Callaway
1Q/2003 Plant Inspection Findings

Initiating Events

Significance: Dec 28, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadequate control of over temperature-delta temperature delta flux penalty circuit amplifier gain resulted in a reactor trip.
A noncited violation of 10 CFR Part 50, Appendix B, Criteria III, Design Control, occurred when the licensee failed to maintain control of the over temperature-delta temperature delta flux penalty circuit amplifier gain. The finding was greater than minor because the condition resulted in a transient initiator and contributed to an unplanned reactor trip, an initiating event. This finding was evaluated using Appendix A of the reactor safety significance determination process and determined to be of very low safety significance because the finding did not contribute to the likelihood of a primary or secondary system loss of coolant accident, did not contribute to both the likelihood of a reactor trip and the unavailability of mitigation equipment, and did not increase the likelihood of a fire or flood. This finding is in the licensee's corrective action system as Callaway Action Request System Number 200208352.
Inspection Report# : 2002006*(pdf)*

Mitigating Systems

Significance: Mar 22, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure of the turbine-driven auxiliary feed pump due to incorrectly manufactured and installed part.
A noncited violation of 10 CFR Part 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, for failure to correctly manufacture and install a valve stem on the turbine-driven auxiliary feedwater turbine. Appropriate quantitative and qualitative measures were not utilized to assure that the valve stem was manufactured to the correct dimensions, as required by Appendix B, prior to installation. This finding had actual safety significance because the condition resulted in the failure of the turbine-driven auxiliary feedwater pump to respond to a valid demand signal. The finding was more than minor because it was associated with the mitigating system equipment performance cornerstone attribute and adversely affected the availability/reliability cornerstone objective. This finding was of very low safety significance because the condition was not a design or qualification deficiency, did not represent the actual loss of a safety function of a system, did not represent the actual loss of a safety function of a single train for greater than its Technical Specification allowed outage time, did not represent the loss of a non-Technical Specification related train for greater than 24 hours, or did not screen as potentially risk significant due to a seismic, fire, flooding, or severe weather initiating event.
Inspection Report# : 2003003*(pdf)*

Significance: N/A Aug 23, 2002
Identified By: NRC

Item Type: FIN Finding
Assessment of corrective actions for inoperable auxiliary feedwater pump.
The NRC performed this supplemental inspection to assess the licensee's corrective actions associated with the inoperability of a motor-driven auxiliary feedwater pump. This performance issue was previously characterized as having low to moderate risk significance in NRC Inspection Report 50-483/02-07. During this inspection, the NRC concluded that the licensee had effectively identified and implemented corrective actions for the root and contributing causes for the inoperability of the auxiliary feedwater pump. Based on effective implementation of the corrective actions, it appeared that the inoperability of the pump as a result of foam being entrained in the suction of the pump, was adequately addressed. The effectiveness of the overall corrective action program changes documented in NRC Inspection Report 50-483/02-09, and the licensee's letter to NRC, dated May 8, 2002, will be reviewed during the Problem Identification and Resolution inspection, currently scheduled for December 2002. The performance issue associated with the White inspection finding will remain open until that review is completed.
Inspection Report# : 2002009*(pdf)*

Significance:  Jul 06, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate corrective action for diesel generator overspeed trip switch.
A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, occurred because the corrective action taken by the licensee regarding the emergency diesel Generator B overspeed trip switch was inadequate. On June 21, 2001, the screws that held the overspeed trip switch intact were found to be loose. The emergency diesel generator had to be removed from service for repair. Repair consisted of tightening the screws that held the switch in place. No other repair action was taken nor was a root cause analysis conducted. On April 9, 2002, the same screws on the same switch were loose and found to be damaged. This also required the emergency diesel generator to be removed from service for repair. Procedure APA-ZZ-00500, "Corrective Action Program," Revision 31, required that a thorough root cause analysis be performed for this level deficiency. The corrective actions taken in response to the first failure, including the failure to perform a root cause analysis, were not adequate to prevent the second failure. This problem identification and resolution finding was more than minor because failure of the overspeed trip switch could have made the diesel generator inoperable. This finding affected the mitigating system cornerstone. The finding was found to be of very low safety significance using the significance determination process because the emergency diesel generator was not determined to be inoperable and the other emergency diesel generator was available. Because this finding was of very low safety significance, and the finding was entered into the licensee's corrective action program as Callaway Action Request System Numbers 200103939 and 200202342, it is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy (Section 40A2.1).
Inspection Report# : 2002002*(pdf)*

Significance:  Jun 25, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Unsecured fire door.
A noncited violation of Operating License Condition 2.C(5)(c) occurred when the licensee failed to take compensatory action when the 3-hour rated fire doors that separated the two trains of control room air conditioning were unlatched and not closed. This finding is more than minor because if a fire had occurred while the doors were unlatched and not closed, they could not perform their function of preventing a fire from spreading from one fire area to another fire area. This finding affected the mitigating system cornerstone. This finding was evaluated using Appendix F of the reactor safety significance determination process and determined to be of very low safety significance because the combustible load for the area was low and because the fire detectors on each side of the doors were operable. This finding was entered into the licensee's corrective action system as Callaway Action Request System Number 200204041.

