radiographer's assistant wears a direct reading dosimeter, an operating alarm rate meter, and a personal dosimeter at all times during radiographic operations as required by 10 CFR 34.47(a). Specifically, on October 22, 2009, a radiographer inadvertently left his personal dosimeter in a tool bag inside a permanent radiographic cell while performing radiographic shots.
EA-2010-086	NUCLEAR FUEL SERVICES, INC	NUCLEAR FUEL SERVICES, INC	07000143	P. O. BOX 337, MS 123	ERWIN	TN	37650	Fuel Facility	Problem - SL III	$140,000	$140,000	02-Sep-10	On September 2, 2010, a Notice of Violation, Exercise of Enforcement Discretion, and Proposed Imposition of a Civil Penalty in the amount of $140,000 was issued to Nuclear Fuel Services, Inc. (NFS). This action was based on a Severity Level III problem involving three violations associated with an event which occurred on October 13, 2009. The three violations involved (1) the failure to have adequate engineered or administrative controls for operations of the bowl cleaning station in violation of 10 CFR 70.61(b), (2) the failure to comply with multiple facility operating procedures regarding the facility system change process; and (3) the failure to maintain records necessary to support NFS's determination that specific facility changes did not require prior NRC approval in violation of 10 CFR 70.72. Specifically, during routine facility operations in the uranium-aluminum line of the Blended Low-enriched Uranium Preparation Facility, nitric acid was added into the bowl cleaning stations which contained small particles of high-enriched uranium scrap material, and the resultant solution produced an unexpectedly high exothermic chemical reaction deforming some of line process piping. The temperatures from the reaction created excess nitrogen compound gases which resulted in the evacuation of the building. Although the failure to have adequate engineered or administrative controls for operations of the bowl cleaning station did not result in any actual personnel exposure consequences in this case, a more significant event could have resulted in a high consequence occupational exposure under different circumstances. In recognition of particularly poor licensee performance and previous escalated enforcement history, the NRC exercised enforcement discretion and doubled the $70,000 Civil Penalty derived from the normal civil penalty assessment process.
EA-2010-094	Duke Energy Corp	Oconee	05000287	P. O. Box 1006	CHARLOTTE	NC	28201	Operating Reactor	Violations - Yellow & White Significance Violation - SL III			12-Aug-10	On August 12, 2010, the NRC issued a Yellow and a White finding with associated violations and a Notice of Violation (NOV) for a Severity Level III violation to Duke Energy Carolinas, LLC (Duke) as a result of inspections at the Oconee Nuclear Station Units 1, 2 and 3. The Yellow finding involved the failure to ensure the Standby Shutdown Facility (SSF) Reactor Coolant Makeup (RCM) subsystem for all three units remained operable as required by Technical Specifications. The White finding involved the failure to identify and correct Unit 2 and Unit 3 SSF RCM letdown line degradation in a timely manner after degradation was identified on Unit 1, as required by 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." A 10 CFR 50.9, "Completeness and Accuracy of Information," NOV for a Severity Level III violation was also assessed to Duke for submitting materially inaccurate information. Duke provided information which described an alternate flow path that could be used to control pressurizer level during an SSF event. However, it was discovered that this flow path was not available due to a closed manual valve inside containment.
EA-2010-096	GE VALLECITOS NUCLEAR CENTER	GE VALLECITOS NUCLEAR CENTER	07000754	6705 VALLECITOS ROAD	PLEASANTON	CA	94586	Fuel Facility	Violation - SL III			16-Dec-10	On December 16, 2010, the NRC issued a Notice of Violation to GE-Hitachi Nuclear Energy Americas for two Severity Level III violations involving the failure to implement Special Nuclear License SNM-960 Condition S-9 and 10 CFR 20.1501. Specifically, on February 16, 2010, one worker identified contamination on his wrist at 240-260 corrected counts per minute, but failed to log the personnel contamination as required by licensee procedure; and on February 16, 2010, the licensee did not make or cause to be made surveys that were reasonable under the circumstances to evaluate the concentrations or quantities of radioactive material.
