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

August 6, 2003

Garry L. Randolph, Senior Vice
President and Chief Nuclear Officer
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P.O. Box 620
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SUBJECT: CALLAWAY PLANT - NRC PROBLEM IDENTIFICATION RESOLUTION INSPECTION REPORT 05000483/2003-010

Dear Mr. Randolph:

On July 24, 2003, the above mentioned report was mailed. In the reproduction of the document, page 2 of the report details was issued blank. Please replace the blank page with the attached page 2. We regret any inconvenience this may have caused.

Sincerely,

/RA/

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Docket: 50-483
License: NPF-30

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ADAMS: ☐ Yes ☐ No Initials: _____
☐ Publicly Available ☐ Non-Publicly Available ☐ Sensitive ☐ Non-Sensitive

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| 08/06/03 | | | | |

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b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The team reviewed approximately 60 Callaway action requests and supporting documentation. This effort was accomplished to verify that licensee's evaluation of problems identified considered the full extent of conditions, operability of affected systems, reportability requirements, generic implications, common causes, and previous occurrences. In addition, the team reviewed the licensee's evaluation of select industry experience information to assess if issues applicable to the licensee's facility were appropriately addressed.

Specific documents reviewed during this inspection are listed in the attachment to this report.

(2) Issues

The issues reviewed by the team revealed that the proper categorization had been assigned to identified issues. In general, problems were adequately evaluated and corrected with some exceptions. One exception included a failure to promptly identify and correct an industry known deficient condition affecting the functionality of multiple safety-related circuit breakers. Another exception involved the failure to promptly identify and correct a voided condition affecting both trains of the containment spray system even though abnormal system response to surveillance testing was observed during several occasions dating back to 1995. These failures, reflected some isolated problems with problem identification, extent of condition reviews, root cause determinations, and corrective actions.

The team reviewed Callaway Action Request 200200694 pertaining to the licensee identifying an underlying problem associated with the effectiveness of past incident investigations and/or evaluations to determine the extent of condition for equipment problems. Although corrective actions to address this condition were still in progress the team noted that a significant effort was being taken by the licensee to improve performance in this area. Specifically, the licensee was in the process of developing clear roles and responsibilities for each layer of management to improve the level of oversight and guidance and increase the amount of communications between all levels of the staff. The licensee was also in the process of developing and implementing an equipment reliability improvement program that was projected to be fully implemented by June of 2004.

Circuit Breaker Failures

Introduction. The licensee failed to promptly identify, correct, or preclude recurrence of an industry known potential significant condition adverse to quality associated with failures of Magne-Blast 4160 volt circuit breakers. The breaker failures were the result of a defective contact block assembly used as control switches in the breaker control circuits. The team determined this condition was a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, and a finding of very low safety significance.