Inspection Report# : 2002002*(pdf)*

Significance: G May 24, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate calculation of diesel loading.
Requirements in Procedure EDP-ZZ-04023, "Calculations", Revision 14, were not applied correctly to the diesel generator steady-state loading calculation contained in Callaway Drawing E-21005, "List of Loads Supplied by Emergency Diesel Generator," Revision 25. The drawing functioned as a calculation, but lacked the quality requirements for calculations required by this procedure. The failure to follow procedural requirements was identified as a violation of Criterion V to 10 CFR Part 50, Appendix B, "Instructions, Procedures, and Drawings." This finding was of very low safety significance since there was no actual loss of safety function (the diesel generators retained adequate margin). Because of the low safety significance and the licensee's action to place the issue in their corrective action program (CAR 200203017), this violation is being treated as a noncited violation in accordance with Section VI.A.1 of the Enforcement Policy
Inspection Report# : 2002004*(pdf)*

Significance: G May 24, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to control design input for degraded voltage relay calculation.
Calculation E-B-21, "LSELS Degraded Voltage Setpoint Calculation," Revision 0, used to determine the degraded voltage relay dropout setting, referred to superseded calculations for important design inputs, and had not been updated to reflect plant configuration and loading changes. This was contrary to the requirement in Procedure EDP-ZZ-04023 that calculations be revised whenever a new or revised calculation (having an effect on the calculation) is issued. The failure to follow procedural requirements was identified as a violation of Criterion V to 10 CFR Part 50, Appendix B, "Instructions, Procedures, and Drawings." This finding was of very low safety significance since there was no actual loss of safety function (the degraded voltage relay setpoint remained valid). Because of the low safety significance and the licensee's action to place the issue in their corrective action program (CARs 200203080 and 200203057), this violation is being treated as a noncited violation in accordance with Section VI.A.1 of the Enforcement Policy.
Inspection Report# : 2002004*(pdf)*

Significance: G May 24, 2002
Identified By: NRC
Item Type: FIN Finding
Incomplete and incorrect methods to evaluate degraded voltage conditions.
Two licensee calculations contained incomplete and incorrect methods of evaluating degraded voltage conditions. Calculation E-B-21, "LSELS Degraded Voltage Setpoint Calculation," Revision 0, did not consider the voltage requirements for non-motor loads in determining the degraded voltage relay setting. In addition, Calculation ZZ-214, "Motor Operated Valve Feeder Cable Voltage Drops," Addenda 1, Revision 2, for determining minimum voltage to motor-operated valves, did not consider the effect of motor starting currents in circuit elements upstream of the motor control centers. This finding, which did not involve a violation of NRC requirements, was of very low safety significance because the calculation errors did not result in an actual loss of safety function (the degraded voltage relay setpoint remained valid).
Inspection Report# : 2002004*(pdf)*

Significance: G Apr 23, 2002
Identified By: Self Disclosing
Item Type: FIN Finding
Foreign material in condensate transfer system.
A leather weld rod pouch lodged inside the fill valve to the condensate storage tank could have adversely affected the auxiliary feedwater system if the pouch became dislodged while filling the tank. This finding is more than minor because the lack of foreign material exclusion controls could have resulted in the leather weld rod pouch entering the condensate storage tank and adversely affecting the auxiliary feedwater system. This finding affects the mitigating system cornerstone. This finding was found to be of very low safety significance using the reactor safety significance determination process because no loss of safety function occurred and only one of three auxiliary feedwater pumps would have been affected. This finding was entered into the licensee's corrective action program as Callaway Action Request System Number 200202678.
Inspection Report# : 2002002*(pdf)*

Barrier Integrity

Significance: G Jan 08, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to isolate an inoperable containment penetration flow path.
A noncited violation of Technical Specification Action 3.6.3, Containment Isolation Valves, occurred when the licensee failed to isolate an inoperable component cooling water containment penetration flow path within the prescribed 4 hours. This finding had actual safety significance because it resulted in one of two automatic containment isolation engineering features to be disabled and would have become a more significant safety condition if left uncorrected. This finding was more than minor because it was associated with barrier performance, the containment isolation reliability cornerstone attribute, and adversely affected the barrier integrity cornerstone objective. This finding was evaluated using Appendix A of the reactor safety significance determination process and determined to be of very low safety significance because the condition did not affect the control room barrier function or represent an actual open containment pathway.
Inspection Report# : 2003003*(pdf)*

