Case Number	Licensee Name	Facility	Docket Number	Address	City	State	Zip	Type	Actions	SL	Penalty Proposed	Prop CP Date	Imp CP Amount	Imp CP Date	Penalty Paid	Paid Date	Case Summary
IA-2009-035	V. A., DEPARTMENT OF	V. A., DEPARTMENT OF	03034325	2200 FORT ROOTS DRIVE	NORTH LITTLE RO	AR	72114	Individual Actor - Materials	Order - Demand for Information - 05/24/2010 Order - Demand for Information - 05/26/2009 Order - Prohibition - 02/23/2011								On February 23, 2011, the NRC issued an Order prohibiting involvement in NRC licensed activities to Dr. Gary Kao in order to provide the NRC with reasonable assurance that the protection of public health and safety will not be compromised until such time that Dr. Kao provides NRC with sufficient information relative to the corrective actions he has taken to address his part in the medical events that occurred at the VA Philadelphia Medical Center from February 2002 through June 2008, and resulting identified violations (EA-09-038). Specifically, the Order prohibits Dr. Kao's involvement in any NRC licensed activity until rescinded by the NRC, contingent upon Dr. Kao's completing specialized training, demonstrating the ability to correctly identify and report medical events, and providing other documentation to the NRC supporting completion of the requirements specified in the Order. The Order noted that Dr. Kao voluntarily stopped performing brachytherapy treatments and committed to take all necessary and appropriate steps to ensure that he was current on all applicable requirements should he perform brachytherapy treatments in the future. The Order will be effective 20 days after it is published in the Federal Register.
IA-2010-010	V. A., DEPARTMENT OF	V. A., DEPARTMENT OF	03034325	2200 FORT ROOTS DRIVE	NORTH LITTLE RO	AR	72114	Individual Actor - Materials	Order - Demand for Information - 05/24/2010 Order - Other - 02/23/2011								On February 23, 2011, the NRC issued an Order requiring notification of future involvement in NRC licensed or Agreement State regulated activities to Mr. Gregory Desobry in order to provide the NRC with an opportunity to verify the effectiveness of corrective actions that Mr. Desobry had taken in response to his involvement in the medical events that occurred at the VA Philadelphia Medical Center from February 2002 through June 2008 and the resulting identified violations (EA-09-038). Specifically, the Order requires Mr. Desobry to make a one-time notification to the NRC within 20 days of his accepting employment as a medical physicist in NRC licensed or Agreement State regulated activities. The Order noted that Mr. Desobry provided a description of the corrective actions he had taken in a June 28, 2010, reply to a Demand for Information that the NRC issued on May 24, 2010. The Order will be effective 20 days after it is published in the Federal Register.
EA-2010-077	SUPERIOR WELL SERVICES, LTD.	SUPERIOR WELL SERVICES, LTD.	03034542	1380 ROUTE 286 EAST, SUITE 121	INDIANA	PA	15701	Well Logger	Problem with Civil Penalty - 10/21/2010 Problem with Civil Penalty - 10/21/2010 Alternative Dispute Resolution - 01/04/2011 Order with Civil Penalty - 02/08/2011		$27,000.00 $7,000.00 $17,000.00	10/21/2010 10/21/2010 02/08/2011			$17,000.00	03/04/2011	On February 8, 2011, the NRC issued an Immediately Effective Confirmatory Order to the Superior Well Services, Ltd. (SWS) to confirm commitments made as a result of an Alternate Dispute Resolution (ADR) mediation session held on January 4, 2011. The licensee requested ADR following the NRC's October 21, 2010, Notice of Violation and Proposed civil penalty of $34,000, for five violations that were categorized into two severity level (SL) III problems. The first SL III problem involved three violations related to the temporary loss of two radioactive well logging sources. The second SL III problem involved two violations related to the deliberate failure to conduct radiological surveys and the creation of inaccurate survey records. As part of the agreement, SWS took number of actions addressing all of the violations, to ensure that the corrective actions are effective, and to ensure that lessons learned from these events are extended to the well logging industry. In addition, SWS took several corrective actions prior to the ADR mediation session. In recognition of SWS's proposed extensive corrective actions, in addition to corrective actions already taken, the NRC agreed to reduce the civil penalty originally proposed to $17,000.
EA-2010-100	MATTINGLY TESTING SERVICES, INC.	MATTINGLY TESTING SERVICES, INC.	03020836	12555 W. ANDREWS LN.	MOLT	MT	59057	Radiographer	Order - Revocation - 09/22/2010 Order - Revocation - 09/02/2010 Hearing - 09/22/2010 Order - Other - 02/22/2011								On February 22, 2011, the NRC ASLB Hearing Board issued a Memorandum and Order accepting a Settlement and Dismissing the Hearing Proceeding in the matters of Mattingly Testing Services, Inc., (MTS) Order Revoking License (EA-10-100) and Mark M. Ficek Order Prohibiting Engagement in NRC-licensed Activities (IA-10-028) that were both issued on September 2, 2010. Specifically, the NRC staff and two parties, employees of MTS, who had requested a hearing on the September 2 Orders had agreed to a settlement on February 4, 2011, in lieu of continuing the hearing proceeding. The Settlement Agreement was forwarded to the ASLB and approved. The February 22, 2011 Board Order superseded the September 2, 2010 Order Revoking License issued to MTS and the Order Prohibiting Engagement in NRC-licensed Activities issued to Mark M. Ficek. The Order and Settlement included the following terms and conditions: (1) the MTS license remains revoked and parties agree that it will not be reinstated; (2) Mr. Ficek is prohibited from engaging in NRC-licensed activities until September 2, 2017 (the settlement further defines NRC-licensed activities); (3) for a three year period after September 2, 2017, Mr. Ficek is required to notify NRC of employment involving NRC-licensed activities; (4) Mr. Ficek is allowed non-controlling ownership in an NRC licensee, subject to conditions specified in the settlement prohibiting Mr. Ficek's
EA-2010-129	ARMY, DEPARTMENT OF THE	ARMY, DEPARTMENT OF THE	04009083	2511 JEFFERSON DAVIS HIGHWAY	ARLINGTON	VA	22202	Other	Notice of Violation - 08/01/2011	SL III							On August 1, 2011, the NRC issued a Notice of Violation to the Department of the Army (Army) for a Severity Level III violation involving the failure to implement 10 CFR 40.3, "License Requirements." Specifically, from April 1978, when NRC license SUB-459 expired, to the present, the Army continued to possess depleted uranium (DU) associated with the Davy Crockett weapons system in the form of spent fragments of spotting rounds (obtained from 1962 to 1968, and expended prior to 1968) at firing ranges located at the Army's two installations in Hawaii, Schofield Barracks and Pohakuloa Training Area. In addition to the two installations in Hawaii, the Army has also identified the presence of spent DU spotting rounds at other Army installations across the United States.
