



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-4005**

November 7, 2003

EA-03-060

Garry L. Randolph, Senior Vice
President and Chief Nuclear Officer
Union Electric Company
P.O. Box 620
Fulton, Missouri 65251

**SUBJECT: CALLAWAY PLANT - NRC SUPPLEMENTAL INSPECTION REPORT
05000483/2003012**

Dear Mr. Randolph:

On September 8 through 10, 2003, the NRC conducted an onsite supplemental inspection at your Callaway Plant, and completed an in-office inspection between October 27 and 30, 2003. A preliminary exit meeting was held onsite on September 10, 2003, and a telephonic conference exit call was held with plant management on October 30, 2003. The enclosed report documents the inspection findings which were discussed with you and other members of your staff.

The NRC issued a White inspection finding and Notice of Violation in Inspection Report 50-483/03-08. This finding involved a failure to meet the requirements of planning standard 10 CFR 50.47(b)(5). The performance weakness associated with this finding involved a failure to establish a means to notify members of the public in the emergency planning zone of an emergency using tone alert radios in areas lacking effective siren coverage.

This supplemental inspection was conducted to provide assurance that the root and contributing causes of the White inspection finding were understood and to provide assurance that the corrective actions were sufficient to address the causes, and prevent recurrence of the problems. Detailed observations, assessments, and conclusions of the inspection are presented in the enclosed inspection report.

The inspection concluded that the root causes of the finding were appropriately evaluated and understood. The corrective actions implemented as a result of your evaluations addressed the root and contributing causes.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Union Electric Company

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Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

Dwight D. Chamberlain, Director
Division of Reactor Safety

Docket: 50-483
License: NPF-30

Enclosure:
NRC Inspection Report
05000483-2003012

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket: 50-483
License: NPF-30
Report: 05000483/2003012
Licensee: Union Electric Company
Facility: Callaway Plant
Location: Junction Highway CC and Highway O
Fulton, Missouri
Dates: September 8 through 22, and October 27 through 30, 2003
Inspector: Paul J. Elkmann, Emergency Preparedness Inspector
Approved: Dwight D. Chamberlain, Director, Division of Reactor Safety

SUMMARY OF FINDINGS

Callaway Plant
NRC Inspection Report 50-483/03-12

IR 05000483-2003012; 09/08-22/2003; Callaway Plant; Supplemental Inspection for one White finding in the emergency preparedness cornerstone.

The supplemental inspection was conducted by a region-based emergency preparedness inspector. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using Inspection Manual Chapter 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

A. Inspector Identified Findings

Cornerstone: Emergency Preparedness

The NRC performed this supplemental inspection to assess the licensee's evaluation associated with the failure to meet requirements of 10 CFR 50.47(b)(5), in that the licensee did not establish a means to notify members of the public in the emergency planning zone of an emergency using tone alert radios in areas lacking effective siren coverage. This performance issue was previously characterized as having low to moderate risk significance (White) in NRC Inspection Report 50-483/03-08. During this supplemental inspection, performed in accordance with Inspection Procedure 95001, the inspector determined that the licensee performed a satisfactory evaluation of the White finding. The licensee's evaluation identified the primary root causes of the performance issue to be: (1) situations that were not covered in procedures, (2) inadequate supervision of the Senior Nuclear Clerks, and (3) turn-over processes for the Senior Nuclear Clerks required improvement.

Given the licensee's acceptable performance in addressing the issue, the White finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in Inspection Manual Chapter 0305, "Operating Reactor Assessment Program." The issue was identified in the first quarter of 2003, therefore it will no longer be considered in assessing plant performance after the fourth quarter of 2003.

