RIV-2007-A-0117 Callaway

DRP

139 DAYS

Concern

Assigned To:

RPBB

. Ol Action: No

OI Report:

Severely damaged A and B Train RHR suction relief valves were allowed to remain in service for 20 months. The valves were damaged in Feb 2004 and removed from service in Oct 2005. The valves were damaged due to an inadequate design of the Pressurizer Relief Tank common relief valve discharge header. A similar event had occurred in 1988 with damage remaining undetected until one of the valves failed in 1993.

	1	Branch	Assigned	Planned	Completed
1	Acknowledgement Letter	ACES	10/19/2007	11/18/2007	11/25/2007
2	Initial ARB Meeting		10/19/2007	11/18/2007	10/29/2007
	Concerns 1-3, Refer with response. Concerns 4&5, RPBB to reconsider. Concerns 6-9 Refer with response. Concern 10, Refer with no response.	in.	\$.		
3	Staff Review	RPBB			10/25/2007
	Develop ARB disposition record.				
4	ARB Meeting	ACES	10/29/2007	11/13/2007	11/26/2007
	Concern 4-Refer to licensee. There is no Callaway management has this information Concern 5- RPBB to provide basis for closest concern 5- RPBB to provide ba	on also.	uclear authori	ty than Mr. N	aslund.
5	Referral Letter	ACES	10/29/2007	12/03/2007	12/07/2007
	Refer Concerns 1 - 4, 6 - 9, to licensee fo only.	r respons	e. Refer Con	cern 10 for in	nformation
6	Response to Referral	ACES	12/07/2007	01/23/2008	
					01/17/2008
	Licensee phoned and requested an exten	sion (2-w	eeks) until 01	/23/08.	01/17/2008
7	Licensee phoned and requested an exten Review Submittal	sion (2-w	eeks) until 01 01/18/2008		02/20/2008
	Review Submittal	RPBB	01/18/2008		02/20/2008
8	Review Submittal Closure Memo	RPBB	01/18/2008		02/20/2008
8	Review Submittal Closure Memo Provide basis for closure for Concern 5	RPBB RPBB ACES	01/18/2008 11/26/2007	02/01/2008	02/20/2008 01/16/2008 02/19/2008
9	Review Submittal Closure Memo Provide basis for closure for Concern 5 Response to Referral	RPBB RPBB ACES	01/18/2008 11/26/2007	02/01/2008	02/20/2008 01/16/2008 02/19/2008
9	Review Submittal Closure Memo Provide basis for closure for Concern 5 Response to Referral Based upon discussions with RPBB, the li	RPBB RPBB ACES censee p	01/18/2008 11/26/2007 rovided a sup	02/01/2008	02/20/2008 01/16/2008 02/19/2008 sponse.

-2007-A	-011	17 Calla	way			DRP	139 D
Concern	2	Assigned To:	RPBB	4	7000	Action: No Report:	
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UNITED STATES NUCLEAR REGULATORY COMMISSION 611 RYAN PLAZA DRIVE, SUITE 400 ARLINGTON, TEXAS 76011-4005

October 23, 2007

MEMORANDUM TO: Vincent G. Gaddy, Chief, Reactor Projects Branch B

FROM:

Harry A. Freeman, Senior Allegation Coordinator

SUBJECT:

REVIEW OF ALLEGATION MATERIAL RIV-2007-A-0117

ACES has received the attached material related to the Callaway Plant. This allegation is scheduled to be discussed at the November 5, 2007, ARB. Please review the material by October 30 for the following:

- Determine what each of the individual's concerns are, whether they are NRC regulated activities or not. Provide a brief statement of the concern. It is not necessary to include all of the background information.
- List each concern on a copy of the file "ARB Disposition Record" located at r:\#aces\forms\allegation forms\ARB Disposition Record.xml.
- List possible regulatory requirements (i.e. 10 CFR 26 etc.) that may apply to concern if known.
- Under significance, provide a followup priority (i.e. high immediate action required, or normal - routine followup).
- Provide a recommendation for disposition (i.e. OI investigation, inspection, referral to licensee, or none). List this under "action."
- List the branch you believe that should be responsible for the action.
- Provide a planned completion date, if known.

An electronic copy of the Concerns List should be sent to R4ALLEGATION. This form must be received by 1:00 p.m. on Wednesday for inclusion in the following Monday's ARB. Should you have any questions, please call me. Please document your time as follows:

Indirect Charges
A10304 Support for Allegations (Reactors)
A10191 Support for Allegations (Materials)
BJ2

Direct Inspection Activities

AF Allegation Followup

BJ2 Allegation Prep/Doc

AFT Allegation Travel

Attachments: As Stated

cc w/attachment: Allegation File

From:

Vincent Gaddy

To:

R4ALLEGE

Date:

Tue, Oct 23, 2007 7:01 AM

Subject:

Callaway Receipt Form

Harry/Judith,

Attached is the allegation receipt form for concerns given to us following the public meeting w/ Callaway. The email is also attached. I'm prepared to complete concerns listwhen directed.

Larry sent the email to licensee management as well as Lochbaum.

Harry Freeman - Criscione's Comments from NRC Public Meeting on October 19, 2007

From: "Criscione, Larry S." <LCriscione@ameren.com>

To: <vgg@nrc.gov> Date: 10/19/2007 11:03 AM

o far fir

Subject: Criscione's Comments from NRC Public Meeting on October 19, 2007

CC: "Peck, Michael (NRC)" <msp@nrc.gov>, "Dumbacher, David (NRC)" <ded@nrc.gov>,

<dlochbaum@ucsusa.org>, "Naslund, Charles D." <CNaslund@ameren.com>, "Heflin, Adam C." <AHeflin@ameren.com>, "Herrmann, Timothy E." <THerrmann@ameren.com>, "Diya, Fadi M."

<FDiya@ameren.com>, "Mills, Keith A." <KMills2@ameren.com>, "Graessle, Luke H."
<LGraessle@ameren.com>, "Maglio, Scott A." <SMaglio@ameren.com>, "Neterer, David W."

<DNeterer@ameren.com>, "Weekley, Matthew R" <MWeekley@ameren.com>, "Milligan, James W."

<JMilligan@ameren.com>

Mr. Gaddy,

Attached are the comments I intended to address at the NRC Public Meeting on October 19, 2007. At your request, I am emailing them to you and the other meeting participants. I recognize the difficulty the Nuclear Regulatory Commission and AmerenUE face in attempting to address topics like this in a public meeting forum with little preparation.

Please forward these comments to the appropriate individuals in your organization.

I look forward to your response. I would also appreciate to be included in any distribution of the meeting minutes. If you are unable to reach me via this email when the meeting minutes are distributed, you can contact me at (573) 230-3959.

Thank you, Larry Criscione

The first issue I wish to address is the reason why Callaway was unable to address the known design deficiencies in the Pressurizer Relief Tank during Refueling Outage 15.

On February 11, 2004 the operating crew at Callaway Plant increased the Reactor Coolant System pressure above the Safety Injection Signal block permissive reset point before Steam Header Pressure was above the Steam Line Pressure Safety Injection set point. This caused all six pumps in the Emergency Core Cooling System to start and inject water into the core. As water was injected into the core, the pressure in the Pressurizer rose until it exceeded the lift set point of the Pressurizer Power Operated Relief Valves. Over the next 15 minutes, the Power Operated Relief Valves lifted about a dozen times. With each lift, radioactive steam at greater than 2300 psig and greater than 600°F was evacuated from the Pressurizer into the Common Relief Valve Discharge Header of the Pressurizer Relief Tank.

Because of an, at the time, unknown, inadequate system design, the pressure transient in the header caused by the high enthalpy steam induced a water hammer event which significantly damaged both the 'A' and 'B' train Residual Heat Removal system Suction Relief Valves. The assembly pin of one of the valves was sheared into eight pieces and for the other valve the pin was broken into three pieces. The fact that these valves were severely damaged went unrecognized at the time; the damage was not discovered for more than 31 months. For 20 of the 31 months, the valves remained in the system. A similar event had occurred in 1988 with the damage remaining undetected until one of the valves failed while raising Reactor Coolant System Pressure in 1993.

Because these valves are not tested on a staggered test basis, their inability to perform their design function was not noticed for an entire 18 month fuel cycle. (A staggered test basis means that for components with a certain test frequency, which in this case is 36 months, the testing of the two trains would be staggered such that one train would be tested during the middle of the other train's test frequency. If these valves had been on a staggered test basis, then during Refueling Outage 13 in the Spring of 2004 one valve would have been removed and tested and then 18 months later during Refueling Outage 14 in the Fall of 2005 the opposite train's valve would have been removed and tested. Because a staggered test basis was not in affect at the time, no valves were removed during the Spring of 2004, but instead both valves were removed during the Fall of 2005.)