EA-2010-153	WESTINGHOUSE ELECTRIC COMPANY LLC	WESTINGHOUSE ELECTRIC COMPANY LLC	07001151	5801 BLUFF ROAD	HOPKINS	SC	29061-912	Fuel Facility	Regulatory Conference/PEC - 01/21/2011 Problem - 02/25/2011								On February 25, 2011, a Notice of Violation was issued to Westinghouse Electric Company, Commercial Nuclear Fuel Division, for a Severity Level III problem which existed on and before July 23, 2010, involving three violations associated with the Integral Fuel Burnable Absorber (IFBA) Filter Press used in the waste water handling system. Specifically, the violations involved (1) the failure to establish double contingency for the IFBA filter press to protect against an inadvertent criticality as required by License Condition 6.1.1, (2) the failure to designate items relied on for safety (IROFS) to limit the risk of a high consequence event as required by 10CFR70.61(e), and (3) the failure to designate the passive engineered controls of the IFBA filter press as an IROFS as required by the license and license application based on the conclusion that the accident scenario was not credible. In addition, two Severity Level IV violations were issued involving the failure to establish adequate operating procedures for the filter press and the failure to make a change to facility equipment in accordance with approved procedures.
EA-2010-161	PROFESSIONAL SERV. INDUSTRIES, INC.	PROFESSIONAL SERV. INDUSTRIES, INC.	03033792	1901 SOUTH MEYERS RD.,STE. 400	OAKBROOK TERRAC	IL	60181	Radiographer	Order - Confirmatory - 08/18/2011 Order with Civil Penalty - 08/18/2011						$15,000.00	08/31/2011	On August 18, 2011, the NRC issued an Immediately Effective Confirmatory Order to Professional Service Industries, Inc., confirming commitments reached as part of an alternative dispute resolution (ADR) mediation settlement agreement. The NRC identified eight apparent safety violations as well as apparent security-related violations involving the performance of industrial radiography in the Rock Springs, Wyoming, area. In addition, the NRC indicated that willfulness on the part of an office manager and a radiographer appeared to have been a factor in two of the apparent violations. PSI made no admission that they deliberately violated any NRC requirement. As part of the agreement, PSI agreed to take several corrective actions involving increased management oversight and individual accountability including, but not limited to: (1) developing and implementing a disciplinary program managed by the corporate staff that provides a graded approach for radiation safety and security infractions; (2) enhanced routine and refresher training for staff; (3) annual safety culture training for Radiation Safety Officers; (4) enhanced annual audits of the Radiation Safety Program; and (5) advance notification if PSI will be working in NRC jurisdiction under reciprocity. PSI also agreed that a Confirmatory Order with a Notice of Violation and $15,000 civil penalty would be issued in order to avoid further action by the NRC. Prior to any enforcement action by the
EA-2010-231	ALASKA INDUSTRIAL X-RAY, INC.	ALASKA INDUSTRIAL X-RAY, INC.	03010346	4047 KINGSTON DRIVE	ANCHORAGE	AK	99504	Radiographer	Alternative Dispute Resolution - 04/19/2011 Order - Confirmatory - 06/07/2011 Order with Civil Penalty - 06/07/2011		$1,000.00	06/07/2011			$1,000.00 $1,000.00	06/17/2011 06/17/2011	On June 7, 2011, a Confirmatory Order (effective immediately) was issued to Alaska Industrial X-Ray Inc. (AIX) to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) settlement agreement. During inspection and investigation, NRC identified a deliberate violation associated with two conditions of the Order Modifying License (EA-08-195): (1) failure to have an independent consultant or contractor perform field audits and submit the audit reports to AIX, and the NRC, as required by Condition 1 of the Order, from August 2008 through March 2010 and (2) failure to have an independent consultant or a contractor evaluate the effectiveness of AIX's radiation safety program, as required by Condition 3 of the Order, from September 2008 through October 2010. In response to these violations, the licensee requested ADR. As part of the agreement, AIX agreed to take a number of actions including training for all AIX employees engaged in licensed activities on what is meant by willfulness, conducting an annual review of its radiation safety and compliance program by an independent auditor, conducting quarterly audits of AIX radiographers as they perform radiography, and paying a civil penalty in the amount of $1,000.

A/1

EA-2010-257	Carolina Power & Light Co.	Robinson 2	05000261	P. O. Box 1551	RALEIGH	NC	27602	Operating Reactor	Notice of Violation - 01/31/2011 Notice of Violation - 01/31/2011	White White							On January 31, 2011, the NRC issued a Notice of Violation to Carolina Power and Light Company for two violations associated with two White Significance Determination Process findings. The first violation involved the failure to adequately implement requirements, as required by Technical Specifications 5.8.1, "Procedures," of multiple procedures during an uncontrolled cooldown of the Reactor Coolant System (RCS) and subsequent safety injection. Specifically, on March 28, 2010, following a reactor trip, the licensee: (1) failed to take required procedural actions to stop an uncontrolled cooldown that resulted in a safety injection; (2) failed to identify a loss of component cooling water flow to the thermal barrier heat exchangers coincident with a failure to identify a loss of charging pump suction that resulted in inadequate seal injection flow, (3) re-energized electrically faulted equipment that damaged surrounding equipment and resulted in electrical ground alarms, which required an Alert emergency declaration. The second violation involved failure to adequately design and implement operator training based on learning objectives as required by 10 CFR 55.59(c)4. Specifically, prior to March 28, 2010, training lesson material failed to identify the basis of a procedural action involving reactor coolant pump seal cooling, as required by a systems approach to training, as defined in 10 CFR 55.4.
