



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION III  
799 ROOSEVELT ROAD  
LENEXA, ILLINOIS 60137

Attachment 1  
Page 1 of 2

JAN 25 1991

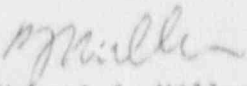
MEMORANDUM FOR: S. G. DuPont, Senior Resident Inspector, Braidwood  
(Quad Cities SIT Team Leader)

FROM: Hubert J. Miller, Director, Division of Reactor Projects

SUBJECT: SPECIAL INSPECTION TEAM (SIT) CHARTER

Enclosed for your implementation is the Charter for the inspection of the events associated with the Quad Cities Unit 1 loss of RCS inventory which occurred on January 24, 1991. This charter is prepared in accordance with the NRC Inspection Manual Chapter 0325. The objectives of the SIT are to communicate the facts surrounding this event to Regional and Headquarters management, as well as to identify and communicate any generic safety concerns related to findings and conclusions of the onsite inspection.

If you have any questions regarding implementation of the enclosed Charter, please contact me directly.

  
Hubert J. Miller, Director  
Division of Reactor Projects

Enclosure: SIT Charter

cc w/enclosure:  
A. B. Davis, RIII  
C. J. Paperiello, RIII  
T. O. Martin, RIII  
C. J. Haughney, NRR  
J. A. Zwolinski, NRR  
J. F. Wechselberger  
E. L. Jordan, AEOD  
C. E. Rossi, NRR  
R. J. Barrett, NRR

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Special Inspection Team (SIT) Charter  
Quad Cities Unit 1 Loss of Reactor Coolant Inventory

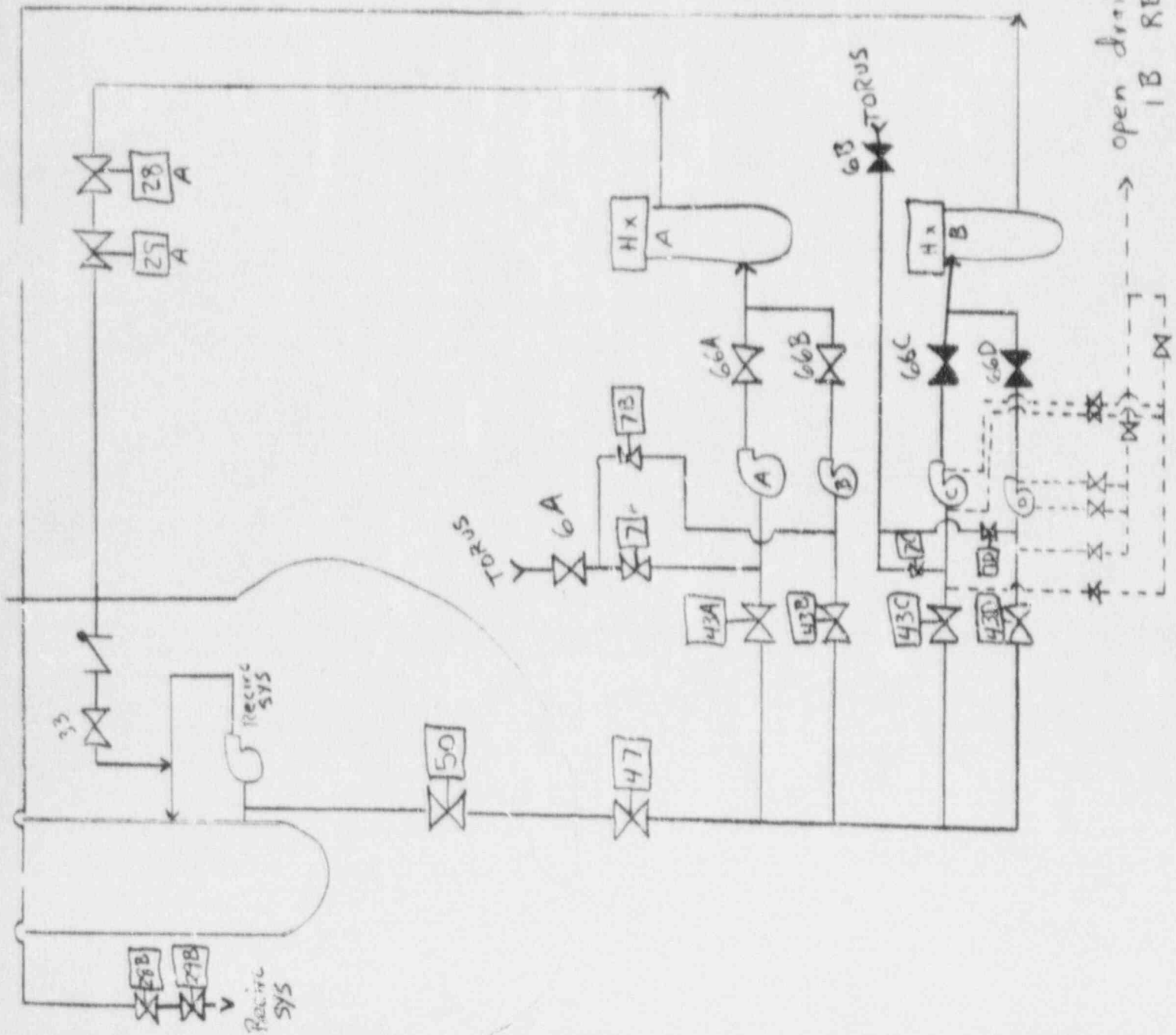
You and your team are to perform an inspection to accomplish the following:

1. Develop and validate the sequence of events associated with the loss of reactor coolant inventory that occurred on Unit 1 on January 24, 1991.
2. Evaluate the adequacy of licensee preparation for the evolution with respect to personnel briefings, tag-outs, procedures, and overall coordination.
3. Determine the adequacy of the licensee's response to this event and whether the immediate actions taken and subsequent investigation was appropriate. In this regard, evaluate the apparent lack of a questioning attitude by the people involved, as evidenced by the decision to continue the evolution without a thorough understanding of what had earlier occurred.
4. Independently determine the root cause for the initial opening of the shutdown cooling suction valve, "1-1001-43C."
5. Determine and validate the volume of water discharged from the RCS to the Reactor Building.
6. Review communications between the Control Room and the Communications Center with regard to activities by maintenance and other non-operations personnel.
7. Review supervisory overview and control by the operating shift of in-plant activities by non-operating department personnel.
8. Review the administrative controls over in-plant activities with attention to activities by non-operating department personnel.
9. Review the implementation of lessons learned from the Braidwood Unit 1 event of October 4, 1990, and determine whether this current event could have been avoided by more effective actions.

You should inform the licensee that we expect that they will not consider plant startup until we are assured that they 1) thoroughly understand the event and its causes; and 2) have corrective actions in place to preclude a recurrence. Their findings and actions should be discussed with the Director or Deputy Director, Division of Reactor Projects.

Team and Management briefings should be conducted as follows:

1. A daily call at 10 a.m. (CST) between the Team Leader and B. Burgess, Chief, Reactor Projects Section 1B.
2. A daily conference call at 4 p.m. (CST) with Region III and NRR management. The Team Leader will coordinate a telephone bridge through the Headquarters Daily Officer.



open drain valves piped to IB RBFDS