We unknowingly had two damaged valves in the system during the entire 18 months of fuel cycle 14. In October 2005, both Residual Heat Removal system suction relief valves were removed from the system; this was 20 months after they had been damaged. Because the testing of these valves has been contracted out to an off-site facility, the valves were not tested until August 2006; this was 31 months after they had been damaged. On September 12, 2006 the Root Cause team for CARS 200607188 met to determine what caused the valves to be damaged. I was the Operations representative on that team. During the first week, I proposed that both Residual Heat Removal system suction relief valves may have been damaged due to a back pressure transient on the Pressurizer Relief Tank common relief discharge header during the February 2004 Safety Injection. By the end of the second week the team had enough evidence to prove this proposition. On September 22, 2006 a Night Order was issued to the Operating crews warning them that if a Pressurizer Power Operated Relief Valve were to lift from Normal Operating Pressure, it would be likely that neither Residual Heat Removal system suction relief valves would be capable of performing their function.

During every autumn month in 2006 I personally met with Fadi Diya and with Tim D. Hermann of the Design Engineering group to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header by the first opportunity; the first opportunity being Refueling Outage 15 during the Spring of 2007. Despite their acknowledgement of the problem, no one was assigned to modify the piping design until December 2006. In late March 2007, more than six months after the inadequate design was noted, the modification package to correct the design deficiencies was removed from Refueling

Outage 15.

I have several questions regarding this issue. The first set is with regard to being unable to prepare the modification package to correct the inadequate piping design in a six month time frame:

- 1. Is the fact that no one was assigned to the task of preparing the modification package during the months of September, October and November an indication that the staffing level of the Design Engineering group is insufficient?
- 2. Is the fact that a critical design modification could not be performed in six months an indication the experience level of the Design Engineering group is insufficient?
- 3. Several engineers at Callaway Plant have complained to me in recent weeks regarding statements made by Mr. Naslund and Mr. Herrmann. A statement attributed to Mr. Naslund was "Engineers come, engineers go." A statement attributed to Mr. Herrmann was "Engineers are a dime a dozen." Supposedly Mr. Herrmann recently told an engineer who had been at the plant since construction days that "If you leave, I can have two new engineers for the price of you." In light of these comments, does Callaway Plant value experienced engineers who are capable of properly assessing and addressing nuclear safety concerns?
- 4. The next question I have is why the Residual Heat Removal system suction relief valves, which were removed from the system in October 2005 were not tested until 10 months later in August 2006. What necessitated the 10 month delay?
- 5. The next question I have is why the plant rejected the suggestion that the Residual Heat Removal system Suction Relief Valves be tested on a Staggered Test Basis so that instead of doing both valves during even number Refueling Outages, one valve would be done in every Refueling Outage. Had a Staggered Test Basis plan been in affect during Refueling Outage 13, then one of the damaged valves would have been removed an entire fuel cycle earlier and the degraded condition of the other valve (the valve still in the system) would have been known prior to using it for the Cold Overpressure Mitigation System during the first half of Refueling Outage 14. In response to this request, the company has stated the following:

Testing on a staggered schedule is not recommended because if the removed valve has indications of degradation, the same must be assumed of the installed valve which will require immediate replacement because the internal condition of the valve cannot be determined with the valve in service. The current test frequency of both valves every other refueling outage is the preferred method because both valves are tested at the same time and as such a failure of one valve does not question the operability or material condition of the installed certified valves. As such a Tech Spec Action statement entry is not required.

The statement just read is interpreted by me to state that Callaway Plant would prefer not to have an indication that a valve installed in the system is degraded because then they could possibly have to take the plant off-line to fix the degraded valve (thereby losing some revenue from electricity generation). In other words, we would rather have two unknown degraded valves for an extra 18 months than one known degraded valve for 18 months because we would have to take action to correct a known degraded valve. If this is not a fair summary of the response, please let me known how I should be interpreting this response.

The next issue I wish to address is adequate staffing of the Fire Brigade.

In January 2004 an unannounced fire drill was conducted at Callaway Plant. In CAR 200400065, the Fire Marshall documented in the drill critique comments that due to the length of time it took the Outside Operator to arrive, the crew used the Primary Equipment Operator on a hose team. At the time, the Primary Equipment Operator was credited as the Safe Shutdown Operator required by the Final Safety Analysis Report and was therefore not eligible to be on the Fire Brigade.

On September 18, 2004 there was a small fire on the Communications Corridor roof. An Event Review Team meeting was held on September 20, 2004 to analyze the response of the Fire Brigade to this fire. This meeting was attended by the Equipment Operators who were manning the Fire Brigade on the day of the fire. Twice during the meeting there were discussions which lasted several minutes concerning the use of the Outside Operator in staffing the Fire Brigade. The Leader of the meeting at one point stated that the issue (of using the Outside Operator on the Fire Brigade) should be address in the response to the Callaway Action Request which was tracking the issue. This issue was actually never addressed in the response to either of the two Callaway Action Requests documenting the event (CAR 200407284 or CAR (DOC)(C)) nor did it appear in the meeting minutes from the Event Review Team meeting at which the discussion occurred.

In November 2004 I attended Fire Brigade Training with the crew which fought the Communications Corridor roof fire. Their supervisors were not present at the training and I was the only salaried person from Operations in attendance. The equipment operators expressed a concern that issues brought up during the Event Review Team meeting in September were being covered up by the company. The specific issue was using the Outside Operator for a Fire Brigade assignment. I informed the operators that my experience was the ERT minutes are typically a verbatim transcription of the meeting and I doubted that anything said at the meeting would not appear in the meeting minutes (I was wrong on this issue. ERT minutes are only sometimes verbatim transcriptions and are more often summaries). I took an action from the training session to investigate the matter and if necessary to generate a Callaway Action Request to address the operators' concerns.

I was able to obtain the tape of the September ERT meeting from a clerk in the Performance Improvement department. I wrote CAR 200408626 to address the Equipment Operators' concerns and attached a partial transcription of the ERT minutes to that CAR. While writing CAR 200408626 I was challenged by my supervisor that the union operators were merely using the issue of not assigning the Outside Operator to the Fire Brigade in order to force the company to allot more overtime. I continued writing CAR 200408626 anyway and when I was finished it my supervisor told me the issue would merely be answered the same way it had been answered in the past.

Despite my request that CAR 200408626 be screened as an Adverse Condition, it was assigned to my supervisor by the CAR Screening Committee as an Action Notice. With the exception of one minor side issue (the whereabouts of the Fire Brigade trainers during the September 2004 ERT meeting), CAR 200408626 was answered the same day it was screened with no further consideration of the issues in light of the experiences from the September 2004 fire.

In early 2005, the US NRC Senior Resident Inspector at Callaway Plant (Michael Peck) took up the issue of the Outside Operator being credited for the Fire Brigade. That resulted in CAR 200501985 being written by the Department Performance Coordinator of Operations. Because of the NRC Resident's attention to the issue, CAR 200501985 was screened as an Adverse Condition and ultimately resulted in the discontinuance of assigning the Outside Operator to the Fire Brigade.

Upon learning about CAR 200501985, I wrote CAR 200502693 concerning how the issue of assigning the Outside Equipment Operator to the Fire Brigade was brought to the attention of

Operations Management in both September and November 2004 and could have been addressed in house, thus avoiding a NRC finding.

CAR 200502693 was discussed with the entire "chain of command" of the Performance Improvement department up to and including the Senior Vice President of Nuclear. No changes to the Corrective Action Process were made as a result of CAR 200502693 but some of the suggested changes were made late in 2005 due to industry benchmarking.

In October 2006, CAR was assigned to the same supervisor who had answered CAR 200408626 regarding the use of the Outside Operator on the Fire Brigade. CAR contained the wording of the NRC's violation from the first quarter 2005 concerning inadequate Fire Brigade staffing. The main focus of the violation was that for a significant amount of time during the first quarter of 2005 Callaway Plant failed to maintain the required five Fire Brigade members on site. At the end of the violation, the issue was tied to the "crosscutting" issue of inadequate Problem Identification & Resolution. In the Closure statement of CAR had because CAR 200400065 and CAR 200408626 were screened as Action Notices (now replaced with "Business Tracking") and were therefore outside the Corrective Action Process.

This argument was inane because I sent CAR 200408626 to screening as an Adverse Condition and stated in the Description (with reasons provided) that it was an Adverse Condition; yet, it was screened as an Action Notice anyway. Although it can be argued that the standards were different in 2004, this argument is itself inane since the screening of CAR 200501985 (due to NRC attention) as an Adverse Condition proves CAR 200408626 was inappropriately screened. Regardless, by October 2006 CAR 200400065 and CAR 200408626 would have both met the criteria of Adverse Condition and so claiming they were outside the Corrective Action Process is merely unproductive quibbling designed to avoid acceptance of a valid comment from the NRC.