EA-2010-258	BOZEMAN DEACONESS FOUNDATION	BOZEMAN DEACONESS FOUNDATION	03033305	915 HIGHLAND BOULEVARD	BOZEMAN	MT	59715	Hospital	Alternative Dispute Resolution - 03/25/2011 Order with Civil Penalty - 07/08/2011		$3,500.00	07/08/2011			$3,500.00	07/22/2011	On July 8, 2011, a Confirmatory Order (effective immediately) was issued to Bozeman Deaconess Hospital (BDH) to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) settlement agreement. During inspection and investigation, NRC identified two willful violations. The violations involved the failures to secure licensed materials from unauthorized removal or access as required by 10 CFR 20.1801 and to control and maintain constant surveillance of licensed material as required by 10 CFR 20.1802. In response to these violations, the licensee requested ADR. BDH agreed to take a number of actions as part of this Confirmatory Order: providing training to hospital staff and managers involved in NRC licensed activities by an independent third-party organization; modifying the internal requirements for new worker training and for its annual refresher training; developing and implementing a procedure that allows hospital employees and contractors to raise radiation safety concerns to hospital management; and paying a civil penalty in the amount of $3,500.
EA-2010-272	Carro & Carro Enterprises, Inc.							Radiographer	Notice of Violation - 02/11/2011	SL III							On February 11, 2011, the NRC issued a Notice of Violation to Carro & Carro Enterprises, Inc. (CCE) for a severity level III violation involved CCE's failure to obtain authorization in a specific NRC license to own and possess the portable moisture density gauge, which contained byproduct material. Specifically, from November 30, 2008, through June 28, 2009, CCE owned and/or possessed byproduct material, a discrete radium-226 source contained in a portable moisture density gauge, without authorization in a specific or general license issued in accordance with NRC regulations.
EA-2011-008	BRISTOL HOSPITAL, INC.	BRISTOL HOSPITAL, INC.	03001249	P.O. BOX 977	BRISTOL	CT	060110977	Hospital	Notice of Violation - 02/17/2011	SL III							On February 17, 2011, the NRC issued a Notice of Violation to Bristol Hospital, Inc. for a Severity Level III violation involving the failure to notify the NRC Operations Center of two medical events, in accordance with 10 CFR 35.3045(c), which requires a report within the next calendar day of discovery. Specifically, on January 12, 2010, Bristol Hospital experienced two medical events involving patients receiving less than the intended prescribed dose during two different permanent prostrate brachytherapy seed implants. The administered doses differed from the prescribed doses by 50 rem to an organ or tissue, and the total doses differed by greater than 20 percent from the prescribed doses. As of March 1, 2010, Bristol Hospital personnel had information available to determine that these medical events had occurred on January 12, 2010, and should have therefore reported the events by March 2, 2010. However, the licensee did not verbally report the events to the NRC until June 2, 1010 following NRC questioning of the circumstances during an inspection.
EA-2011-009	DEL VALLE GROUP	DEL VALLE GROUP	03038392	P.O. BOX 2319	TOA BAJA	PR	00951-231	Gauge	Notice of Violation - 05/11/2011	SL III							On May 11, 2011, the NRC issued a Notice of Violation to Del Valle Group (DVG) for a Seventy Level III violation involving the failure to obtain authorization in a specific NRC license to own and possess three portable moisture density gauges, as required by 10 CFR 30.3(a). Specifically, from November 30, 2008 through October 28, 2010, DVG owned and/or possessed byproduct material (discrete radium-226 sources contained in three portable moisture density gauges) without authorization in a specific or general license issued in accordance with NRC regulations.
EA-2011-010	OAKWOOD HOSPITAL - ANNAPOLIS CENTER	OAKWOOD HOSPITAL - ANNAPOLIS CENTER	03002099	33155 ANNAPOLIS AVENUE	WAYNE	Mi	48184	Hospital	Problem - 03/04/2011 Notice of Violation - 03/04/2011 Notice of Violation - 03/04/2011	SL III SL III							On March 4, 2011, the NRC issued a Notice of Violation to Oakwood Hospital – Annapolis Center for a Severity Level III problem involving: (1) the licensee's usage of a dose that differed from the prescribed dose by more than 20 percent which is contrary to 10 CFR 35.63(d), and (2) the failure to verify that the assayed dosage was within 10 percent of the prescribed activity as required by License Condition 15.A. Specifically, the licensee administered approximately 124.5 millicuries of sodium pertechnetate technetium-99m (Tc-99m) to a patient instead of the prescribed dosage of 10 millicuries of Tc-99m tetrofosmin, a difference in excess of 20 percent. The licensee failed to verify that it had the correct syringe which resulted in the incorrect radiopharmaceutical and dosage being administered to the patient.
EA-2011-016	Community Health Network, Inc.	Community Health Network, Inc.	03001625	1500 N. RITTER AVENUE	INDIANAPOLIS	IN	46219	Hospital	Notice of Violation - 04/20/2011	SL III							On April 20, 2011, the NRC issued a Notice of Violation to the Community Hospitals of Indiana for a Severity Level III violation involving the failure to fully implement procedures to provide high confidence that a brachytherapy treatment was in accordance with the written directive as required by 10 CFR 35.41(a). Specifically, on September 30, 2010, an authorized medical physicist missed a step in the procedure that established the starting position for the high dose remote afterloader brachytherapy treatment. The failure to implement this step resulted in a medical event.
EA-2011-018	Tennessee Valley Authority	Browns Ferry 1	05000259	400 W. Summit Hill Dr. ET 12A	KNOXVILLE	TN	37902	Operating Reactor	Regulatory Conference/PEC - 04/04/2011 Notice of Violation - 05/09/2011	Red							On May 9, 2011, the NRC issued a violation of Technical Specifications associated with a Red Significance Determination Process finding involving the failure to implement an IST program in accordance with the American Society of Mechanical Engineers (ASME), Code for Operation and Maintenance of Nuclear Power Plants (OM Code), 1995 Edition, 1996 Addenda, Section ISTC 4.1 In a letter dated June 8, 2011, the Tennessee Valley Authority (TVA) appealed the Final Significance Determination of this Red Finding. The NRC performed an independent review of this finding and in a letter dated August 16, 2011, concluded that TVA failed to establish adequate programs, as required by 10 CFR Part 50.55a(b)3(ii), to ensure that motor-operated valves continued to be capable of performing their design basis safety functions. The inadequacy of TVA programs resulted in the Unit 1 LPCI outboard injection valve, 1-FCV-74-66, being left in a significantly degraded condition and the Unit 1 LPCI/RHR Loop II unable to fulfill its safety function. The basis and outcome of the final risk significance determination evaluation on this Red finding remained unchanged.
