APR \$ 1994

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MEMORANDUM FOR: R. A. Westberg, Team Leader, Braidwood Augmented Inspection Team (AIT)

FROM: T. O. Mortin, Deputy Director, Division of Reactor Projects

SUBJECT: AIT CHARTER - BRAIDWOOD UNIT 2 STUCK CONTROL ROD

Enclosed for your implementation is the final Charter to evaluate the events associated with the April 5, 1994, Braidwood Unit 2 reactor trip with a stuck control rod. This Charter was prepared in accordance with the NRC Incident Investigation Manual and the April 18, 1992, Manual Chapter 0325 AIT implementing procedure.

The objectives of the AIT are to:

- communicate the facts surrounding this event to regional and headquarters management,
- identify immediate Unit 2 findings applicability to Unit 1,
- identify and communicate any generic safety concerns related to this event to regional and headquarters management,
- document the onsite inspection findings and conclusions.

If you have any questions regarding these objectives or the enclosed Charter, please do not hesitate to contact me.

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T. O. Martin, Deputy Director Division of Reactor Projects

Enclosure: AIT Charter

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See Attached Distribution

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RATE	iaRR	RIII OROv	RIII	RIII
Landsman 04/8/94	Zwolinski 04/ /94	Grant 04/3 /94	Axelson 04/6/94	TMartin 04/0/94

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R. A. Westberg

Distribution

cc w/enclosure: J. B. Martin, RIII H. J. Miller, RIII E. G. Greenman, RIII F. J. Miraglia, NRR L. A. Reyes, NRR J. W. Roe, NRR G. E. Rossi, NRP J. A. Zwolinski, NRR A. E. Chaffee, NRR J. E. Dyer, NRR W. M. Dean, OEDO R. L. Spessard, AEOD G. M. Holahan, AEOD S. G. DuPont, SRI R. R. Assa, NRR

BRAIDWOOD UNIT 2 STUCK CONTROL ROD AIT CHARTER

- Determine the sequence of events following the reactor trip and stuck control rod event on April 5, 1994.
- Evaluate the appropriateness of the licensee's actions to immediately deal with the issues including use of procedures, near-term testing, shutdown margin, and notifications.
- Evaluate the appropriateness of the licensee's plans to free the stuck rod.
- Determine root causes and contributors for Rod K-2 sticking at position 210 including precursors, if any.
- 5. Determine generic implications of the event, if any.
- Assess licensee management and engineering organization effectiveness to investigate technical problems, control activities safely, determine root causes, and document plans, activities and findings.
- 7. Determine whether there had been appropriate attention given to the faulted main transformer including: preventive maintenance, oil samples, or any other monitoring (such as thermographic) that may have alerted the licensee to an impending failure.