Forney

UNION ELECTRIC COMPANY
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ST. LOUIS, MISSOURI

DONALD F. SCHNELL
VICE PRESIDENT

MAILING ADDRESS
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August 9, 1984

Mr. James G. Keppler
Regional Administrator
Office of Inspection & Enforcement
U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

ULNRC-904

Dear Mr. Keppler:

ANALYSIS OF LICENSEE EVENT REPORTS
CALLAWAY PLANT
DOCKET NUMBER 50-483

You have expressed a concern with the number of Licensee Event Reports (LER's) generated at Callaway Plant since the issuance of the operating license. In response to your concern, Messrs. Warnick and Forney from your staff visited Callaway on July 24 and 25 to discuss the LER's in detail and to observe our operations. Subsequently, on August 8, 1984, members of my staff and I came to your offices to review these items with you, members of your staff, and NRR representatives. As I emphasized to you, we also have concerns over the number of LER's experienced to date and have initiated actions to improve this situation.

By way of review, we have currently a total of twenty-three Licensee Event Reports, which may be categorized as follows:

Category 1: Twelve reports relate to security personnel and equipment and, as we discussed with you, we have an aggressive corrective action program in progress. We are working closely with the supplier of our security system hardware and other support personnel to improve the reliability and capability of the existing security computer system. In addition, we intend to replace the present security computers with more powerful machines to provide assurance that the system performs as expected. We have noted improvement in the reliability of the system from the actions already undertaken, and we expect this improvement to continue.

Category 2: We have experienced five events related to our system of radiation monitors. Corrective action has been initiated which includes a revised alarm response procedure for the radiation monitoring system and additional training programs

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on operation of the radiation monitor console and the relevant Technical Specifications. In addition, we have initiated design changes to provide for audible alarms and re-flash capability for annunciators associated with the system. These actions have improved our operations in this area. We have not experienced a reportable event related to radiation monitors since June 18, the effective date of our corrective action.

Category 3: We reported one item of malicious mischief which caused loss of power to several radiation monitors and initiation of containment purge and control room vent isolation signals. Our extensive investigation of this event and corrective action is addressed in our letter to you relative to Licensee Event Report 84-011, ULNRC-890, dated August 9, 1984.

Category 4: We have reported two events because of discretionary reactor trips. These discretionary actions were taken not because unsafe conditions were experienced, but as a precautionary measure by the Reactor Operator because numerous simultaneous activities were diverting his attention. In situations of this type, it is our opinion that an LER should not be required since the operator's action was taken to enhance protection of the plant.

Category 5: We experienced three non-related events as follows: one involved a fire watch survey during which some rooms were overlooked. This occurred early in our fire watch program and corrective action for this item has been implemented. Another event dealt with a procedural error which caused a valve to be opened out of sequence and resulted in depressurization of the reactor coolant system. This procedure had been utilized on at least two previous occasions under different plant configurations without incident. However, the procedure was in error for this particular configuration. Appropriate corrective action has been implemented for this item. The third event dealt with a technical specification violation involving the source range flux doubling circuit. During the system testing sequence, both trains of the flux doubling circuit were not always operable although plant operators maintained the plant in a known, safe condition at all times. The violation occurred primarily because of a misinterpretation of a requirement. In our discussions with you, we noted that Callaway is the first plant to operate with source range flux doubling circuitry designed to prevent boron dilution, and the first plant with Technical Specification

requirements governing this circuitry. We have initiated a request to clarify the Technical Specifications to assure resolution of this problem.

In summary, we believe that we have aggressively pursued corrective action for the personnel errors, equipment problems and procedural difficulties which initiated the subject Licensee Event Reports. As an additional action to improve our overall performance, we have initiated a 12-hour, 4-shift rotation for our operating personnel to provide fewer shift turnovers and more supervision on watch. We have also placed our Superintendent-Operations and his assistants on shift to provide more direct management support for plant activities. We are determined to reduce the number of LER's generated by operation of Callaway Plant and believe that the actions described herein will be effective.

Very truly yours,

Donald F. Schnell

Donald F. Schnell

DFS/bjp

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