



ENCLOSURE 2
UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PA 19406-1415

February 18, 2000

MEMORANDUM TO: Wayne Lanning, Director, Division of Reactor Safety
A. Randolph Blough, Director, Division of Reactor Projects

FROM: Hubert J. Miller
Regional Administrator *HJ Miller*

SUBJECT: AUGMENTED INSPECTION TEAM (AIT) CHARTER -
INDIAN POINT 2 STEAM GENERATOR TUBE FAILURE

You are directed to perform an Augmented Inspection Team (AIT) to review the steam generator tube failure event of February 15, 2000 and associated Indian Point 2 licensee's actions. In addition, the team will gather information regarding the licensee's actions to meet steam generator inspection and maintenance commitments. The cause and nature of the steam generator tube failure will be the subject of a separate NRC review. The team will review the facts surrounding the occurrence of the failure and the licensee's response. The inspection shall be conducted in accordance with NRC Management Directive 8.3, Part III, Augmented Inspection Team and the guidance provided in Inspection Procedure 93800, and Regional Instruction 1010.1. This memorandum and the attached inspection plan provide additional specific instructions, which details the scope of the inspection.

DRS is assigned responsibility for the overall conduct of this inspection. DRP is assigned responsibility for resident inspector and clerical support and coordination with other NRC offices. Mr. Larry Doerflein is the Team Manager for this inspection. Mr. Raymond Lorson is designated as the onsite Team Leader. Team composition is described at the end of this memorandum. Team members will work for Mr. Lorson and are assigned to this task until the report is completed. Evaluation of risk assessments will be performed by the regional office. DRS is responsible for the timely issuance of the inspection report and identification of any potential generic issues. DRS, in coordination with DRP, is responsible for the identification of followup of issues raised during the AIT, including possible enforcement actions.

The inspection entrance meeting was held on February 18, 2000. In accordance with MD 8.3 the inspection report must be transmitted to the Region I Administrator by March 20, 2000, unless relief is appropriately granted.

Attachment: Augmented Inspection Team (AIT) Charter and Membership

W. Lanning
A. Blough

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Distribution w/attachments:

T. Marsh, NRR
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D. Screnci, PAO
R. Bores, SLO
W. Raymond, Indian Point 2 SRI
AIT Members

ATTACHMENT

AUGMENTED INSPECTION TEAM (AIT) CHARTER AND MEMBERSHIP

CONDUCT OF THE INSPECTION

The team should understand the scope and direction of the licensee's investigations and assessment of the events, and their initial responses. Through sampling and independent verification, the team may use facts and information collected by the licensee's investigation teams. The pace and nature of team activities should be gauged to assure, where practicable, that they do not unduly impact the licensee's efforts.

The team leader shall develop an inspection plan, that outlines the areas of responsibility for the team members to ensure the identification and documentation of the relevant facts to support the objectives below.

Inspection procedure 93800 provides guidance on the general conduct of an AIT.

OBJECTIVES

Conduct a timely, thorough, and systematic review of the circumstances surrounding the February 15, 2000, steam generator tube failure reactor trip and Alert. Use collected information and documentation to complete the following:

- A. Determine the sequence of events and causal factors for significant occurrences in the sequence. Document any equipment problems, failures, and/or personnel errors which may have occurred related to the event.
- B. Compare the actual plant response with the design basis; evaluate any procedure and process issues; and determine the relationship of precursors, if any, to this event, as appropriate.
- C. Evaluate operator response to the event including the use of emergency operating procedures. Evaluate subsequent operator actions for restoring equipment. Evaluate the quality of procedures, controls, and engineering support available to cope with this event.
- D. Determine whether the licensee actions immediately prior to, during, and after the event were focused on understanding and limiting future risk.
- E. Evaluate whether the licensee had been meeting established commitments related to inspecting, maintaining, and monitoring the performance of steam generator tubes. However, issues related to the licensing basis for steam generator tubes and the cause and nature of the steam generator tube failure are outside the scope of the team charter. These will be separately evaluated by NRR.
- F. Assess the risk and safety significance of the event related to any problems identified. Provide sufficient information so that the overall risk significance of the event and the subsequent licensee actions may be assessed.

- G. Evaluate the timeliness, appropriateness and effectiveness of the actions taken by the emergency response organization for this event; determine whether emergency plan implementation procedures were followed; and assess the performance of the emergency response organization relative to weaknesses identified previously (e.g., response to the August 31, 1999 Unusual Event at IP2).
- H. Evaluate the adequacy of the licensee post-trip technical evaluations and any planned or implemented corrective actions.

TEAM COMPOSITION

The assigned team members are as follows:

Team Manager:	Larry Doerflein, DRS
Onsite Team Leader:	Raymond Lorson, DRP
Assistant Team Leader:	David Kern, DRP
Onsite Team Members:	Barry Norris, DRS
	Gregory Cranston, DRS
	James Noggle, DRS
	Craig Smith, DRP
	Events Analysis Specialist, NRR

Regional Assistance:	
Risk:	Jim Trapp
Emergency Planning:	Nancy McNamara