UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

March 31, 2000

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

SUBJECT: PLANT PERFORMANCE REVIEW - CALLAWAY PLANT

Dear Mr. Randolph:

The purpose of this letter is to communicate our assessment of your performance and to inform you of our planned inspections at your facility. On March 8, 2000, we completed a Plant Performance Review (PPR) of Callaway Plant. We conduct these reviews to develop an integrated overview of the safety performance of each operating nuclear power plant. We use the results of the PPR in planning and allocating inspection resources and as inputs to our senior management meeting (SMM) process. This PPR evaluated inspection results and safety performance information for the one-year period through February 11, 2000, but emphasized the last 6 months to ensure that our assessment reflected your current performance. Our most recent summary of plant performance at Callaway Plant was provided to you in a letter dated March 19, 1999, and was discussed with you in a public meeting on April 1, 1999.

The NRC has been developing a revised reactor oversight process that will replace our existing inspection and assessment processes, including the PPR, the SMM, and the Systematic Assessment of Licensee Performance (SALP). We recently completed a pilot program for the revised reactor oversight process at nine participating sites and are making necessary adjustments based on feedback and lessons learned. We are beginning initial implementation of the revised reactor oversight process industry-wide, including your facility, on April 2, 2000.

This PPR reflects continued process improvements as we make the transition into the revised reactor oversight process. You will notice that the following summary of plant performance is organized differently from our previous performance summaries. Instead of characterizing our assessment results by SALP functional area, we are organizing the results into the strategic performance arenas embodied in the revised reactor oversight process. Additionally, in assessing your performance, we have considered the historical performance indicator data that you submitted in January 2000 in conjunction with the inspection results. The results of this PPR were used to establish the inspection plan in accordance with the new risk-informed inspection program (consisting of baseline and supplemental inspections). Although this letter incorporates some terms and concepts associated with the new oversight process, it does not reflect the much broader changes in inspection and assessment that will be evident after we have fully implemented our revised reactor oversight process.

Template RGN-001

During the last 6 months, Callaway Plant operated at or near full power; however, the period included a refueling outage and two reactor trips. Although the NRC identified some performance issues during this assessment period, we note that Callaway Plant continues to operate in a safe manner.

In the reactor safety strategic arena, performance resulted in safe operation. Program weaknesses and material condition issues involving, for example, the essential service water system, have been captured by your corrective action program. Personnel errors identified during this assessment period also appeared to be isolated and not programmatic in nature. However, some of the personnel errors point to previously identified challenges in Workman's Protection Assurance (protective tagging) activities. All of these issues can be adequately reviewed within the baseline inspection program.

We did not identify any significant performance issues in the radiation safety or safeguards strategic arenas. Therefore, based on our overall assessment, only baseline inspections are planned.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were used during this PPR process to arrive at our integrated view of your performance trends. The PIM for this assessment is grouped by the prior SALP functional areas of operations, maintenance, engineering and plant support, although the future PIM will be organized along the cornerstones of safety as described in the revised reactor oversight process. The enclosed PIM includes items summarized from inspection reports or other docketed correspondence regarding Callaway Plant. We did not document all aspects of licensee programs and performance that may be functioning appropriately. Rather, we only documented issues that we believe warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since our last inspection report was issued but had not yet received full review and consideration. We will make this material publically available as part of the normal issuance of our inspection reports and other correspondence.

Enclosure 2 lists our planned inspections for the period April 2000 through March 2001 at Callaway Plant to allow you to resolve scheduling conflicts and personnel availability in advance of our inspector arrival onsite. The inspection schedule for the latter half of the period is more tentative and may be adjusted in the future due to emerging performance issues at Callaway Plant or other Region IV facilities. We also included some NRC noninspection activities in Enclosure 2 for your information. Routine resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at 817-860-8148.

Sincerely,

William D. Johnson, Chief
Project Branch B
Division of Reactor Projects

Docket No.: 50-483
License No.: NPF-30

Enclosures:
1. Plant Issues Matrix
2. Inspection Plan

cc w/enclosures:
Professional Nuclear Consulting, Inc.
19041 Raines Drive
Derwood, Maryland 20855

John O'Neill, Esq.
Shaw, Pittman, Potts & Trowbridge
2300 N. Street, N.W.
Washington, D.C. 20037

H. D. Bono, Supervising Engineer
Quality Assurance Regulatory Support
Union Electric Company
P.O. Box 620
Fulton, Missouri 65251

Manager - Electric Department
Missouri Public Service Commission
301 W. High
P.O. Box 360
Jefferson City, Missouri 65102

Ronald A. Kucera, Director
of Intergovernmental Cooperation
P.O. Box 176
Jefferson City, Missouri 65102

Otto L. Maynard, President and
Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, Kansas 66839

Dan I. Bolef, President
Kay Drey, Representative
Board of Directors Coalition
for the Environment
6267 Delmar Boulevard
University City, Missouri 63130

Lee Fritz, Presiding Commissioner
Callaway County Court House
10 East Fifth Street
Fulton, Missouri 65151

Alan C. Passwater, Manager
Licensing and Fuels
AmerenUE
One Ameren Plaza
1901 Chouteau Avenue
P.O. Box 66149
St. Louis, Missouri 63166-6149

J. V. Laux, Manager
Quality Assurance
Union Electric Company
P.O. Box 620
Fulton, Missouri 65251

Jerry Uhlmann, Director
State Emergency Management Agency
P.O. Box 116
Jefferson City, Missouri 65101

Mayor of Chamois
Star Route
Chamois, Missouri 65024

Presiding Commissioner
P.O. Box 826
Linn, Missouri 65051

Emergency Preparedness
Coordinator
P.O. Box 826
Linn, Missouri 65051

Osage County Sheriff
P.O. Box 619
Linn, Missouri 65051

Public Administrator
Star Route
Chamois, Missouri 65024

Emergency Preparedness
Coordinator
P.O. Box 817
Fulton, Missouri 65251

Callaway County Sheriff
P.O. Box 817
Fulton, Missouri 65251

Presiding Commissioner
Montgomery County Courthouse
211 E. Third
Montgomery City, Missouri 63361

