# Peach Bottom 3
# 4Q/2009 Plant Inspection Findings

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## Initiating Events

**Significance:** G Dec 04, 2009
Identified By: Self-Revealing
Item Type: FIN Finding
**Inadequate Procedure Adherence Results in Trip of 3 'A' Recirc Pump and Plant Transient**
A self-revealing finding was identified when PBAPS personnel incorrectly performed a maintenance procedure for tuning the reactor recirculation pump (RRP) motor generator (MG) set voltage regulator. Specifically, maintenance personnel adjusted a potentiometer in the wrong direction, which resulted in a trip of the RRP and an unplanned plant transient.

This finding is more than minor because the finding is associated with the human performance attribute of the Initiating Events Cornerstone, and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions. Specifically, this error resulted in an unplanned plant transient that reduced reactor power from 75 percent to 33 percent. In accordance with IMC 0609, Attachment 4, the inspectors determined this finding to be of very low safety significance (Green) since the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. This finding has a cross-cutting aspect in the area of human performance, Work Practices, because PBAPS did not define and effectively communicate expectations regarding procedural compliance and personnel did not follow procedures [H.4(b)]. Specifically, PBAPS personnel did not follow procedure IC 11 02011 instructions for tuning the 3 ‘A’ RRP MG set voltage regulator. (Section 4OA3.1)

Inspection Report# : 2009003 *(pdf)*

**Significance:** G Mar 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**Inoperable 'A' Wide-Range Neutron Monitoring (WRNM) Results in a Condition Prohibited by Technical Specifications**
A self-revealing, Green NCV of Unit 3 TS 3.0.4 was identified by the inspectors on January 26, 2009, when a half-scram occurred on Unit 3, shortly after Unit 3 entered Mode 2 for plant startup. Specifically, the ‘A’ Wide-Range Neutron Monitoring (WRNM) was inoperable as a result of inadequate procedural guidance regarding adjustments made to the mean square voltage (MSV) offset during the outage (prior to the January 26, 2009, startup). The inadequate procedural guidance allowed adjustments to be made which resulted in the WRNM not making a smooth transition from the counting region to the MSV region of operation, causing the ‘A’ WRNM to be inoperable and resulting in an unexpected half-scram when the WRNM transitioned from the counting region to the MSV region of operation. As a result, TS 3.3.1.1 requirements for the number of available channels of WRNM short period RPS trip in Mode 2 had not been met. TS 3.0.4 requires that when a LCO is not met, entry into a mode or other specified condition shall only be made when the associated actions to be entered permit continued operation in the mode or other condition specified for an unlimited period of time. Corrective actions included entering the issue into the CAP, conducting an event review, and submitting a License Event Report (LER) to the NRC, and revising the WRNM adjustment procedure.

The finding is more than minor because it is associated with the procedure quality attribute and adversely affected the Initiating Events Cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions. The finding was of very low safety significance because it did not contribute to the likelihood that both a reactor trip would occur and that mitigation equipment would not be available. This finding has a cross-cutting aspect in the area of human performance (resources) because the licensee’s procedure did not provide adequate guidance to prevent adjusting the MSV offset to an unacceptable value. [IMC 0305 aspect: H.2(c)] (Section

1R15)

Inspection Report# : 2009002 *(pdf)*

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# Mitigating Systems

**Significance:** G Dec 31, 2009
Identified By: NRC
Item Type: FIN Finding
**Failure to Follow Procedures and Implement the Exelon Nuclear Cable Condition Monitoring Program For Non Safety Related Control And Power Cables Within The Scope Of The Maintenance Rule.**
The inspectors identified a finding for the failure to follow the Exelon fleet procedure for cable monitoring (ER-AA-3003) of non-safety-related cables within the scope of the 10 CFR 50.65 (the Maintenance Rule). Specifically, PBAPS had reported to the NRC that they were implementing this procedure for cables within the scope of GL 2007-01; however, actions were not specified to identify or remediate the cause of repetitive flooding and restore the function of the degraded electrical manhole/vault drain systems. PBAPS initiated IR 1016075 to enter the issues associated with this finding into the CAP.

This finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone and the associated cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. This finding was evaluated in accordance with IMC 0609.04, Phase 1 – "Initial Screening and Characterization of Findings" and was determined to be of very low safety significance because it did not represent an actual loss of safety function or contribute to external event core damage sequences. This finding had a cross-cutting aspect in the area of PI&R, Operating Experience, because Exelon did not adequately implement and institutionalize industry operating experience through changes to station processes and procedures [P.2 (b)]. Specifically, work order instructions were inadequately scoped in that they were limited to manholes with safety-related cables and did not include all manholes with Maintenance Rule power cables contrary to the scope identified in ER-AA-3003 or GL 2007 01.

Inspection Report# : 2009005 *(pdf)*

**Significance:** G Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**Continuously Submerged Cables Design Deficiency**
The inspectors identified an NCV of 10 CFR, Part 50, Appendix B, Criterion III, "Design Control," because PBAPS has not maintained safety-related power cables (including low voltage cables) in an environment for which they were designed and tested. Specifically, PBAPS did not adequately select and review for suitability of application of materials a 480 volt ac power cable feeding a safety-related motor control center (E424 O A) that has been in a submerged environment in manhole 35 for an extended period of time and at least since 2002. Additionally, PBAPS personnel did not take actions to properly evaluate and mitigate the effects of long term submergence of these safety-related electrical power cables.

This finding is more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone and the associated cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. This finding was evaluated in accordance with IMC 0609.04, Phase 1 – "Initial Screening and Characterization of Findings" and was determined to be of very low safety significance because it did not represent an actual loss of safety function nor contribute to external event core damage sequences. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because Exelon did not thoroughly evaluate problems such that the resolutions addressed causes including evaluating for operability conditions adverse to quality. Specifically, station personnel did not adequately evaluate the impacts on operability and service life of operating the cables submerged in water for an extended period of time [P.1(c)].

Inspection Report# : 2009005 *(pdf)*

**Significance: SL-IV** Sep 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Perform a 50.59 Review Prior to Installing Jumpers on 'E' Wide Range Neutron Monitoring (WRNM)**
An inspector-identified, Severity Level IV NCV of 10 CFR 50.59 was identified when PBAPS made temporary alterations to their facility to address a degraded condition without performing a 50.59 review. Specifically, PBAPS installed a jumper that bypassed the trip feature of the Unit 3 'E' wide-range neutron monitoring (WRNM) system instead of using the WRNM bypass switch as is described in their plant's Final Safety Analysis Report (FSAR). Exelon entered this issue into their CAP and the jumper was subsequently removed restoring the original system configuration.

Because this was a violation of 10 CFR 50.59, it was considered a violation that potentially impeded or impacted the regulatory process; therefore, this violation was dispositioned using the traditional enforcement process. This finding was more than minor because there was a reasonable possibility that the change requiring a 10 CFR 50.59 Safety Evaluation (SE) would require NRC review and approval prior to implementation in accordance with 10 CFR 50.59 (c)(2). This possibility is based on the likelihood that a second WRNM could be bypassed, with the bypass switch built into the WRNM system, without resulting in a trip of the associated reactor protection system (RPS). This condition would be contrary to the design of the WRNM and RPS, thereby creating the possibility for a malfunction of a structure, system, and component (SSC) important to safety with a different result than any previously evaluated in the FSAR (as updated). Although the SDP is not designed to assess traditional enforcement violations, the NRC assesses the significance of 10 CFR 50.59 violations through the SDP for risk insights. Accordingly, the inspectors evaluated the finding in accordance with IMC 0609, SDP, Attachment 0609.04, Phase 1 – "Initial Screening and Characterization of Findings," Table 4a, for the Mitigating Systems cornerstone. The issue, associated with the installation of the one jumper, was determined to be of very low safety significance (Green) since the issue was determined to be a qualification issue confirmed not to result in loss of operability of the system.