Emergency Preparedness

Significance: TBD Mar 21, 2003
Identified By: NRC
Item Type: AV Apparent Violation
Failure to meet the Alert Notification System design criteria due to programmatic deficiencies resulting in an inaccurate Tone Alert Radio database in apparent violation of 10 CFR 50.47(b)(5).
Between September 1998, and November 2002, due to programmatic inadequacies, a small percentage of residences in the licensee's plume exposure emergency planning zone would not have received an emergency alerting signal in the event of an emergency at the Callaway facility. The failure to establish a means to notify members of the public in the emergency planning zone was a violation of 10 CFR 50.47(b)(5), and also represented an apparent human performance cross cutting issue involving the timely recognition and correction of degraded conditions. The finding had greater than

minor significance because the condition resulted in a loss of alert notification capability to about 1.5 percent of the emergency planning zone population, and if left uncorrected the condition would have continued to degrade. Using the Emergency Preparedness Significance Determination Process the finding was preliminarily determined to have low to moderate safety significance (White) because it was a violation of 10 CFR 50.47(b)(5) and represented a risk-significant planning standard degraded function failure. This finding was entered in the licensee's corrective action program as Callaway Action Request System Item CARS 200208007.
Inspection Report# : 2003008*(pdf)*

Occupational Radiation Safety

Significance:  Feb 13, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to perform radiological surveys.
Inspectors identified two examples of a violation of 10 CFR 20.1501(a) for failure to perform radiological surveys. The licensee failed to collect airborne samples to evaluate the potential for airborne activity during the removal and reinstallation of contaminated insulation on Valve BB8378A on October 29 and November 15, 2002, respectively. This violation is being treated as a noncited violation consistent with Section VI.A.1 of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Callaway Action Request System Number 200300355. The issue was more than minor because the failure to perform a radiological survey has the potential for unplanned or unintended dose which could have been significantly greater as a result of higher levels of airborne activity. The safety significance of this finding was determined to be very low by the Occupational Radiation Safety Significance Determination Process because it did not involve ALARA planning and controls, there was no personnel overexposure, there was no substantial potential for personnel overexposure, and the finding did not compromise the licensee's ability to assess dose.
Inspection Report# : 2003003*(pdf)*

Public Radiation Safety

Physical Protection

Significance: N/A Feb 14, 2003
Identified By: NRC
Item Type: FIN Finding
Verification of Compliance With Interim Compensatory Measures Order
On February 25, 2002, the NRC imposed by Order, Interim Compensatory Measures to enhance physical security. The inspectors determined that, overall, the licensee appropriately incorporated the Interim Compensatory Measures into the site protective strategy and access authorization program; developed and implemented relevant procedures; ensured that the emergency plan could be implemented; and established and effectively coordinated interface agreements with offsite organizations.
Inspection Report# : 2003002*(pdf)*

Miscellaneous

Significance: N/A Jan 30, 2003
Identified By: NRC
Item Type: FIN Finding
Implementation of identification and resolution of problems program
Issues associated with a failure to identify and adequately evaluate an operability issue associated with the auxiliary feedwater system and two examples of inadequate corrective actions for conditions adverse to quality provided indications that the licensee had weaknesses in their problem identification and resolution program. The team found the licensee effectively implemented changes to address these problem identification and resolution program weaknesses. Problems were identified at the proper threshold and entered into the corrective action program. Risk information was effectively used to prioritize the extent of evaluation and to determine the schedule for implementation of corrective actions. Corrective actions, when specified, were typically implemented in a timely manner. During interviews workers indicated no reluctance to place safety issues into the problem identification and resolution program. However, a licensee survey indicated that some employees felt that they had received negative repercussions for raising issues.
Inspection Report# : 2002003*(pdf)*

Significance: SL-III May 14, 2001
Identified By: NRC
Item Type: VIO Violation
Discrimination against a security officer and a training instructor for having engaged in protected activity
10 CFR 50.7(a) prohibits discrimination by a Commission licensee against an employee for engaging in certain protected activities. On October 27, 1999, the security officer and the training instructor identified to the Wackenhut Corporation a violation of NRC requirements at the Callaway Nuclear Plant. Based at least in part on this protected activity, the Wackenhut Corporation unfavorably terminated the security officer's employment for lack of trustworthiness and gave a written reprimand to the training instructor on November 19, 1999. In consideration of the severity of the actions taken against the former security officer and the training instructor, the level of management involved in the adverse action, and the nature of contractor/licensee relationships, this violation has been categorized in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 at Severity Level III (EA-01-005, dated May 14, 2001).
Inspection Report# : 2001003*(pdf)*

Last modified : May 30, 2003