Report Details

01 INSPECTION SCOPE

The NRC performed this supplemental inspection to assess the licensee's evaluation associated with the failure to establish a means to notify members of the public in the emergency planning zone of an emergency using tone alert radios in areas lacking effective siren coverage. This performance issue was previously characterized as having low to moderate risk significance (White) in NRC Inspection Report 50-483/03-08 and is related to the emergency preparedness cornerstone in the reactor safety strategic performance area. The licensee's evaluation consisted of:

- Root Cause Analysis AUCA-03-006, "Number of Residences in the EPZ Found to Not Have Tone Alert Radios"
- Callaway Action Request System (CARS) 200208007, "Number of Residences in the EPZ Found to Not Have Tone Alert Radios"
- CARS 200300778, "Request for Review of Outside Support of Regulatory Responsibilities"
- CARS 200301479, "Update Process to Identify the Hearing-Impaired in the EPZ"
- CARS 200303795, "Revise EPZ Information Brochure"
- CARS 200304756, "Consolidate Maps used to determine Eligibility for Tone Alert Radios"
- CARS 200306307, "Incomplete Action taken on Closure of Tone Alert Radio CARS 200208007"
- SEGR 03-08-003, "Independent Technical Review Report on Tone Alert Radio Distribution"

02 EVALUATION OF INSPECTION REQUIREMENTS

02.01 Problem Identification

- a. Determination of who (i.e., licensee, self-revealing, or NRC) identified the issue and under what conditions.

The licensee identified this issue as a result of a routine tone alert radio surveillance conducted November 2002. The surveillance revealed that an unexpectedly high number of new utility connections had been received (the licensee uses new utility connection information to identify households which are outside effective siren coverage). Subsequent investigation by the licensee determined that customers had been transferred between electric service providers, that some existing connections had not been reported to the licensee, that the licensee had not adequately evaluated all new utility connections that had been received, and that tone alert radios had not been issued to some households in the emergency planning zone.

- b. Determination of how long the issue existed, and prior opportunities for identification.

The licensee last validated their tone alert radio database in 1998 following a problem which also resulted in some households not receiving tone alert radios. As part of the investigation into the 2002 event, the licensee determined that the 1998 validation had been incomplete because one electric service provider was unable to supply customer data specific to the emergency planning zone. In 2002, the licensee attempted to validate its emergency planning zone data base using the original customer service requests and records rather than a computer-generated customer report. Because of incomplete or missing historical records kept by the same electric service provider, the licensee was unable to clearly determine when the electrical connection information needed to issue tone alert radios became inaccurate. Nevertheless, the inspector concluded that the licensee had performed a full validation of its tone alert database in 2002 and that tone alert radios had been appropriately issued to all households requiring them.

The licensee determined that there were no previous opportunities to identify that they were not being provided complete information about new utility connections in the emergency planning zone. Specifically, the scope of the licensee's ongoing quality assurance audit, and self-assessment activities would not have extended to reviews of activities performed by the electric service providers. The inspector agreed with the licensee's evaluation.

- c. Determination of the plant-specific risk consequences (as applicable) and compliance concerns associated with the issue.

The licensee evaluated this issue as having only moderate safety significance because: (1) the likelihood of a large early release due to a steam generator tube rupture or loss of coolant accident is less than $1E-7$ per year, and (2) best-estimate radiological calculations suggested that households requiring tone alert radios would not require dose-driven protective actions following a serious radiological accident. The inspector concluded that the licensee's safety significance determination did not consider emergency preparedness as a defense-in-depth measure, or the NRC's planning basis for radiological accidents.

The inspector determined that compliance aspects of the failure to distribute tone alert radios within the emergency planning zone was addressed in CARS 200304665, "Tone Alert Radio Notice of Violation and White Finding".

02.02 Root Cause and Extent of Condition Evaluation

- a. Evaluation of methods used to identify root causes and contributing causes.

The licensee used a combination of structured root cause analysis techniques to evaluate this issue including event and causal factors analysis, the Taproot method, and the Institute of Nuclear Power Operation's Human Performance Enhancement System. The inspector determined that the licensee followed its procedures for performing root cause analysis.

b. Level of detail of the root cause evaluation.

The licensee's overall analysis was conducted to an acceptable level of detail. The inspector determined that all necessary analysis activities were captured in Callaway Action Requests (CARS, corrective action system entries) and that these documents, together with the root cause analysis report, identified and documented the root causes for this event.

The licensee determined that three causal factors were associated with this issue:

- Corrective actions from a previous event were inadequate to prevent recurrence
- Receipt of utility connection reports generated by the electric service providers were not addressed in procedures
- The Desk Top Instructions used by the Senior Nuclear Clerks did not contain an adequate level of detail to describe their tasks.