EA-2010-100	MATTINGLY TESTING SERVICES, INC	MATTINGLY TESTING SERVICES, IN	03020636	12555 W. ANDREWS LN	MOLT	MT	59057	Radiographer	Order - Revocation			02-Sep-10	On September 2, 2010, the NRC issued an Order Revoking License (Immediately Effective) to Mattingly Testing Services, Inc., for multiple violations of NRC requirements. Specifically, (1) on various dates beginning on May 3, 2009, the licensee, in part deliberately, failed to implement specified actions required by Confirmatory Order (EA-08-271) involving: (i) conducting an assessment of the radiation safety program, (ii) providing initial safety training to the licensee staff, (iii) ensuring that an independent consultant's recommended program improvements were provided within 30 days of completing the required reviews, (iv) providing the independent consultant's 2009 annual audit results to the NRC, (v) conducting the initial field audit of radiography operations by the independent consultant by May 3, 2009, and (vi) submitting a required license amendment request by May 3, 2009; (2) from May 13, 2006 through September 9, 2009, the licensee deliberately failed to establish and maintain a prearranged response plan with the Local Law Enforcement Agency (LLEA) in accordance with Increased Controls Order (EA-05-090), Attachment B, Section IC-2(b); (3) on March 6, 2007, the licensee president deliberately failed to provide complete and accurate information to an NRC inspector in accordance 10 CFR 30.9, regarding the licensee's effort to establish a prearranged response plan with the LLEA; (4) on October 22, 2009, while under oath, the licensee president deliberately failed to provide complete and accurate information to an NRC investigator in accordance with 10 CFR 30.9 regarding the licensee's effort to establish a prearranged response plan with the LLEA; (5) on July 4, 16, and August 29-30, 2009, the licensee failed to maintain a dependable means to detect, assess, and respond to unauthorized access to radioactive materials in accordance with Increased Controls Order (EA-05-090) Appendix B, Section IC-2(c); (6) on June 22, 2009, the licensee failed to properly secure a radiographic exposure device for transport with proper blocking and bracing to prevent loss during transit in accordance with 10 CFR 20.1802, 10 CFR 34.35(d), and 10 CFR 71.5 that led to the device being lost in the public domain; and, (7) on June 22, 2009, the licensee willfully failed to immediately notify the NRC about the lost radiographic exposure device in accordance with 10 CFR 20.2201.
EA-2010-110		AGREEMENT STATE-FLORIDA	15000009					Gauge	Violation - SL III			19-Jul-10	On July 19, 2010, the NRC issued a Notice of Violation to Southern Earth Sciences, Inc (SES), for a Severity Level III violation involving the failure to file NRC Form 241 "Report of Proposed Activities in Non-Agreement States," at least three days prior to engaging in licensed activities within NRC jurisdiction, as required by 10 CFR 150.20. Specifically, between January 2008 and April 2009, SES, a holder of a Florida license, stored or used portable gauges in an area of exclusive federal jurisdiction without a specific license issued by the NRC, nor had SES filed a Form-241 with the NRC.
EA-2010-113		AGREEMENT STATE-ILLINOIS	15000012					Gauge	Violation - SL III			24-Aug-10	On August 24, 2010, the NRC issued a Notice of Violation to Chicago Testing Laboratory, Inc., for a Severity Level III violation involving the possession and usage of byproduct material without authorization from a specific or general license. Specifically, on multiple occasions between July 6, 2006, and August 30, 2009, Chicago Testing Laboratory, Inc., an Agreement State licensee, possessed and used devices containing sealed sources in a non-Agreement State, and was not authorized in either a specific or general license.