Director of Emergency Services
Montgomery County Courthouse
211 E. Third
Montgomery City, Missouri 63361

Montgomery County Sheriff
Montgomery County Courthouse
211 E. Third
Montgomery City, Missouri 63361

Presiding Commissioner
Gasconade County
119 E. First Street, Room 2
Hermann, Missouri 65041

Emergency Preparedness
Coordinator
Gasconade County
119 E. First Street, Room 2
Hermann, Missouri 65041

Gasconade County Sheriff
119 E. First Street, Room 22
Hermann, Missouri 65041

Gasconade County Public
Administrator
501 S. Second St.
Owensville, Missouri 65066

Mayor of Fulton
P.O. Box 130
Fulton, Missouri 65251

Chief of Police
P.O. Box 130
Fulton, Missouri 65251

Fulton City Administrator
P.O. Box 130
Fulton, Missouri 65251

Mayor, City of Morrison
Route 1
Morrison, Missouri 65061

Mayor, City of Mokane
P.O. Box 41
Mokane, Missouri 65059

Mayor of Rhineland
P.O. Box 384
Rhineland, Missouri 65069

Assistant Emergency Director
Route 1, Box 2
Rhineland, Missouri 65069

Eastern Associate Commissioner
10 E. 5th Street
Fulton, Missouri 65251

Western Associate Commissioner
10 E. 5th Street
Fulton, Missouri 65251

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R. K. Frahm, PPR Program Manager, NRR/ILPB **(RKF)**
B. A. Boger, Associate Dir. for Inspection and Programs **(BAB2)**
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United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region IV
CALLAWAY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
02/09/2000	2000001	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**No formal controls on personnel and equipment entering switchyard.** The licensee's guidance for controlling access to the switchyard while at power was lacking. Operations personnel authorized and security personnel granted access to the switchyard. However, after security personnel granted access, additional personnel and equipment could enter the switchyard without further authorization from operations personnel. Licensee contingency planning procedures did recommend that switchyard entries be limited to operations personnel during critical evolutions such as midloop operations and reduced inventory conditions.
Dockets Discussed: 05000483 Callaway						
01/26/2000	2000001-01	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**Failure to correct the out of specification component cooling water surge tank level.** Control room operators failed to identify a decreasing level in a component cooling water surge tank. Surge tank level decreased below the acceptance criteria. Operators documented that the surge tank level was below the acceptance criteria while taking control room logs. Operators did not document the suspected cause of the low surge tank level or take action to restore the level in the surge tank as required by procedure. Failing to take action to restore the surge tank level when it trended below the minimum acceptance criteria is a violation of 10 CFR Part 50 Appendix B, Criterion V. Operators took action to stop the decreasing level when the surge tank low level annunciator alarmed. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy.
Dockets Discussed: 05000483 Callaway						
01/12/2000	2000001	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** 3B **Ter:**	**Deficiencies with removing a containment isolation from service.** The inspectors identified several deficiencies that contributed to a containment isolation valve being removed from service without proper time tracking or retests being specified. These deficiencies included the licensee's inattention to detail regarding the scheduling and isolation for the containment isolation valve, the lack of communication between the shift supervisor and the shift technical advisor, and not recognizing that removing the valve from service placed the plant in a limiting condition for operation.
Dockets Discussed: 05000483 Callaway						
01/08/2000	1999014	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 2A **Sec:** **Ter:**	**Residual heat removal system maintained in good condition.** Configuration control, material condition, and alignment of the residual heat removal system were good. This was evident by the sound state of the mechanical and electrical portions of the system and of the associated support systems (e.g., components were properly aligned, adequately supported, reasonably free of oil, boron, or other leakage, and minimal corrosion was observed).
Dockets Discussed: 05000483 Callaway						
12/17/1999	1999015	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1B **Sec:** **Ter:**	**Operators failed to detect the low switchyard voltage condition.** Licensed operators failed to detect to the low voltage condition in the switchyard following the transient on August 11, 1999. The switchyard voltage dropped to a level below the operability limits for approximately 10 hours on August 11th and 12 hours on August 12th without being detected or mitigated by plant operators. Subsequently, plant and system operators were alerted to the condition and took appropriate corrective actions.
Dockets Discussed: 05000483 Callaway						
12/17/1999	1999015	**Pri:** OPS **Sec:**	NRC	WK	**Pri:** 1A **Sec:** 1B **Ter:** 1C	**Lack of formal operating agreements and personnel performance expectations between site personnel and s** No formal operating agreements related to switchyard voltage requirements or personnel performance expectations exist between the Callaway Plant site and Energy Supply Operations personnel. The lack of such agreements contributed to: 1) a lack of understanding of voltage requirements on the part of Energy Supply Operations personnel, 2) an incomplete understanding on the part of licensed operators as to the operability requirements associated with offsite power, and 3) the amount of time necessary to restore switchyard voltage to acceptable levels following the August 11, 1999, event.
Dockets Discussed: 05000483 Callaway						

