ARB SUMMARY		Responsible Branch	RPBB	RIV-2007-A-0028
Facility Name	Callaway	ARB Date:	April 9, 2007	
Docket Number	050-483	OI Case No.:		
ARB DECISION				
Purpose of ARB	Discuss clarification of concerns and new potential discrimination.			
Previous Decisions	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.			
Today's Decision	Concern 3- RPBB to inspect. Concern 4- ACES to offer early ADR, if ADR fails, OI to investigate high priority.			
Basis for Another ARB				
REFERRAL				
Refer to:		Criteria Reviewed?		
Referral Rationale				
OI INVESTIGATION				
Priority Rationale	High- Level of management involved			
DOL Deferral Rationale				
ARB PARTICIPANTS (* denotes ARB Chairman Approval)				
JWalker	HFreeman	KFuller	MHaire	AHowell*
DWhite	FBrush	RCaniano	KClayton	

B/2

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.				Criterion V, TSs
	RPBB	Inspect		N	N
3	The licensee does not have a healthy SCWE. The environment for raising concerns was poor for three events [October 2003 below RCS Minimum Temperature for Critical Operation, June 2005 slow to isolate SI accumulator during shutdown transient, August 2005 slow to isolate SI accumulator during shutdown for ESW pin hole leak down power]. As a result problems were not promptly identified and corrected by the operations shift manager, the operations manager, the employee concerns program manager, or quality assurance organization or regulatory affairs.				SCWE
	RPBB	Inspect		N	N
4	Alleger claims discrimination for having raised safety concerns in the form of having his SRO license terminated.				10 CFR 50.7
	ACES	Offer Early ADR		N	N

Revised 5/22/02

EARLY ADR CHECKLIST
Allegation No. RIV-2007-A-0028

The NRC's ADR Pilot Program requires the ARB to determine whether an individual has made a prima facie case of discrimination before early ADR is offered to the individual.

The following checklist should be used in presenting early ADR recommendations to the ARB. ACES should work with Regional Counsel, as necessary, in collecting the necessary information from the alleger and in making recommendations to the ARB.

Answer the following questions based solely on the information provided by the individual making the assertions. No independent investigation should be done to determine the veracity of the statements.

1. Did the individual engage in protected activity (i.e., raise nuclear safety concerns or any concern that may impact anything that is under NRC jurisdiction)? Yes

   If so, how? In 2005, the alleger raised and pushed an issue regarding clarification of isolating the SI accumulators.

2. Was management aware of the protected activity? Yes

   If so, how did management become aware? He raised the issue to his management, the CAP, the ECP, and to senior management.

3. Was the individual subjected to adverse action? Yes

   If so, what was it? The licensee terminated the alleger's SRO license in June 2006.

4. Is there an inference that the adverse action was taken because of protected activity? Yes

   If so, how are they connected? The alleger believes that the licensee terminated his SRO license because he raise the and pushed for resolution of the SI accumulator isolation issue. Alleger had been issued the SRO licensee only 2 years earlier.

From: Harry Freeman
To: R4ALLEGATION
Date: 3/30/2007 10:27:47 AM
Subject: 07028 Phone Call With Alleger 072907

On March 29, 2007, Linda Smith, Vincent Gaddy and I contacted the alleger to clarify his SCWE concerns. The following provides clarifying information regarding his concerns.

The alleger described an issue he raised in 2005 regarding a statement in the FSAR that indicates that at approximately 425 F and 1000 pounds, that the SI accumulators would be isolated. Apparently, the corrective action process took a long time to address this issue and the ECP program was of little help coming to resolution. The issue was eventually resolved and the NRC does not need to address the technical aspects of the issue.

The alleger claimed discrimination for having raised safety concerns related to the SI accumulator issue above. The licensee advised the NRC that this individual and 2 others did not need to maintain their SRO licensee in August 2006. The alleger believes that the reason he lost his license was at least in part because he kept pushing to have his SI accumulator issue addressed. He stated that the other two individuals received better bonus (?) than he did and it was only after he complained to the ECP (that he was being subjected to discrimination) that the license decided to offer him the same bonus. The alleger still wanted the ECP to investigate why his license was removed but they did not conduct any investigation.

Regarding the October 2003 shutdown issue, the alleger believes that there should have been a lessons learned on the issue, which could have prevented a similar June 2005 shutdown transient but that because of the personal relationship that (b)(7)c has with (b)(7)c that he has not and will not perform an adequate investigation. The alleger stated that he did not believe that the actions taken at the time violated TS or jeopardized plant safety.

He clarified his SCWE concern as follows. The environment for raising concerns was poor for three events [October 2003 below RCS Minimum Temperature for Critical Operation, June 2005 slow to isolate SI accumulator during shutdown transient, August 2005 slow to isolate SI accumulator during shutdown for ESW pin hole leak down power]. As a result problems were not promptly identified and corrected by the operations shift manager, the operations manager, the employee concerns program manager, or quality assurance organization or regulatory affairs. The concerned individual planned to provide a copy of CAR 2007 0 1278 to the resident inspectors. This CAR documented a review of 9 reactor shutdowns for similar issues.

The alleger did not object to referral of his issues to the licensee by the NRC.