EA-2010-124	WESTINGHOUSE ELECTRIC COMPANY LLC	WESTINGHOUSE ELECTRIC COMPANY	07001151	DRAWER R	COLUMBIA	SC	29250	Fuel Facility	Problem - SL III	$17,500	$17,500	03-Nov-10	On November 3, 2010, a Notice of Violation and Proposed Imposition of a Civil Penalty in the amount of $17,500 was issued to Westinghouse Electric Company, Commercial Nuclear Fuel Division, for a Severity Level III problem involving two violations associated with a spill of uranium bearing ammoniated waste water inside the plant on January 25, 2010. Specifically, the violations involved (1) the failure to identify in the Integrated Safety Analysis (ISA) that a spill in the quarantine tank system could lead to an intermediate consequence event as required by 10CFR70.62(c)(1), and (2) the failure to designate items relied on for safety (IROFS) to limit the risk of an intermediate consequence event resulting from an overflow of the quarantine system as required by 10CFR70.61(e). In addition, two Severity Level IV violations involving failure to follow license condition requirements, and a Severity Level IV problem involving three violations associated with failure to follow Site Emergency Plan requirements were issued.
EA-2010-135	ANALYTICAL BIO-CHEMISTRY LABS , INC	ANALYTICAL BIO-CHEMISTRY LABS	03005154	7200 E. ABC LANE	COLUMBIA	MO	65205	Other	Violation - SL III			13-Oct-10	On October 13, 2010, the NRC issued a Notice of Violation to Analytical Bio-Chemistry Laboratories, Inc., for a Severity Level III problem involving two violations. The first violation involves the failure to notify the NRC in writing within 60 days of the decision to permanently cease principal activities in any separate building that contains residual radioactivity and is unsuitable for release as required by 10 CFR 30.36(d)(2). Specifically, as of February 2010, the licensee decided to permanently cease principal activities in two buildings that contained residual radioactivity, and the NRC was not notified until June 30, 2010, and July 14, 2010. The second violation involves the failure to submit a decommissioning plan and receive NRC approval of procedures used in aggressive remediation activities as required by 10 CFR 30.36(g). Specifically, on June 22, 2010, the licensee demolished and removed contaminated countertops, floors, and fume hoods with associated ventilation ducts. These types of activities involved techniques not routinely applied during cleanup or maintenance operations such that there was the potential for health and safety impacts to the workers.
EA-2010-138	UNIVERSAL ENGINEERING SCIENCES, INC	UNIVERSAL ENGINEERING SCIENCES	03038028	3532 MAGGIE BOULEVARD	ORLANDO	FL	32811	Gauge	Violation - SL III			27-Aug-10	On August 27, 2010, the NRC issued a Notice of Violation to Universal Engineering Sciences, Inc. (UES), for a Severity Level III violation involving the failure to file NRC Form 241 "Report of Proposed Activities in Non-Agreement States," at least three days prior to engaging in licensed activities within NRC jurisdiction, as required by 10 CFR 150.20. Specifically, UES used portable gauges containing sealed sources, at numerous areas of exclusive federal jurisdiction within the States of Florida and Georgia, without obtaining a specific license issued by the NRC or filing NRC Form-241 with the NRC, as required.
EA-2010-140	ARMY, DEPARTMENT OF THE	ARMY, DEPARTMENT OF THE	03001317	6900 GEORGIA AVENUE, NW	WASHINGTON	DC	20307	Hospital	Problem - SL III			25-Oct-10	On October 25, 2010, the NRC issued a Notice of Violation to the Walter Reed Army Medical Center (WRAMC), for a Severity Level III problem. The violations involved the licensee's failure to control and maintain constant surveillance of the licensed material in an unrestricted area as required by 10 CFR 20.1802 and failure to conduct operations so that the dose in any unrestricted area from external sources did not exceed 0.002 rem (0.02 millisievert) in any one hour. Specifically, between May 1 and 3, 2010, WRAMC did not control and maintain constant surveillance of packages containing licensed radioactive materials, which were improperly stored by WRAMC personnel in an unrestricted area under a counter in the concierge workstation, resulting in a dose greater than 0.002 rem in any one hour within the first floor lobby of the WRAMC.

