AmerenUE Callaway Plant PO Box 620 Fulton, MO 65251

September 22, 2006

U.S. Nuclear Regulatory Commission Attn: Document Control Desk Mail Stop P1-137 Washington, DC 20555-0001

ULNRC05333



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Ladies and Gentlemen:

DOCKET NUMBER 50-483 CALLAWAY PLANT UNIT 1 UNION ELECTRIC CO. FACILITY OPERATING LICENSE NPF-30 LICENSEE EVENT REPORT 2006-006-00 <u>Unexpected Inoperability of 'B' Emergency Exhaust System due</u> to a Failed Handswitch on the Operations Main Control Board.

The enclosed licensee event report is submitted in accordance with 10CFR50.73(a)(2)(i)(B) to report an unexpected inoperability of the 'B' Emergency Exhaust System due to a failed handswitch on the Operations main control board.

This letter does not contain new commitments.

Sincerely

Adam C. Heflin / Vice President, Nuclear Operations

ACH/dwg Enclosure



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Mr. Bruce S. Mallett Regional Administrator U.S. Nuclear Regulatory Commission Region IV 611 Ryan Plaza Drive, Suite 400 Arlington, TX 76011-4005

Senior Resident Inspector Callaway Resident Office U.S. Nuclear Regulatory Commission 8201 NRC Road Steedman, MO 65077

Mr. Jack N. Donohew (2 copies) Licensing Project Manager, Callaway Plant Office of Nuclear Reactor Regulation U. S. Nuclear Regulatory Commission Mail Stop O-7D1 Washington, DC 20555-2738

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Records Center Institute of Nuclear Power Operations 700 Galleria Parkway Atlanta, GA 30339 ULNRC05333 September 22, 2006 Page 3

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> Certrec Corporation 4200 South Hulen, Suite 630 Fort Worth, TX 76109

(Certrec receives ALL attachments as long as they are non-safeguards and public disclosed).

Send the following without attachments:

Ms. Diane M. Hooper Supervisor, Licensing WCNOC P.O. Box 411 Burlington, KS 66839

Mr. Scott Bauer Regulatory Affairs Palo Verde NGS P.O. Box 52034, Mail Station 7636 Phoenix, AZ 85072-2034

Mr. Scott Head Supervisor, Licensing South Texas Project NOC Mail Code N5014 P.O. Box 289 Mr. Dennis Buschbaum TXU Power Comanche Peak SES P.O. Box 1002 Glen Rose, TX 76043

Mr. Stan Ketelsen Manager, Regulatory Services Pacific Gas & Electric Mail Stop 104/5/536 P.O. Box 56 Avila Beach, CA 93424

Mr. John O'Neill Pillsbury Winthrop Shaw Pittman LLP 2300 N. Street N.W. Washington, DC 20037

