ARB SUMMARY		Responsible Branch	RPBB	RIV-2007-A-0028
Facility Name	Callaway	ARB Date:	March 19, 2007	
Docket Number	050-483	OI Case No.:		
ARB DECISION				
Purpose of ARB	Initial			
Previous Decisions	N/A			
Today's Decision	Concern 1- RPBB to inspect. Concern 2- RPBB to inspect non-willful aspects and identify any potential violations. Re-ARB to discuss OI followup of potential willfulness. Concerns 3-6, ACES/RPBB/EB2- to contact alleger, regarding objection to referral and to get clarification regarding concerns.			
Basis for Another ARB				
REFERRAL				
Refer to:		Criteria Reviewed?		
Referral Rationale				
OI INVESTIGATION				
Priority Rationale				
DOL Deferral Rationale				
ARB PARTICIPANTS (* denotes ARB Chairman Approval)				
JWalker	HFreeman	KFuller	MVasquez	SGraves
RCaniano	AVegel*	DWhite	VGaddy	MShannon

B/1

Information in this record was deleted
in accordance with the Freedom of Information
Act, exemptions 7C
FOIA- 2008-0011

CONCERNS LIST				RIV-2007-A-0028
Concern (Brief Statement)				Regulatory Requirement
Branch	Action (Inspect, Refer, Investigate, No Action)	Planned Completion	Significance (High, Normal)	OI Priority (H, N, L)
1 On October 23, 2003, while shutting down to Mode 3, the RCS temperature dropped below the Minimum Temperature for Critical Operation. However, the temperature transient was not documented in a condition report until 38 days later when identified by a training instructor. At the time the condition report was assigned a significance level 4. The concern individual (CI) expressed concern that this significance level was too low. The condition also was not documented in the shift supervisor log.				Criterion V, TSs
RPBB	Inspect	5/19/07	N	N
2 The operating crew waited 90 minutes to fully insert control rods following shutting down the reactor. The CI believes this delay may have been intentional to avoid scrutiny of crews actions, since the crew was supposed to maintain Mode 2 in case the equipment necessitating the shutdown was repaired. The CI states that purposefully delaying inserting the control rods, not logging entry into Technical Specifications and not documenting significant operational transients in the corrective action program are dishonest and negligent omissions.				Wrong doing (50.5), Criterion V/TSs
RPBB	Inspect		N	N
3 Based on past history, the CI is unimpressed with the ability of the ECP to pursue issues. The CI views the Callaway ECP as merely a program to placate employees who have indicated they have concerns they intend to address with the NRC. The CI has no confidence that the ECP will appropriately address this issue				SCWE
ACES RPBB/ EB2	Contact alleger		N	N
4 The CI had unfavorable dealing in the past with senior management (b)(7)c and feels uncomfortable addressing these concerns with his management.				SCWE
ACES RPBB/ EB2	Contact alleger		N	N

CONCERNS LIST				RIV-2007-A-0028
	Concern (Brief Statement)			Regulatory Requirement
Branch	Action (Inspect, Refer, Investigate, No Action)	Planned Completion	Significance (High, Normal)	OI Priority (H, N, L)
5 The CI has no confidence that anyone in Callaway's corrective action program has the interrogation skills to competently conduct interviews with the involved individuals.				SCWE
ACES RPBB/ EB2	Contact alleger		N	N
6 The CI does not believe, the (b)(7)c (b)(7)c will adequately investigate this concern due his relationship with (b)(7)c				SCWE
ACES RPBB/ EB2	Contact alleger		N	N

Revised 5/22/02

ALLEGATION RECEIPT FORM

Received By:	Michael Peck	Receipt Date:	March 2, 2007
Receipt Method (meeting, phone call, letter, etc.)		Resident Office drop in/letter	

FACILITY

Facility Name	Callaway Plant
Location	Fulton, MO
Docket(s)	05000483

CONCERN

Summary the of Concerns (be brief)

1. Unnecessary delay completing a Technical Specification required Shutdown (see attached letter).
2. Failure to document a significant operational transient (see attached letter).
3. Less than adequate safety culture (see attached letter).

Obtain concern specifics. What is the concern, when did it occur, who was involved, etc. If the concern involves discrimination, fill in the last section of the form.

Please see attached letter.

What is the potential safety impact? Is this an ongoing concern?

Indication of poor plant safety culture.
Problems with Corrective Action and Employee Concerns Program.

What requirement/regulation governs this concern?