This violation involved a facility change that likely would have required a license amendment before its implementation. Comparing this item to the examples in NRC Enforcement Policy, Supplement I, "Reactor Operations," this finding is similar to Item D.5, "Violations of 10 CFR 50.59 that result in conditions evaluated as having very low safety significance (i.e., Green) by the SDP." This is a Severity Level IV violation. Additionally, this finding was determined to have a crosscutting aspect in the area of Human Performance, Decision Making component, which states the licensee should use conservative assumptions in decision making and adopt a requirement to demonstrate that the proposed action is safe. Specifically, Exelon did not perform a 10 CFR 50.59 safety evaluation or screening when making a temporary alteration to the RPS system which would be installed for the remainder of the operating cycle. (Section 1R18.2) (IMC 0305 Aspect H.1(b)) (Section 1R18.2)
Inspection Report# : 2009004 *(pdf)*

**Significance:** G Aug 07, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Take Adequate CAs for Grease Applied to DC Contactors**
The inspectors identified a non-cited violation (NCV) of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," for failure to identify and correct a condition adverse to quality. Specifically, in March 2009, Exelon did not take adequate corrective action to address a procedure deficiency and to ensure that grease inappropriately applied to Cutler Hammer direct current (DC) contactor pivot pins, in an unknown number of DC breakers in the high pressure coolant injection (HPCI) and reactor core isolation cooling (RCIC) systems at Unit 2 and 3, would be identified and removed in a timely manner. Because the grease could harden over time and cause inadequate DC breaker performance, the inspectors determined that this condition, if left uncorrected, could prevent certain Units 2 and 3 HPCI and RCIC system valves from performing their safety-related function. Exelon entered this issue into their corrective action program as issue report (IR) 950438 and IR 950439
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The finding affected the Mitigating Systems cornerstone and was determined to be more than minor because the

condition, if left uncorrected, could have become a more significant safety concern. By not requiring, by procedure, the removal of all grease from the affected Cutler Hammer DC contactor pivot pins, Exelon did not ensure that all of the potentially affected DC motor-operated valves in the Unit 2 and Unit 3 HPCI and RCIC systems would be available to perform their design functions if called upon. The inspectors evaluated this finding using Phase I of Manual Chapter 0609 and determined the finding to be of very low safety significance (Green) because it was not a design or qualification deficiency confirmed not to result in loss of operability or functionality, did not represent a loss of system or train safety function, and was not potentially risk significant due to external events. This finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program, because Exelon failed to take appropriate corrective actions to address a safety issue in a timely manner, commensurate with the safety-significance and complexity [P.1(d)]. Specifically, Exelon did not take appropriate corrective actions to ensure that grease inappropriately applied to Cutler Hammer DC contactor pivot pins would be, by procedure, identified and removed in a timely manner. (Section 4OA2.1.c)

Inspection Report# : 2009008 *(pdf)*

**Significance:** G Jun 30, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**MOV Program Procedures Were Inadequate with Regard to periodicity of preventive Maintenance Activities for Stem Lubrication.**
A self-revealing NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified. Specifically, Exelon’s Motor Operated Valve (MOV) Program procedures lacked specific instructions to prescribe an acceptable frequency for performing valve stem lubrication, which resulted in test failures of safety-related MOVs and affected the reliability of the MOVs’ safety functions.

On Unit 2, the inspectors determined that the finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). In accordance with IMC 0609, Attachment 4, the inspectors determined that the finding was of very low safety significance (Green) because it was not a design or qualification deficiency, did not represent a loss of system safety function, and was not associated with any external events. On Unit 3, the inspectors determined that the finding was more than minor because it was associated with the configuration control attribute of the Barrier Integrity Cornerstone and affected the cornerstone objective of providing reasonable assurance that physical design barriers (e.g., containment) protect the public from radionuclide releases caused by accidents or events. In accordance with IMC 0609, Attachment 4, the inspectors determined that the finding was of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment. For both units, this finding has a cross-cutting aspect in the area of Problem Identification and Resolution (PI&R), Corrective Action Program, because PBAPS did not thoroughly evaluate problems such that the resolutions addressed the causes and extent of condition [P.1(c)]. Specifically, PBAPS failed to thoroughly evaluate previous conditions of degraded and hardened grease on safety-related valves, such that the extent of the condition was considered and the cause was resolved. (Section 4OA2)

