

March 10, 2003

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Stop P1-137
Washington, DC 20555-0001



ULNRC-04815

Ladies and Gentlemen:

**DOCKET NUMBER 50-483
CALLAWAY PLANT UNIT 1
UNION ELECTRIC CO.
FACILITY OPERATING LICENSE NPF-30
LICENSEE EVENT REPORT 2003-001-00
Improper Administrative Controls Result in Technical Specification Violation**

The enclosed licensee event report is submitted in accordance with 10CFR50.73(a)(2)(i)(B) to report a condition which was prohibited by the plant's Technical Specifications.

Very truly yours,
Warren A. Witt
Warren A. Witt
Manager, Callaway Plant

WAW/slk

Enclosure

IE22

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2) NUMBER (2)	LER NUMBER (6)			PAGE (3)
Callaway Plant Unit 1	05000483	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 4
		2003	- 001	- 00	

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

I. DESCRIPTION OF THE REPORTABLE EVENT

A. REPORTABLE EVENT CLASSIFICATION

This event has been classified as reportable under 10CFR50.73(a)(2)(i)(B), any operation or condition which was prohibited by the plant's Technical Specifications

B. PLANT OPERATING CONDITIONS PRIOR TO THE EVENT

Callaway Plant was in Mode 1 at 100 percent power.

C. STATUS OF STRUCTURES, SYSTEMS OR COMPONENTS THAT WERE INOPERABLE AT THE START OF THE EVENT AND THAT CONTRIBUTED TO THE EVENT

"A" Train Component Cooling Water from Reactor Coolant Pump Thermal Barrier Outer Containment Isolation Valve, EGHV0061 was out of service for maintenance.

D. NARRATIVE SUMMARY OF THE EVENT, INCLUDING DATES AND APPROXIMATE TIMES

On 01/07/03, with Callaway Plant in Mode 1 at 100 percent power, the Operations Department was performing a Component Cooling Water (CCW) Train "A" Containment Isolation Valve Test. During the performance of the test, valve EGHV0061 (Component Cooling Water from Reactor Coolant Pump Thermal Barrier Outer Containment Isolation Valve) failed to stroke to the fully closed position. EGHV0061 was stroked a second time with the same result. EGHV0061 was declared inoperable at 20:12 and Technical Specification (T/S) 3.6.3.A 1 was entered. T/S 3.6.3.A 1 requires the isolation of the affected penetration flow path by use of at least one closed and de-activated automatic valve, closed manual valve, blind flange, or check valve with flow through the valve secured. The Bases Section includes the statement " The method of isolation must include the use of at least one leak rate isolation barrier that cannot be adversely affected by a single active failure. Isolation barriers that meet this criterion are a closed and de-activated automatic valve, a closed manual valve (this includes power operated valves with the power removed), a blind flange, and a check valve with flow through the valve secured. (A remote manual valve's Main Control Board power isolate switch may be used to de-activate the valve.)". At 20.20, EGHV0061 was fully closed and power was removed from the valve to satisfy T/S 3.6.3.A.1.

The return flowpath from the Reactor Coolant Pump Thermal Barrier was established through EGHV0062 (the inner Containment Isolation Valve) and EGHV0133 (the bypass valve for EGHV0061) with administrative controls, which consisted of a dedicated Control Room Operator. This action was performed to satisfy T/S 3.6.3.A.1 for this flowpath. Later it was determined that EGHV0133 and EGHV0062 were both powered from Bus NG02B. This discovery revealed that the administrative controls were inadequate. This was a condition prohibited by the Plant's T/S.

The root cause of the event was a failure to recognize the common power source for both valves.

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E. METHOD OF DISCOVERY OF EACH COMPONENT, SYSTEM FAILURE, OR PROCEDURAL ERROR

The failure of EGHV0061 was discovered during scheduled testing.
The NRC Senior Resident Inspector noted that EGHV0133 and EGHV0062 have a common power source

II. EVENT DRIVEN INFORMATION

A. SAFETY SYSTEMS THAT RESPONDED

Not applicable for this event.

B. DURATION OF SAFETY SYSTEM INOPERABILITY

The total out of service time was 71 hours and 58 minutes from January 7, 2003 at 20:12, until January 10, 2003 at 20:10.

C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT.

A probabilistic risk assessment was conducted to evaluate the failure of EGHV0061, and the subsequent reliance on valves EGHV0062 and EGHV0133 for containment isolation. The risk assessment took into account that both of the aforementioned valves are powered from the same safety-related bus (NG02B) and the assessment assumed that operator action to close a valve was necessary for containment isolation. The risk assessment is considered to be a reasonable estimate of the impact on large early release. The assessment determined that this event was not risk significant with respect to the health and safety of the public.

III. CAUSE OF THE EVENT

The root cause of the event was a failure to recognize the common power source for both valves

IV. CORRECTIVE ACTIONS

The test procedure was revised to establish a dedicated local operator in communication with the Control Room as the required administrative control when EGHV0133 is open. This administrative control meets the requirement of T/S 3 6.3 Note 1 with consideration for the common power source to EGHV0062 and EGHV0133.

V. PREVIOUS SIMILAR EVENTS

A review of Callaway's Corrective action Program and LERs for the last three years identified one LER. LER 2000-004-00 documented the inoperability of a containment isolation valve. The cause was a design error

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during a modification that was performed to resolve NRC Information Notice 92-18 concerns.

VI. ADDITIONAL INFORMATION

The system and component codes listed below are from the IEEE Standard 805-1984 and IEEE Standard 803A-1984 respectively.

System: CC

Component: ISV