10 CFR 50, Appendix B, Criteria XVI and Plant Technical Specifications (Mode)

What records should the NRC review?

CARs 2007012798& 200308555, plant computer data from October 21, 2003

What other individuals could the NRC contact for information?

Duff Bottorf and Glen Pruitt

How did the individual find out about the concern?

Review of a condition adverse to quality record.

Was the concern brought to management's attention? If so, what actions have been taken, if not, why not?

Yes- Entered into the Corrective Action Program as "Level 4" CAR (trend only)

Why was the concern brought to the NRC's attention?

The concerned individual has lost confidence in Corrective Action and Employee Concerns Programs.

ALLEGATION RECEIPT FORM

ALLEGER INFORMATION

Full Name	*[Redacted]*	Employer	AmerenUE
Mailing Address (Home)	*[Redacted]*	Occupation	Engineer
Telephone (Daytime) (Home) (Other)	*[Redacted]*	Relationship to facility	Employee
Preference for method and time of contact	Phone/mail	Was the individual advised of identity protection	Yes
Referral	Explain that if the concerns are referred to the licensee, that alleger's identity will not be revealed and that the NRC will review and evaluate the thoroughness and adequacy of the licensee's response. If the concerns are an agreement state issue or the jurisdiction of another agency, explain that we will refer the concern to the appropriate agency, and if the alleger agrees, we will provide the alleger's identity for followup.		
Does the individual object to the referral?	Yes	Does the individual object to releasing their identity?	No
Regulations prohibit NRC licensees (including contractors and subcontractors) from discriminating against individuals who engage in protected activities (alleging violations of regulatory requirements, refusing to engage in practices made unlawful by statues, etc.).			
Does the concern involve discrimination?	No	Was the individual advised of the DOL process?	Yes

What was the protected activity?

Review of a condition adverse to quality record.

What adverse actions have been taken? When?

None

Why does the individual believe the actions were taken as a result of engaging in a protected activity?

N/A

March 1, 2007

[redacted]

Mr. Michael Peck
Senior Resident Inspector
Nuclear Regulatory Commission

Mr. Peck:

On October 21, 2003 Callaway Plant was shutting down to MODE 3 to comply with T/S 3.8.7. At approximately 0938, with the plant in MODE 1, 8% power, a secondary plant transient began when the Turbine and MSR Drains were opened per OTN-AC-00001. This transient lasted approximately 25 minutes and resulted in RCS temperature dropping below the Minimum Temperature for Critical Operation for approximately 10 minutes between 1000 and 1013. The resulting pressurizer level transient caused a letdown isolation and entry into OTO-BG-00001. Note the following:

- The cause of the temperature transient was not captured in the Callaway Action Request System on the day the event occurred. The event was eventually documented in the Callaway Action Request System 38 days later by an Engineering Training Instructor (Vincent "Duff" Bottorf) as Adverse Condition 200308555. This training instructor stated to me that the Shift Supervisor for the event was very defensive about the event and did not want the issue documented with a CAR.

- There is no record in the Shift Supervisor Log nor in the Callaway Action Request System of passing below the Minimum Temperature for Critical Operation or of entering T/S 3.4.2.

At 1013 the turbine was tripped and the crew logged entry into MODE 2; Delta T Power was 4.9%, Tavg was 552°F, IRNI power was 1.4E-5 ica and SUR was -0.01 dpm. One minute later (1014) Delta T Power was 4%, Tavg was 555°F, IRNI power was 1E-5 ica and SUR was -0.16 dpm. The 3°F temperature rise resulted in a negative reactivity insertion which caused the reactor to shutdown. At 1018, OTO-BG-00001 was exited; Delta T power was 2.4%, Tavg was 557°F, IRNI power was 2.4E-6 ica and SUR was -0.16 dpm.

By 1025 Delta T power was approximately stable, indicating reactor power had lowered below the Point of Adding Heat; Delta T power was 1.8%, Tavg was 560°F, IRNI power was 7.34E-8 ica and SUR was -0.28 dpm. By the time 1E-8 ica was reached (1028) the maximum negative start up rate (for the transient) of -0.29 dpm had already been reached; Delta T Power was 1.8%, Tavg was 560°F. By 1046 reactor power was approximately stable (power would drop less than half a decade in the next 75 minutes) at 6.22E-11 ica. At 1125 the Channel 2 SRNI energized, reading 3044 cps and at 1138 the Channel 1 SRNI energizes reading 2593 cps. Control Rods were not inserted until 1204.