This item was discussed in Inspection Report 2009-004 (Section 4OA5.2).
Inspection Report# : 2009003 *(pdf)*

**Significance:** G Jun 08, 2000
Identified By: NRC
Item Type: AV Apparent Violation
**Assoc Circuit - Reliance on signal spurious assumption of one per system per fire.**
PECO's specification for performing circuit analyses of post-fire safe shutdown equipment stipulates that only one spurious actuation for each system affected by any one fire be analyzed. For the areas inspected, the team determined that PECO adequately protected against fire-induced spurious actuations. The team did not identify any additional spurious actuations which would have prevented achieving safe shutdown conditions in the post-fire operating environment.

The assumption that only a single spurious actuation need be considered for any one system for any one fire is an apparent violation of the requirements of Section III.G. and III.L. of Appendix R to 10 CFR 50. PECO entered this issue into their corrective action program and have implemented reasonable compensatory measures. However, the issue of multiple spurious actuations of equipment in a post-fire environment is in contention between the NRC and the nuclear industry. As such, any further enforcement action will be deferred pending final resolution of this issue by the Nuclear Energy Institute and the NRC staff, in accordance with Enforcement Guidance Memorandum 98-02, Revision 2, issued February 2, 2000.
Inspection Report# : 2000003 *(pdf)*
Inspection Report# : 2007002 *(pdf)*

**Significance: N/A** Jun 08, 2000
Identified By: NRC
Item Type: AV Apparent Violation
**Assoc Circuit - Mechanical Damage from Fire Induced Cable Faults not evaluated.**
PECO adopted a licensing position that mechanical damage to alternative shutdown equipment resulting from fire-induced cable faults, as described in Information Notice 92-18, was outside the scope of the licensing and design bases of the facility. As a result, PECO did not evaluate the control circuits of the alternative shutdown equipment to determine if it was susceptible to this problem. Since a detailed review of the alternative shutdown capability at PBAPS was not performed as part of the scope of this inspection, the risk associated with this issue was not established.

This issue is being treated as an apparent violation of Condition 2.C.4 of the operating licenses for both Unit 2 and Unit 3, which requires PECO to implement and maintain the fire protection program described in the NRC Safety Evaluation Reports. PECO has entered this issue into their corrective action program and has implemented reasonable compensatory measures pending final resolution of the issue. However, the issue of mechanical damage to safe shutdown equipment due to fire-induced cable faults is in contention between the NRC and the nuclear industry. As such, any further enforcement action will be deferred pending final resolution of this issue by the Nuclear Energy Institute and the NRC staff, in accordance with Enforcement Guidance Memorandum 98-02, Revision 2, issued February 2, 2000.
Inspection Report# : 2000003 *(pdf)*
Inspection Report# : 2007002 *(pdf)*

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# Barrier Integrity

**Significance:** G Sep 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**PBAPS Failed to Maintain the Capability to Ensure at Least 500 gpm SFP External Make-up flow Was Achievable Within Two Hours.**
This finding, affecting the Barrier Integrity Cornerstone, is related to mitigative measures developed to cope with losses of large areas of the plant; in response to Section B.5.b. of the February 25, 2002, Interim Compensatory Measures (ICM) Order (EA-02-026) and related NRC guidance. This finding has been designated as "Official Use Only - Security-Related Information;" therefore, the details of this finding are being withheld from public disclosure. This finding has a cross-cutting aspect in the area of Human Performance (Resources). [H.2(d)]. See inspection report for more details.

Inspection Report# : 2009010 *(pdf)*

**Significance:** G Sep 30, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**Inadequate Procedure Adherence Results in the Loss of Safety Function of Systems Supplied by the SGIG**

**System**
A self-revealing Green NCV was identified for failure to comply with Technical Specification (TS) 5.4.1, "Procedures," which required that procedures be established, implemented, and maintained for the safety grade instrument gas (SGIG) system. Specifically, the SGIG Pressure Building Circuit Outlet Block Valve (HV 0 7C 10) was manipulated without procedure guidance, was out of its normal position, and resulted in the inoperability of certain valves associated with the primary containment and containment atmosphere dilution (CAD) systems for both units.