EA-2010-141	CHRISTIANA CARE HEALTH SERVICES	CHRISTIANA CARE HEALTH SERVICE	03001303		WILMINGTON	DE	19899	Hospital	Violation - SL III			24-Aug-10	On August 24, 2010, the NRC issued a Notice of Violation to the Christiana Care Health Services (CCHS), for a Severity Level III violation involving the failure to develop and maintain written procedures to provide high confidence that each administration requiring a written directive was performed in accordance with the written directive as required by 10 CFR 35 41. Specifically, CCHS's written procedures for high dose rate remote afterloader (HDR) treatments did not: (i) include a quality assurance process to test and evaluate proper functioning of all measurement tools used to determine treatment parameters; and, (ii) specify how personnel should respond when unknown and questionable treatment distances were encountered during HDR simulation measurements. As a result of these procedural inadequacies, a medical event occurred, in which the patient received a dose to unintended tissue and did not receive the prescribed dose to the intended tissue during an HDR treatment conducted between January 18 and January 22, 2010
EA-2010-171	ST. FRANCIS HOSPITAL & MEDICAL CTR	ST. FRANCIS HOSPITAL & MEDICAL	03001246	114 WOODLAND STREET	HARTFORD	CT	06105	Hospital	Violation - SL III			10-Nov-10	On November 10, 2010, the NRC issued a Notice of Violation to St. Francis Hospital and Medical Center (St. Francis) for a Severity Level III violation involving the failure to meet the physical presence requirements of 10 CFR 35 615(f)(2) during high dose radiation (HDR) treatments. Specifically, on July 1, 2010 and other occasions prior to that date, a St. Francis authorized medical physicist was not physically present during initiation and continuation of patient treatments involving the HDR unit
EA-2010-174	McConnell Dowell	American Samoa						Gauge	Violation - SL III			06-Oct-10	On October 6, 2010, the NRC issued a Notice of Violation to McConnell Dowell (American Samoa), Ltd., for a Severity Level III violation involving the receipt, possession, and usage of byproduct material without authorization from a specific or general license as required by 10 CFR 30 3(a). Specifically, as early as 2008 to July 26, 2010, the licensee received, possessed and used two portable nuclear gauges in American Samoa, an area of exclusive Federal jurisdiction, without a specific license issued by the U.S. Nuclear Regulatory Commission
EA-2010-182	SANFORD MEDICAL CENTER	SANFORD MEDICAL CENTER	03003249	P.O. BOX 5039	SIOUX FALLS	SD	57117	Hospital	Violation - SL III			12/10/2010	On December 10, 2010, the NRC issued a Notice of Violation to Sanford Medical Center for a Severity Level III violation involving the failure to secure the high dose-rate remote (HDR) afterloader brachytherapy unit in accordance with License Condition 19 A and Section 3 3.1.1 of Standard Operating Procedure, NM-X2, "Radiation Safety Procedures for the Nucletron Microselectron HDR, Version 2." Specifically, on June 15 through July 29, 2010, the licensee failed to secure the HDR afterloader unit from unauthorized removal or access from its storage area when the unit was not in use because a mechanical locking mechanism failed to function as designed, leaving the unit unsecured
EA-2010-192	Carolina Power & Light Co	Brunswick	05000325	P. O. Box 1551	RALEIGH	NC	27602	Operating Reactor	Violation - White Significance			21-Dec-10	On December 21, 2010, the NRC issued a violation of 10 CFR 50 54(q) associated with a White Significance Determination Process finding involving the failure to follow and maintain in effect Emergency Plans which required activation of the Operations Support Center (OSC), Technical Support Center (TSC), and Emergency Operations Facility (EOF) within 60 to 75 minutes following the declaration of an Alert or higher emergency classification. Specifically, on June 6, 2010, the licensee failed to activate the OSC, TSC, and EOF until approximately two and one-half hours after an Alert was declared
EA-2010-205	Carolina Power & Light Co.	Robinson	05000261	P. O. Box 1551	RALEIGH	NC	27602	Operating Reactor	Violation - SL III			07-Dec-10	On December 7, 2010, the NRC issued a White finding with associated violation and Notice of Violation (NOV) for a Severity Level III violation to Carolina Power and Light Company (doing business as Progress Energy Carolinas Inc (PEC)) as a result of inspections at the H B. Robinson Steam Electric Plant Unit 2. The White finding involved the failure to identify and correct a problem associated with the "B" Emergency Diesel Generator (EDG) output breaker in 2008. Again in 2009, a similar malfunction caused the EDG to be declared inoperable for a period greater than Technical Specifications. A 10 CFR 50 9, "Completeness and Accuracy of Information," NOV for a Severity Level III violation was also assessed for submitting materially inaccurate information. PEC provided information which stated that the breaker was tested in accordance with a maintenance procedure. However, the NRC determined that they had not conducted full testing in accordance with the procedure, and only completed the instructions for returning the breaker to service.
