

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-483/87034(DRP)

Docket No. 50-483

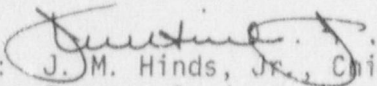
License No. NPF

Licensee: Union Electric Company
Post Office Box 149 - Mail Code 400
St. Louis, MO 63166

Facility Name: Callaway Plant, Unit 1

Meeting At: Region III Office, Glen Ellyn, Illinois

Meeting Conducted: October 2, 1987

Approved By:  J. M. Hinds, Jr., Chief
Reactor Projects Section 1A

10.27.87
Date

Meeting Summary

Meeting on October 2, 1987 (Report No. 50-483/87034(DRP))

Areas Discussed: An enforcement conference conducted to discuss events in which (1) a mispositioned valve resulted in the reduced flow capability of one essential service water train and (2) breached control room pressure boundary seals resulted in the inoperability of both trains of the control room emergency ventilation system.

DETAILS

1. Meeting Attendees

Union Electric Company

D. F. Schnell, Vice President - Nuclear
W. D. Campbell, Manager, Nuclear Engineering
A. P. Neuhaufen, Manager, Quality Assurance
J. D. Blosser, Manager, Callaway Plant

Nuclear Regulatory Commission - Region III

C. J. Paperiello, Deputy Regional Administrator
J. A. Hind, Director, Division of Radiation Safety and Safeguards
W. L. Forney, Chief, Reactor Projects Branch 1
W. D. Shafer, Chief, Emergency Preparedness and Radiological Protection Branch, Division of Radiation Safety and Safeguards
B. A. Berson, Regional Counsel
L. R. Greger, Chief, Facilities Radiation Protection Section, Division of Radiation Safety and Safeguards
R. M. Lerch, Technical Assistant, Reactor Projects Branch 1
W. H. Schultz, Enforcement Specialist
C. F. Gill, Senior Radiation Specialist
B. H. Little, Senior Resident Inspector, Callaway
G. A. VanSickle, Project Inspector, Callaway

Nuclear Regulatory Commission - NRR

T. W. Alexion, Licensing Project Manager, Callaway

2. Enforcement Conference Details

The enforcement conference was held to discuss two events: (1) the reduction in flow capability of one essential service water train due to a mispositioned (not completely open) valve and (2) the inoperability of both trains of the control room emergency ventilation system resulting from breached control room pressure boundary seals. These events are described in Inspection Reports No. 50-483/87028(DRP) and No. 50-483/87023 (DRSS), respectively.

After the opening remarks, the licensee gave its account of the essential service water event. The licensee's chronology, which involved a series of work request issues, voidings, and reissues for the subject valve and the eventual discovery of the problem during a containment cooler flow verification test, was essentially the same as that provided by Inspection Report No. 50-483/87028. The licensee identified the following corrective actions:

- The valve was fully opened and caution tagged.

- The licensee reviewed selected voided and open work requests, particularly focusing on those affecting safety systems, to determine whether other component deficiencies had gone uncorrected as a result of voided work requests and reissues. No such problems were identified.
- The licensee's procedures for voiding work requests were strengthened by requiring that the complete scope of a voided work request must be included in the work request which supersedes it.

The licensee noted that several other technical specification surveillances and predictive monitoring programs would have identified that the valve was mispositioned. The licensee also stated that a detailed engineering analysis had determined that the reduced flow through the partially closed valve would have been sufficient for the system to perform its required safety functions.

The licensee next provided its account of the event involving breached control room pressure boundary seals. The licensee chronology, involving the failure of emergency ventilation system train "A" to pass a control room pressurization surveillance, the subsequent plugging of control room penetrations, and the later determination that train "B" had also been inoperable, was essentially the same as that provided by Inspection Report No. 50-483/87023. The licensee identified the following corrective actions:

- The penetrations were sealed.
- A hold was placed on making further penetrations.
- A defective damper was replaced.
- The fire barrier program was enhanced to include consideration of the impact of breaching pressure boundary seals.

The licensee added that, although the control room emergency ventilation system could not provide the required positive pressure in the control room, it was capable of limiting doses to control room personnel within GDC 19 criteria. This determination was based on an analysis conducted by the Bechtel Power Corporation.

The licensee closed its presentation on the two events with a brief discussion of improvements in its program for conducting required 10 CFR 50.59 reviews, and expressed its belief that increased management attention in this area should help eliminate future events like that involving the breached control room pressure boundary seals.

The senior NRC representative acknowledged the licensee's presentation and stated that the Region III recommendation concerning enforcement action for the event would be forwarded to the NRC Office of Enforcement for its concurrence. After review by that Office, the licensee would be notified in writing of the NRC's proposed enforcement action.