AmerenUE
Callaway Plant

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June 10, 2003

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
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ULNRC-04848

Ladies and Gentlemen:

REPLY TO PRELIMINARY WHITE FINDING
INSPECTION REPORT NO. 50-483/2003-008
CALLAWAY PLANT
UNION ELECTRIC CO.

This responds to Mr. Dwight D. Chamberlain's letter dated May 2, 2003, which transmitted a Preliminary White Finding for events discussed in Inspection Report 50-483/2003-008. Our response to the Preliminary White Finding is presented in the attachment. On June 2, 2003, Mr. Ronald A. Kopriva, Senior Project Engineer, Division of Reactor Projects Branch B, authorized a response date of June 10, 2003.

None of the material in the response is considered proprietary by Union Electric.

If you have any questions regarding this response, or if additional information is required, please contact Mr. Mark A. Reidmeyer, Regional Regulatory Affairs Supervisor at 573/676-4306.

Very truly yours,

G. L. Randolph

GLR/MAR/slk
Attachment: 1) Reply to Preliminary White Finding

IE01

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AmerenUE takes its obligation to protect the health and safety of the public very seriously and sincerely regrets the fact that it missed sending Tone Alert Radios to some residents who should have received them. AmerenUE does not wish to challenge the finding as preliminarily characterized. However, the Callaway organizational response to this issue merits clarification.

The inspection report notes prior opportunities to identify and correct the weakness in the maintenance of the tone alert radio population in the Callaway Plant Emergency Planning Zone (EPZ). AmerenUE does not disagree that prior corrective actions failed to adequately address the problem, nor did routine monthly monitoring of changes to the Tone Alert Radio database surface the weakness. While the identified weakness is indicative of past performance, AmerenUE believes Callaway's current standards for problem identification and resolutions are substantially different. Specifically:

- The concern was brought to management's attention due to the questioning attitude of the Senior Nuclear Clerk and entered into the corrective action system. Had this not occurred, normal monthly updating of the database and distribution of Tone Alert Radios to affected households would have completed the monthly surveillance. The inaccuracies in the Tone Alert Radio database and the process for detecting errors in the database would have remained unchanged. Moreover, due to the importance associated with the public prompt notification system, the corrective action was assigned the highest significance level, to ensure a formal root cause process was utilized. This significance level assured dedication of resources to resolve the matter in a manner consistent with its significance.
- The concern was evaluated for reportability using the criteria of 10 CFR 50.72(b)(3)(xiii), Loss of Emergency Preparedness Capabilities. This evaluation was completed on November 27, 2002, the day following identification of the concern. The issue was determined not to be reportable, since the missing radios did not constitute a major loss of the public prompt notification system; i.e. the Tone Alert Radios, per the Event Reporting Guidelines of NUREG-1022, Revision 2. However, as a prudence measure, the NRC Chief, Division of Reactor Safety, Plant Support Branch was notified of this concern by telephone on November 27, 2002. During this conversation, the results of the reportability determination were explicitly discussed.
- Tone Alert Radios were sent to all initially identified affected residences on November 27, 2002. As reviews of the Tone Alert radio database were completed, radios were supplied to residences as additional discrepancies were identified. As noted, this comprehensive review did take approximately four months to complete.

While we are not satisfied with the circumstances that permitted this concern to remain undetected, AmerenUE does believe the response to this concern was prompt and comprehensive and is indicative of substantially improved capabilities to resolve problems.

The inspection report also discusses the failure to promptly identify and correct a degraded condition as a direct contributor to the preliminary finding. As we understand the process, cross cutting issues can be identified in the areas of problem identification and resolution, human performance and safety conscious work environment. Inspection Report Section 4OA2, Identification and Resolution of Problems, captures this issue as a cross cutting issue involving problem identification and resolution. However, the last paragraph of this section states, "The inspectors determined that these programmatic and implementation weaknesses represented a human performance cross cutting issue involving the timely recognition and correction of degraded conditions." As a result, the characterization of the issue lacks clarity. AmerenUE has resolved this matter based on our understanding of the issue. We believe a clear characterization of the issue's cross cutting aspects is necessary to ensure the potential finding is properly addressed.