EA-2011-022	Luzenac America, Inc.,							Other	Notice of Violation with Civil Penalty - 07/07/2011	SL III					$8,500.00	08/04/2011	On July 7, 2011, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $8,500 to Luzenac America, Inc., for a Severity Level III violation involving the failure to transfer a device containing byproduct material to a licensee authorized to receive it, as required by 10 CFR 31.5(c)(8)(i). Specifically, as of December 2, 2010, Luzenac transferred a fixed nuclear gauge containing byproduct material to a recycling company that was not authorized to receive it.
EA-2011-024	Nebraska Public Power District	Cooper	05000298	1414 15th St.	COLUMBUS	NE	68601	Operating Reactor	Regulatory Conference/PEC - 04/27/2011 Notice of Violation - 06/10/2011	White							On June 10, 2011, the NRC issued a violation of 10 CFR 50, Appendix B, Criterion XVI and Criterion V, associated with a White Significance Determination Process finding involving the failure to establish measures to assure a condition adverse to quality was corrected and ensure the activities affecting quality were prescribed by documented procedures appropriate to the circumstances. Specifically, Violation 05000298/2008008-1, dated June 13, 2008, identified a condition adverse to quality in that two procedures would not work as written. While correcting that violation, the licensee failed to perform sufficient evaluation of the circuits to identify and correct a problem with three motor-operated valves needed to establish core cooling. Failure to correct the condition adverse to quality resulted in inadequate procedures in that they contained steps that were inappropriate to the circumstances because they would not work as written to reposition the three motor-operated valves.

EA-2011-025	Omaha Public Power District	Fort Calhoun	05000285	444 South 16th St. Mall	OMAHA	NE	68102	Operating Reactor	Regulatory Conference/PEC - 06/02/2011 Notice of Violation - 07/18/2011	White							On July 18, 2011, the NRC issued a violation of 10 CFR 50, Appendix B, Criterion XVI, associated with a White Significance Determination Process finding involving the failure to assure that the cause of a significant condition adverse to quality was determined and corrective actions taken to preclude repetition. Specifically, between November 3, 2008 and June 14, 2010, the licensee failed to preclude shading coils from repetitively becoming loose material in the M2 reactor trip contactor. The licensee failed to identify that the loose parts in the trip contactor represented a potential failure of the contactor if they became an obstruction, and therefore, failed to preclude repetition of this significant condition adverse to quality, that subsequently resulted in the contactor failing.
EA-2011-027	WEST VIRGINIA UNIVERSITY HOSPITALS.	WEST VIRGINIA UNIVERSITY HOSPITALS. WEST VIRGINIA UNIVERSTY HOSPITALS.	03020233 03036074	P.O. BOX 9006, MEDICAL CENTER	MORGANTOWN	WV	26506-900	Hospital	Notice of Violation - 03/25/2011	SL III							On March 25, 2011, the NRC issued a Notice of Violation to West Virginia University Hospitals Inc. (WVUH) 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, WVUH did not notify the NRC until July 7, 2010, after discovering that a dose administered on January 20, 2010 differed from the prescribed dose.
IA-2011-012	Entergy Nuclear Operations, Inc.	Palisades	05000255	700 First St.	HUDSON	WI	54016	Licensed Operator	Notice of Violation - 03/18/2011	SL III							On March 18, 2011, the NRC issued a Notice of Violation to Mr. Roger A. Shaffer, formerly a licensed operator at the Palisades Nuclear Plant, Unit No. 1, for a Severity Level III violation involving 10 CFR 55.53(j). Specifically, on December 20, 2010, Mr. Shaffer participated in the Entergy Nuclear Operations, Inc random fitness for duty testing program and subsequently tested positive for marijuana.
EA-2011-037	PROVIDENCE HOSPITAL	PROVIDENCE HOSPITAL	03002022	16001 W. NINE MILE ROAD	SOUTHFIELD	MI	48037	Hospital	Notice of Violation - 05/17/2011	SL III							On May 17, 2011, the NRC issued a Notice of Violation to Providence Hospital for a Severity Level III violation involving the failure to develop written procedures to provide high confidence that each administration was in accordance with the written directive as required by 10 CFR 35.41(a). Specifically, as of August 30, 2010, the licensee's brachytherapy procedure did not provide high confidence that the needles would be inserted to the right depth as the licensee did not require the use of available means such as biological or needle markers.
EA-2011-043		AGREEMENT STATE-LOUISIANA	15000017					Radiographer	Order - Confirmatory - 12/19/2011 Order with Civil Penalty - 12/19/2011		$13,500.00	12/19/2011					On December 19, 2011, an Immediately Effective Confirmatory Order was issued to Accurate NDE and Inspection, LLC (Accurate), to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) mediation session held on September 28, 2011. This enforcement action is based on two willful violations involving (1) the failure to maintain accurate personnel monitoring information; and (2) the failure to comply with a state license requirement for radiographers to notify the licensee radiation safety officer (RSO) before attempting to retrieve a disconnected source. Three additional violations were identified involving (1) the failure to wear personnel dosimeters while performing radiographic operations, (2) the failure to conduct a radiation survey when a radiographic exposure device was placed into storage; and (3) the failure to immediately report the loss of a sealed source. Accurate agreed to take a number of actions including (1) providing and recording initial and annual training to deter willful violations and address specified related topics, (2) developing and submitting procedures for training the RSO or any manager designated to be on-call; (3) submitting copies of procedures to the NRC when performing radiographic
EA-2011-047	Dominion Nuclear Connecticut, Inc.	Millstone 2	05000336	Rope Ferry Road	WATERFORD	CT	06385	Operating Reactor	Regulatory Conference/PEC - 07/19/2011 Notice of Violation - 08/08/2011 Notice of Violation - 08/08/2011	White White							On August 8, 2011, the NRC issued a White Significance Determination Process finding and Notice of Violation (NOV) for two violations to Dominion Nuclear Connecticut, Inc. as a result of inspections at the Millstone Power Station Unit 2. The finding was based on multiple human performance errors, and the NOV was based on two violations which involved the licensee's failure to meet its Technical Specifications requirements. Together these failures caused and exacerbated the February 12, 2011, unanticipated eight percent reactor power increase during the main turbine control valve testing.