366			U.S. NUCLE	AR RI	EGULATO	RY COMMI	SSION	APPROV	ED BY OMB	: NO. 3150-0	104	EXPIRE	S: 06/30/2007
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FACILITY NAME (1)	DOCKET (2) NUMBER (2)	I	ER NUMBER (6)			PAGE (3	i)_
Callaway Plant Unit 1	05000483	YEAR 2006	SEQUENTIAL NUMBER	REVISION NUMBER 00	2	OF	
ATIVE (If more space is required, use additional cop	pies of NRC Form 366	4) (17)					
50 73(a)/2)(i)B - Operation of Cor	dition Prohibited I	ov Technic	al Specificatio	ne			
50.73(a)(2)(v)C - Event or Conditi50.73(a)(2)(v)C - Event or Conditi	on that Could Hav	e Prevent	ed Fulfillment	of a Safety	Funct	ion:	
50.73(a)(2)(v)D – Event or Conditi Mitigate the Cor	on that Could Hav sequences of an	e Prevente Accident.	ed Fulfillment o	of a Safety	Funct	ion:	
B. PLANT OPERATING CONDITION	S PRIOR TO THE	EVENT					
Mode 1, 100% Reactor Power							
C. STATUS OF STRUCTURES, SYS START OF THE EVENT AND THA	TEMS OR COMP AT CONTRIBUTE	ONENTS ⁻ D TO THE	THAT WERE I	NOPERAB	SLE AT	THE	
No system, structures, or compone to the event.	ents were Inopera	ble at the s	start of this eve	ent which c	ontrib	uted	
D. NARRATIVE SUMMARY OF THE	EVENT, INCLUDI		S AND APPRO		TIMES	;	
On 08/05/2006 the Callaway Oper- Negative Pressure Test on the Tra Specification surveillance requirem Damper, GLD0047, failed to close Exhaust System was declared inop Additionally, the Auxiliary Building declared inoperable due to the inop inoperable. The Control Room Su Auxiliary Building Supply Damper, the Auxiliary Building air supply. T request was initiated to document	ations shift crew v ain B Emergency E nents 3.7.13.4 and as expected. At perable due to dar Exhaust Plenum/N perability of the Tr pervisor directed f GLD0046, and re these actions were the GLD0047 dar	vas perforr Exhaust Sy I 3.7.13.5, I0:20 on 0 nper GLD0 Jnit Vent F rain B Eme the Operat move the p e complete nper failure	ning an Auxilia ystem, as requi when Auxiliary 8/05/2006, the D047 failing to Particulate /lod ergency Exhau ions shift crew power fuses to ed at 10:39. A	ary Building ired by Teo / Building S Train B Er close durin ine Detecto st System to close th GLD0046 corrective	Train Chnical Supply merge ig testion was being he Trai to isol action	B ncy ing. also n A late	
A job was initiated for a Maintenan necessary repairs. Upon inspection damper motor was not receiving por the Main Control Board was suspe handswitch. As the Electrical Main Supervisor noticed, from the back protruding from the end of the cont contacts within the handswitch ass Electrical Maintenance crew replace	ice crew to inspec in of the damper and ower and a failure icted. Another job intenance crew pre side of the control icact block of the ha isembly were not all ced the handswitch	t the damp of damper of the pus was initia pared to re panel, the andswitch igned in th n, they exe	per and dampe motor, it was hbutton hand ted to replace emove the han contact block assembly. Th peir normal cor ercised the old	r motor and determined indicating s the suspect dswitch, the plunger wat is indicated ofiguration. handswitch	d perfo d the switch t as d the ro Whei h seve	orm on elay n the eral	