EA-2010-207	PPL Susquehanna, LLC	Susquehanna	05000388	2 NORTH NINTH STREET	ALLENTOWN	PA	18101	Operating Reactor	Violation - White Significance			10-Dec-10	On December 16, 2010, the NRC issued a White finding to PPL Susquehanna, LLC as a result of inspections at the Susquehanna Steam Electric Plant Unit 1 and 2. The White finding involved inadequate procedures related to the maintenance and operation of the main condenser waterboxes and circulating water system, which resulted in an internal flooding event, a manual scram, and a loss of the normal reactor heat sink. There were no NRC violations associated with the finding.
EA-2010-234	KANSAS STATE UNIVERSITY	KANSAS ST., TRIGA MARK	05000188	DEPT OF NUCLEAR ENG	MANHATTAN	KS	66502	Research Reactor	Violation - SL III			22-Nov-10	On November 22, 2010, the NRC issued a Notice of Violation to Kansas State University for a severity level III violation involving 10 CFR 20 1101(a). Specifically, on or prior to September 22, 2010, the licensee did not implement a radiation protection program commensurate with the scope and extent of licensed activities that was sufficient to ensure compliance with the provisions of the regulations in Part 20. Examples include, (1) On or prior to September 22, 2010, the licensee did not make a survey as required by 10 CFR 20 1501 when the licensee failed to determine the magnitude and extent of radiation levels that would be caused by irradiating oil samples on September 21, 2010 that subsequently resulted, on September 22, 2010, in an unexpected high shallow-dose equivalent of 12 5 rem to the skin of the extremities (hands) of the operator handling the experiment and an unexpected change in the restricted area dose rates that exceeded 50 rem per hour on September 22, 2010; (2) On September 22, 2010, the licensee failed to supply and require the use of extremity monitoring devices to personnel who were likely to receive in 1 year, from sources external to the body, a dose in excess of 10 percent of the limits in 20 1201(a) in that, a person handling oil samples and a sample holder, which read in excess of 50 rem per hour, was not wearing, and had not been issued, extremity monitoring. (3) On or prior to September 22 2010, the licensee did not have an adequate procedure as required by Technical Specification Section 6 3 to assure the safety of personnel within the Laboratory for conducting sample irradiations, in that, Experiment Procedure 1, "Isotope Production," did not require extremity dosimetry – finger rings – for those handling samples. It did not have a maximum sample withdrawal rate, and it did not specify threshold exposure/dose rates (hold points) to clearly indicate at what dose rate a sample should not be withdrawn from the pool
IA-2009-041	BETA GAMMA NUCLEAR RADIOLOGY, INC.	BETA GAMMA NUCLEAR RADIOLOGY,	03035572	P.O. BOX 7891, PMB 372	GUAYNABO	PR	00970	Individual Actor - Materials	Violation - SL III Order - Confirmatory			21-Jan-10	On January 21, 2010, the NRC issued a Notice of Violation (NOV) and Immediately Effective Confirmatory Order to Dr. Perez Monté, former Radiation Safety Officer for Beta Gamma Nuclear Radiology, Inc., (BGNR) to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) mediation session held on October 27, 2009. This enforcement action is based on an apparent deliberate violation of 10 CFR 30.10, which requires, in part, that an employee of a licensee may not deliberately submit to the NRC information that the person submitting the information knows to be incomplete or inaccurate in some respect material to the NRC. Contrary to this requirement, Dr. Perez Monté submitted information known to be inaccurate in some respect material to the NRC, in violation of 10 CFR 30 10(a)(2), and as a result, caused BGNR to maintain inaccurate information contrary to 10 CFR 30 9, in violation of 10 CFR 30 10(a)(1). Dr. Perez Monté agreed to: (1) not serve as RSO at BGNR or other licensed facilities for at least two years and (2) provide outreach to the nuclear medicine community to help deter others from violating NRC regulations. In recognition of these commitments, the NRC agreed to not issue Dr. Perez Monté an Order prohibiting involvement in NRC-licensed activities other than the two year restriction on serving as RSO, and also issued him an NOV containing a SL III violation of 10 CFR 30.10