United States Nuclear Regulatory Commission
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Region IV
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
12/17/1999	1999015-01	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 1C **Sec:** 2B **Ter:**	**Inadequate surveillance procedures and methods for ensuring the operability of offsite power.** A violation of Technical Specification 6.8.1 was identified because the licensee's methods and surveillance procedure associated with verifying the operability of offsite power were inadequate. The procedure did not incorporate considerations of post-trip switchyard voltage or instrument uncertainties and inaccuracies. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This item was placed in the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-3604 .
Dockets Discussed: 05000483 Callaway						
11/26/1999	1999014	**Pri:** OPS **Sec:**	Self	NEG	**Pri:** 1A **Sec:** 1B **Ter:**	**Unclear annunciator response procedure and failure to properly identify plant equipment contributed to a re** Unclear terminology in the annunciator response procedure and control room operators not recognizing the appropriate power supply for the steam generator level control circuitry resulted in an equipment operator being dispatched to verify the status of the wrong power supply feeder breaker. The operator was dispatched to the secondary power supply feeder breaker. He should have been dispatched to the primary power supply feeder breaker. With the primary power supply already inoperable, the equipment operator attempted to ensure that the secondary power supply breaker was fully closed by pushing it to its fully closed position. When this occurred, the secondary power supply momentarily lost power which caused the main feedwater regulating valve to Steam Generator A to close and both main feedwater pumps to go to their low speed stop position. This caused a reactor trip on a low level in Steam Generator A. Operator response following the reactor trip was good.
Dockets Discussed: 05000483 Callaway						
11/10/1999	1999013	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**Inadvertent boron addition events.** Failure of operators to understand the recirculation flow path of the centrifugal charging pumps and failure to maintain an awareness of the boron concentration in the suction header of the centrifugal charging pumps were the causes of two inadvertent boron addition events. Each inadvertent addition caused a decrease in reactor power of approximately 3 percent and required operators to take actions to stabilize the plant.
Dockets Discussed: 05000483 Callaway						
11/04/1999	1999013	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Good command and control during reactor startup.** Control room operators demonstrated good command and control during the reactor startup following completion of refueling Outage 10. Reactor engineering personnel and control room operators were attentive during the approach to criticality.
Dockets Discussed: 05000483 Callaway						
10/27/1999	1999013-01	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 1A **Sec:** **Ter:**	**Failure to follow procedure, resulting in essential service water entering feedwater lines.** Operators failed to follow the procedure while testing the auxiliary shutdown panel. Specifically, control room personnel directed local operators to open the wrong valve. This caused the flow of essential service water through the turbine-driven auxiliary feedwater pump and into the main feedwater headers of all four steam generators. Failure to follow the surveillance procedure was a violation of Technical Specification 6.8.1. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy.
Dockets Discussed: 05000483 Callaway						
10/16/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**Observation of Reactor Shutdown** Control room communications, briefings, supervisory control, and self-checking were very good during the plant shutdown and cooldown in preparation for refueling Outage 10.
Dockets Discussed: 05000483 Callaway						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region IV
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
10/16/1999	1999009	**Pri:** OPS **Sec:** **Ter:**	NRC	POS	**Pri:** 1A **Sec:** 3A	**Draining of the Reactor Coolant System and Operations in Midloop Condition** Unit operators demonstrated good attention to detail, communications, and control while draining the reactor coolant system and conducting midloop operations.
Dockets Discussed: 05000483 Callaway						
09/04/1999	1999008	**Pri:** OPS **Sec:** **Ter:**	NRC	POS	**Pri:** 2A **Sec:** 4A	**AFW walkdown showed good results.** The inspectors independently verified operability of the auxiliary feedwater system. The system was well maintained as indicated by good cleanliness, material condition, system lineup, and state of support systems (Section O2.2).
Dockets Discussed: 05000483 Callaway						
08/17/1999	1999008	**Pri:** OPS **Sec:** **Ter:**	NRC	POS	**Pri:** 1A **Sec:** 3A	**Operator performance during plant startup was good** Operators demonstrated good communications, procedural adherence, and command and control during a reactor startup (Section O1.2).
Dockets Discussed: 05000483 Callaway						
08/13/1999	1999007	**Pri:** OPS **Sec:** **Ter:**	Licensee	NEG	**Pri:** 3A **Sec:** 3B	**Operators performed acceptably with some concerns about emergency operating procedure usage** The inspectors concluded the operators performed acceptably during the examination. The operators practiced three-leg communications, peer checks, and effective crew briefings during the simulator portion of the operating examination. The operators exhibited weaknesses in procedure usage, situational awareness, and knowledge of system response of the power operated relief valves.
Dockets Discussed: 05000483 Callaway						
08/13/1999	1999007	**Pri:** OPS **Sec:** **Ter:**	Licensee	NEG	**Pri:** 3B **Sec:** 5B	**Root cause analysis of crew performance in simulator examinations was found to be weak** The documentation of contributors to the root cause analysis of the performance concerns related to the staff crew in the simulator examination did not include all significant factors. The narrow documentation reduced the effectiveness of long-term performance tracking using the post examination review records.
Dockets Discussed: 05000483 Callaway						
08/13/1999	1999007	**Pri:** OPS **Sec:** **Ter:**	Licensee	POS	**Pri:** 3A **Sec:** 3B	**Operations management present at all stages of licensed operator requalification program** The facility evaluators generally were effective in examining operators to identify deficiencies or weaknesses in the trainees and the training program. The facility evaluators administered the examinations professionally and documented their findings well to support their evaluations. Operations management involvement in the licensed operator requalification program was noted to be present at all stages of the program implementation.
Dockets Discussed: 05000483 Callaway						

