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**Timothy P. Cleary**  
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Sequoyah Nuclear Plant

June 9, 2009

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

10 CFR 2.201

Gentlemen:

In the Matter of )  
Tennessee Valley Authority (TVA) )

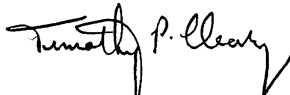
Docket Nos. 50-327  
50-328

**SEQUOYAH NUCLEAR PLANT (SQN) - NRC OFFICE OF INVESTIGATIONS  
REPORT 2-2008-024, SEQUOYAH NUCLEAR PLANT INSPECTION REPORT  
NOS. 05000327/2009007 AND 05000328/2009007 AND NOTICE OF VIOLATION  
(NOV) - REPLY TO NOV EA-08-348**

The enclosure to this letter provides TVA's reply to the subject NOV of 10 CFR 50.9 of the NRC's regulations. The basis for this violation is documented in NRC's letter to Mr. Preston D. Swafford, dated May 12, 2009.

There are no regulatory commitments contained in this submittal. If you have any questions, please call me at (423) 843-7001 or Beth A. Wetzel at (423) 843-7170.

Sincerely,

  
Timothy P. Cleary

Enclosure  
cc: See page 2

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BAW:JWP:SKD

cc (Enclosure):

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**ENCLOSURE**

**TENNESSEE VALLEY AUTHORITY (TVA)  
SEQUOYAH NUCLEAR PLANT (SQN)  
UNITS 1 AND 2**

**INSPECTION REPORT NOS. 05000327/2009007 AND 05000328/2009007  
REPLY TO A NOTICE OF VIOLATION (NOV) EA-080348**

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**I. RESTATEMENT OF VIOLATION**

“During an NRC investigation conducted between February 20, 2008 and December 16, 2008, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is listed below:

10 CFR 50.9 (a) requires that information provided to the Commission by a licensee or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects. Technical Specification 6.8.1 requires procedures described in Appendix A of RG 1.33, Revision 2 to be established, implemented, and maintained. Paragraph 10 of Appendix A of RG 1.33 requires, in part, that chemical control procedures be written to prescribe the limitations on concentrations of agents that may cause corrosive attack or fouling of heat transfer surfaces and specify laboratory instructions and calibration of laboratory equipment. Licensee procedure SPP-5.3, Chemistry Control, Revision 5, implemented this requirement for all TVA nuclear facilities.

Step 3.1.3 of procedure SPP-5.3 required Chemistry licensee personnel, including Chemistry Supervisors, to implement chemistry quality assurance and quality control (QA/QC) programs. Appendix D of procedure SPP-5.3 described chemistry quality assurance, quality control and referenced procedure CHTP-109, Chemistry QAIQC, for the details. Step 4.2.3E of procedure CHTP-109 required that a known control standard check within the same concentration range as the instrument calibration range be performed along with each batch of samples and described a batch as less than or equal to 10 samples in a 12 hour period.

Contrary to the above, on January 25, 2008, a Chemistry Shift Supervisor deliberately entered false data into the Chemistry Department internal laboratory statistics database. Specifically, on January 24, 2008, the licensee employee failed to perform the required QA/QC standard check for the evening shift, and the following day entered false data into the database. This information was material to the NRC in that the substance of the information is used to determine compliance with the Technical Specifications. The Chemistry Shift Supervisor's deliberate entry of false data into the internal laboratory statistics database caused the licensee (TVA) to be in violation of 10 CFR 50.9 (a).

This is a Severity Level IV violation.”

## II. TVA'S REPLY TO THE VIOLATION

### 1. Reason For The Violation

The reason for the violation was the result of a willful act of an employee.

On December 27, 2007, Chemistry started requiring calibration checks to be performed once per shift in accordance with Chemistry Standing Order 07-79. The previous frequency requirement had been to perform the calibration check once per day.

On January 25, 2008, during a review of the calibration data, it was identified that a calibration check had not been performed for the previous night shift for a chloride and sulfate analysis. A problem evaluation report (PER) was initiated, in accordance with the Corrective Action Program, documenting the calibration check not being performed.

It was later identified that the logged information was false data and a subsequent PER was initiated. The failure to perform the calibration check was bounded by the calibration checks that were performed before and after the missed calibration check. The NRC was notified of the incident.

Upon investigation by TVA, the Chemistry Shift Supervisor admitted that he failed to perform a calibration check and that he deliberately entered false data into the Labstats database in an effort to conceal that a calibration check had not been performed.

[Note: The Chemistry Shift Supervisor was a union represented employee, not a member of management, and had no supervisory duties over other Chemistry personnel.]

### 2. Corrective Steps That Have Been Taken And The Results Achieved

Following identification of the issue, the employee was suspended until a full investigation of the matter could be performed.

In the course of TVA's investigation the Chemistry Shift Supervisor admitted that he failed to perform a required calibration check and that he attempted to conceal the failure to perform the check. Based on the employee's admission and the seriousness of the offense, disciplinary action was taken in accordance with TVA's Employee Discipline Policy. The employee was suspended from work without pay for a period of 30 days. Upon return to work, the employee was demoted to a Senior Chemistry Technician with fewer responsibilities.

Since being returned to duty, the employee's performance has been fully adequate.

### 3. Corrective Steps That Have Been Taken To Avoid Further Violations

The incident was discussed with Chemistry Department personnel during all hands meetings, which addressed the seriousness of the incident, the importance of

providing complete and accurate information, and the consequences of falsifying data as it affects TVA and the individuals who are involved.

In addition to discussing the incident, the Chemistry Manager discussed an article titled "What Was I Thinking?" This article concerned a Senior Reactor Operator at another utility that mistakenly entered incorrect information into the plant computer and subsequently attempted to cover up the mistake by falsifying the record. The article addressed what contributed to the event, including human performance error traps and human performance error tools that could have been utilized to prevent the error.

4. Date When Full Compliance Will Be Achieved

SQN is in full compliance.