The licensee identified eight root causes associated with the causal factors, and two contributing causes:

- Situations that were not covered in procedures
- Inadequate supervision of the Senior Nuclear Clerks
- Turn-over processes for the Senior Nuclear Clerks required improvement
- Continuing training needs improvement
- Correction action needs improvement
- Tasks performed by the Senior Nuclear Clerks were not analyzed
- Communications with other work groups needs improvement
- Procedures or direction were confusing or incomplete
- The Annual Public Information Brochure distributed within the emergency planning zone does not give clear instructions on requesting a tone alert radio if the residence does not have one (contributing)
- Inadequate communication occurred between supervision and clerks, clerks and customers, and between the Callaway EP Department and AmerenUE Jefferson City offices (contributing)

The inspector evaluated the root cause analysis document against the requirements of the licensee's procedure APA-ZZ-00500, "Corrective Action Program," Revision 34, and determined that the root cause analysis contained all of the required elements.

The licensee identified inadequate corrective actions for Suggestion Occurrence Solution SOS-199803339 as a causal factor for the failure to distribute tone alert radios identified in 2002. The licensee determined that corrective actions in 1998 were inadequate or incomplete because all of the causal factors were not identified due to a lack of knowledge about root cause analysis methods. NRC Inspection Report 50-483/2003-08 noted that not all of the corrective actions identified for SOS-199803339 were completed, in that the tone alert database had not been corrected. The inspector concluded that the 1998 corrective actions were incomplete because corrective actions were not identified or implemented for one of the identified causes. Specifically, the licensee identified one root cause of the 1998 event as inadequate turnovers provided to successive Senior Nuclear Clerks, yet none of the corrective actions taken in 1998 addressed improving the turnover process.

- c. Consideration of prior occurrences of the problem and knowledge of prior operating experience.

The licensee conducted a key-word search of their corrective action database and identified four previous events connected with tone alert radios. One of these events (CAR 199803339) was nearly identical to this event in that it also involved a failure to distribute tone alert radios due to inadequacies in the emergency preparedness database. The licensee determined that inadequate corrective actions from this prior event were a causal factor for this issue.

The licensee also performed a review of external operating experience using the Institute of Nuclear Power Operations database and was unable to identify any similar issues. The inspector did not identify any contrary information.

- d. Consideration of potential common cause(s) and extent of condition of the problem.

The inspector concluded that the licensee's overall extent of condition review as documented by the corrective action process was acceptable. The inspector determined that the licensee's extent of condition review involved: (1) identification of the number of households which had not been issued tone alert radios, (2) review of emergency preparedness programs to identify instances where databases critical to the EP function might be compromised, and (3) an assessment (CARS 20030778) to identify all cases where they relied on outside organizations to ensure compliance with regulatory responsibilities. The licensee concluded that no other program relied on activities or data provided by outside organizations. The inspector determined that the action items for CAR 20030778 were complete.

The failure to distribute tone alert radios constituted a non-compliance with the licensee's Federal Emergency Management Agency Alert and Notification System Design Report. The inspector determined that the licensee completed two reviews of the design report

(Quality Assurance Audit report AP 02-016 and CARS 20025615) and determined that there were no additional concerns. The inspector's agreed with the licensee's evaluation.

The NRC defines extent of cause as "the extent to which the root causes of an identified problem have impacted other plant processes, equipment, or human performance." The inspector determined that the licensee's root cause analysis process required that a generic implications review be performed to determine if the causes of the condition impacts other equipment, programs, procedures, or operations. The licensee completed the evaluation by performing a trend analysis of root cause codes and key words, and by interviewing personnel that may be affected by the root causes. The inspector determined that the licensee's extent of cause review appropriately assessed the scope of the identified concerns.

02.03 Corrective Actions

a. Appropriateness of corrective actions

The licensee took extensive immediate corrective actions, which included:

- 1) Additional electric service provider data to validate the customer list in the tone alert radio database
- 2) Telephone calls to 108 households to determine whether they had been issued radios, and whether they were within siren coverage
- 3) Immediate delivery of additional tone alert radios from the vendor
- 4) Provisions for mobile route alerting in areas identified as lacking tone alert radios through the Callaway County Emergency Management Director
- 5) Delivery of approximately 90 new tone alert radios to households in the emergency planning zone approximately 20 days after initial identification of the problem

The inspector determined that the immediate corrective actions addressed the safety concern of a failure to establish a means to notify members of the public in the emergency planning zone of an emergency using tone alert radios in areas lacking effective siren coverage. The inspector determined that compliance with planning standard 10 CFR 50.47(b)(5) had been restored approximately 20 days after discovery of the event and all immediate corrective actions had been completed in an acceptable time.

