ENCLOSURE 1

NOTICE OF VIOLATION

Tennessee Valley Authority
Browns Ferry 1, 2, and 3

Docket Nos. 50-259, 50-260, and 50-296
License Nos. DPR-33, DPR-52, and DPR-68

During the NRC Office of Investigation inquiry conducted during the period June 19, 1989 through March 1, 1990, a violation of NRC requirements was identified. The violation involved the willful falsification of quality documents. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1990), the violation is listed below:

10 CFR Part 50.9, states that information required by the Commission regulations to be maintained by the licensee shall be complete and accurate in all material respects. 10 CFR Part 50, Appendix B, Criterion XVII, Quality Assurance Records, requires in part that test records shall be maintained to furnish evidence of activities affecting quality. Test records shall, as a minimum, identify the inspector or data recorder, the type of observation, the results, the acceptability, and the action taken in connection with any deficiencies noted.

Contrary to the above a TVA contractor employee falsified the test records for a portion TP-082 conducted during the 1987-1988 timeframe. revealed a high probability that this portion of med. Other unauthorized changes to Change Noti were made by the employee to test records without p

Signature

This is a Severity Le ment VII) and is applicable to all Units.

No response to this violation is required.

FOR THE NUCLEAR REGULATORY COMMISSION

Alois J. Ignatonis
for Bruce Wilson, Assistant Director
for Inspection Programs
TVA Projects Division
Office of Nuclear Reactor Regulation

Dated at Atlanta, Georgia
this 1st day of June 1990

ENCLOSURE 2

SYNOPSIS

On October 16, 1988, TVA notified the NRC Browns Ferry Nuclear Plant Site Manager that they had identified discrepancies and what appeared to be unauthorized changes made by a contract employee to the Unit 2 restart test records for the diesel generators and the related 4100 volt distribution system. TVA management immediately became involved and a Licensee Reportable Event Determination (LRED) was issued, and the only person who appeared to be involved was removed from the site.

The TVA Nuclear Quality Assurance (NQA) Group was directed by TVA management to develop an action plan and conducted an investigation to determine if the tests had actually been performed, evaluate the performance of the individual for all other restart tests that he was involved with, and provide reasonable assurance that the overall restart test program had been properly conducted. The TVA NQA investigation report was issued on November 10, 1988. The NRC documented the question about the adequacy of the DG testing in IR 88-32 as IFI 259,260,296/88-32-02.

The NRC Office of Investigation (OI) conducted an inquiry from June 19, 1989 until March 1, 1990, to determine whether test records were falsified and, if so, whether the problem extended to the other tests.

The NRC OI inquiry consisted of:

- Review of the TVA NQA Investigation Report
- Interview with the Manager of Nuclear Investigations, OIG, TVA
- Interview with the QA Manager, NQA Group, TVA who conducted the investigation
- Review of memoranda and a letter related to the investigation and resulting action by TVA.

TVA had concluded that:

- The contract employee had violated QA procedures in a number of instances by entries, changes, or deletions on QA test records without initialing, signing or dating the entries.

- There was a high probability that a part of the DG restart test had not been run as indicated by the test records. This test was rerun.

- Except for the above, there was a high level of confidence that the restart test program had been successfully implemented. The problem seemed to be isolated involving one individual.

TVA had immediately fired the contractor employee and subsequently withheld any contractor award fee for the DG restart test. TVA submitted all of their information to the U.S. Attorney for the Northern District of Alabama, who declined Federal prosecution in favor of the actions taken by TVA.

Based on the review of all the above, NRC OI concluded that they would conduct no further inquiry.

The resident inspector staff verified that the part of the DG restart test that had been in question had been successfully tested. This was documented in IR 89-35 in which IFI 88-32-02 was closed. The resident staff witnessed numerous restart tests and have reviewed significant amounts of test data, and no other instances of incomplete or inaccurate test records have been identified. These inspections are documented in most monthly resident inspection reports in 1988, and 1989.

NRC review of all of the available information has resulted in the conclusion that a willful violation has occurred resulting in incomplete or inaccurate information which the NRC requires be kept by a licensee and, that a violation of 10 CFR 50.9 and 10 CFR 50, Appendix B, Criterion XVII, has occurred (Violation 260/90-15-01, Failure to maintain adequate test records). The corrective action taken by TVA was reviewed by the NRC and is adequate; therefore, no response to this violation is required.