Based on the above, the inspectors determined that manipulating the SGIG Pressure Building Circuit Outlet Block Valve (HV 0 7C 10) without procedure guidance was a performance deficiency that was reasonably within PBAPS's ability to foresee and prevent. The inspectors concluded that the manipulating HV 0 7C 10 without a procedure was a more than minor finding because it was associated SSC and barrier performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that the containment would protect the public from radionuclide releases caused by accidents or events. Specifically, certain valves associated with the primary containment and containment atmosphere dilution (CAD) systems could not be operated as designed due to this valve being out of its normal position. Traditional enforcement does not apply since there were no actual safety consequences or potential for impacting the NRC=s regulatory function, and the finding was not the result of any willful violation of NRC requirements. Accordingly, the inspectors assessed the finding in accordance with IMC 0609, SDP, Attachment 0609.04, Phase 1 – "Initial Screening and Characterization of Findings," Table 4a, for the Containment Barrier cornerstone. The finding was determined to be of very low safety significance (Green) since the finding did not represent an actual open pathway in the physical integrity of the reactor containment (isolation valves).

The inspectors determined that this finding had a cross cutting aspect in the area of Human Performance, Work Practices component, because human error prevention techniques, such as peer and self checking, were inadequately used to prevent mispositioning the SGIG Pressure Building Circuit Outlet Block Valve (HV 0 7C 10). (Section 4OA3.3) (IMC 0305 Aspect H.4(a))
Inspection Report# : 2009004 *(pdf)*

**Significance:** G Mar 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**Inadequate Work Instructions Result in Inadvertent ESF Actuation**
A self-revealing NCV of 10 CFR 50 Appendix B, Criteria V, "Instructions, Procedures and Drawings" was identified when inadequate work instructions resulted in a momentary shorting of a terminal lead during maintenance, which caused an inadvertent Unit 3, primary containment isolation valve (PCIV) signal and entry into a one-hour shutdown Technical Specification (TS) Action Statement on March 3, 2009. Specifically, the work instructions allowed the technicians to lift and manipulate energized leads on a safety-related pressure switch without providing any guidance as to the risk and consequences that inadvertent grounding of those energized leads could cause. Because the risk and consequences were not considered and an inadvertent grounding occurred, a PCIV signal resulted that closed normally open valves on both the containment atmosphere control (CAC) system and the instrument nitrogen system containment penetrations. In addition, both PCIV valves on containment atmosphere dilution (CAD) system were rendered inoperable which required the operators to enter an unplanned one-hour TS Action Statement (3.6.1.3.B) and would have required a plant shutdown within the following 12 hours. Corrective actions included replacing the blown fuse, entering the issue into the CAP, and making a required 60 day verbal report to the NRC.

The finding is more than minor because it could reasonably be viewed as a precursor to a significant event. Specifically, the failure to assess the risk of inadvertent grounding of energized leads on safety equipment could pose a credible hazard as an initiating event during plant operation. The finding was of very low safety significance because the valves in question failed closed and did not represent an actual open pathway in the physical integrity of reactor containment. This finding has a cross-cutting aspect in the area of human performance (work control) because the licensee's work instructions did not provide appropriate risk insights regarding the risks associated with potential grounding of the energized leads. [H.3(a)]
(Section 1R13)

Inspection Report# : 2009002 *(pdf)*

**Significance: SL-IV** Mar 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**Departure from a Method of Evaluation Without Prior NRC Approval**
Severity Level IV. An inspector identified Severity Level IV NCV of 10 CFR 50.59 was identified when PBAPS made a safety analyses change that departed from a method of evaluation described in the UFSAR without obtaining prior NRC approval and a license amendment. Specifically, PBAPS used a spent fuel pool criticality analysis methodology that was not previously approved by the NRC, and did not adopt an NRC approved methodology en toto and apply it consistent with applicable terms, conditions, and limitations. Corrective actions for this problem included entering the issue into the CAP and making plans to develop a technical evaluation that would demonstrate, using methodologies approved for PBAPS, that adequate margin to criticality exists for the nonconforming condition presented by the degraded Boraflex in the SFP storage racks. Additionally, PBAPS has submitted a LAR, to use alternative SFP criticality analyses, to the NRC on June 25, 2008.

