UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-8931

January 31, 2000

MEMORANDUM TO: Leonard D. Wert
Team Leader
Augmented Inspection Team

FROM: Luis A. Reyes //RA//
Regional Administrator

SUBJECT: AUGMENTED INSPECTION TEAM CHARTER

An Augmented Inspection Team (AIT) has been established to inspect and assess the Hatch Unit 1 reactor trip and subsequent transient that occurred on January 26, 2000. The specific system failures and issues of concern are: (1) the loss of feedwater flow that initiated the transient; (2) the problems experienced when attempting to operate the pressure relief system; (3) the problems with restoring operation of the reactor core isolation cooling (RCIC) system following the high reactor vessel water level trip; (4) the failure of the high pressure coolant injection (HPCI) system to trip on high reactor vessel water level; and, (5) the cause and contributing factors for flooding of the main steam system.

The team composition is as follows:

Team Leader:	L. Wert (RII)
Team Members:	J. Munday (RII)
	T. Fredette (RII)
	J. Starefos (RII)
	W. Bearden (RII)
	G. Hammer (NRR)

The objectives of the inspection are to: (1) determine the facts surrounding the specific event; (2) assess the licensee response to the event; (3) assess licensee activity during their event review and recovery; and, (4) assess the generic aspects of the system failures and any operational issues.

For the period during which you are leading this inspection and documenting the results, you shall report directly to me. The guidance of NRC Inspection Procedure 93800, “Augmented Inspection Team,” and Management Directive 8.3, “NRC Incident Investigation Procedures,” apply to your inspection. If you have any questions regarding the objectives of the attached charter, contact me.

Attachment: AIT Charter

cc w/att: (See Page 2)

cc w/att: F. Miraglia, DEDR
S. Collins, NRR
H. Berkow, NRR
T. Marsh, NRR
F. Congel, OEDO
M. Tschiltz, OEDO
J. Munday, RII
C. Casto, RII
R. Wessman, NRR

AUGMENTED INSPECTION TEAM CHARTER
PLANT HATCH UNIT 1
FEEDWATER TRANSIENT AND REACTOR TRIP

Basis for the formation of the AIT - The reactor trip and subsequent transient at Hatch Unit 1 on January 26, 2000, appears to have the characteristics which meet the criteria of Management Directive 8.3, including: (1) multiple failures in safety-related systems; (2) possible adverse generic implications; and, (3) complications with probable causes unknown or difficult to understand.

Associated with the reactor trip of Hatch Unit 1 on January 26, 2000, the specific system failures of concern are: (1) the loss of feedwater flow that initiated the transient; (2) the problems experienced when attempting to operate the pressure relief system; (3) the failure of the high pressure coolant injection system to trip on high reactor vessel level; (4) the problems with restoring reactor core isolation cooling system operation following the high reactor vessel level trip; and, (5) the cause and contributing factors for flooding of the main steam system. Accordingly, the objectives of the inspection are to: (1) determine the facts surrounding the specific event; (2) assess the licensee response to the event; (3) assess licensee activity during their event review and recovery; and, (4) assess the generic aspects of the system failures. To accomplish these objectives, the following will be performed:

- Develop a sequence of events associated with the event of concern
- Assess the performance of plant systems during the event
- Assess the performance of licensed operators during the event
- Assess the licensee's activities related to the event investigation (e.g., root cause analysis, extent of condition, precursor event review, etc.) and evaluate the effectiveness of the related event review team
- Assess the licensee's activities related to event recovery (e.g., actions to restore system operability)
- Assess the potential impact of the partially flooded main steam system on the design basis operation of RCIC, HPCI, and pressure relief system
- Assess the potential generic aspects of the safety relief valve operation and the operation of RCIC and HPCI
- Document the inspection findings and conclusions in an inspection report within 30 days of the inspection
- Conduct a public exit meeting

ATTACHMENT