The licensee's long-term corrective actions included:

- 1) Verification of the current service territories of each electric service provider doing business within the emergency planning zone

- 2) A task analysis of the duties of the Senior Nuclear Clerks with regard to distributing tone alert radios
- 3) Replacement of the previous Desk Top Instruction describing distribution of tone alert radios with procedure KSP-ZZ-00008, "Tone Alert Radios," Revisions 0 and 1
- 4) Training to the Senior Nuclear Clerks responsible for distributing tone alert radios regarding procedure KSP-ZZ-00008, along with their supervisor; the licensee also designated a back-up Senior Clerk and provided similar training
- 5) Establishment of a Memorandum of Understanding with electric service providers to formalize the collection and reporting of customer hookup data to the licensee
- 6) Upgraded computer programs used by Ameren to replace field connection documents with a unified monthly computer-generated report
- 7) Revision of Surveillances ST-12055, ST-12100, ST-12101, and ST-2102, to provide better directions and standards for documenting the receipt of utility connection data and the distribution of tone alert radios
- 8) Revision of the annual tone alert data base surveillance to require that all electric service providers be audited in a rolling three year period
- 9) Revision of the text of the annual Emergency Planning Zone Brochure to provide additional information about requesting tone alert radios
- 10) Replacement of several outdated individual maps with a single set of large scale maps which included county roads, siren coverage zones and electric transformer locations. The licensee also assumed responsibility to update and maintain these maps as needed
- 11) Revision of the text of annual advertisements placed in local media by the licensee to provide additional information about requesting tone alert radios

The licensee identified an inadequate turn-over process for Senior Nuclear Clerks as one of the causes of the 1998 event which resulted in inadequate distribution of tone alert radios. A need to improve turn-over processes for Senior Nuclear Clerks was also identified as a root cause of the 2002 failure to distribute tone alert radios. The inspector determined that corrective actions for the 1998 event were inadequate in part because no actions were taken to improve turn-over processes. One of the licensee's long-term corrective actions for the 2002 event was to require the Supervisors of Senior Nuclear Clerks to become more knowledgeable about tone alert radio distribution, and for them to monitor or perform the turn-over. The inspector identified that the licensee had developed no additional training, checklists, or guidance to ensure consistency in performing turn-overs. The inspector concluded that the lack of standards for performing turn-overs could represent a future vulnerability. The licensee initiated CARS

200306726, "Evaluate Formalizing the Tone Alert Radio Clerk Turnover Process" to address this concern.

The inspector determined that the corrective actions were responsive to all of the root and contributing causes identified by the licensee.

b. Prioritization of corrective actions.

The inspector concluded that the corrective actions were properly prioritized. Actions of an immediate nature were given the highest priority and the provision of new tone alert radios was accomplished on an acceptable schedule. Actions to establish the reliability of future utility connection data were given the next priority, followed by actions to provide better guidance to the Senior Nuclear Clerks. A completion date and a responsible manager were assigned for each corrective action, and these were tracked through the corrective action system.

c. Establishment of a schedule for implementing and completing the corrective actions.

The inspector determined that the licensee had completed all corrective actions for the root cause analysis and for the associated Callaway Action Requests (CAR) 200208007, 200300778, 200301479, 200303795, 200304756, and 200306307, with the exception of a post-implementation effectiveness review. The inspector reviewed a sample of six corrective actions and concluded that they had been implemented successfully although in some cases formal documentation was lacking, such as completion of a task analysis of the tone alert distribution process to support procedure development. The inspector also determined that the thoroughness of some corrective actions, such as resolution of "grey areas" in the Desk Top Instructions, could not be evaluated because the root cause analysis and corrective actions did not identify the specific weaknesses which constituted "grey areas."

d. Establishment of quantitative or qualitative measures of success for determining the effectiveness of the corrective actions to prevent recurrence.