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08/11/1999	1999011	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**Operator Performance During Reactor Transient and Extraction Steam Line Break was Good** Operator performance was good and was exemplified by cautious decision making in regard to identifying the need to trip the reactor, close the main steam isolation valves, and evacuate the turbine building following rupture of a 6-inch drain line between a moisture separator reheater first stage reheater drain tank and feedwater Heater 6B. Equipment affected by the event did present some challenges to the operators, but the loss of availability of equipment affected by the drain-line break did not compromise the ability to shut down the plant (Section O1.1).
Dockets Discussed: 05000483 Callaway						
07/24/1999	1999006	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**Tours were thorough and well performed.** The inspectors accompanied several operators during routine tours of the plant and found the tours to be thorough and well performed. The inspectors also verified that a portion of the containment isolation valve lineup was in accordance with operations surveillance procedures.
Dockets Discussed: 05000483 Callaway						
07/12/1999	1999005	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Good communications by operations personnel** Operations personnel demonstrated good communications, coordination, command and control, and procedure usage during routine control room activities, including shift turnovers. Management oversight of these activities was appropriate. Equipment operators were knowledgeable of responsibilities in their assigned areas.
Dockets Discussed: 05000483 Callaway						
05/01/1999	1999003	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** 3A **Ter:** 5C	**Problems in Workman's Protection Assurance activities continue to exist** The number of new suggestion-occurrence-solution reports initiated in 1999 regarding workman's protection assurance activities suggests that the licensee-identified adverse trend in 1998 has not improved. Furthermore, quality assurance personnel did not review progress in resolving the 1998 adverse trend during an audit of the operations department performed early 1999. The licensee recently began taking action to review the effectiveness of past corrective actions.
Dockets Discussed: 05000483 Callaway						
04/19/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3B **Ter:**	**Operator training on effects of axial offset anomally was thorough** Operator training on the effects of the axial offset anomaly on continued plant operation was thorough. The instructors displayed comprehensive technical knowledge. There was very good participation by the trainees, particularly on suggested procedure improvements. The instructors captured the suggestions for further evaluation. Plant management ensured that all licensed operators had received this training prior to standing watch with the revised procedures in effect.
Dockets Discussed: 05000483 Callaway						
03/30/1999	1999003-01	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** 3A **Ter:**	**Operator inadvertently pulled the wrong fuses while hanging tags for an emergency diesel generator outage** The failure to pull the correct fuses for the Emergency Diesel Generator B control panel, during a planned maintenance outage, was a violation of Technical Specification 6.8.1. There were no personnel injuries because of redundant tagging. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-0593.
Dockets Discussed: 05000483 Callaway						

United States Nuclear Regulatory Commission
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Region IV
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
03/20/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 1B Ter:	**Good performance by operations personnel during routine activities** Operations personnel demonstrated good communications, coordination, command and control, and procedure usage during routine control room activities including shift turnovers. Management oversight of these activities was appropriate. Equipment operators were knowledgeable of responsibilities in their assigned areas.
Dockets Discussed: 05000483 Callaway						
01/08/2000	1999014	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: 3A Ter:	**Continued challenges in work control** The licensee continued to experience minor work control errors during the second half of the refueling outage. The licensee identified a potential trend adverse to quality in the workman's protection assurance program (Suggestion-Occurrence-Solution Report 99-3114). The licensee attributed these recent failures to personnel errors due to confusion over tagging requirements.
Dockets Discussed: 05000483 Callaway						
12/08/1999	1999014-01	Pri: MAINT Sec:	Self	NCV	Pri: 1B Sec: 2B Ter:	**Inadequate surveillance procedure.** An inadequate procedure was the cause of a turbine setback that reduced reactor power to approximately 88 percent. The procedure was initially written to be performed while shutdown. The review that was performed later to allow the procedure to be performed at power did not identify that enabling the turbine setback protective function while locking out a circulating water pump would cause a turbine setback. Once operators recognized the turbine setback, they responded quickly to disable the turbine setback protective function and stop the power reduction. This is a violation of 10 CFR Part 50 Appendix B, Criterion V. This Severity Level IV violation is being treated as a noncited violation consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation was entered into the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-3576.
Dockets Discussed: 05000483 Callaway						
