



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

March 2, 2006

Charles D. Naslund, Senior Vice
President and Chief Nuclear Officer
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**SUBJECT: RESPONSE TO COMMENTS RELATING TO A NONCITED VIOLATION AND AN
APPARENT VIOLATION IN NRC INSPECTION REPORT 05000483/2005004**

Dear Mr. Naslund:

On January 11, 2006, the NRC responded to a letter from Mr. Young of your staff, dated December 14, 2005, and indicated that we would review AmerenUE's comments to the 2005 third quarter integrated inspection of the Callaway Plant. The inspection results were documented in our November 5, 2005, letter and integrated into NRC Inspection Report 05000483/2005004. In the December 14 letter, AmerenUE provided clarification to the identification, cause, and safety significance analysis of Apparent Violation (AV) 05000483/2005004-01, Failure to Ensure Only One Centrifugal Charging Pump Was Capable of Injecting to the Reactor Coolant System. The letter also provided clarification to the identification and safety-significance of Noncited Violation (NCV) 05000483/2005004-02, Operator Did Not Verify the Tappet Nut Was Completely Seated When Resetting the Turbine Mechanical Overspeed Trip Mechanism.

With regard to the issue involving the apparent violation for the failure to ensure only one centrifugal charging pump was capable of injecting into the reactor coolant system, the NRC reviewed the issue using Manual Chapter 0609, Significance Determination Process, Appendix G, Shutdown Operations Significance, Checklist 2, and consulted with the NRC's senior reactor analyst. Based on these discussions, it was determined that the issue should be reviewed by an NRC risk analyst familiar with cold overpressure mitigation issues. This safety-significance review was performed and the results were determined to be of very low safety significance (Green) and are documented in Section 4OA5.3 of NRC Inspection Report 05000483/2005005. In addition, the NRC considered the criteria used to evaluate the issue as self-revealing. NRC Inspection Manual Chapter 0612, Power Reactor Inspection Reports, issued on September 30, 2005, provides a revised definition of a licensee-identified issue. Because this issue was open at the time the inspection ended (December 31, 2005), the NRC evaluated the finding against the latest inspection manual guidance and determined that the finding should be dispositioned as licensee-identified. Because this is a licensee-identified violation, no crosscutting aspects are identified. With regard to the comments involving the causes, the NRC will review your root cause and corrective actions as part of the baseline inspection program. This finding is documented in Section 4OA7 of NRC Inspection Report 05000483/2005005 as a licensee-identified violation.

The NRC has reviewed the comments provided by AmerenUE regarding the self-revealing noncited violation of Technical Specification 5.4.1.a, "Procedures," for the failure to properly align the turbine-driven auxiliary feedwater pump mechanical overspeed trip mechanism after surveillance testing. The NRC utilized Manual Chapter 0612, Power Reactor Inspection Reports, issued January 14, 2004, to assess this issue. Manual Chapter 0612 defines licensee-identified as those findings identified through a licensee program or process that are specifically intended to identify the problem. Some examples of licensee programs that likely result in such findings are postmaintenance testing, surveillance testing, ASME Section XI testing, drills, critiques, event assessments, evaluations, or audits conducted by or for the licensee. Most Green findings documented in the licensee's corrective action program are considered licensee-identified.

The NRC did not find that AmerenUE had a written program or process addressing system engineer walkdowns or walkdown expectations. In this case the misalignment was identified by a system engineer while walking down the system. The NRC recognizes that the misalignment was identified in AmerenUE's corrective action program; however, the NRC did not find that the walkdown of the turbine-driven auxiliary feedwater pump was part of a surveillance, postmaintenance test, or other activity to specifically verify system operability. With regard to the statement in the NRC inspection report that "The trip linkage misalignment resulted in increased probability of an inadvertent TDAFP trip during accident conditions," the NRC found that the trip linkage was not in a configuration that the turbine is tested in and that the configuration resulted in a degraded but operable system. The NRC agrees with the AmerenUE assessment that concluded that the turbine-driven auxiliary feedwater pump remained capable of performing its safety function, which was the basis used to screen the finding as having very low safety significance as described in Manual Chapter 0609, Significance Determination Process, Appendix A, Significance Determination of Reactor Inspection Findings for At-Power Situations.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

William B. Jones, Chief
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