I have several questions regarding the above events:

- 1. Since the Spring of 2005 Operations has adopted the practice of not assigning the Outside Operator to the Fire Brigade. Currently only one of the six operating crews is able to staff all the required watch stations and Fire Brigade positions without using overtime. Two of the crews one Equipment Operator short. Two of the crews are two Equipment Operators short and one of the crews is short three equipment operators. Is there a reason that after more than two and one half years Operations has not staffed the Equipment Operator ranks to the point that all the crews can support the required watch stations as well as the Fire Brigade?
- 2. Many Equipment Operators at the plant believe the company attempted to cover up the issue of assigning the Outside Operator to the Fire Brigade during the September 2004 Event Review Team meeting. Can you explain why this issue did not appear in the meeting minutes?
- 3. CAR 200408626 was written to address the concerns of craft personnel whereas CAR 200501985 was written concerning the same issue but to address the concerns of the NRC Resident Inspector. CAR 200408626 was screened an Action Notice and essentially dismissed in hours whereas CAR 200501985 was screened an Adverse Condition and received an Apparent Cause investigation. Does Callaway Plant value the concerns and input of its craft personnel into the Corrective Action Process?
- 4. CAR 200408626 and CAR 200400065 would be screened as Adverse Conditions by the current criteria applied at Callaway Plant, yet in recent documents (e.g. CAR (b)(7)(C) from October 2006) we still discount these documents during our analysis because they were screened as Action Notices at the time. What is being done to ensure important issues brought to our attention in the past but not appropriately addressed due to our low

standards at the time are now re-classified and addressed prior to the recurrence of an adverse condition?

 As already noted, CAF (B)(7)(C) had a component to it which concerned the inadequate resolution of an issue when earlier identified in the Corrective Action Process. was assigned to the individual who failed to properly address the issue the first time, and he successfully (in terms of being allowed to close CAR 200608601) claimed that the issue had been appropriately addressed when it had first appeared due to the way it was inaccurately categorized as not being an Adverse Condition. This appears like the "Fox guarding the hen house." This more recently occurred in an unrelated topic identified in CAI (b)(/)(C) That CAR, which documented inappropriate control of the qualification process for a Main Control Room watch station, was assigned to the individual who inappropriately managed the process. Again, in another case of the "Fox guarding the hen house" that individual unsurprisingly closed the CAR to no inappropriate activity had occurred. What can we do at Callaway Plant to ensure Adverse Conditions are not assigned to individuals who have a vested interest in not ensuring they are addressed?

The third issue I wish to address involves "cronyism" in the Operations Department at Callaway Plant.

I have several other issues which I would like to address, however their investigations are still in progress with both the internal Callaway Plant Quality Assurance organization and externally with the Nuclear Regulatory Commission. Although I am not satisfied with the progress of these investigations, since they are not yet closed I do not believe it necessary to address them in this forum at this time. I would like to thank the Nuclear Regulatory Commission and the company for their time and would like to offer that I am available to discuss any of these concerns in further detail. I believe that most concerned parties know how to contact me.

ALLEGATION RECEIPT FORM Allegation Number: RIV-2007-A-0117

Received By: Vincent Gaddy	Receipt Date: 10/19/2007	
Receipt Method: E-mail	Other Method	
	FACILITY	100
Facility Name: Callaway Plant		
Location: MO		
Docket(s): 50-483		
General Discussion:		

CONCERN 1
Summary of Concern (be brief) Failure to address a known deficiency in the PRT during Refuel 15 - for specific see attached email
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. Mod to correct deficiency was not implemented
What is the potential safety impact? Is this an ongoing concern? Relief valve could be damaged
Mhat requirement/regulation governs this concern? 50.59
What records should the NRC review? Mod package
What other individuals could the NRC contact for information?
Nas the concern brought to management's attention? If so, what actions have been taken, if not, why not? Yes
Mhy was the concern brought to the NRC's attention? Not satisfied with management's response

CON	CERN	2
Summary of Concern (be brief) Inadequate staffing in the Fire Brigade - for specifics see attache	d email	
Obtain concern specifics. What is the concern, when did it occur, section of the form. Fire Brigade can't be staffed w/o overtime	who was involve	ed, etc. If the concern involves discrimination, fill in the last
What is the potential safety impact? Is this an ongoing concern? None, as long as OT is allowed. Currently being satisfied w OT		
What requirement/regulation governs this concern? License condition 5c		
What records should the NRC review? CARs 200400065, 200408626, 200501985, 200502693, (b)(7)(C)	7.	
What other individuals could the NRC contact for information?		
Was the concern brought to management's attention? If so, what Yes,	actions have be	een taken, if not, why not?
Why was the concern brought to the NRC's attention? Not satisfied with management' response		

CONCERN 3

Summary of Concern (be brief)

Cronyism in the Operations Department - for specifics see attached email

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.

Individual promoted to Asst Ops Manager based relationship to Ops Manager, not qualifications

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

What requirement/regulation governs this concern?

What records should the NRC review?

What other individuals could the NRC contact for information?

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

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

ALLEGATION RECEIPT FORM

ALLEGER	ALLEGER INFORMATION				
Full Name: Larry Criscione	Telephone: Office: 000 - 000 _ 0000				
Mailing Address: 1412 Dial Court Springfield, IL 65704	Home: 000 _ 000 _ 0000 Mobile: 000 _ 000 _ 0000				
[Debra S. Katz Katz, Marshall & Banks, LLP]					
Employer: AmerenUE/Callaway Plant	Relationship to Facility: Licensee Employee				
Occupation:	Ops Department				
Preference for method and time of contact. Method Telephone Other Method Time Select Select Comments	Was the individual advised of identity protection? ☐ Yes				
and that the NRC will review an response. If the concerns are a	referred to the licensee, that alleger's identity will not be revealed devaluate the thoroughness and adequacy of the licensee's in agreement state issue or the jurisdiction of another agency, explain the appropriate agency, and if the alleger agrees, we will provide the				
Does the individual object to the referral?	Does the individual object to releasing their identity?				
	ntractors) from discriminating against individuals who engage in protected				
Does the concern involve discrimination?	Was the individual advised of the DOL process?				
What was the protected activity? When did it occur?	e e				
Who in management/supervision was aware of the protected activity? Licensee management (CNO, VP engr, Plant director) all copied on t					
What adverse actions have been taken (termination, demotion, not be					
What was managements reason for the adverse action?					
Why does the individual believe the actions were taken as a result of	engaging in a protected activity?				

From:

To:

Date:

Vincent Gaddy R4ALLEGE Thu, Oct 25, 2007 8:40 AM RIV-2007-A-0117

Subject:

ARB DISPOSITION RECORD	Allegation Number: RIV-2007 -A-011
Facility Callaway Plant Name:	Docket Number: 50-483
Responsible Division: DRP	ARB Date:
Received Date 30 Days 10/19/2007	150 Days 3 17/6 8 180 Days 4/16/08
Purpose of the ARB:	
Basis for Another ARB:	
R	EFERRAL
Does Alleger Object to Referral T Yes V No	□ N/A
If any of the following factors apply, an allegation sha	Il not be referred to the licensee.
alleger of confidential source.	I to the licensee without compromising the identity of the or inspection because of knowledge gained from the referral.
The allegation is made against the licensee's ma address the allegation.	nagement or those parties who would normally receive and
The state of the s	ARTICIPANTS
Chairman:	
Concern 1 . Discipli	ine Reactor Department Code
Enginee	
Responsible Branch: RPBB	OI Case Number:
Concern Description:	
for 20 months. The valves were damaged a 2005. The valves were damaged due to an	inadequate design of the Pressurizer Relief Tank imilar event had occurred in 1998 with damage
Severely damaged A and B Train RHR suctor 20 months. The valves were damaged a 2005. The valves were damaged due to an common relief valve discharge header. A semaining undetected until one of the valve Regulatory Requirement:	in Feb 2004 and removed for service in Oct inadequate design of the Pressurizer Relief Tank imilar event had occurred in 1998 with damage
Severely damaged A and B Train RHR suctor 20 months. The valves were damaged 2005. The valves were damaged due to an common relief valve discharge header. A seremaining undetected until one of the valve Regulatory Requirement: Test/Design Control	in Feb 2004 and removed for service in Oct inadequate design of the Pressurizer Relief Tank imilar event had occurred in 1998 with damage
Severely damaged A and B Train RHR suctor 20 months. The valves were damaged 2005. The valves were damaged due to an common relief valve discharge header. A seremaining undetected until one of the valve Regulatory Requirement: Test/Design Control	in Feb 2004 and removed for service in Oct inadequate design of the Pressurizer Relief Tank imilar event had occurred in 1998 with damage
Severely damaged A and B Train RHR suctor 20 months. The valves were damaged 2005. The valves were damaged due to an common relief valve discharge header. A seremaining undetected until one of the valve Regulatory Requirement: Test/Design Control Safety Significance - N/A Basis:	in Feb 2004 and removed for service in Oct inadequate design of the Pressurizer Relief Tank imilar event had occurred in 1998 with damage is failed in 1993.
Severely damaged A and B Train RHR suctor 20 months. The valves were damaged 2005. The valves were damaged due to an common relief valve discharge header. A stremaining undetected until one of the valve Regulatory Requirement: Test/Design Control Safety Significance - N/A Basis: Valves no longer is service.	in Feb 2004 and removed for service in Oct inadequate design of the Pressurizer Relief Tank imilar event had occurred in 1998 with damage is failed in 1993.
Severely damaged A and B Train RHR suctor 20 months. The valves were damaged 2005. The valves were damaged due to an common relief valve discharge header. A stremaining undetected until one of the valve Regulatory Requirement: Test/Design Control Safety Significance - N/A Basis: Valves no longer is service. Check if question is applicable to the concern. If is it a declaration, statement, or assertion if is the impropriety or inadequacy associated.	in Feb 2004 and removed for service in Oct inadequate design of the Pressurizer Relief Tank imilar event had occurred in 1998 with damage is failed in 1993. of impropriety or inadequacy? and with NRC regulated activities?

