

Sequoyah Nuclear Plant, Post Office Box 2000, Soddy Daisy, Tennessee 37384

October 8, 2025

10 CFR 2.201

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555-0001

> Sequoyah Nuclear Plant, Unit 1 Renewed Facility Operating License No. DPR-77 NRC Docket No. 50-327

Subject:

Reply to a Notice of Violation; EAF-RII-2025-0138

Reference: NRC letter to TVA, "Sequoyah Nuclear Plant - NRC Radiation Safety Inspection

Report 05000327/2025012 and Investigation Report 2-2024-011 and Notice of

Violation", dated September 12, 2025

The Enclosure to this letter provides Tennessee Valley Authority's (TVAs) response to the Notice of Violation in accordance with Reference letter.

There are no regulatory commitments contained in this letter. Should you have any questions concerning this submittal, please contact Mr. Rick Medina, Site Regulatory Compliance Manager, at (423) 843-8129 or rmedina4@tva.gov.

Respectfully,

Kevin M. Michael Site Vice President Sequoyah Nuclear Plant

Enclosure: Reply to a Notice of Violation; EAF-RII-2025-0138

cc: (w/ Enclosure)

NRC Regional Administrator – Region II

NRC Senior Resident Inspector - Sequoyah Nuclear Plant

ENCLOSURE Tennessee Valley Authority

Sequoyah Nuclear Plant
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Restatement of Severity Level IV Violation

During a U.S. Nuclear Regulatory Commission (NRC) investigation completed on April 23, 2025, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the following violation identified in Inspection Report 05000327/2025012 is being cited:

Sequoyah Technical Specification (TS) 5.4.1 states, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A. Regulatory Guide 1.33, Appendix A, Section 7, covers radiation protection (RP) procedures for access control to radiation areas including a radiation work permit (RWP) system.

Procedure NPG-SPP-05.18, "Radiation Work Permits," Revision 10, Section 3.1.4, required individual workers to notify RP staff of any change in job scope.

Procedure NPG-SPP-05.1, "Radiological Controls", Revision 16, Section 3.2.12, stated that each worker shall be responsible for awareness and compliance with the radiation protection requirements of an RWP and for meeting the prerequisites for RWP entry.

RWP 24130013, Revision 0, stated, in part, that any equipment moved from primary steam generator (SG) platforms to laydown areas must be surveyed and bagged/wrapped as determined by RP staff and that RP must survey all equipment prior to removal from laydown areas. RWP 24130013 also required workers to wear two sets of gloves and two sets of shoe covers.

Contrary to the above, on April 15, 2024, the licensee failed to implement existing RP procedures associated with access control to radiation areas that included an RWP system, as evidenced by the examples listed below. The failure to follow RP procedures resulted in the contamination of multiple individuals with low levels of radioactive material.

- Licensee contractors did not notify RP staff of a change in job scope as required by NPG-SPP-05.18. Specifically, the contractors were directed to install SG manways on Unit 1 but proceeded to expand the job scope to remove highly contaminated equipment from the SG primary platforms and laydown areas without notifying RP staff.
- Licensee contractors did not comply with the requirements in RWP 24130013 as required by procedure NPG-SPP-05.1. Specifically, the contractors removed several highly contaminated objects from the Unit 1 SG primary platforms and laydown areas without RP staff present to perform the required surveys and oversee bagging of the objects, and failed to appropriately utilize protective clothing when crossing the HCA step-off pad.

This is a Severity Level IV violation (NRC Enforcement Policy Sections 2.2.1.d and 6.7.d).

Reason for the Violation:

TVA substantiated that the failure to fully implement the existing Radiation Protection (RP) procedures resulted in a failure to meet Technical Specification 5.4.1 (Procedures) as cited in Regulatory Guide 1.33.

TVA determined that the violation was caused by insufficient RP oversight and monitoring of demobilization activities in elevated radiological risk areas. A lack of RP presence during critical work and weak job coverage controls created opportunity for field personnel to bypass normal RP controls without immediate challenge and prevented RP personnel from detecting or stopping work when the field crew expanded the scope of their briefed activities.

Corrective Steps That Have Been Taken and Results Achieved:

Radiation Protection Supervision captured the lessons learned and utilized a physical oversight plan in the subsequent site outage (U2R26). A tracking matrix for radiation worker behaviors was added to the outage daily meeting reports, with RP and other groups conducting radiation worker-specific observations. Procedural requirements for radiologically controlled areas (RCAs) and activities were reviewed with RP personnel.

No radiation worker events were identified in the subsequent outage (U2R26).

Corrective Steps That Will Be Taken:

The issues that caused the violation will be addressed by providing guidance and coaching to the RP First Line Supervisors. These issues include not having enough RP staff during critical work, weak control over job coverage, not following procedures properly, and not having enough oversight or monitoring.

Radiation Protection Supervision will validate the effectiveness of the corrective actions following the completion of the upcoming refueling outage (U1R27) in November 2025.

Date When Full Compliance Will Be Achieved:

Full compliance will be achieved when RP Supervision completes briefing and reinforcement of contributing causes leading to the violation and the requirements for RP procedure adherence. Briefings and documentation are expected to be completed by October 17, 2025.