EA-2011-056	U. S. ENRICHMENT CORP. - PADUCAH	U. S. ENRICHMENT CORP. - PADUCAH	07007001	P. O. BOX 1410	PADUCAH	KY	42001	Fuel Facility	Alternative Dispute Resolution - 07/22/2011 Order - Confirmatory - 08/17/2011								On August 17, 2011, the NRC issued a Confirmatory Order (effective immediately) to the United States Enrichment Corporation (USEC), to confirm commitments made as a result of an Alternative Dispute Resolution (ADR) settlement agreement. During an investigation NRC identified a violation involving an incident in which an operator deliberately violated applicable radiation protection procedures. Specifically, the violation involved the failure to adhere to the requirements of a USEC Paducah procedure that requires personnel to perform a whole body frisk when exiting from areas controlled for removable contamination. In response, the USEC requested ADR in an attempt to resolve the enforcement matter. USEC agreed to take a number of actions as part of this Confirmatory Order. These actions included a prompt investigation into the incident, the conduct of multiple staff briefings by USEC-Paducah management, procedural reviews and revisions as warranted, appropriate retraining and communication of lessons learned to staff, a review of the circumstances that took place during the routine operational activities that resulted in the existence of contaminated material, and disciplinary action for the employee involved in the incident. In addition, USEC committed to enhancing new employee orientation and General Employee Training at Paducah to ensure that personnel clearly understand the consequences of deliberate acts of non-compliance with regulations or procedures, and expanding its independent, Safety Conscious Work
EA-2011-061	ESCANABA PAPER COMPANY	ESCANABA PAPER COMPANY	03013087	P. O. BOX 757	ESCANABA	MI	498290757	Gauge	Notice of Violation - 10/17/2011	SL III							On October 17, 2011, the NRC issued a Notice of Violation to Escanaba Paper Company for a Severity Level III violation involving the failure to ensure that only persons specifically licensed by the U.S. Nuclear Regulatory Commission (NRC) or an Agreement State perform services involving the dismantling and non-routine maintenance or repair of components related to the radiological safety of the gauge. Specifically, on May 9, 2011, the licensee performed non-routine maintenance on a fixed level gauge by using a rod to change the position of the shutter contrary to NRC License No. 21-17630-01, Condition 17.B. The licensee was not specifically licensed by the NRC or an Agreement State to perform this service.
EA-2011-083	Southern California Edison Co.	San Onofre 2 San Onofre 3	05000361 05000362	P.O. BOX 800	ROSEMEAD	CA	91770	Operating Reactor	Notice of Violation - 08/04/2011	SL III							On August 4, 2011, the NRC issued a Notice of Violation to SONGS for a Severity Level III violation involving the failure to certify that the qualifications and status of a senior operator licensee were current and valid and that the senior operator licensee had completed a minimum of 40 hours of shift functions under the direction of an operator or senior operator, as required by 10 CFR 55.53(e) and (f). Specifically, on October 21 and October 27, 2010, the licensee did not certify that qualifications of the senior operator licensee were current and valid and scheduled the senior operator to perform licensed activities (core alterations) as refueling senior operator supervisor while his license was INACTIVE. Additionally, the senior operator was not medically qualified in accordance with ANSI 3.4 (1996) to perform licensed duties.
EA-2011-086	INTERNATIONAL CYCLOTRON, INC.	INTERNATIONAL CYCLOTRON, INC.	03037882	CALLE JOSE MARTI #56	HATO REY	PR	00918	Materials Distributor	Regulatory Conference/PEC - 08/30/2011 Notice of Violation with Civil Penalty - 12/19/2011 Order - Suspension - 12/19/2011	SL III	$7,000.00	12/19/2011			$7,000.00	12/27/2011	On December 19, 2011, the NRC issued a Notice of Violation and Proposed Imposition of a Civil Penalty in the amount of $7000, and an Order suspending licensed activities within 60 days, to International Cyclotron, Inc. (ICI), for a Severity Level III violation of 10 CFR 30.35. The violation involved ICI's failure to provide a decommissioning funding plan. Specifically, on August 20, 2009, ICI was issued an NRC license authorizing the possession and use of unsealed byproduct material of applicable quantities set forth in Appendix B to 10 CFR Part 30 and ICI has not provided a decommissioning funding plan that contains a signed original of the financial instrument obtained to provide financial assurance for decommissioning, as required by 10 CFR 30.35. Further, based on ICI's failure to fully and timely respond to repeat NRC requests for information, and to compel ICI to comply with NRC regulations, the NRC issued an Order Suspending Licensed Activities (Order). According to this Order, if ICI does not submit to the NRC an acceptable financial assurance instrument within 60 days of the date of the Order, ICI is required to suspend all activities authorized under its License. This Order will remain in effect until ICI submits a financial assurance instrument and the NRC informs ICI that the instrument is accepted.
EA-2011-088	HENRY FORD MACOMB HOSPITAL	HENRY FORD MACOMB HOSPITAL	03002106	15855 19 MILE ROAD	CLINTON TOWNSHI	MI	48038	Hospital	Notice of Violation - 06/24/2011	SL III							On June 24, 2011, the NRC issued a Notice of Violation to Henry Ford Macomb Hospital for 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 the written directive as required by 10 CFR 35.41(a). Specifically, as of December 9, 2010, the licensee's procedure did not include steps to verify that the transfer tube assembly used at the time of the administration was the same length as the one identified in the treatment plan implementing the written directive. This resulted in four patients receiving radiation doses to areas not included within the planned treatment area.

EA-2011-094	MERCY HOSPITAL	MERCY HOSPITAL	03002016	1500 EAST SHERMAN BOULEVARD	MUSKEGON	MI	49444	Hospital	Notice of Violation - 06/08/2011	SL III							On June 8, 2011, the NRC issued a Notice of Violation to Mercy Hospital for a Severity Level III violation involving the failure to develop, implement, and maintain written procedures to provide high confidence that each administrabon is in accordance with the written directive as required by 10 CFR 35.41(a). Specifically, between June 18, 2008 and February 23, 2011, the licensee performed approximately 200 high dose-rate (HDR) remote afterloader administrations requiring written directives, and failed to develop written procedures to provide high confidence that each administration was in accordance with the written directive.
