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

August 7, 2007

Ex 7C

(b)(7)c

SUBJECT: ALLEGATION NO. RIV-2007-A-0028

Dear (b)(7)c

This refers to my April 11, 2007, letter which acknowledged receipt of your concerns regarding the Callaway Plant. Additionally, I advised you that the NRC would initiate actions to review your concerns related to a couple of operational events that may not have been adequately investigated and to the safety conscious work environment at Callaway.

The NRC has completed its inspection of your concerns. The enclosed "Resolution of Concerns" documents each of your concerns and summarizes the NRC resolution. In summary, two of your concerns were substantiated.

Thank you for informing us of your concerns. We believe that our actions in this matter have been responsive to your concerns. We take our safety responsibilities to the public very seriously and will continue to do so within the bounds of our lawful authority. Unless the NRC receives additional information that suggests that our conclusions should be altered, we plan no further action and we consider this case closed.

Should you have any additional questions regarding our resolution, please contact Mr. Vincent Gaddy, Chief, Reactor Projects Branch B, at 800-952-9677 Extension 141, or you can call me at 800-952-9677 Extension 245, Monday - Friday between 8:00 a.m. and 4:30 p.m. Central time.

Sincerely,

Harry A. Freeman

Harry A. Freeman
Senior Allegation Coordinator

Enclosure:
Resolution of Concerns

cc via Regular Mail:
(b)(7)c

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

C/14

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Exemptions 7C
FOIA/PA 2009-0042

Concern 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. This condition report did not address why the control rods were not inserted until 90 minutes following the reactor shutting down. A later condition report documenting the issue (CARS (b)(7)c 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.

Resolution 1 - Substantiated

In your letter dated April 20, 2007, you advised that on March 20, 2007 you presented CARS (b)(7)c to the Reactivity Management Review Committee and that the CARS significance was rescreened at Level 3.

The NRC reviewed computer point trend data, operator logs, Technical Specification requirements, corrective action documents and operator procedural guidance.

The October 23, 2003, plant transient resulted in RCS temperature decreasing approximately 2 degrees F. below the Technical Specification 3.4.2 minimum allowed RCS temperature while critical. Fifteen minutes late a mode change from Mode 2 (Startup) to Mode 3 (Hot Standby) occurred. This Technical Specification limiting condition for operation entry and mode change were not documented per requirements. The operators procedural guidance expected to be able to control RCS temperature and reactor power stable using control of steam loads to establish a reactor critical condition of about 5 E -6 amps. The reactor did become subcritical without immediate operator action and did transition through five decades of power decrease due to the transient in a 20-minute period. No attempts were made to restore power and after 2 hours, the procedural requirement to insert control rods was implemented. Thirty-eight days later a corrective action document (CAR) identified the discrepancy.

The licensee recently initiated CARs (b)(7)c and (b)(7)c which highlighted the need to re-review the 2003 event to ensure procedural content and operator training was adequate to respond to future events. These corrective action documents have been assigned significance Level 3 and the actions prescribed have the potential to address the 2003 inadequacies.

The concerns described in Allegation RIV- 2007-A-0028, and confirmed by inspection, were contrary to the requirements of the licensee's Technical Specification bases and operating procedures and were an initiating events reactor restart concern. The NRC plans to document this violation in NRC Inspection Report 2007-003.

ENCLOSURE

Concern 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 the crew's 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.]

Resolution 2 – Partially Substantiated

The NRC technical staff reviewed computer point trend data, operator logs, Technical Specification requirements, corrective action documents and operator procedural guidance as they related to the first sentence of Concern 2. The technical staff also reviewed the information to determine whether there were indications of misconduct that would warrant an investigation by the Office of Investigations.

The technical staff determined that the reactor did become subcritical without immediate operator action and did transition through five decades of power decrease due to the transient in a 20-minute period. No attempts were made to restore power and after 2 hours, the procedural requirement to insert control rods was implemented. This time delay was not prudent and did suggest that the operators may not have exercised optimum reactivity management and may not have had adequate plant awareness. The inspector's review of operating procedures did not find any timeliness guidance on performing the steps to insert the control rods.

Concern 3

The licensee does not have a healthy SCWE. The environment for raising concerns was poor for an issue brought forward in May 2005 concerning when the FSAR requires the isolation of the Safety Injection Accumulators. The problem was 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. Action was only taken after the CI stated he was planning to address the issue with the NRC.

Resolution 3 – Not Substantiated

As followup to this concern, the inspectors interviewed several Operations first line supervisors, reviewed computer point trend data, operator logs, CARs (b)(7)c and (b)(7)c FSAR Section 5.2.2.10.4 and Technical Specification requirements, corrective action documents and operator procedure guidance.

To determine whether a healthy environment exists today, the inspectors interviewed several Operations department first line supervisors. All responses indicated that the Operations shift manager, operations managers, ECP manager and other managers were not a factor in their likelihood to self identify and follow through actions to correct discovered problems. Each also stated that problem identification highlighting their own or crew errors would also not be a factor in their likelihood to participate in the corrective action program. Two individuals

stated they had recently made personal errors yet were encouraged to develop the corrective actions. The individuals interviewed believed that the SCWE had improved since 2003 and 2005. The licensee had an independent contractor, Synergy, perform SCWE surveys in 2003, 2005, and 2007. The 2003 and 2005 survey results were completed prior to the respective events provided by the alleger. These did provide a focus on the Operations department but did not indicate an unhealthy environment for raising concerns. The surveys showed that overall plant SCWE had improved to be "very good to strong" in 2005 and 2007. Several departments were noted as needing improvement but Operations department was not one of them.

Concern 4

You were subjected to employment discrimination, in the form of having your (b)(7)c (b)(7)c in (b)(7)c for having raised and pursued resolution of an issue involving the isolation of the safety injection accumulators in August 2005.

Resolution 4

Based upon your request, no action was taken to address this concern.

bcc w/Resolution of Concerns:
Allegation File

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

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(b)(7)c

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(b)(7)c

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AUG 14 2007

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I-A-0028

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