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RATIVE (If more space is required, use additiona	al copies of NRC Form 3664	4) (17)		I	<u> </u>		
After the handswitch was replative damper to ensure functional Emergency Exhaust System. Emergency Exhaust System w The System Engineer reviewed configuration observed by the GLD0047, if a Safety Injection position found, the normally clo would not allow current to pass would have occurred.	aced, the Operations of ality of the newly insta Technical Specificatio vas declared operable d the handswitch cont Electrical Supervisor, Signal would have oc osed contacts of the h s from the handswitch	rew satisfa lled hands n action 3 at 22:30 c act design would hav curred. W andswitch to the dan	actorily perform witch and ope 7.13.A was ex on 08-05-2006. and confirmed e prevented th ith the contact were stuck in oper actuator i	ned a stroke rability of the ited and the d the hands he actuation block plung the open po f a Safety In	e time e Trai e Trai witch of da ger sti ositior ijectic	e test on in B n B in the imper uck in th n, which on Signa	าย
E. METHOD OF DISCOVERY OF		T, SYSTEN	/I FAILURE, O	R PROCED	URA	L ERRC)R
The Callaway Operations crew the Train B Emergency Exhaus Supply Damper, GLD0047, fail motor, it was determined the d indicating switch on the Main C handswitch. As the Electrical I noticed, from the back side of t the contact block of the handsy assembly were not aligned in t	was performing an A st System, as required led to close as expect amper motor was not Control Board was sus Maintenance crew pre the control panel, the witch assembly. This heir normal configurat	uxiliary Bu I by Techn ed. Upon receiving p pected. A pared to re contact blo indicated t ion.	ilding Train B ical Specificat inspection of the bower and a fa job was initiat emove the han bock plunger wa he relay conta	Negative Pri ions, when <i>I</i> ne damper a ilure of the p ed to replac dswitch, the s protruding cts within th	essur Auxili and d pushl e the Sup g from e har	re test o ary Build amper button h ervisor the end ndswitch	n din d o
II. EVENT DRIVEN INFORMATION							
A. SAFETY SYSTEMS THAT RES	SPONDED						
No automatic actuations occurs systems responded.	red in response to the	failure of	the handswitch	n in this ever	nt and	d no saf	ety
B. DURATION OF SAFETY SYST	EM INOPERABILITY						
The date of discovery for this e Building Supply Damper, GLD0 Emergency Exhaust System. I associated circuitry, there was Therefore, the System Enginee surveillances, to determine the simulated safety injection signa operated successfully on 07-09 tested the slave relay and circu performance of this test proced automatically closed damper G	event is 08/05/2006, w 0047, failed to close de However, after reviewing no conclusive evidence reviewed document last known successfue al to damper GLD0047 0-2006 during the perf- nitry associated with the lure, a simulated safet SLD0047.	hen the O uring surve ing the cor ce that the ation, inclu l operation 7. It was d ormance o handsw ty injection	perations shift eillance testing figuration of the damper failed uding past Tec of the hands etermined the of a surveillanc itch and damp signal through	crew found of the Train he handswit at the time hnical Speci witch circuitr damper was e procedure er. During t h the handsy	the A n B ch ar of dis ificati ry for s last e, whi he witch	uxiliary scovery. on a ch	

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NRC FORM 366AU.S. NUCLEAR REGULATORY COMMIS (1-2001)	SION							
LICENSEE EVENT REPORT (LER)								
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NARRATIVE (If more space is required, use additional copies	s of NRC Form 366	4) (17)						
While performing the restoration sec damper GLD0047 when restoring the could have occurred at this time. To Emergency Exhaust System was inc surveillance procedure of 09:55 on 0 when the damper was declared oper and the damper was tested success Emergency Exhaust System was fro the inoperability was 27 days, 12 ho Train B Emergency Exhaust System Technical Specification actions for th 08-05-2006:	tion of the test p e 'B' train Emerge oconservatively operable, the sta 7-09-2006 is us rable on 08-05-2 fully for operable m 09:55 on 07- urs, and 35 min was inoperable ne following con	procedure, gency Exh establish f art time for ed. The e 2006 at 22 ity. There 09-2006 to utes. Beca during thi ditions was	the ha aust Sy the perio the perio ause the fore, the 22:30 ause it is perio s not perio	ndswitc /stem. rforman he peric er the h ie inope on 08-0 was not d of tim erforme	h was use The hands me the Tra ice of the s od of inope andswitch rability of f 05-2006. T t recognize e, entry int d until 10::	ed to op switch i ain B slave ro erability was ro the Tra The du ed that to appl 20 on	ben failure elay v was eplaced ain B ration of the icable	
3.7.13.A One Emergency Exh Restore Emergency Exhaust S 3.7.13.C Required Action and MODE 1, 2, 3, or 4.	aust System tra System train to (associated Cor	in inopera DPERABL npletion T	able in N E statu ime of (MODES s within Conditic	5 1, 2, 3, or 7 days. on A or B r	⁻ 4. not me	t in	
A review of Control Room Logs was Exhaust System from 07-09-2006 0 Exhaust System was found to be inc	performed to de 9:55 through 08 perable during	etermine th -05-2006 the followin	ne opera 22:30. ng time	ability o The Tr periods	f the Train ain A Eme s:	A Em ergency	ergency /	
07/14/06 15:10 – 07/14/06 15 EFHV0043	5:16 Train A Es	sential Sei	rvice W	ater inc	perable di	ue to w	ork on	
07/20/06 09:11 – 07/20/06 09 due to surveillance testing.	9:24 Train A Lo	ad Shed E	imerger	ncy Loa	d Sequend	cing in	operable	
07/24/06 10:25 – 07/25/06 01 connection.	:44 Train A En	nergency E	Exhaust	t inoper	able due to	o repai	r of hot	
07/25/06 09:14 – 07/25/06 09 testing.):35 Train A En	ergency E	Exhaust	t inoper	able due to	o surve	eillance	
07/27/06 01:47 – 07/27/06 02 surveillance testing.	:10 Train A Es	sential Ser	rvice W	ater inc	perable di	ue to		
Because both trains of the Emergence entry into applicable Technical Speci	cy Exhaust Syst fication action f	em were in or the follo	noperal wing co	ble duri ondition	ng these ti was also	ime pe missed	riods, 1:	
3.7.13.B Two Emergency Exhau Restore Auxiliary Building bound	ist System train ary to OPERAB	s inoperab LE status	ble in M within 2	ODES 24 hour	1, 2, 3, or 4 s.	4.		
(Continued)								