EA-2011-095	GLOBAL NUCLEAR FUEL - AMERICAS, LLC	GLOBAL NUCLEAR FUEL - AMERICAS, LLC	07001113	P. O. BOX 780	WILMINGTON	NC	284020780	Fuel Facility	Regulatory Conference/PEC - 09/29/2011 Notice of Violation with Civil Penalty - 11/14/2011	SL III					$17,500.00	12/07/2011	On November 14, 2011, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $17,500 to Global Nuclear Fuel-Americas, LLC for a Severity Level (SL) III problem involving the failure to maintain the double contingency principle as it was compromised during the operation of the sinter test grinder and the risk of a high consequence event (criticality accident) increased. The NRC determined that five violations of NRC requirements directly related to the root causes that allowed the event occurred. Specifically, (1) on March 1, 2011, the licensee failed to ensure that a process design incorporated sufficient margins of safety to require at least two unlikely, independent, and concurrent changes in process conditions before a criticality accident was possible; (2) on March 1, 2011, the licensee failed to apply sufficient controls to the extent needed to reduce the likelihood of occurrence of a criticality, high consequence event, in the sinter test grinder HEPA filter enclosure so that, upon implementation of such controls, the event was highly unlikely; (3) on February 4, 2009, the licensee failed to verify as part of the change process that the controls selected and installed for the sinter test grinder HEPA enclosure would limit the UO2 holdup to less than 25 kgs by controlling a differential pressure across the ventilation housing to 4-inches of water or less; (4) on February 18, 2009, the licensee failed to conduct a criticality
EA-2011-096	Entergy Operations, Inc.	River Bend 1	05000458	P.O. BOX 31995	JACKSON	MS	39286	Operating Reactor	Order - Confirmatory - 08/24/2011 Alternative Dispute Resolution - 07/18/2011								On August 24, 2011, the NRC issued a Confirmatory Order (Effective Immediately) to Entergy Nuclear Operations Inc. and Entergy Operations Inc. (collectively Entergy) to formalize commitments made as a result of an ADR mediation session held on July 18, 2011 in Washington DC. By letter dated May 20, 2011, the NRC identified an apparent violation of 10 CFR 50.7 to Entergy Operations Inc. based on the NRC's Office of Investigations, March 17, 2011 report (OI Case No. 4-2010-053). Specifically, the NRC had reached a preliminary conclusion that an employee at the River Bend Station was rated lower in his/her 2008 annual performance appraisal based in part on the employee questioning the qualifications necessary to perform certain work activities in compliance with applicable plant procedure(a). Prior to the issuance of the NRC's May 20, 2011 letter but following a separate NRC inquiry, Entergy conducted its own internal investigation of the circumstances giving rise to the apparent violation. The NRC recognized that as a result of its investigation, Entergy took several specific actions at the River Bend Station and several fleet-wide actions. The fleet-wide actions included conducting supervisory and Employee Concerns Program personnel training on 10 CFR 50.7; reviewing all closed internal retaliation type cases in 2008 and 2009; reviewing all 2009 appraisals for employees with overall "improvement required" rating; and revising several quality-affecting procedures. As a result of the settlement agreement from the ADR mediation session, Entergy agreed to take a number of additional fleet-wide actions. A summary of those fleet-wide actions are: (1) reorganizing the quality control organization's reporting structure; (2) reinforcing the company's commitment to a safety conscious work environment through a written communication from a senior Entergy nuclear executive; (3) reviewing and, as necessary, revising the existing general employee training on 10 CFR 50.7 to include insights from the circumstances giving rise to this matter; (4) reviewing and, as necessary, revising training to new
EA-2011-100	Outside Organization: OWENSBY AND KRITIKOS INC.	GRETNA,Louisiana	15000017					Radiographer	Notice of Violation - 06/08/2011	SL III							On June 8, 2011, the NRC issued a Notice of Violation to the Owensby and Kritikos, Inc., for a Severity Level III violation involving the licensee's failure to control and maintain constant surveillance of the licensed material in an unrestricted area as required by 10 CFR 20.1801 and 20.1802. Specifically, during inspection on July 29, 2010, the radiography camera was found on the floor of the unlocked darkroom and no radiography personnel were maintaining constant surveillance over the material.
EA-2011-109	LIBERTY HOSPITAL	LIBERTY HOSPITAL	03010532	2525 GLENN W. HENDREN DRIVE	LIBERTY	MO	640691002	Hospital	Notice of Violation - 07/22/2011	SL III							On July 22, 2011, the NRC issued a Notice of Violation to Liberty Hospital for a Severity Level III violation involving the failure to develop written procedures to provide high confidence that each administration was in accordance with the written directive as required by 10 CFR 35.41(a). Specifically, as of October 6, 2010, the licensee's procedure did not require the position of the prostate to be verified prior to seed placement. As a result, the prostate received 16.9 Gray (Gy) as opposed to the prescribed dose of 125 Gy.
EA-2011-110	Northern States Power Company - Minnesota	Prairie Island 1 Prairie Island 2	05000282 05000306	700 First St	HUDSON	WI	54016	Operating Reactor	Regulatory Conference/PEC - 07/28/2011 Notice of Violation - 08/17/2011	White							On August 17, 2011, the NRC issued a Notice of Violation to Northern States Power Company for a violation associated with a White Significance Determination Process finding. The violation involved the failure to maintain the direct current electrical power subsystems operable in Modes 1 through 4, as required by Technical Specification 3.8.4 Specifically, from December 21, 1994 to approximately October 22, 2010, all battery chargers in Unit 1 were susceptible to a common mode failure under design basis accident conditions. Under those conditions, the battery chargers would stop providing an output, or "lock-up," when their alternating current input voltage dropped below their nameplate minimum voltage at the battery charger motor control center.
EA-2011-115	CHARLESTON RADIA.THERAPY CONSU,PLLC	CHARLESTON RADIA.THERAPY CONSU,PLLC	03028869	3100 MACCORKLE AVE. SE. STE.B1	CHARLESTON	WV	253041222	Hospital	Notice of Violation - 06/30/2011	SL III							On June 30, 2011, the NRC issued a Notice of Violation to Charleston Radiation Therapy Consultants, PLLC (CRTC) 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 an indeterminate number of occasions on and prior to April 28, 2011, neither a CRTC authorized user (AU), nor a physician under the supervision of an AU, was physically present during continuation of patient treatments involving the HDR unit.