The inspector determined that the root cause analysis included criteria for determining the future effectiveness of corrective actions: corrective actions will be evaluated as fully successful if less than or equal to five households in the emergency planning zone are found not to have received tone alert radios. The inspector concluded that the success criteria were acceptable. The licensee generated CAR 200300851 to track performance of the effectiveness review associated with the root cause analysis. This review is scheduled for the first quarter of 2004.

03 MANAGEMENT MEETINGS

Exit Meeting Summary

On September 10, 2003, the inspector presented the preliminary results of the supplemental emergency preparedness inspection conducted September 8-10, 2003, to Mr. G. Randolph, Senior Vice President and Chief Nuclear Officer, and other members of his staff. Mr. Randolph

acknowledged the observations presented. The inspector confirmed that proprietary information was not provided or examined during the inspection.

On October 30, 2003, the Plant Support Branch Chief, NRC Region IV, conducted a telephonic meeting to discuss the NRC's assessment of the root cause evaluation with Mr. Keith Young, Manager Regulatory Affairs, and other members of the licensees staff.

04 Other Activities

4OA3 Event Followup

The Final Significance Determination for NRC Inspection Report 05000483/2003008 documented a violation that involved a failure to distribute tone alert radios to households in the emergency planning zone which required them. The inspector reviewed the licensee's root cause determination and associated corrective action documents (Callaway Action Request System 200208007, 200300778, 200301479, 200303795, 200304665, 200304756, and 200306307) pertaining to the violation of the requirements of planning standard 10 CFR 50.47(b)(5). The licensee's evaluation identified three primary root causes. The licensee identified 11 correction actions which taken together: (1) validated the current tone alert database, (2) procedurized activities performed by the Senior Nuclear Clerks, (3) improved maps and other user aids, and (4) formalized program requirements and expectations between the licensee and the providers of information used to distribute tone alert radios.

The inspector concluded that the licensee's corrective actions addressed the root causes.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

K. Bruckerhoff, Supervisor, Emergency Preparedness
S. Crawford, Emergency Response Coordinator, Emergency Preparedness
G. Gilbert, Consulting Engineer, Corrective Actions
L. Graessle, Superintendent, Protective Services
J. Hiller, Engineer, Regulatory Affairs
G. Randolph, Senior Vice President, Generation, and Chief Nuclear Officer
M. Schnack, Supervising Engineering, Corrective Actions
C. Younk, Manager, Quality Assurance

NRC

M. Peck, Senior Resident Inspector

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None.

Opened and Closed During this Inspection

None.

Closed During this Inspection

50-483/0308-01	VIO	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) (EA-03-060).
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Previous Items Discussed

None.

DOCUMENTS REVIEWED

APA-ZZ-00500, "Corrective Action Program," Revision 34
KSP-ZZ-00007, "Offsite Effectiveness of the Emergency Preparedness Program," Revision 1
KSP-ZZ-00007, "Offsite Effectiveness of the Emergency Preparedness Program," Revision 2
KSP-ZZ-00008, "Tone Alert Radios," Revision 1
KSP-ZZ-00008, "Tone Alert Radios," Revision 2

Callaway Plant Alert and Notification System Design Report, July 2001 Revision

Onsite Review Committee Scorecard for Root Cause Analysis AUCA 03-006

Pre-Job Brief Overview for Root Cause Analysis AUCA 03-006

Root Cause Analysis AUCA 03-006, "Number of Residences in the EPZ found to not have Tone Alert Radios"

Root Cause Manual, Revision 1

Surveillance Task Sheet S71222563, "Monthly Distribution of Tone Alert Radios"

SEGR 03-08-003, "Independent Technical Review Report on Tone Alert Radio Distribution"

Callaway Action Request System 199803339, "RMS Supervisor Investigating Delay in Issuance of Tone Alert Radios to Residents of the Emergency Planning Zone discovered that no Tone Alert Radios had been issued to New Residents in the Emergency Planning Zone since January 1998"

Callaway Action Request System 200205505, "Update Definitions of "Generic Implications" and Extent of Condition"

CARS 200304665, "Tone Alert Radio Notice of Violation and White Finding"

CARS 200306726, "Evaluate Formalizing the Tone Alert Radio Clerk Turnover Process"