Action	Assigned Branch Assigned Date	Planned Date
Refer to Licensee for Response	RPBB	
Comments:		
Additional Comments		

Concern 2			Reactor Department Code
	120	Engineering	Engineering
Responsible Brancl	n: RPBB	OI Case Nu	mber:
were not tested u valves been teste plant reject the su staggered test ba	es discussed in Contil August 2006, du d sooner, the dama aggestion that the R sis so that instead	ue to the licensee's te age would have been tHR system suction re	d from service in Oct 2005, they st staggering method. Had the identified earlier. Also, why did the lief valves be tested on a uring even numbers refueling
Regulatory Require TS 5.4.1/Test Cor			
☑ Is it a declaration ☑ Is the improprie ☑ Is the validity of	n service. s applicable to the co	sertion of impropriety of sociated with NRC region?	
Action Refer to Licensee f Comments: Additional Commen		Assigned Branch As RPBB	ssigned Date Planned Date

Concern	3	Discipline Engineering		or Department Code Engineering
Responsibl	e Branch:	RPBB	OI Case Number:	

Concern Description:

During Fall 06, the concerned individual met with the Plant Director and Design Engineering to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header at the first opportunity (Spring 2007 refueling outage, Refuel 15). Despite acknowledgement of the problem, no one was assigned to work on a

mod to correct the problem until Dec 2006. The mod to correct the problem was subsequently removed from Refuel 15. Since no one was assigned to work on the mod in Sep. Oct, and Nov 2006, is this an indication of inadequate design engineering staffing or is it an indication of inadequate design engineering experience? Regulatory Requirement: None Safety Significance -Normal Inadequate staffing/experience could eventually adversely affect engineering performance. Check if question is applicable to the concern. Is it a declaration, statement, or assertion of impropriety or inadequacy? ▼ Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? If all of the above statements are checked, the issue is an allegation. Assigned Branch Assigned Date Planned Date Action

Action Assigned Branch Assigned Date Planned Date

Refer to Licensee for Response RPBB

Comments:

Additional Comments

Concern	4		Discipline hilling Effect	Reactor Department Code Engineering
Responsible	e Branch:	RPBB	OI Case Nun	mber:
engineers	ring comm	atement attributed	d to Mr. Herrmann, (Vi	VP), "Engineers come and "P-Engineering) was "Engineers

The following comment is attributed to Mr. Naslund (CNO/VP), "Engineers come and engineers go." A statement attributed to Mr. Herrmann, (VP-Engineering) was "Engineers are a dime a dozen." Mr. Herrmann told an engineer that had been at the plant since construction days that "If you leave, I can have two new engineers for the price of you." Based on these comments, does Callaway Plant valve experienced engineers who are capable of properly assessing nuclear safety concerns?

Regulatory Requirement:

Safety Significance - Normal

Basis:

Potential chilling environment.

Check if question is applicable to the concern.

- Is it a declaration, statement, or assertion of impropriety or inadequacy?
- Is the impropriety or inadequacy associated with NRC regulated activities?
- ✓ Is the validity of the issue unknown?

If all of the above statements are checked, the issue is an allegation.

Action	Assigned Branch	Assigned Date	Planned Date
Refer to Licensee for Response	RPBB		
Comments:			
Additional Comments			

Concern <u>5</u>		Discipline Safety Culture	Reactor Department Code Operations	
Responsible Branc	h: RPBB	OI Case Number:	<u>Operations</u>	
		or case williber.		
Concern Description: On Sept 20, 2004, during an Event Review Team meeting following a September 18, 2004, fire on the communications corridor roof, equipment operators questioned the practice of using outside operators to staff the fire brigade. This issue was not addressed. In Nov 2004, equipment operators expressed concern that this issue was being covered up. Although the issue was discussed in the event review team, the issue is not included in the meeting minutes.				
Regulatory Require SCWE	ement:			
Safety Significance Basis:	- <u>Normal</u>			
Check If question is applicable to the concern. Is it a declaration, statement, or assertion of impropriety or inadequacy? Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? If all of the above statements are checked, the issue is an allegation.				
Action		Assigned Branch Assigned	Date Planned Date	
Refer to Licensee 1	or Response	RPBB		
Comments:		14 E 11-50 St 1 1 VIII 120 3+140 3		
Additional Commer	ts			

Concern	6	,	Discipline Operations	Reactor Department Code Operations
Responsib	e Branch:	RPBB	OI Case Number	r:
Concern D	escription:			

Since removing the practice of requiring outside operators to support the fire brigade in Spring 2005, only one of six operating crews is able to staff all required watch stations w/o overtime. Two crews are one equipment operator short, two crews are two equipment operators short, and one crew is three equipment operators short. Why has it taken two and

one half years for	one half years for Operations to fully staff the fire brigade?				
Regulatory Require	ement:				
Safety Significance - N/A					
Basis:	· ·				
Using OT, fire bri	gade is fully staffed	<u>1</u>			
Check if question is	s applicable to the c	oncern.			
☐ Is it a declarati	on, statement, or as	ssertion of impropriety or ina	dequacy?		
B		ssociated with NRC regulated	activities?		
☑ Is the validity of	of the issue unknow	n?			
If all of the above statem	nents are checked, the issu	ue is an allegation.			
Action		Assigned Branch Assigned	ed Date Planned Date		
Refer to Licensee	or Response	RPBB			
Comments:					
Additional Commer	its				
Concern 7		Discipline	Reactor Department Code		
Concern <u>r</u>	S	afety Culture	<u>Operations</u>		
Responsible Branch	n: RPBB	OI Case Number:			
Concern Description					
		away personnel to address CAR 200501985 was writte			
		of the fire brigade. CAR 200			
as Action Notice	(lower significance)). CAR 200501985 was scr	eened as Adverse Condition		
		as assigned a low significat he concerns and input of its	nce until an NRC finding was employees into the		
corrective action	•	To contoning and input or its	ompreyess mile and		
Regulatory Require	ment:				
Cofot Cionificano	Normal				
Safety Significance	- Normal				
Basis:					
Check if question is	applicable to the co	oncern.			
To it a declaration	on statement or as	cortion of impropriety or inac	deguacy?		
Is it a declaration, statement, or assertion of impropriety or inadequacy? Is the impropriety or inadequacy associated with NRC regulated activities?					
	✓ Is the validity of the issue unknown?				
If all of the above stateme	ents are checked, the issue	e is an allegation.			
Action	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	Assigned Branch Assigne	d Date Planned Date		
Refer to Licensee for	or Response	RPBB			

Comments:	
Additional Comments	

	_		District		Daniel D
Concern	<u>8</u>		Discipline Corrective Action	n	Reactor Department Code Operations
Responsible	Branch	n: <u>RPBB</u>		OI Case Number:	
Concern Des	criptio	n:			
CAR 20040 equipment took the out CAR. Due significance	08626 operat tside e to rece . Wha	and CAR 20040 or had to be us equipment to arr ent changes in t at is being done	ed as a memb rive). Both thes the CAP, these to ensure that	er of the hose tea se CARs were scr e issues would no	005 during a drill the primary m due to the length of time it eened as Action Notices w be assigned higher creened historical issues verse condition?
Regulatory R	equire	ment:			
Safety Signif	icance	- Normal		****	
Basis:					
Check if ques	stion is	applicable to th	e concern.		
☑ Is it a de	claratio	on, statement, o	r assertion of in	mpropriety or inad	equacy?
☑ Is the im	proprie	ety or inadequac	y associated wi	th NRC regulated a	activities?
Is the val	lidity o	f the issue unkn	own?		
If all of the above	e statem	ents are checked, the	issue is an allegation	on.	
Action			Assigned	d Branch Assigned	Date Planned Date
Refer to Lice	ensee f	or Response	RPBB		
Comments:					
Additional Co	mmen	ts			•

Concern 9		Piscipline Reactor Department Code ective Action Operations
Responsible Br	anch: RPBB	OI Casé Number:
can be done t	watch station) was assig	priate control of the qualification process for a main ned to the individual that manages this process. What ions are not assigned to individuals who have a vested

the first time.				
Regulatory Requirement:				
Criterion XVI				
Safety Significance - Normal				
Basis:				
Problem may still be occurring.				
Check if question is applicable to	the concern.			
l control of the cont				
Action	Assigned Branch Assigne	d Date Planned Date		
Refer to Licensee for Response	RPBB			
Comments:				
Additional Comments	8			
Concern 10	Discipline	Reactor Department Code		

r .				
Concern 10			Reactor Department Code	
			<u>Modifications</u>	
Responsible Branch:	: Select	OI Case Number:		
Concern Description: A former shift supervisor was promoted to Asst Operations Manager last year. However, this individual was onshift during the October 2003 event in which the crew left the control rods withdrawn following an inadvertent reactor shutdown; during an inadvertent safety injection in Feb 2004, and in Nov 2005 when poor decisions were made while synchronizing to the grid, resulting in a letdown isolation on low pressurizer level. However this individual vacations with the Operations Manager. How does Callaway ensure critical positions are filled by qualified candidates and not through cronyism?				
Regulatory Requirement: None Safety Significance - N/A				
Basis:				
Check if question is applicable to the concern. ✓ Is it a declaration, statement, or assertion of impropriety or inadequacy? ✓ Is the impropriety or inadequacy associated with NRC regulated activities? ✓ Is the validity of the issue unknown?				
	nts are checked, the issue is an allegat	ion.		
Action Refer to Licensee for		ed Branch Assigned	Date Planned Date	
Veter to Ficensee Iol	<u>KESPOIISE</u> KPDD			

Comments:	
Additional Comments	

From:

Richard W Deese R4ALLEGATION

To: Date:

Wed, Nov 14, 2007 12:15 PM

Subject:

SENSITIVE ALLEGATION MATERIAL ******* RIV-2007-A-0117

Concerns 4 & 5 were assigned to be re-visited.