IA-2009-068	COMMERCE, DEPARTMENT OF	COMMERCE, DEPARTMENT OF	03003732	325 BROADWAY, MC 104 02	BOULDER	CO	80305	Individual Actor - Materials	Order - Prohibition			01-Mar-10	On March 1, 2010, an Order was issued to Mr. Lawrence Gmmm, a former radiation safety officer at the U.S. Department of Commerce's National Institute of Standards and Technology facility in Boulder, Colorado (NIST-Boulder), prohibiting him from involvement in NRC-licensed activities for a period of one year. This enforcement action is based on Mr. Gmmm's deliberate failure to provide complete and accurate information to the NRC in a February 15, 2007 license amendment application requesting authorization for NIST-Boulder to possess and use source and special nuclear material, including plutonium. Specifically, Mr. Gmmm stated that the doors to the laboratory where the sources were to be stored were equipped with a key-card locking system when, in fact, the laboratory had no key-card locking system, was considered an open laboratory, and was typically not locked. Mr. Gmmm also provided inaccurate information regarding internal monitoring of occupationally exposed workers and the use of dosimetry for frequent users of the laboratory, who didn't actually work with the material but who worked in the same laboratories where the materials were stored and used. This represents a violation of 10 CFR 30.10(a)(2), which, in part, prohibits licensee employees from deliberately submitting information to the NRC that the person knows to be incomplete or inaccurate in some material respect
IA-2009-075	Duke Power Company, LLC	McGuire	05000369	P. O. Box 1006	CHARLOTTE	NC	28201	Individual Actor - Reactors	Order - Prohibition			02-Jun-10	On June 2, 2010, an Order was issued to Ms. Mary K Files, a contractor working at McGuire Nuclear Station, prohibiting her from involvement in NRC-licensed activities for a period of five years from the date the Order was issued. This enforcement action is based on Ms. Files deliberate failure to adhere to Duke Energy Carolines, LLC, fitness-for-duty requirements. Specifically, on October 20, 2008, Ms. Files introduced and used marijuana inside the Protected Area at McGuire Nuclear Station.
IA-2009-076	Duke Power Company, LLC	McGuire	05000369	P. O. Box 1006	CHARLOTTE	NC	28201	Individual Actor - Reactors	Violation - SL III			02-Jun-10	On June 2, 2010, a Severity Level III violation was issued to Mr. Dusty Bolman for a violation involving 10 CFR 50 5, "Deliberate Misconduct." While working as a contract welder at the McGuire Nuclear Station, Mr. Bolman became aware of the potential use of marijuana inside the Protected Area, but deliberately failed to immediately report the event to management as required by station procedure
IA-2010-028	MATTINGLY TESTING SERVICES, INC.	MATTINGLY TESTING SERVICES, IN	03020836	12555 W. ANDREWS LN.	MOLT	MT	59057	Individual Actor - Materials	Order - Prohibition			02-Sep-10	On September 2, 2010, the NRC issued an Order (Immediately Effective) Prohibiting Involvement in NRC Activities to Mr. Mark M. Ficek for multiple deliberate violations of NRC requirements and a violation of Confirmatory Order (EA-08-055). The Order specified that Mr. Ficek is prohibited involvement from all NRC-licensed activities for a period of 7 years, and that Mr. Ficek is required to notify the NRC upon initial involvement in NRC-licensed activities for an additional two years after the 7 year prohibition period expires. Specifically, the NRC found that Mr. Ficek, president of Mattingly Testing Services, Inc., (1) deliberately failed to implement the requirements of Confirmatory Order (EA-08-271), which dispositioned a number of willful violations through alternative dispute resolution in 2009, including conducting an assessment of the licensee's safety programs and providing safety training to the licensee's staff; (2) deliberately failed to establish and maintain a prearranged