EA-2011-145	CARMEUSE LIME, INC.	CARMEUSE LIME, INC.	03036577	25 MARION AVENUE	RIVER ROUGE	MI	48218	Gauge	Notice of Violation - 09/02/2011 Problem - 09/02/2011	SL III							On September 2, 2011, a Notice of Violation was issued to Carmeuse Lime, Inc., for a Severity Level III Problem involving three violations. The first violation involved the failure to have the individual specifically authorized by Condition 12.A of the license fulfill the duties and responsibilities as the Radiation Safety Officer (RSO). Specifically, the individual left the company in 2007, and the licensee failed to appoint a new RSO and amend its license. The second violation involved the failure to conduct a physical inventory every six months, or at other intervals approved by the NRC, to account for all sealed sources and/or devices received and possessed under the license as required by Condition 15 of the license. The third violation involved the failure to test each gauge for the proper operation of the on-off mechanism (shutter) and indicator, if any, at intervals not to exceed six months or at intervals specified in the certificate of registration as required by Condition 16.B of the license.
EA-2011-146	CARDINAL HEALTH	CARDINAL HEALTH	03036973	7000 CARDINAL PLACE	DUBLIN	OH	43017	Materials Distributor	Notice of Violation - 11/09/2011	SL III							On November 9, 2011, the NRC issued a Notice of Violation to Cardinal Health PET Manufacturing Services, Inc., for a Severity Level III violation involving the failure to monitor the occupational exposure to an adult who was likely to receive, in one year from sources external to the body, an extremity dose in excess of 5 rem as required by 10 CFR 20.1502(a)(1). Specifically, on June 16, 2010, a Cardinal Health PET Manufacturing Services employee removed his extremity (ring) dosimetry on two separate occasions prior to handling a chemical cartridge containing approximately 4 curies of fluorine-18.
IA-2011-037								Individual Actor - Materials	Notice of Violation - 11/09/2011	SL III							On November 9, 2011, the NRC issued a Notice of Violation to Christopher A. Moore, former Radiation Safety Officer at Cardinal Health PET Manufacturing Services, Inc., in St. Louis, Missouri, for a Severity Level III violation involving 10 CFR 30.10, "Deliberate Misconduct." Specifically, on June 16, 2010, Mr. Moore caused Cardinal Health PET Manufacturing Services, Inc., an applicant for an NRC license, to be in violation of 10 CFR 20.1502(a)(1) which requires that a licensee (in this case, an applicant) monitor the occupational exposure to adults likely to receive, in one year from sources external to the body, a dose in excess of 10 percent of the limits in 10 CFR 20.1201(a). The nature of Mr. Moore's position made him subject to 10 CFR 20.1502(a)(1). However, Mr. Moore deliberately removed his extremity (ring) dosimetry on two separate occasions prior to handling a chemical cartridge containing approximately 4 curies of fluorine-18.

EA-2011-148	FirstEnergy Nuclear Operating Co.	Perry 1	05000440	76 South Main St.	AKRON	OH	44308	Operating Reactor	Notice of Violation - 08/25/2011 Notice of Violation - 08/25/2011 Notice of Violation - 08/25/2011	White White White							On August 25, 2011, the NRC issued a Notice of Violation to First Energy Nuclear Operating Company for three violations associated with a White Significance Determination Process finding involving work activity during the retraction of a stuck source range monitor (SRM) from the reactor vessel. The first violation involved the failure to perform an evaluation of the potential radiological hazards associated with the work activity, as required by 10 CFR 20.1501. The second violation involved the failure to perform a complete radiological characterization of the SRM, as required by Technical Specification (T.S.) 5.7.1.b. The third violation involved the failure to establish a procedure that addressed the control of highly radioactive materials removed from the reactor vessel, as well as, the failure to implement a procedure to ensure that the licensee's ALARA plan contained steps to ensure that the ambient radiation field in the work areas were being controlled and that the workers actions were in accordance with ALARA considerations, as required by T.S. 5.4.1.
EA-2011-163	BEAUMONT HEALTH SYSTEM	BEAUMONT HEALTH SYSTEM	03002006	3601 WEST 13 MILE ROAD	ROYAL OAK	MI	480736769	Hospital	Notice of Violation - 09/02/2011	SL III							On September 2, 2011, the NRC issued a Notice of Violation to William Beaumont Hospital for a Severity Level III violation involving the failure to develop written procedures to provide high confidence that each administration was in accordance with the written directive as required by 10 CFR 35.41(a). Specifically, as of May 5, 2011, the licensee's written procedures for yttrium-90 treatments did not specify how personnel should administer a treatment using a fine bore catheter and a high concentration of microspheres in order to prevent blockage within the catheter.
EA-2011-165	CRITTENTON HOSPITAL MEDICAL CENTER	CRITTENTON HOSPITAL MEDICAL CENTER	03002157	1101 W. UNIVERSITY DRIVE	ROCHESTER	MI	483071831	Hospital	Notice of Violation - 09/02/2011	SL III							On September 2, 2011, the NRC issued a Notice of Violation to Crittenton Hospital for a Severity Level III violation involving the failure to develop written procedures to provide high confidence that each administration was in accordance with the written directive as required by 10 CFR 35.41(a). Specifically, between September 2009 and January 2011, the licensee failed to address in its written procedure the need to verify that the step size used in the treatment plan was correctly translated into the high dose rate (HDR) remote afterloader unit. As a result, the device's control unit default step size of 2.5 mm was used instead of the 5 mm used in the treatment planning system.
EA-2011-174	Entergy Nuclear Generation Company	Pilgrim 1	05000293	11 Lincoln Street	Plymouth	MA	02360	Operating Reactor	Notice of Violation - 11/21/2011	White							On November 21, 2011, the NRC issued a Notice of Violation to Entergy Nuclear Operations, Inc. for a violation of Technical Specification 5.4, "Procedures," associated with a White Significance Determination Process finding involving multiple examples of Entergy's failure to conduct safety-related activities as described in written procedures prior to and during a reactor startup operation. Specifically, on May 10, 2011, Pilgrim personnel failed to implement conduct of operations and reactivity control standards and procedures during a reactor startup which resulted in a reactor scram.