11/27/1999	1999013	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: Ter:	**Good material condition.** Material condition and housekeeping in the auxiliary building, fuel building, control building, diesel generator building, essential service water pump house, and turbine building were good.
Dockets Discussed: 05000483 Callaway						
10/16/1999	1999009	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: 3A Ter:	**Work control errors during the refueling outage.** Maintenance personnel, operators, and support staff demonstrated poor attention to detail on several occasions while removing systems from service and restoring them to service. Some of the more significant errors included cutting out a drain valve on a depressurized system that still had a red tag on it, pulling the wrong fuse for an accumulator fill line valve, and clearing an isolation that unintentionally opened the volume control tank suction valve from the refueling water storage tank and spilled 2000 gallons into the auxiliary building drains. These maintenance errors had the potential to challenge personnel and reactor safety.
Dockets Discussed: 05000483 Callaway						
10/08/1999	1999012	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3A Ter: 3C	**Inservice inspection program plan was well organized and implemented.** The licensee's second 10-year interval inservice inspection program plan, which included 17 requests for relief and 7 ASME code cases, met the requirements of the 1989 Edition of the ASME Code and had been appropriately implemented for the current Refueling Outage, RF10. Contractor inservice inspection personnel and steam generator tube eddy current quality data analysts were knowledgeable and properly certified. Observed examination, acquisition, and analysis activities were effectively controlled, with good overall contractor performance noted.
Dockets Discussed: 05000483 Callaway						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region IV
CALLAWAY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
09/04/1999	1999008	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2A **Sec:** **Ter:**	**Overall material condition and housekeeping of several plant systems were good.** The overall material condition and housekeeping of several plant systems were good. The inspectors identified a few minor discrepancies for which the licensee initiated corrective action (Section M2.1).
Dockets Discussed: 05000483 Callaway						
08/20/1999	1999011	**Pri:** MAINT **Sec:**	NRC	WK	**Pri:** 2B **Sec:** **Ter:**	**Flow Acceleration Corrosion Program Weakness** The inspectors identified a weakness in the licensee's flow-accelerated corrosion program in that the program did not require inspecting the pipe upstream or downstream of a component (e.g., elbow tee, expander) scheduled for inspection. The licensee's program was not consistent with industry guidance to inspect two pipe diameters upstream and two pipe diameters downstream of the component scheduled for inspection. Inspecting the downstream pipe within two pipe diameters of the elbow could have identified the excessive wear (Section M2.1).
Dockets Discussed: 05000483 Callaway						
07/24/1999	1999006-01	**Pri:** MAINT **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** 2B **Ter:**	**Missed TS Surveillance due to misinterpretation of the requirements.** On March 9, 1999, the licensee determined that Technical Specifications were not being properly implemented to response time test the engineered safety features actuation system (Licensee Event Report 50-483/99-002-00). The signals not properly tested were: (1) testing for steam generator water level low-low initiation of motor-driven auxiliary feedwater pump actuation; and (2) Containment Phase A isolation initiation of containment purge. Following discovery, the signals were tested and were satisfactory. The failure to adequately test the engineered safety features actuation system constitutes a violation of Technical Specification 4.3.2.2.. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Suggestion-Occurrence Report 99-0439 (M8.1).
Dockets Discussed: 05000483 Callaway						
07/12/1999	1999005	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** 2B **Ter:**	**Adverse trends in material condition of essential service water system** The licensee was slow in recognizing the adverse trend in material condition for the essential service water system. The system experienced a number of vibration-induced problems. The licensee's completed and planned corrective actions were appropriate and comprehensive.
Dockets Discussed: 05000483 Callaway						
05/01/1999	1999003	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** 4B **Ter:**	**External material condition and housekeeping was very good with the exception of the essential service wat** With the exception of the essential service water system, external equipment material condition and housekeeping throughout the plant was generally very good. Several pin hole leaks occurred in essential service water system piping during this report period. The operability determinations were acceptable. The leaks were repaired promptly, in accordance with code requirements, and with the proper emphasis on optimizing safe plant conditions.
Dockets Discussed: 05000483 Callaway						
03/20/1999	1999001	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**Material condition and housekeeping was good, but failure of some heating elements is an operator distracti** Material condition and housekeeping throughout the plant was generally very good; however, periodic failures of heating elements for the ultimate heat sink cooling tower sump heaters were found to be a distraction for operators and maintenance personnel, plus did not meet management's expectations for system reliability and availability. In addition, oil seepage from the emergency diesel generators was noted. Neither of these items affected equipment or system operability. The licensee initiated actions to address these deficiencies.
Dockets Discussed: 05000483 Callaway						