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C. SAFETY CONSEQUENCES AND	MPLICATIONS C	F THE E	/ENT.					
This event did not have a signific	ant impact on nucle	ar safety.	The Eme	rgen	cy Exhaus	st Syst	em and	
radioactivity during the recirculati	on of sump fluids for	llowing a	large brea	ung k LO	CA with c	e oi ore da	mage,	
but have no function to prevent c	ore damage. There	efore, this	event has	no ir	npact on c	core da	mage	
nequency.								
The integrity of the Auxiliary Build	ling pressure bound During the recircula	dary is tak ition phase	en into cor e of the LC	nside CA :	eration as a sequence.	a part (. it is a:	of the ssumed	
that ECCS components in the Au	xiliary Building will	leak. Ten	percent of	this	leaked su	imp flu	id	
flashes to steam. This provides a fluids. The Emergency Exhaust \$	a release mechanis System is credited t	m for the i o mitigate	odines cor this releas	ntain se pa	ed within t athway, T	he sur he safe	np etv-	
grade filters in the Emergency Ex	haust System are	credited fo	r removal	of io	dines.			
Callaway surveillance procedures	s maintain a running	g total of E		pone	ent leakage	e. The	1	
acceptance criterion is that the su	um of leakage from	all compo	nents mus	t not	exceed o	ne gall	on per	
Building is twice the surveillance	acceptance criteria	two gpm	sumes that).	liea	kage into t	ne Au	killary	
During the period of time the Aux	iliany Building press		hanuwae d	oara	dad the s	um of	FCCS	
leakage was less than 10 drops p	per minute. This is	substantia	ally below t	he o	ne gpm va	alue us	ed as	
an acceptance criterion. Leakage	e of ECCS compon	ents into ti ity due to t	he Auxiliar	y Bu ed d	ilding was	low er	hough	
Auxiliary Building Pressure bound	dary.	ity due to		eu u	egradator		,	
With regard to probabilistic safety	v. this event has no	impact on	the Callav	vavo	core dama	ae or l	arge	
early release frequencies.	,					0		
In summary, this issue is not safe	ty-significant based	I on the fo	llowing:					
 system redundancy, the short duration of the time 	intonyola during wh	ich hath tr	ning word	inon	orobio			
 the Short duration of the time the Maintenance Rule Safety 	Significance categ	orization.	ans were	mop	erable,			
III. CAUSE(S) OF THE EVENT AND CO	RRECTIVE ACTIO	N(S)						
To evaluate the handswitch failure, th	e System Engineer	inspected	d the defec	tive	handswitc	h asse	mbly.	
The handswitch was a model type E3	0 pushbutton positi	on indicat	ion switch	man	ufactured	by Cul	tler-	
to stick in a position other than its nor	mal state, so the ex	epartmen act cause	t, the hand was not re	swite eadil	cn could n ly apparen	ot be r it. The	nade	
System Engineer dismantled the hand	dswitch assembly a	nd found	curled met	al sh	avings an	d othe	r	
of metal alloys different than the meta	al alloys used in the	handswite	ch contacts	nete S.	a snavings	were	made	
(Continued)								