This deficiency was evaluated using the traditional enforcement process since it potentially adversely impacts or impedes the NRC's ability to carry out its regulatory mission, in that, PBAPS did not request and receive prior NRC approval for changes in licensed activities. The finding is more than minor and a Severity Level IV violation because it is similar to example D.5 of Supplement I, "Reactor Operations," to the NRC's Enforcement Policy. Specifically, the finding involved a violation of 10 CFR 50.59 that resulted in conditions evaluated as having very low safety significance (i.e., Green) by the SDP. Using the Phase 1 SDP, the inspectors determined that the condition resulting from the violation of 10 CFR 50.59 screened to Green because it could affect the functionality of the fuel barrier (cladding). The finding was reviewed for a cross-cutting aspect. It was determined the performance characteristic that was the most significant contributor to the performance deficiency did not align with the cross-cutting aspects described in the human performance or PI&R component areas. Therefore, no cross-cutting aspect was assigned.

Inspection Report# : 2009002 *(pdf)*

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

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## Miscellaneous

**Significance: N/A** Aug 07, 2009

Identified By: NRC
Item Type: FIN Finding
**Identification and Resolution of Problems**
The inspectors concluded that Exelon was generally effective in identifying, evaluating and resolving problems. Specifically, Exelon personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with the safety significance. For most cases, Exelon appropriately screened issues for operability and reportability and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. Corrective actions taken to address the problems identified in Exelon's corrective action process were typically implemented in a timely manner. However, for one issue reviewed by the inspectors, inadequate implementation of corrective actions resulted in one NRC-identified finding.

The inspectors also concluded that, in general, Exelon adequately identified, reviewed, and applied relevant industry operating experience to Peach Bottom Atomic Power Station (PBAPS) operations. In addition, based on those items selected for review by the inspectors, Exelon's audits and self-assessments were thorough and probing.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any concerns that site personnel were not willing to raise safety issues nor did they identify conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : 2009008 *(pdf)*

**Significance: SL-IV** Jul 09, 2009
Identified By: NRC
Item Type: VIO Violation
**Operator willfully reading unauthorize material in the Main Control Room**
A Primary Reactor operator (PRO) was identified by your staff to be reading the novel on a computer while on watch in the Peach Bottom MCR on July 16, 2007. Your procedure, referenced in the Notice, states that non-job-related reading materials, including novels, are not permitted in the Operations
Department areas and that the use of the computers must be limited to company-related work.
The NRC became aware of this issue during a Safety Conscious Work Environment (SCWE) inspection conducted in March 2008, as part of the follow-up to the finding of inattentive security officers (Inspection Report 2008-405, ML081490058).

Since this finding involved deliberate misconduct by a licensee employee, it was characterized using the NRC Traditional Enforcement Process. Comparing this issue to the examples in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," this violation is similar to example 2(f) in that a licensee procedural requirement was not met. In this example, the issue is minor because it represents a failure to implement a procedural requirement that had no safety impact under the given situation. Given that the PRO was able to respond to plant conditions while reading the novel, for approximately ten minutes, and was not the primary plant reactor operator (a watchstation relied upon to detect safety significant abnormal plant conditions), there was minimal safety impact due to the PRO's actions. Although this violation would normally be minor, since the PRO's actions were determined to be deliberate by the NRC, the Severity Level (SL) of the violation has been increased to SL IV, in accordance with Section 2.10.f, of the NRC Enforcement Manual. Further, because the violation involves deliberate actions and the PRO is considered to be a licensee official as defined in the NRC Enforcement Policy, this violation is being cited.

This finding was determined to not be indicative of current plant performance; therefore, no cross-cutting aspect was identified.
Inspection Report# : 2009009 *(pdf)*

Last modified : March 01, 2010