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PLANT ISSUE MATRIX
By Primary Functional Area

Region IV
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
03/20/1999	1999001-01	Pri: MAINT Sec:	Self	NCV	Pri: 2A Sec: 3A Ter: 4A	**Failure to terminate solenoid valves during preventive maintenance task** In violation of Technical Specification 6.8.1.a, electricians failed to terminate the eight solenoid valves for the main steam bypass valves during a preventive maintenance task. As a result, the bypass valves would not operate during the post-maintenance slave relay surveillance test. Electricians subsequently terminated and successfully tested the valves to assure operability. This Severity Level IV violation is being treated as a non-cited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-0212.
Dockets Discussed: 05000483 Callaway						
03/20/1999	1999001-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 2A Sec: 2B Ter: 4C	**Failure to perform surveillance of emergency diesel generator ability to override a degraded voltage signal** There were multiple examples of a violation of Technical Specification surveillance requirements as a result of the failure to perform surveillances of the emergency diesel generators' ability to override a degraded voltage signal and cause immediate shed of the emergency electrical bus upon a safety injection signal and subsequent plant mode changes made while relying on those surveillances. On December 17, 1997, the licensee discovered this problem. The licensee was performing reviews mandated by NRC Generic Letter 96-01. The licensee failed to perform these surveillances as a result of inadequate procedures. The licensee revised the appropriate procedures and successfully performed the testing. The failure to test the emergency diesel generators in accordance with Technical Specification 4.8.1.1.2.g constitutes an additional example of non-cited Violation 50-483/98025-03 and is not being cited separately (Licensee Event Report 50-483/97005-06).
Dockets Discussed: 05000483 Callaway						
03/08/1999	1999005-01	Pri: MAINT Sec:	Licensee	NCV	Pri: 1A Sec: 2B Ter:	**Failure to implement OL Amendment 106 requirement within 30 days** The failure to meet flow rate surveillance requirements for Control Room Emerency Ventilation System Train B from January 19, 1996, until July 22, 1998, was a violation of Technical Specifications 4.7.6.c.1, 4.7.6.c.3, and 4.7.6.e.1. Although the documented system flow was greater than the Technical Specification allowed maximum, the licensee concluded, and the inspectors agreed, that the system was always capable of meeting its design safety function. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-0259.
Dockets Discussed: 05000483 Callaway						
12/03/1999	1999014-02	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	**Failure to correct a condition that placed the plant outside design bases.** On December 3, 1999, the licensee reported that due to a computer software discrepancy the potential existed for a 1 gpm reactor coolant system leak to not be detected within 1 hour as stated in the Updated Safety Analysis Report. The computer programming discrepancy was corrected, restoring compliance. During research, the licensee identified that this problem was identified in 1997. A software change was developed but never implemented. Failing to take correction action when the problem was identified in 1997 was a violation of 10 CFR Part 50, Appendix B, Criterion XVI. This Severity Level IV violation is being treated as a noncited violation consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation was entered into the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-3541.
Dockets Discussed: 05000483 Callaway						
11/27/1999	1999013	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: 4B Ter:	**Actions to improve essential service water system reliability were good.** The licensee has continued to make progress in improving the reliability of the essential service water system. Replacing essential service water pumps improved system flow rates and orifices have been installed to reduce system vibration. Plans to address containment cooler flow rate, corrosion induced failures, and fouling were also developed. However, none of these issues challenged the operability of the essential service water system.
Dockets Discussed: 05000483 Callaway						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
10/16/1999	1999009	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Electrosleeving of Steam Generator Tubes** Command and control, procedural precautions, and contingency actions in support of the Electrosleeving of steam generator tubes were comprehensive and the processes were deliberately conducted. Licensee and Framatome staff knowledge of systems and procedures was thorough. **Dockets Discussed:** 05000483 Callaway
08/20/1999	1999011	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4C **Sec:** **Ter:**	**Failure to Update Isometric Drawings** The licensee and the inspectors identified an instance where some pipe material changes were not shown on plant isometric drawings after a minor modification. The system was not safety related. The problem is being resolved by the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-1641 (Section E2.2). **Dockets Discussed:** 05000483 Callaway
08/11/1999	1999015	**Pri:** ENG **Sec:**	Self	WK	**Pri:** 4A **Sec:** 4C **Ter:**	**System load flow analyses failed to incorporate considerations of load growth and economic deregulation.** The system load flow analyses, which were in effect at the time of the event, had not accurately incorporated considerations of load growth and power wheeling stemming from power market deregulation. This resulted in an underestimation of the system loading conditions which were observed at the time of the August 11, 1999, event. Additionally, prior to the August 11, 1999 reactor trip, the licensee did not have adequate provisions to minimize the probability of losing electric power from any of the remaining supplies as a result of, or coincident with, the loss of power generated by the nuclear power unit. **Dockets Discussed:** 05000483 Callaway
07/12/1999	1999005	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 4B **Ter:**	**Properly prepared modification packages to replace orifice plates in the essential service water system** The modification package to replace the orifice plates in the essential service water return lines from the component cooling water heat exchangers was properly prepared. The licensee appropriately and successfully performed the required postmodification testing. **Dockets Discussed:** 05000483 Callaway
05/01/1999	1999003	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:** 5B	**Safety analysis for axial offset anomally was thorough** The Onsite Review Committee's discussion of the formal safety evaluation allowing continued operations with the axial offset anomaly was thorough, well-prepared, and adequately documented. The engineering department was effectively and actively involved throughout the safety evaluation approval process. **Dockets Discussed:** 05000483 Callaway
03/20/1999	1999001	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 4A **Ter:** 4C	**Good modification packages** Modification packages to replace the feeder breakers for the essential service water to turbine-driven auxiliary feedwater pump valves were properly prepared with clear installation instructions. **Dockets Discussed:** 05000483 Callaway

