



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

August 2, 2001

Garry L. Randolph, Senior Vice
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Dear Mr. Randolph:

SUBJECT: NRC INSPECTION REPORT 50-483/2001-08

On June 8, 2001, NRC Inspection Report 50-483/2001-08 was mailed to you. Subsequently, we learned of an error in the report number on page 2 of the Summary of Findings. Enclosed is a corrected page for the Summary of Findings. We regret any inconvenience that this may have caused you.

Sincerely,

/RA/

Gail M. Good, Chief
Plant Support Branch
Division of Reactor Safety

Docket: 50-483
License: NPF-30

Enclosure:
Page 2 of Summary of Findings

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SUMMARY OF FINDINGS

Callaway Plant NRC Inspection Report No. 50-483/00-16

| IR 05000483-01-08; on 04/23/2001-04/27/2001; Union Electric Co; Callaway Plant.
Supplemental Inspection Report - degraded cornerstone

Cornerstone: Occupational Radiation Safety

This supplemental inspection was performed by the NRC to assess the licensee's evaluation of Refueling Outage 10 job doses that were not as low as is reasonably achievable (ALARA). Three findings were previously characterized as having low to moderate safety significance (White) in NRC Inspection Report 50-483/00-17. During this supplemental inspection performed in accordance with Inspection Procedure 95002, the inspectors determined that the licensee performed a thorough evaluation of the causes of radiation doses that were not ALARA and correctly identified the extent of the conditions that led to the doses. The doses were identified by the licensee during post-job reviews following Refueling Outage 10. The licensee's evaluation identified the primary root causes of the performance issues to be: (1) management's failure to establish expectations for keeping doses ALARA, (2) management's failure to communicate a priority for keeping doses ALARA, (3) a culture that did not support the ALARA concept, and (4) administrative controls that did not assure documented ALARA concerns would receive proper priority, appropriate consideration, and comprehensive resolution. With regard to the extent of condition, the licensee found that only the fourth root cause extended beyond the radiation protection department. The licensee specified appropriate corrective actions to address the root causes and had implemented most actions by the start of Refueling Outage 11. However, many of the corrective actions were not institutionalized to prevent recurrence of the problems during outages following Refueling Outage 11. The licensee acknowledged this potential problem and entered it into the corrective action program. The licensee was working on separate, broader corrective actions for the fourth root cause. In addition, the licensee intends to conduct effectiveness evaluations of the corrective actions to ensure their effectiveness.

Because of the licensee's acceptable performance in addressing job doses that were not ALARA, the White findings associated with this issue will only be considered in assessing plant performance for a total of four quarters, in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program." Implementation of the licensee's corrective actions will be reviewed further during a future inspection.

During the independent review, the inspectors identified that temporary shielding had been moved without a review by health physics supervision, in violation of Procedure HTP-ZZ-01101 and Technical Specification 5.4.1. Moving lead shielding without health physics supervision review has a credible impact on safety because unshielded contact dose rates were as high as 450 millirem per hour and the general area dose rate was 80 millirem per hour, and the occurrence could have involved a worker's unplanned, unintended dose or potential of such a dose which could have been significantly greater if radiation levels were higher. However, since there was no overexposure or substantial potential for an overexposure and the ability to assess dose was not compromised, the finding is considered to be of very low safety significance. Because of the very low safety significance of the item and because the licensee