Concern 4 recommendation:

Refer to licensee. There is no higher nuclear authority that Mr. Naslund. Callaway management has this information also. Let's see what they say or do. If we do not like their response, we can Re-ARB.

Concern 5 recommendation:

No action. This was the subject of a previously closed allegation (confirmed by Deese). The allegation of a cover-up appears to be a stretch. The cognizant supervisor had already made up his mind on the use of the outside equipment operator (he was wrong and we issued a violation afterward) in the fire brigade and could have easily dismissed it for that reason. No merit is seen in pursuing the potential cover-up aspect.

CC:

Gaddy, Vincent

From:

Vincent Gaddy

To:

R4ALLEGATION

Date:

Sat, Jan 12, 2008 6:27 AM

Subject:

Closure Memo for RIV-2007-A-0117, Concern 5

Closure Memo for the above allegation is attached.

CC:

Richard W Deese

January 12, 2008

MEMORANDUM TO:

Harry Freeman, Senior Allegations Coordinator

FROM:

Vincent Gaddy, Chief, Projects Branch B, DRP, RIV

SUBJECT:

ALLEGATION RIV-A-2007-0117 CONCERN 5 CLOSURE MEMO

This memorandum provides information to address the alleger's concern regarding the subject allegation. The NRC has completed its follow-up and inspection of Concern 5. As stated below, the NRC did not substantiate the concern. An unsubstantiated concern does not mean that the information that was provided was untrue, it only means that we did not find sufficient information during our inspection to support the concern.

Unless the NRC receives additional information that suggests that these conclusions should be altered, Branch B plans no further action and considered this concern close.

Resolution of Concern

Concern 5:

On September 20, 2004, during an Event Review Team meeting following a September 18, 2004, fire on the communications corridor roof, equipment operators questioned the practice of using outside operators to staff the fire brigade. Your client is concerned that his issue was not addressed. In November 2004, equipment operators expressed concern that this issue was being covered up. Your client is concerned that although the issue was discussed in the event review team meeting, the issue is not included in the minutes.

Resolution:

The inappropriate use of outside operators on the fire brigade was the subject of previously closed Allegation RIV-2005-A-0015. Based on the documented history of the issue before and the information attained during NRC inspection of Allegation RIV-2005A-0015, the alleger's concern with a potential cover-up of this issue were **not substantiated**.

In January of 2005, a concerned individual raised concerns to the Callaway Senior Resident Inspector regarding the licensee's scheduling of outside operators to the fire brigade. The individual was concerned that the response time for the outside operator, who routinely was outside the Protected Area, would be greater than 20 minutes — which would not be quick enough for the outside operator to respond in a rapid manner per the function of the fire brigade. The individual also stated that station management was reassigning a second operator to the fire brigade during drills. This practice was seen as inappropriate by the concerned individual.

The allegation was presented to the Allegation Review Board and assigned to DRP Branch B to inspect. The Callaway Senior Resident Inspector led the inspection effort of this allegation. During his inspection, the inspector substantiated the concerns as a violation of NRC requirements, specifically the inspector concluded that the Callaway Operations Department failed to maintain five available fire brigade members on site at all times.

The alleger, in this present allegation, asserted that there was a cover-up in that although the issue was discussed in the event review team meeting, the issue is not included in the minutes. This appeared to stem from the alleger's involvement with some equipment operators who expressed concern that the issue was being covered up.

During his inspection of the original allegation issue, the Callaway senior resident inspector determined that the issue had already been recognized by individuals at the station. Two corrective action documents (CARs) had previously been generated. These were CARs 2004-8626 and 2004-0065. Operations department management response to these CARs was that the ongoing practice of assigning outside equipment operators to the fire brigade was an acceptable practice. Discussions between operations supervision and the inspector led the inspector to conclude that the cognizant supervisor had already conclusively made up his mind on the acceptability of the practice.

By establishing his policy on the use of outside equipment operators on the fire brigade, many employees accepted and worked with the decision, like they would accept and work with other policy decisions made by supervision. When Event Review Team members for the November 2004 fire brigade drill voiced their opinions on the use of the outside equipment operator on the fire brigade, their expression of concern was therefore not the first one and the practice had previously been determined to be acceptable.

The alleger asserts that by not including this concern in the meeting minutes, Callaway Plant management was covering up the issue. In an e-mail sent to plant management after a public meeting held between the NRC and Callaway management, the alleger writes that these meeting minutes do not have to be an exact transcript and are required to only be a summary. The inspectors were unaware of any regulatory requirements governing inclusion of the issue in the transcripts. Therefore, the inspectors concluded that the failure to put information in a summary where it was not required, and on an issue which management had previously addressed in the corrective action program, did not represent enough evidence to substantiate the presence of a cover-up of the issue.

As a result of his inspection of the original issue, the inspector was able to substantiate the Allegation RIV-2005-A-0015 and proved the Callaway Plant operations department policy to be incorrect and in violation of the Callaway Plant Fire Protection Program. This violation was documented in NRC Inspection Report 05000483/2005002. In response to the non-cited violation that was issued, the Callaway Operations Department changed the policy such that outside equipment operators were and are no longer assigned to the fire brigade. The NRC believes this issue has therefore been addressed.

From:

Vincent Gaddy

To:

R4ALLEGATION

Date:

Wed, Jan 16, 2008 1:41 PM

Subject:

Closure Memo for Allegation RIV-A-2007-0117, Concern 5

see attached

January 16, 2008

MEMORANDUM TO:

Harry Freeman, Senior Allegations Coordinator

FROM:

Vincent Gaddy, Chief, Projects Branch B, DRP, RIV

SUBJECT:

ALLEGATION RIV-A-2007-0117 CONCERN 5 CLOSURE MEMO

This memorandum provides information to address the alleger's concern regarding the subject allegation. The NRC has completed its follow-up and inspection of Concern 5. As stated below, the NRC did not substantiate the concern. An unsubstantiated concern does not mean that the information that was provided was untrue, it only means that we did not find sufficient information during our inspection to support the concern.

Unless the NRC receives additional information that suggests that these conclusions should be altered, Branch B plans no further action and considered this concern close.

Resolution of Concern

Concern 5:

*/.

On September 20, 2004, during an Event Review Team meeting following a September 18, 2004, fire on the communications corridor roof, equipment operators questioned the practice of using outside operators to staff the fire brigade. Your client is concerned that his issue was not addressed. In November 2004, equipment operators expressed concern that this issue was being covered up. Your client is concerned that although the issue was discussed in the event review team meeting, the issue is not included in the minutes.

Resolution:

The NRC did not substantiate this concern.

The alleger asserted that there was a cover-up in that although the issue was discussed in the event review team meeting, the issue is not included in the minutes.

The Callaway senior resident inspector and senior project engineering during December 2007, determined that the issue had been recognized by individuals at the station. Two corrective action documents (CARs) had previously been generated. These were CARs 2004-8626 and 2004-0065. Operations department management response to these CARs was that the ongoing practice of assigning outside equipment operators to the fire brigade was an acceptable practice.

When Event Review Team members for the November 2004 fire brigade drill voiced their opinions on the use of the outside equipment operator on the fire brigade, their expression of concern was therefore not the first one and the practice had previously been determined to be acceptable.

The alleger asserts that by not including this concern in the meeting minutes, Callaway Plant management was covering up the issue. The inspectors were unaware of any regulatory requirements governing inclusion of an issue in the meeting minutes/transcripts. Therefore, the inspectors concluded that the failure to put information in a summary where it was not required, and on an issue which management had previously addressed in the corrective action program (even though the corrective action was incorrect), did not represent enough evidence to substantiate the presence of a cover-up of the issue.