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
02/04/2000	2000006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3B **Sec:** 3C **Ter:**	**The radioactive wast effluent management program was effectively implemented and showed improved perf** Overall, an effective radioactive effluent monitoring program was implemented. The processing, sampling, and analyses of radioactive liquid and gaseous waste effluents and the performance of effluent discharges were conducted in accordance with Final Safety Analysis Report and Offsite Dose Calculation Manual requirements. Improved performance was noted in the reduction of liquid and gaseous effluent radionuclide curies released and offsite doses during the period 1996 through 1999. Since 1996, the curie amount of radioactive liquid released was reduced 91 percent with a corresponding whole body dose reduction of 73 percent. The curie amount of gaseous effluents released since 1996 was reduced 70 percent with gamma and beta dose reductions of approximately 43 and 59 percent, respectively.
Dockets Discussed: 05000483 Callaway						
01/14/2000	2000004	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1B **Sec:** 1C **Ter:**	**A required notification of site area emergency was not made during a simulator walkthrough scenario.** One crew did not notify simulated offsite agencies and NRC of a site area emergency declaration during an evaluated simulator walkthrough scenario. This omission would have had little offsite effect because a general emergency was declared 5 minutes later, and the general emergency notification met the timeliness requirement for the site area emergency.
Dockets Discussed: 05000483 Callaway						
01/14/2000	2000004-01	**Pri:** PLTSUP **Sec:**	NRC	IFI	**Pri:** 1B **Sec:** 1C **Ter:**	**Several protective action recommendations made by one crew during a simulator walkthrough scenario wer** During the simulator walkthroughs, an exercise weakness was identified for failure of one crew to make timely and accurate protective action recommendations. A protective action recommendation was transmitted that was not approved by the shift supervisor. A second protective action recommendation was communicated to a single county, but not to all offsite authorities as required by procedure. Licensee evaluators characterized the crew performance as weak in the area of protective action recommendations and initiated Suggestion Occurrence Solution 00-0107 to evaluate corrective actions.
Dockets Discussed: 05000483 Callaway						
01/14/2000	2000004-02	**Pri:** PLTSUP **Sec:**	NRC	URI	**Pri:** 1C **Sec:** **Ter:**	**Emergency action levels were not maintained by incorporation of identified improvements.** Pending further NRC review, an unresolved item was identified involving maintenance of emergency action levels.
Dockets Discussed: 05000483 Callaway						
11/08/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Proper implementation of the physical security program.** A proper security system testing and maintenance program was conducted and documented. Timely repair of security equipment resulted in a low number of compensatory postings. The protected area detection system was well designed and maintained. All attempts by the licensee to intrude into the protected area were detected. The testing of the security backup power supply system was effective in demonstrating the capability of the system to perform its intended function. The security diesel generator was reliable and well maintained. The event logs and supporting incident reports were accurate and neat, and the security staff was correctly reporting security events. Security personnel were well trained on the program requirements. Medical examinations for security officers were well documented (Sections S2.1, S2.2, S2.4, S3.1 and S5.1).
Dockets Discussed: 05000483 Callaway						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
11/08/1999	1999016-01	**Pri:** PLTSUP **Sec:**	Licensee	NCV	**Pri:** 1C **Sec:** 3A **Ter:**	**Failure to Maintain Compensatory Measures** A violation of the contingency plan was identified for failure to maintain continuous compensatory measures of the perimeter intrusion detection system. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. This violation was entered into the licensee's corrective action system as Suggestion Occurrence Solution (SOS) No. 99-0431.
Dockets Discussed: 05000483 Callaway						
11/08/1999	1999016-02	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** 1C **Sec:** 3B **Ter:**	**Failure to implement adequate compensatory measures.** A violation of the security plan was identified for failure to provide an equivalent level of protection during an outage of the computer controlled intrusion detection system. This violation included information in a related security post instruction that was inconsistent with requirements of the security plan. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. This violation was entered into the licensee's corrective action system as Suggestion Occurrence Solution (SOS) No. 99-3155.
Dockets Discussed: 05000483 Callaway						
10/16/1999	1999009-01	**Pri:** PLTSUP **Sec:**	Licensee	NCV	**Pri:** 1C **Sec:** 3A **Ter:**	**Unposted High Radiation Area in the Auxiliary Building** After a radioactive filter was dropped onto some plastic sheets and rags during a filter replacement, the plastic sheets and rags were placed in a trash bag. This bag was not surveyed. Four days later, the electronic dosimeters of workers moving the trash bag alarmed, and a high radiation area was identified around the bag (300 mrem/hr at 12 inches). Failure to perform an adequate survey, which led to an unposted high radiation area, was a violation of 10 CFR 20.1501. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-2022.
Dockets Discussed: 05000483 Callaway						
09/16/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1B **Sec:** **Ter:**	**The operations support area staff's performance was lacking in some areas.** Some inplant emergency teams were unnecessarily delayed in responding to plant equipment failures. Some in-plant tasks were not reflected on the operations support tracking board (Section P4.4).
Dockets Discussed: 05000483 Callaway						
09/16/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**The licensee's overall performance during the biennial exercise was good.** Overall, performance was good. The control room, technical support center, operations support area, and emergency operations facility successfully implemented key emergency plan functions including emergency classifications, protective action recommendations, notifications, and dose assessment.
Dockets Discussed: 05000483 Callaway						
09/16/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**The postexercise critiques were good.** The postexercise critiques were thorough, open and self-critical. The licensee identified good suggestions for improvement. The management critique was also self-critical as well as informed and detailed. There was good overlap between the NRC and licensee's observations. Overall, the critiques were effective in identifying areas in need of corrective actions.
Dockets Discussed: 05000483 Callaway						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
09/04/1999	1999008	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: Ter:	**Good radiation protection practices utilized during new fuel receipt inspection** During the performance of swipe surveys associated with new fuel receipt inspection, health physics technicians and operators demonstrated good ALARA practices and were knowledgeable of radiological requirements (Section R4.1).
Dockets Discussed: 05000483 Callaway						
07/31/1999	1999008-02	Pri: PLTSUP Sec:	NRC	NCV	Pri: 1C Sec: Ter:	**Keys left in unattended vehicle** The licensee's failure to control a vehicle (unattended with keys in ignition) within the protected area is a violation of Section 1.6.2 of the security plan. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-1504 (Section S2.1).
Dockets Discussed: 05000483 Callaway						
05/20/1999	1999005-02	Pri: PLTSUP Sec:	NRC	NCV	Pri: 1C Sec: Ter:	**Failure to provide proper lighting** The failure to provide minimum illumination of 0.2 foot-candles to outdoor portions of the plant was a violation of Section 3.1.3.1 of the Security Plan. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Suggestion-Occurrence-Solution Report 99-0995.
Dockets Discussed: 05000483 Callaway						
05/01/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: 3B Ter:	**Good radiation worker practices** Plant workers exhibited good radiation worker practices. Survey maps and postings were current and showed accurate information. Personnel demonstrated good "as low as reasonably achievable" practices during spent fuel pool rerack activities.
Dockets Discussed: 05000483 Callaway						
04/13/1999	1999004-02	Pri: PLTSUP Sec:	NRC	URI	Pri: 4A Sec: 5A Ter:	**Potential equipment damage due to fire-induced circuit failures.** An unresolved item was identified concerning 42 motor-operated valves that could become damaged if they were to spuriously actuate as a result of a hot short caused by a control room fire. If any of the valves were damaged to an extent that they would be incapable of being manually re-positioned during post-control room evacuation procedural steps, then the licensee's alternative shutdown capability would not be in compliance with the Operating License. During a supplemental exit meeting conducted by telephone on April 13, 1999, the licensee committed to make available for NRC review an action plan designed to determine whether any of the subject 42 valves could become damaged in this manner.
Dockets Discussed: 05000483 Callaway						
03/20/1999	1999001	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: 4A Ter: 4C	**Good radiation practices during spent fuel pool rerack** Surveys for the spent fuel pool rerack project were thorough and well-performed. Health physics technicians and supervisors were knowledgeable of the evolution and their individual responsibilities. Extraction of a diver from the pool and subsequent decontamination was performed safely and with proper attention to detail. Health physics technicians and supervisors demonstrated conservative decision making and proper concern for keeping radiological dose as low as reasonably achievable.
Dockets Discussed: 05000483 Callaway						