response plan with the Local Law Enforcement Agency (LLEA), as required by Increased Controls Order (EA-05-090), Appendix B, Section IC-2(b); (3) deliberately provided material false information to an NRC inspector during a site visit on March 6, 2007, in violation of 10 CFR 30 10(a)(2), regarding the licensee's effort to establish a preamanged response plan with the LLEA. (4) deliberately provided material false information to an NRC investigator while under oath on October 22, 2009, in violation of 10 CFR 30 10(a)(2), regarding the licensee's effort to establish a preamanged response plan with the LLEA; and, (5) violated the provisions of Confirmatory Order (IA-08-055) Section V.1 which specified that Mr. Ficek was prohibited for 2 years from the date of the Order (March 6, 2009) from engaging in NRC-licensed activities since during the 2 year period Mr. Ficek (i) directed the activities of an NRC-required independent consultant, (ii) assumed the duties of the Radiation Safety Officer to determine the reporting requirements of an event involving a lost radiographic exposure device, (iii) applied, on behalf of the licensee, for reciprocity to use radioactive materials in an Agreement State pursuant to Mattingly's NRC license, and (iv) continued to answer employees' questions about radiation safety issue and to purchase radiographic exposure devices.
IA-2010-026	AREVA NP, INC (LYNCHBURG)	AREVA NP, INC (LYNCHBURG)	07001201	P O BOX 11646	LYNCHBURG	VA	24506	Individual Actor - Fuel Facility				02-Dec-10	On December 2, 2010, the NRC issued a Notice of Violation to Mr. Richard Montgomery, formerly a criticality engineer for AREVA NP, Inc., for a Severity Level III violation involving 10 CFR 71.8, "Deliberate Misconduct", Section (b)(2). Specifically, on December 9, 2009, and March 11 and 18, 2009, Mr. Richard Montgomery deliberately altered (falsified) three transportation documents entitled "Approval to Transit a UK [United Kingdom] Port, associated with an export shipment of special nuclear material from the United States to Germany by Areva NP, Inc."
IA-2010-037 EA-2010-xxx	Southern Nuclear Operating Co., Inc	Hatch	05000321	P O BOX 1295	BIRMINGHAM	AL	35201	Individual Actor - Reactors				20-Oct-10	On October 20, 2010, the NRC issued a Notice of Violation to Mr. Robert B. Hilton, formerly a licensed operator at the Edwin I. Hatch Nuclear Plant, Unit Nos. 1 and 2, for a Severity Level III violation involving 10 CFR 55.53(j). Specifically, on July 19, 2010, Mr. Hilton participated in Southern Nuclear Operating Company's random fitness for duty testing program and subsequently tested positive for marijuana.

IA-2010-035	Exelon Generation Co , LLC	Peach Bottom	05000277	4300 Winfield Road	WARRENVILLE	IL	60555	Individual Actor - Reactors	Violation - SL III			16-Sep-10	On May 14, 2010, the NRC issued a Notice of Violation to Mr. Emery Plaza, formerly a security officer at Peach Bottom Nuclear Power Station, for violations of 10 CFR 50 5(a)(1), and 10 CFR 50 5(a)(2), and was categorized as a Severity level III violation On September 14, 2009, while employed as a security officer at Exelon Generation Company LLC's (Exelon's) Peach Bottom Nuclear Power Station, the individual engaged in deliberate misconduct by deliberately submitting information to Exelon which he knew to be inaccurate in some respect material to the NRC Specifically, during a random drug screen, he deliberately submitted a substituted urine sample, which he certified on the Exelon custody and control form to be his own and to have not been adulterated in any manner, in an effort to subvert the fitness-for-duty test to avoid detection of illegal drug usage, because he knew the sample was adulterated The submittal of this urine sample was material to the NRC because random drug testing is required by NRC regulations in 10 CFP Part 26, Fitness-for-Duty Programs His deliberate misconduct, if not detected, would have caused Exelon to be in violation of the fitness-for-duty program requirements specified in 10 CFR Part 26

Notes:
1. A problem is a grouping of violations
2. Cases involving security-related issues are not included