R4ALLEGATION - Re: Closure Memo for RIV-2007-A-0117, Concern 5

From:

R4ALLEGATION

To:

Vincent Gaddy

Date:

1/14/2008 12:35:38 PM

Subject:

Re: Closure Memo for RIV-2007-A-0117, Concern 5

CC:

Judith Walker; Karla Fuller; Richard W Deese

Vincent,

I've skimmed through your response to the subject concern and request that you modify it in response to the following comments:

- 1. Since the alleger for the subject allegation is not the individual who raised the concern in RIV-2005-A-0015, do not include reference to that allegation number.
- 2. Do not refer to the NRC's previous inspection of an issue in response to having addressed an allegation. We do not advise the licensee when we are inspecting an issue as a response to an allegation, and therefore, we should not advise an allegar that we had previously inspected an issue in response to an allegation.

Please just refer to the fact that we had previously inspected the concern as documented in inspection report # and provide any clarifying information deemed appropriate. You could say for example, in (month) of 2005, the NRC inspected the licensee's use of The NRC determined that . . . ,

Thanks!

>>> Vincent Gaddy 1/12/2008 6:27:19 AM >>> Closure Memo for the above allegation is attached.

Harry Freeman - Ameren UE Allegation Response

From:

(b)(7)(C)

To: Date:

<haf@nrc.gov> 1/17/2008 5:37 PM

Subject: Ameren UE Allegation Response

Mr. Freeman.

You should have received a Fax of our allegation response for RIV-2007-A-0117. The original is in the mail to you and should go out in tomorrow's mail. If you have any questions, please don't hesitate to ask.

Have a great weekend!!!



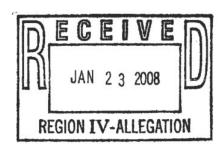


Callaway Plant

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January 17, 2007

Mr. Harry Freeman
Senior Allegation Coordinator
U.S. Nuclear Regulatory Commission Region IV
611 Ryan Plaza Drive – Suite 400
Arlington, TX 76011-4005





Dear Mr. Freeman:

Reply to Allegation No. RIV-2007-A-0117 Callaway Plant Union Electric Company

Our response to the allegation transmitted in Mr. Arthur T. Howell's letter dated December 7, 2007 is presented in the enclosure. As requested, this response is not being submitted on the station docket and distribution is limited. We understand that affidavit requirements are waived for this response. This response does not contain any Safeguards Information as described in 10CFR73.21

If you have any questions regarding this response or if additional information is required, please let me know.

Sincerely,

Luke H. Graessle

ULNRC 05469

Manager, Regulatory Affairs

Ameren UE Callaway Nuclear Plant

Enclosure: Response to Allegation

cc: Employee Concerns File

The 9-page attachment is withheld in its entirety under FOIA exemption 4. The names and other PII of third parties are withheld under FOIA exemption 7C.



Allegation File

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

January 18, 2008

	Y .	
MEMORANDUM TO:	Vincent G. Gaddy, Chief, Reactor Projects Branch	
FROM:	Harry A. Freeman, Senior Allegation Coordinator	Asy
SUBJECT:	LICENSEE'S RESPONSE TO ALLEGATION RIV-	
Please review the atta adequate. The scope limited to, the licensee licensee management the individual conduct concern; (2) the evalu of sufficient depth and considered if the alleg were sufficient. Please provide a writte Your response should a brief/direct answer concern was substant have documented our Include your determination providing a closure ballo ((7)(F)). If recommendation for a	ied to our December 7, 2007, referral related to the achment to ensure that the licensee's response to the of your review should be predicated on many factor is past performance, the safety significance of the transport possibly involved in the matter. You may want to ding the investigation was independent of the organizator was competent in the specific functional area; if scope; (4) the appropriate root causes and generications were substantiated; and (5) the corrective actions were substantiated; and (5) the corrective actions were substantiated; and (5) the corrective action of the action of the adequacy of the licensee's response. It is findings in dated," and provide us ation of the adequacy of the licensee's response. It is can be found at, and provide us ation of the adequacy of the licensee's response. It is can be found at, and provide us ation of the adequacy of the licensee's response. It is can be found at, and provide us ation of the adequacy of the licensee's response. It is can be found at, and provide us ation of the adequacy of the licensee's response. It is can be found at, and provide us ation of the adequacy of the licensee's response. It is can be found at, and provide us ation of the adequacy of the licensee's response. It is can be found at, and provide us ation of the adequacy of the licensee's response. It is can be found at, and, and	ne concerns is ors, such as, but not matter, and the level of consider whether: (1) zation affected by the (3) the evaluation was a implications were etions, if necessary, by February 1, 2008. The list. Please provide that whether the sa copy of the report. Detailed guidance for
Attachments: As Stated		
cc w/attachment:		



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

February 19, 2008

MEMORANDUM TO: Vincent G. Gaddy, Chief, Reactor Projects Branch	MEMORANDUM TO:	Vincent G.	Gaddy,	Chief.	Reactor	Projects	Branch	8
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FROM:

Harry A. Freeman, Senior Allegation Coordinator %

SUBJECT:

LICENSEE'S RESPONSE TO ALLEGATION RIV-2007-A-0117

The licensee has provided a supplemental response to their January 17, 2008, response to the subject allegation. Please review the attachment to ensure that the licensee's response to the concerns is adequate. The scope of your review should be predicated on many factors, such as, but not limited to, the licensee's past performance, the safety significance of the matter, and the level of licensee management possibly involved in the matter. You may want to consider whether: (1) the individual conducting the investigation was independent of the organization affected by the concern; (2) the evaluator was competent in the specific functional area; (3) the evaluation was of sufficient depth and scope; (4) the appropriate root causes and generic implications were considered if the allegations were substantiated; and (5) the corrective actions, if necessary, were sufficient.

Please provide a written response concerning the results of your review by F	ebruary 26, 2008.
The allegation is currently 123 days old. Your response should address the d	
the attached concerns list. Please provide a brief/direct answer stating wh	at was done and
what was found. State whether the concern was substantiated, unsubstanti	ated, or partially
substantiated. If appropriate add, "We have documented our findings in	dated
," and provide us a copy of the report. Include your determination of t	he adequacy of the
licensee's response. Detailed guidance for providing a closure basis can be	found at (b)(7)(F)
(b)(7)(F) If you conclu	
response was not adequate, provide a recommendation for additional NRC a	ction.

Should you have any questions, please call me.

Attachments: As Stated

cc w/attachment: Allegation File The 9-page supplemental response by Ameren, following the attached fax cover sheet and transmittal letter, is withheld in its entirety under FOIA exemption 4. The names and other PII of third parties are withheld under FOIA exemption 7C.



CALLAWAY NUCLEAR P. O. Box 620 Fulton, MO 65251	R PLANT	Message Transmitted By:
FAX No. Verification No.		Date: 2/1/08 Time: 1/:30 P.M.
To: Mr. A. Company: NMC Receiving FAX 8/7	Hary freeman From	AL PAGES:
Verification No.	Mail to Receiving Party (Please provide address)	
Instructions to Receiving	Onerator:	

AmerenUE Callaway Plant PO Box 620 Fulton, MO 65251

February 13, 2008

Mr. Harry Freeman
Senior Allegation Coordinator
U.S. Nuclear Regulatory Commission Region IV
611 Ryan Plaza Drive – Suite 400
Arlington, TX 76011-4005

ULNRC 05477



Dear Mr. Freeman:

Reply to Allegation No. RIV-2007-A-0117 Callaway Plant Union Electric Company

Reference: ULNRC 05465

Our response to the allegation transmitted in Mr. Arthur T. Howell's letter dated December 7, 2007 is presented in the enclosure. As per NRC's telephone conversation with our Employee Concerns Coordinator, and at the request of Mr. Vincent Gaddy, AmerenUE is transmitting a revised response to address a technical question that was unanswered in the first transmission. As requested, this response is not being submitted on the station docket and distribution is limited. We understand that affidavit requirements are waived for this response. This response does not contain any Safeguards Information as described in 10CFR73.21

If you have any questions regarding this response or if additional information is required, please let me know.

Sincerely,

Luke H. Graessle

Manager, Regulatory Affairs

Ameren UE Callaway Nuclear Plant

Enclosure:

Response to Allegation

cc: Employee Concerns File

a subsidiary of Ameren Corporation

February 20, 2008

MEMORANDUM TO:

Harry A. Freeman, Senior Allegations Coordinator

FROM:

Vince Gaddy, Chief, Projects Branch B

SUBJECT:

AMERENUE RESPONSE TO ALLEGATION RIV-2007-A-0117

Callaway Allegation RIV-2007-A-0117 was referred to AmerenUE by letter dated December 7, 2007. The licensee provided a response to this referral in Letter ULNRC 05469, dated January 17, 2008. The original response was revised and resubmitted in Letter ULNRC 05477, dated February 13, 2008 based on inspector questions. Based on our evaluation, the licensee did a thorough review using a person independent of the following concerns. The evaluation appears to be of sufficient depth to address the concerns raised. However, because of the nature of the concerns, and since the investigator did not have an engineering background, the investigators requested technical assistance from various groups within the Callaway organization in order to assure that the details were technically accurate. PBB's evaluation of the licensee's response is included below.

Concern1:

Severely damaged A and B Train RHR suction relief valves were allowed to remain in service for 20 months. The valves were damaged in Feb 2004 and removed from service in Oct 2005. The valves were damaged due to an inadequate design of the Pressurizer Relief Tank common relief valve discharge header. A similar event had occurred in 1988 with damage remaining undetected until one of the valves failed in 1993.