EA-2011-179	ASSOCIATED SPECIALISTS, INC.	ASSOCIATED SPECIALISTS, INC.	03037941	527 MEDICAL PARK DR., STE 204	BRIDGEPORT	WV	26330	Hospital	Problem - 09/21/2011								On September 21, 2011, the NRC issued a Notice of Violation to Associated Specialists, Inc. (ASI), for a Severity Level III problem. The violations involved the licensee's failure to: (1) limit operation with a temporary radiation safety officer (RSO) to a period of 60 days, in accordance with 10 CFR 35.24(c); and (2) ensure that its authorized user (AU) provided adequate supervision to licensee staff who were involved in the receipt, possession, use, transfer or preparation of byproduct material, in accordance with 10 CFR 35.27. Specifically, after ASI's RSO left the company on June 8, 2010, the AU functioned as the temporary RSO until October 13, 2010, a period greater than 60 days. And from August 16, 2009 until April 19, 2011, the AU had limited oversight of the program, such that ASI personnel under the supervision of the AU had not spoken to him and had not received instructions associated with ASI's written radiation protection procedures, NRC regulations, ASI's license conditions, and the requirement that supervised individuals follow the instructions of the supervising authorized user for medical uses of byproduct material.
IA-2011-056	Detroit Edison Co.	Fermi 2	05000341	2000 Second Avenue	DETROIT	MI	48226	Licensed Operator	Notice of Violation - 09/21/2011	SL III							On September 21, 2011, the NRC issued a Notice of Violation to Mr. Craig M. Rice, formerly a licensed reactor operator at the Fermi Power Plant, Unit 2, for a Severity Level III violation involving 10 CFR 55.53(j). On April 25, 2011, Mr. Rice participated in the Detroit Edison Company random fitness for duty testing program and subsequently tested positive for an illegal substance.
EA-2011-208	Florida Power Corp.	Crystal River 3	05000302	P. O. Box 1551	RALEIGH	NC	27602	Operating Reactor	Notice of Violation - 12/20/2011	White							On December 20, 2011, the NRC issued a Notice of Violation to Progress Energy for a violation of 10 CFR 50.54(q) associated with a White Significance Determination Process finding involving the failure of Crystal River personnel to maintain in effect a standard emergency classification scheme which included facility effluent parameters. Specifically, for several years prior to June 2011, the General Emergency classification contained effluent radiation monitors threshold values greater than that which the instruments could accurately measure. During an actual emergency, these monitors would have been relied upon to determine initial offsite response measures, to assess the impact of the release of radioactive materials, and to provide criteria for determining the need for notification and participation of local and State agencies.
EA-2011-209	Outside Organization: Warner Brothers, LLC	East Deerfield,Massachusetts	15000020					Gauge	Notice of Violation - 11/08/2011	SL III							On November 8, 2011, the NRC issued a Notice of Violation to Warner Brothers, LLC 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, on December 6, 2006, and July 7, 2008, Warner Brothers LLC, which only holds a Massachusetts license, used a portable gauge containing a sealed source, at temporary jobsites within the State of Connecticut, without obtaining a specific license issued by the NRC or filing NRC Form-241 with the NRC, as required.
EA-2011-219	LINCOLN UNIVERSITY OF MISSOURI c/	LINCOLN UNIVERSITY OF MISSOURI c/	03010534	820 CHESTNUT STREET	JEFFERSON CITY	MO	651020029	Academic	Notice of Violation - 12/19/2011 Notice of Violation - 12/19/2011 Notice of Violation - 12/19/2011 Notice of Violation - 12/19/2011 Notice of Violation - 12/19/2011	SL III SL III SL III SL III SL III							On December 19, 2011, the NRC issued a Notice of Violation to Lincoln University of Missouri for a Severity Level III problem involving multiple violations of license conditions and NRC regulations. Specifically, the licensee failed to: (1) ensure that the individual named on the NRC license fulfilled the responsibilities of the RSO between May 2009 and August 18, 2011; (2) conduct a physical inventory every 6 months to account for all sources and/or devices received and possessed under the license between May 2009 and August 8, 2011; (3) notify the NRC in writing within 60 days of no longer conducting principal activities for a period of 24 months; (4) maintain records of receipt of radioactive materials for as long as the material was possessed as well as maintain disposal records until termination of the NRC license; and (5) comply with the applicable requirements for performing leak tests and inventories of generally licensed devices.
EA-2011-221	Exelon Generation Co., LLC	Limerick 2	05000353	4300 Winfield Road	WARRENVILLE	IL	60555	Operating Reactor	Notice of Violation - 12/08/2011 Notice of Violation - 12/08/2011	White White							On December 8, 2011, the NRC issued a White Significance Determination Process finding and a Notice of Violations for two violations to Exelon Generation Company, LLC. as a result of inspections at the Limerick Generating Station, Unit 2. The White finding was based on the failure to ensure that sufficient technical guidance was contained in an operating procedure. This failure resulted in two valves failing to fully shut, which rendered two reactor systems inoperable for greater than the Technical Specification allowed outage time. The two violations are based on the Licensee's failure to: 1) establish adequate procedures; and, 2) exceeding Technical Specifications for two reactor systems.
EA-2011-226	Duke Energy Corp.	Oconee 1 Oconee 2 Oconee 3	05000269 05000270 05000287	P. O. Box 1006	CHARLOTTE	NC	28201	Operating Reactor	Notice of Violation - 12/06/2011	Yellow							On December 6, 2011, the NRC issued a Notice of Violation to Duke Energy Carolinas, LLC for a violation of Title 10 of the Code of Federal Regulations, Part 50, Appendix B, Criterion III, "Design Control," associated with a Yellow Significance Determination Process finding involving Duke Energy's failure to perform a review for suitability of application of equipment essential to safety-related functions of structures, systems, and components. Specifically, Oconee personnel failed to maintain the Standby Shutdown Facility pressurizer heater breakers and associated electrical components in accordance with the licensing and design basis of the plant, which resulted in the Standby Shutdown Facility being inoperable from 1983, until June 1, 2011.

EA-2011-251	Carolina Power & Light Co.	Brunswick 2 Brunswick 1	05000324 05000325	P. O. Box 1551	RALEIGH	NC	27602	Operating Reactor	Notice of Violation - 12/27/2011	White							On December 27, 2011, the NRC issued a Notice of Violation to Carolina Power and Light Company for a violation of Title 10 of the Code of Federal Regulations, Part 50, Appendix B, Criterion XVI, "Corrective Action," associated with a White Significance Determination Process finding involving the failure of Brunswick personnel to promptly identify and correct a condition adverse to quality involving the external flood barrier for the emergency diesel generator fuel oil tank rooms as of April 20, 2011. Specifically, the entrance enclosures which house the emergency diesel generator fuel oil tanks had several openings, unsealed penholes, and a narrow gap along the perimeter of the base walls, which would allow water intrusion into the emergency diesel generator fuel oil tank rooms during a design basis external event (hurricane).