RIV-2007-A-0028

There is no indication in the control room log as to what prevented control rod insertion in the 106 minutes between exiting OTO-BG-00001 and finally beginning control rod insertion. There is a log entry at 1137 for exiting OTO-NN-00001. OTO-NN-00001 had been entered earlier in the shift due to problems with inverter NN11. It is unlikely the remaining actions of OTO–NN–00001 were distracting the crew from inserting control rods. Several routine entries were being made during this time period such as starting and completing I&C surveillances or starting and stopping secondary plant equipment.

(b)(7)c with Mr. Bradley, Mr. Ganz, Mr. Weekley and Mr. Olmstead regarding what activities might possibly delay inserting the control rods for over 90 minutes. None of these Shift Managers could think of any evolution which would delay inserting the control rods. All of these individuals did state, in some manner, that they could not evaluate whether or not the delay was appropriate without knowing what all was occurring on shift that day. I have not spoken with any of the crew members on shift at the time (Lantz, Rauch or Alderman). The Reactor Operator is deceased.

At the time the reactor shutdown (it was unrecoverable by 1025) the crew was supposed to be maintaining MODE 2 in the event NN11 was repaired and a shutdown was not necessary. It appears the control rods remained out because the crew did not want the Outage Control Center to know they had lost control of reactor power.

It is not my intent to allege that reactor safety was violated on October 21, 2003. Nor is it my intent to allege that plant operating procedures were not followed. Note the following:

- After the reactor shut down because of the negative reactivity inserted by the +3°F upon tripping the turbine, the reactor was in a stable condition.
- Although shutdown margin was not yet met, negative reactivity was increasing the entire time due to Xenon buildup and the control and shutdown banks were trippable in the event of a transient induced positive reactivity insertion.
- Although all the steps of OTG-ZZ-00005 prior to the step for inserting "control rod banks into the core" implicitly assume the reactor is still critical and although some steps of OTG-ZZ-00005 were not performed (e.g. taking 1E-8 data), there was no explicit deviation from plant operating procedures.

Based on my personal experience with the individuals involved, it appears to me there was an intentional 90 minute delay in inserting control rods to avoid scrutiny of the crew's actions. Purposefully delaying insertion of the control banks, not logging entry into T/S 3.4.2 and not documenting significant operational transients in the Corrective Action Program are dishonest and negligent omissions. This behavior is contrary to the cornerstone of Problem Identification and Resolution.

RIV-2007-A-0028

I am not certain the above events rise to a level which warrant NRC investigation since nuclear safety does not appear to have been in jeopardy. If they do, I would like the NRC to investigate these events as I am not capable of investigating them further. Note the following:

- The events were documented as part of CARS 200701278. The specific allegation above was not as strongly stated in CARS 200701278. At the time CARS 200701278 was written, I was unaware of Mr. Bottorf's problems in getting CARS 200308555 documented.

- CARS 200701278 was screened as a Sig 4 (Corrective Action Only) meaning the Lead Responder need not investigate anything – his task is merely to develop corrective actions to improve our poor performance of MODE 2 operations. At the CARS Screening Committee meeting which assigned this significance level, I expressed my concern that the events of the 2003 NN11 outage needed additional investigation.

- I do not have a good relationship with (b)(7)c and I do not feel comfortable interviewing him concerning these events.

- (b)(7)c Due to his personal relationship with (b)(7)c I do not feel confident (b)(7)c would give this matter a fair investigation.

- I have consulted the Employee Concerns Program at Callaway Plan (b)(7)c in the past (on separate issues) and was unimpressed with their performance and their pursuit of the issues. I view the ECP process at Callaway as merely a program to placate employees who have indicated they have concerns which they intend to address with the NRC and have no confidence they would appropriately address this issue.

- I have no reason to doubt the integrity of the Plant Manager, Mr. Diya, and the Site Vice President, Mr. Heflin. However, I have had unfavorable dealings in the past with their (b)(7)c For this reason, I do not feel comfortable addressing these concerns with my management above Operations.

- Finally, I have no confidence that anyone in the Callaway Corrective Action Program has the requisite interrogation skills to competently conduct the interviews with the involved individuals.

I can be reached away from the plant at [redacted] Duff Bottorf is unaware I am bringing this allegation to you. If you wish to contact him, he can be reached at [redacted] Glen Pruitt was the Shift Engineer for the NN11 shutdown. He is unaware I am bringing this allegation to you. If you wish to contact him, he can be reached at [redacted]

Very respectfully,

[redacted]

RIV-2007-A-0028