NRC Review:

This concern is substantiated.

The licensee identified that the valves were found damaged during offsite testing in August 2006. A root cause team was initiated and determined that the disc assembly pins of the valves were broken as a result of a water hammer event on February 11, 2004, due to the combination of a safety injection (SI) actuation and the actuation of the power operated relief valves (PORVs). The valves were removed from service in October 2005.

Once identified, the licensee declared the cold overpressure mitigation system inoperable from the time the valve pin failure in 2004 until the time the valves were physically replaced in 2005. During this period, the licensee did not enter Technical Specifications 3.4.12, 3.9.5, and 3.9.6 as required, and subsequently reported as Licensee Event Report 2006-008. The inspectors verified this notification was made.

The licensee did acknowledge that the cause of the damage was due to the design of the common relief valve discharge piping. The identified corrective action will change the common relief valve discharge piping configuration to the Pressurizer Relief Tank, removing a common header between RHR suction relief and the Pressurizer PORVs. This modification will be implemented during the next refueling outage. This outage is currently scheduled to begin October 2008. The inspectors will monitor the implementation of this modification.

In February 1988, a low steam line pressure safety injection automatically initiated after a plant trip, causing the PORVs to lift about a dozen times resulting in a similar water hammer transient as that that occurred in 2004 and subsequent disc assembly pin failure for one of the PORVs. The valves were removed in late 1992 and inspected. The apparent cause documented in CARS stated that the failure was due to disk chatter during testing. The root cause analysis performed following the 2004 event determined that the cause of the pin failure in 1993 was incorrect. The 2004 failure could have been prevented if the licensee had properly identified the root cause following the 1988 event.

Concern 2:

Although the valves discussed in Concern 1 were removed from service in Oct 2005, they were not tested until August 2006, due to the licensee's test staggering method. Had the valves been tested sooner, the damage would have been identified earlier. Also, why did the plant reject the suggestion that the RHR system suction relief valves be tested on a staggered test basis so that instead of doing both valves during even numbers refueling outages, one valve would be tested every refueling outage.

NRC Review:

This concern was substantiated to the extent that the valves were removed from service in Oct 2005 and not tested until August 2006. However it was not substantiated that the testing was delayed due to the staggered testing method, and it was also not substantiated that Callaway uses a staggered test method for these valves. The valves are tested by the group method by removing both RHR suction valves every other refueling outage (once per 3 years) according to the standards prescribed in the American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance of Nuclear Power Plants, 2001, Ed., 2003 Addenda and the licensee's IST Plan. The ASME code specifies the test frequency for these valves and this was verified by the inspector. The licensee stated they recognize that these valves are vulnerable to common mode failures, and have determined that both valves in the group will be tested simultaneously because it is likely that a common mode failure could have the same impact on both valves.

Concern 3:

During Fall 06, the concerned individual met with the Plant Director and Design Engineering to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header at the first opportunity (spring 2007 refuel outage, Refuel 15). Despite acknowledgement of the problem, no one was assigned to work on a mod to correct the problem until December 2006. The mod to correct the problem was subsequently removed from Refuel 15. Since no one was assigned to work on the mod in Sep, Oct, and Nov 2006, is this an indication of inadequate design engineering staffing or is it an indication of inadequate design engineering experience?

NRC Review:

The licensee did not substantiate this concern.

Condition Report 200607188 was initiated August 30, 2006, to document the valve damage information. The inspector verified this report was written to document the failure. Following the CR's initiation, a root cause team was appointed and began meeting on September 12 to

investigate the root cause. Following the root cause analysis, a design engineer was assigned full time on October 31, 2006, to perform an independent review of the team's findings and to model the dynamics of the transient for appropriate corrective action. Also in October 2006, the inspector verified that RFR (b)(C) was written to evaluate a possible design change. The licensee also reported that additional resources were made available to the assigned engineer upon his request. Two additional engineers completed the operability determinations and probabilistic risk assessment necessary to support the Operations Department in formulating remedial actions.

Concern 4:

The following statement is attributed to Mr. Naslund (CNO/VP), "Engineers come and engineers go." A statement attributed to Mr. Herrmann, (VP – Engineering) was "engineers are a dime a dozen." Mr. Herrmann told an engineer that had been at the plant since construction days that "If you leave, I can have two engineers for the price of you." Based on these comments, does Callaway Plant value experienced engineers who are capable of properly assessing nuclear safety concerns?

NRC Review

This concern was not substantiated.

No specifics information describing the circumstances or the dates when the alleged statements were made were included. Both Mr. Naslund and Mr. Herrmann deny making the attributed statements with an intent to convey a lack of appreciation for Calllaway's engineering force. During interviews during the problem identification and resolution inspection in February 2008, no engineering personnel expressed a concern that they were not valued by licensee management.

Concern 5:

Since removing the practice of requiring outside operators to support the fire brigade in Spring 2005, only one of six operating crews is able to staff all required watch stations w/o overtime. Two crews are one equipment operators short, two crews are two equipment operators short, and one crew is three equipment operators short. Why has it taken two and one half years for Operations to fully staff the fire brigade?

NRC Review:

This concern was substantiated to the extent that the Operations Department had staffed the operating crews to support the fire brigade using overtime. The use of overtime was within the appropriated work hours limits specified in station procedure APA-ZZ-00905, Limitations of Callaway Plant Staff Working Hours."

The licensee recognized that there were occasional vacancies in the Operations Department and recognized a legitimate business need to ensure adequate staffing for critical areas at Callaway. The licensee indicated they hire classes of operators rather than taking in single replacements due to the extent of training and qualifications needed to perform this work and try at all time to maximize their staffing efforts. The licensee stated that their business plan and staffing strategies were adequate to support the operational needs of the plant.

Concern 6:

CAR 200408626 was written by Callaway personnel to address equipment operators concerns related to the fire brigade. CAR 200501985 was written following an NRC finding associated with inadequate staffing of the fire bridgade. CAR 200408626 was screened as an Action Notice (lower significance). CAR 20050501985 was screened as an Adverse Condition (higher significance). The problem was assigned a low significance until an NRC finding was issued. Does Callaway Plant value the concerns and input of its employees into the corrective action process?

NRC Review:

This concern was substantiated.

The licensee reported that CAR was written to evaluate the practice of using the outside operator as a member of the fire brigade, and was screened by the standards in place at that time. Since the CAR requested an evaluation as a result of a post job critique, the licensee's practice was to classify these low level concerns as Action Notices rather than Adverse Conditions and track them administratively as a means to answer questions, complete follow-up items, or evaluate improvement opportunities.

The following year, CAR 200509185 was initiated following an NRC concern and assigned a higher significance. The licensee admits that the evaluation of CAR 200408626 was inadequate.

The licensee stated they encourage individuals to identify problems and values a culture that self identifies issues at lower and lower thresholds. Employees have many avenues for raising concerns, including using the software CARS application, submitting paper copies of CARS anonymously, discussing issues with supervision, using the ECP and approaching the NRC. Callaway had included these options in training material and new employee indoctrination, and advertises these options in many forms around the site. The inspectors verified this information was available to plant employees.

Concern 7:

CAR 200408626 and CAR 200400065 (documents that in Jan 2005 during a drill the primary equipment operators had to be used as a member of the hose team due to the length of time it took the outside equipment operator to arrive). Both these CARs were screened as Action Notices CARs. Due to the recent change in the CAP, these issues would now be assigned a higher significance. What is being done to ensure that inappropriately screened historical issues are now re-classified and addressed prior to recurrence of an adverse condition?

NRC Review:

This was more a question, rather than a concern. In response, the licensee indicated they had made considerable changes to their corrective action system. These changes included an evaluation of all open CAR documents at the time to rescreen to the appropriate significance category in accordance with the new corrective action system procedure. The change management plan addressed the need to review historical documents, but determined that historical issues did not present a current or on going threat to plant safety or operability. As

such, it was believed that the changes to the CAP were adequately implemented and the licensee was satisfied with the scope of the change management plan for this issue.

Concern 8:

CAR (documents inappropriate control of the qualification process for a main control room watch station) was assigned to the individual that manages this process. What can be done to ensure adverse conditions are not assigned to individuals who have a vested interest in not ensuring they are addressed?

was also assigned to the individual who failed to properly address the issue the first time.

NRC Review:

In the licensee's response they indicated that this concern was not substantiated. However, the licensee does admit that it is their practice to assign issues to individuals in the organization that are bested suited to resolve the concern and remedy the situation.

Callaway's administrative procedure APA-ZZ-00500, Corrective Action Program, outlines responsibilities for the lead of any corrective document as follows:

3.3 Lead

- Coordinates overall response for assigned ADCN CAR in accordance with the requirements of the APA-ZZ-00500 appendix.
- Ensures cause of problem/concern is determined and Corrective Action(s) are implemented to resolve this issue.
- As required, assigns, revises, and monitors CAR actions, sub-actions and due dates.
- Ensures resolution of degraded or non-conforming conditions is completed at the first opportunity as defined in APA-ZZ-00500, Appendix 1, Operability and Functionality Determinations.
- Ensures all CAR Actions are completed and appropriate keywords, trend codes, components, locations, references, programs, and attachments have been added.
- Ensures quality response and proper closure of CAR.