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Region IV
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
02/12/1999	1999002	**Pri:** PLTSUP	NRC	STR	**Pri:** 1C	**Physical security program was good with excellent performance in the access authorization area**
		Sec:			**Sec:**	Performance in the physical security program area was good, and performance in the access authorization area was excellent. An effective access authorization program was established to grant individuals unescorted access to protected and vital areas. The security alarm stations were redundant and well protected. The security radio and telephone communication systems were generally reliable; however, some batteries provided insufficient power to portable radios. An effective program for searching personnel, packages, and vehicles was maintained. Assessment aids provided effective assessment of the perimeter detection zones. The video capture system provided enhanced ability to determine the cause of perimeter security alarms. Changes to security plans were reported within the required time frame and properly implemented in accordance with 10 CFR 50.54(p). Implementing procedures met the performance requirements in the physical security plan. A good program for reporting security events was in place. Senior management support for the security organization was very good. The audits of the security program, the access authorization program, and the fitness-for-duty program were effective, thorough, and intrusive.
					Ter:	

Dockets Discussed:
05000483 Callaway

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Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

03/30/2000 16:13:43

CALLAWAY
Inspection / Activity Plan
04/02/2000 - 03/31/2001

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates Start	Planned Dates End	Inspection Type
	PBB AW1	**- RI - ADVERSE WEATHER PREP.**	**2**				
1	IP 7111101	Adverse Weather Protection		2	04/02/2000	07/08/2000	Baseline Inspections
	PBB TM	**- RI - TEMPORARY MODIFICATIONS**	**2**				
1	IP 7111123	Temporary Plant Modifications		2	04/02/2000	03/31/2001	Baseline Inspections
	PSB-S1	**- ACCESS AUTH/ACCESS CONTROL**	**1**				
1	IP 7113001	Access Authorization Program (Behavior Observation Only)		1	05/01/2000	05/05/2000	Baseline Inspections
1	IP 7113002	Access Control (Search of Personnel, Packages, and Vehicles: Identification ar		1	05/01/2000	05/05/2000	Baseline Inspections
	EMB	**- SAFETY SYSTEM DESIGN AND PERF CAPABILITY**	**6**				
1	IP 7111121	Safety System Design and Performance Capability		5	05/08/2000	05/12/2000	Baseline Inspections
1	IP 7111121	Safety System Design and Performance Capability		5	05/22/2000	05/26/2000	Baseline Inspections
	PBB-TI	**- TI-144, PI DATA REVIEW**	**1**				
1	IP 2515/144	Performance Indicator Data Collecting and Reporting Process Review		1	05/14/2000	08/05/2000	Safety Issues
	PSB-RP1	**- RAD MONITORING INST**	**1**				
1	IP 7112103	Radiation Monitoring Instrumentation		1	06/05/2000	06/09/2000	Baseline Inspections
	OB-EXAMS	**- RO/SRO EXAMS**	**3**				
1	X02024	CW/INITIAL EXAMS		1	06/05/2000	06/09/2000	Not Applicable
1	X02024	CW/INITIAL EXAMS		3	07/10/2000	07/14/2000	Not Applicable
	PBB EA1	**- RI - EQUIPMENT ALIGNMENT 01**	**2**				
1	IP 7111104	Equipment Alignment		2	07/09/2000	08/19/2000	Baseline Inspections
	PBB EP1	**- RI - EMERGENCY PREPAREDNESS 01**	**2**				
1	IP 7111406	Drill Evaluation		2	07/09/2000	10/07/2000	Baseline Inspections
	PSB-RP2	**- ACCESS CONTROL TO RAD SIGN AREAS/PIV**	**2**				
1	IP 7112101	Access Control to Radiologically Significant Areas		1	08/07/2000	08/11/2000	Baseline Inspections
1	IP 71151	Performance Indicator Verification		2	08/07/2000	08/11/2000	Baseline Inspections
	PSB-RP3	**- ALARA PLANNING/CONTROL 1**	**1**				
1	IP 7112102	ALARA Planning and Controls		1	08/07/2000	08/11/2000	Baseline Inspections
	EMB	**- FIRE PROTECTION BAGMAN**	**2**				
1	IP 7111105T	Fire Protection		2	08/08/2000	08/10/2000	Baseline Inspections
	EMB	**- FIRE PROTECTION**	**6**				
1	IP 7111105T	Fire Protection		3	08/21/2000	08/25/2000	Baseline Inspections
	PBB AW2	**- RI - ADVERSE WEATHER PREP.**	**2**				
1	IP 7111101	Adverse Weather Protection		2	10/08/2000	01/06/2001	Baseline Inspections
	PSB-RP4	**- ALARA PLANNING/CONTROL 2**	**1**				
1	IP 7112102	ALARA Planning and Controls		1	11/13/2000	11/17/2000	Baseline Inspections
	PSB-S2	**- SEC PLAN, PIV, & RESP TO CONT EVENTS**	**2**				
1	IP 7113003	Response to Contingency Events (Protective Strategy and Implementation of P		2	11/13/2000	11/17/2000	Baseline Inspections

This report does not include INPO and OUTAGE activities.
This report shows only on-site and announced inspection procedures.

03/30/2000 16:13:43

CALLAWAY
Inspection / Activity Plan
04/02/2000 - 03/31/2001

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates Start	Planned Dates End	Inspection Type
1	IP 7113004	Security Plan Changes		2	11/13/2000	11/17/2000	Baseline Inspections
1	IP 71151	Performance Indicator Verification		2	11/13/2000	11/17/2000	Baseline Inspections
	OB-EXAMS - RO/SRO EXAMS		3				
1	X02024	CW/INITIAL EXAMS		1	11/13/2000	11/17/2000	Not Applicable
1	X02024	CW/INITIAL EXAMS		3	12/18/2000	12/22/2000	Not Applicable
	PSB-EP1 - A&N, ERO, PI&R, EAL/EP, PIV		2				
1	IP 7111402	Alert and Notification System Testing		2	12/18/2000	12/22/2000	Baseline Inspections
1	IP 7111403	Emergency Response Organization Augmentation Testing		2	12/18/2000	12/22/2000	Baseline Inspections
1	IP 7111404	Emergency Action Level and Emergency Plan Changes		2	12/18/2000	12/22/2000	Baseline Inspections
1	IP 7111405	Correction of Emergency Preparedness Weaknesses and Deficiencies		2	12/18/2000	12/22/2000	Baseline Inspections
1	IP 71151	Performance Indicator Verification		2	12/18/2000	12/22/2000	Baseline Inspections
	PBB EP2 - RI - EMERGENCY PREPAREDNESS 02		2				
1	IP 7111406	Drill Evaluation		2	01/07/2001	03/31/2001	Baseline Inspections
	PBB EA2 - RI - EQUIPMENT ALIGNMENT 02		2				
1	IP 7111104	Equipment Alignment		2	02/25/2001	03/31/2001	Baseline Inspections
	OB-PIR - PIR INSPECT		5				
1	IP 71152	Identification and Resolution of Problems		2	02/26/2001	03/02/2001	Baseline Inspections
	EMB - PERMANENT PLANT MODS & CHANGES		3				
1	IP 7111102	Evaluation of Changes, Tests, or Experiments		3	03/05/2001	03/09/2001	Baseline Inspections
1	IP 7111117B	Permanent Plant Modifications		3	03/05/2001	03/09/2001	Baseline Inspections

This report does not include INPO and OUTAGE activities.
This report shows only on-site and announced inspection procedures.