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A root cause analysis team was formed to determine the root cause of the event and determined the root cause of the handswitc contact block of the handswitch assembly, during initial plant construction in 1982. Th holes above the handswitch. The mechanis one or more of these particles of foreign m contributing cause to this event was the loc contact blocks. In evaluating the extent of condition of this handswitches in the area of the modificatio material concerns. The corrective action to handswitches identified. The team recognis changed significantly since the initial const Exclusion procedure was reviewed and wa from recurring. The Cause code of X on page 1 of this LE identified as foreign material within the han	evaluate the of corrective act ch failure was which resulte his modificatio ical motion of aterial into a p ose tolerances event, the tea on, which may o prevent recu ized the proce ruction of Call is determined ER was select idswitch.	data applic ions to pre the introdu d from a m n included the contactor osition wh is in the des in the des m identifie have been irrence inc away Plan to be suffic ed due to f	able to the vent recur uction of fo hodification the drilling to block plu ere the plu sign and m ed ten othe h subjected ludes the r rols regard t. The cur cient to pre	e handswitch rence. This t preign materia to the main g and tapping inger allowed unger became anufacture o r Cutler-Ham to the same eplacement o ling foreign m rent Foreign event this type use of this ev	failure a eam al into th control b of three transpo e wedge f the vin mer E30 foreign of the tel naterial h Material e of even	nd e board e ort of ed. A tage 0 n nad nt	
IV. PREVIOUS SIMILAR EVENTS Operating experience and corrective action	n documents,	pertaining	to Callawa	y Plant, were	e reviewe	ed	
and no previous similar events were found handswitch failure.A search of external ope Experience database. Seventy-three docu similar events were identified. The followin operating experience citing foreign materia	identifying for erating experie ments were re ig results are a l.	eign mate ence was r eturned in a brief des	rial as a ca nade using the OE sea cription of	use or contri the INPO O arch, out of w the most rele	butor to perating hich sixi vant cas	a I teen ses of	
INPO Operating Experience database of event at McGuire Unit 1, in which a har handswitch became evident to the oper Containment Isolation signal was gener expected, the Operators observed one until the phase B Containment Isolation revealed the contact block plunger was pathway of the handswitch plunger.	entry dated Ju ndswitch was rating crew du rated. Instead valve closing n signal was ro s stuck open d	Ily 15, 200 stuck in th rring slave d of all the and then i eset. Exar ue to a pie	4, Failure e open pos relay testi phase B is mmediatel nination of ece of pher	Number 260 sition. The fa ng, when a pl solation valve y reopening s the suspect nolic material	describe iled hase B s closin several f handsw lodged	ed an g as times, itch in the	
INPO Operating Experience database of failure modes associated with Cutler-Ha contact block plungers sticking due to h dust, and the possibility of contact block contact block plunger movement	entry entitled, ammer switch ubricant thick ks becoming o	Control Sv es, includi ening, affe displaced o	witches He ng pushbu cts of wear or damage	alth Report, i tton operator debris and a d and interfer	identifies plunger atmosph ring with	s rs and eric the	

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RATIVE (If more space is required, use additional	copies of NRC Form 366/	A) (17)					
While these examples cited compor examples were found which describ handswitch assembly at Callaway d	nent wear, debris, an ed evidence of meta escribed in this LER	d dust within I shavings a	the contact nd metal del	block asse oris as foun	embly, id in th	no ie	
V. ADDITIONAL INFORMATION							
The system and component codes I Standard 803A-1984 respectively.	isted below are from	the IEEE St	andard 805-	1984 and I	EEE		
System: VF Component: HIS							
The manufacturer of the original and is now a division of Eaton Corp. Th	d replacement hand i e model type of the h	ndicating sw andswitch w	vitch is Cutle vas E30.	r-Hammer,	Inc., v	which	
Manufacturer's Code: C770							

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