Callaway uses a cross functional group called the CARS Screening Committee to determine the proper lead for identified issues. It is the licensee's practice to assign issues to those individuals within the organization who are best suited to resolve the concern and remedy the situation. This generally means that the technical concern raised in any CAR are evaluated against the technical competencies and functional duties of individuals available with the organization to ensure that the right people are assigned to problems are that important to the plant, and that issues presented are prioritized commensurate with the risks they present to personnel or plant safety.

Additionally Callaway's senior leadership meets daily to review corrective action requests that have been entered into the system. This group may elevate the significance of a CAR or reassign the lead based on their review and discussion. This ensures all corrective action documents are reviewed by site leadership. During discussion with licensee senior management, the inspectors verified those meeting that place on a daily basis.

Performed by: Eduardo D. Uribe

Date: June 4, 2008

Y/N	NA	#	Audit Attribute	Comments
1.0	REC	EIVING	G ALLEGATIONS	
Υ		1.1	Allegations received were forwarded to ACES within <u>5 days</u> .	
Υ		1.2	The Allegation Receipt Form was complete and clearly explained the allegation and the circumstances surrounding it.	
Y		1.3	Name, address and telephone number were obtained from the Cl during the initial contact and was provided to ACES with the allegation.	
,	NA	1.4	If the allegation was received electronically, was the identification of the individual confirmed via telephone or by a follow-up e-mail containing the standard response paragraph, or the allegation treated anonymously?	
2.0	ALL	EGATIO	ON REVIEW BOARD	
Υ		2.1	Allegations were reviewed by an ARB within 30 days after the allegation was received in Region IV.	
2		2.2	The ARB consisted of the responsible Division Director (Chairman), the SAC, OI and the Regional Counsel for matters of suspected wrongdoing. If Regional Counsel was not present for wrongdoing case, she was briefed and concurred with the decision.	
Υ		2.3	ARB minutes were complete and clearly captured required actions and assessments.	
N		2.4	Actions assigned at the ARB were completed in a timely manner.	Various dates were exceeded
	NA	2.5	The basis for referral to the licensee, if one or more of the referral criteria were not met.	
N		2.6	Safety significance of the issue was discussed? Allegations of significance safety significance were discussed at an ARB in a time commensurate with their significance.	
	NA	2.7	For discrimination concerns, information to establish a prima facia case was discussed.	
	NA	2.8	The regulatory basis for issues referred to OI was clear.	
	NA	2.8		

Y/N	NA	#	Audit Attribute	Comments
	NA	2.9	The priority of OI investigation, and the basis for the priority, was discussed.	
Y		2.10	Re-ARB of the transcripts following the staff reviews of new issues, change in priority, or closure recommended?	1 of 10 concerns was closed.
	NA	2.11	Deferral discussed for cases pending before the DOL with an open OI investigation, with the basis for the decision regarding whether to defer clearly documented? The decision to defer a case was reviewed after each DOL decision.	13
	NA	2.12	An ARB was held after 6 months and every 4 months thereafter except for cases involving only issues being investigated by OI or DOL. (Cases with OI or DOL were reviewed through an OI brief, enforcement brief, or check of the DOL status).	
3.0	ACK	NOWL	EDGING ALLEGATIONS	
Υ		3.1	Letters issued within 30 days	Ack. Letter was not sent to the individual
Υ		3.2	Clearly and appropriately document concerns identified by ARB.	
N		3.3	Advised of DOL rights.	
N		3.4	Advised of Identity Protection Policy.	
N		3.5	The CI was informed if concerns were or will be referred to the licensee.	
4.0	INSI	PECTIC	DNS	
	NA	4.1	Inspections are performed consistent with ARB recommendations and commensurate with safety significance, and thoroughly addressed the concern.	
	NA	4.2	Inspection documentation reflects area inspected without fingerprinting the CI.	
	NA	4.3	Inspection documentation is included in the case file	
5.0	ALLE	GATIO	N RESOLUTION DOCUMENTATION	
Υ		5.1	Allegation was resolved in a timely manner, given the circumstances of the issue(s).	
Υ		5.2	Closure documentation to the CI clearly and accurately documents each concern, what was done, and whether substantiated, & free of errors. The specific examples provided by the CI are addressed in	

Y/N	NA	#	Audit Attribute	Comments
			the closure of the concern.	
	NA	5.3	Non-allegations are clearly explained as to why we are not following-up	
•)	NA	5.4	If a violation, NCV or an IFI is identified, the disposition of the violation is provided.	
6.0	PER	IODIC	STATUS/MANAGEMENT REVIEWS	
	NA	6.1	Status letters were issued in writing every <u>6 months</u> for cases open greater than 180 days	
A 807 (280)	NA	6.2	Status letters indicate what continues under review.	
	NA	6.3	Status letters are clear, concise, and free of errors.	
	NA	6.4	CI is informed of deferral of issues to the DOL.	
7.0	LICE	NSEE	REFERRALS	
Υ		7.1	Referral criteria are met.	
Υ		7.2	Referral letters provide sufficient information for the licensee to resolve the issue.	
Υ		7.3	Licensee evaluations are independent and thorough.	
Υ		7.4	Referral letter does not compromise CI's identity, requests an evaluation, and response. If referral compromises identity, the CI first agreed to the identity release	
4	L. XX	7.5	If the allegation was referred to the licensee and no further action will be taken, contact the licensee to advise that the allegation is closed.	
8.0	STAT	TE REF	ERRALS	
	NA	8.1	The CI was informed of the NRC's intent to refer and had no objection.	
	NA	8.2	Allegations made against an Agreement State Official were forwarded to the Director, Office of State Programs, for disposition	
	NA	8.3	If the CI agreed to be identified to the State, the allegation case file was closed after appropriate referral to the State and the CI informed of the Referral and POC.	
	NA	8.4	For those cases where the CI does not want to be identified, the case was held open until the State provided an adequate response and that response was provided to the CI	
		8.5	Referral information does not fingerprint the CI or provide	

Y/N	NA	#	Audit Attribute	Comments
	NA		extraneous information	
(1)	1/1/2	8.6 NA.	Referral letter provide sufficient information for review of the bissue(s).	
	MA	8.7		
	NA	8.8	Issues within the jurisdiction of an Agreement State and another government agency were referred to the Agreement State and the other government agency.	
9.0	ОТН	ER GO	VERNMENT AGENCIES	
	NA	9.1	FEMA issues were referred to NRR.	
¥	NA	9.2	OSHA allegations were handled in accordance with Manual Chapter 1007. The ARB considered referring occupational health and safety issues to the licensee.	
	NA	9.3	A POC for the referral agency was provided to the CI.	
	NA	9.4	The Cl's name was not released without the Cl's permission.	
	NA	9.5	If an issue was referred to another NRC office, the office was contacted before the referral was made?	
10.0	DISC	RIMINA	ATION COMPLAINTS	
	NA	10.1	Discrimination complaints being reviewed by the DOL and OI remain open upon completion of the OI investigation pending the results of the DOL evaluation.	
	NA	10.2	For cases deferred to the DOL, the CI was informed of the deferral and the AAA approved of the deferral?	
	NA	10.3	For cases in which a DOL complaint was filed, DOL was contacted before the case was closed to ensure no appeals were outstanding.	
	NA	10.4	NRC considered taking enforcement action based on an ALJ determination of discrimination.	
	NA	10.5	DOL DD, ALJ and ARB decisions are included in the allegation file as appropriate.	N.
	NA	10.6	OI synopses are transmitted to DOL participants as appropriate.	
11.0	AMS/	ALLEG	ATION FILE	
Υ		11.1	All documentation from the CI which identifies the CI is stamped "THIS DOCUMENT IDENTIFIES AN ALLEGER."	Email pages not stamped.

Y/N	NA	#	Audit Attribute	Comments
ع	8	11.2	AMS is accurate and correctly indicates concerns, follow-up and disposition. A "file closed" entry was made in AMS.	
٨	and .	Ufice	AMS contains no names and minimizes fingerprinting information.	
)	NA	11.4	For discrimination complaints, OI provided transcripts of interview with the CI to EICS for review and coordination with the technical staff.	
N	NA	11.5	OI Reports, Three-week memos, and staff evaluations are included in the file as applicable.	
	NA	11.6	OI synopsis provided to the CI and the licensee, as appropriate (if the licensee was unaware of the investigation or enforcement is proposed against an individual and not the licensee, then providing the synopsis may not be appropriate. OE should be contacted if enforcement was taken only against an individual before the synopsis is released).	
y	M		E-mail responsible branch that file is closed.	

bcc: Allegation File

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	VERY
Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. 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 mallplece, or on the front if space permits.	(b)(7)(C)	Agent DAdressee
Mr. Lawrence Criscione 1412 Dial Court	If YES, enter delivery delivery for HAR.	\$ 2 2 2 2 3 3 4 3 4 3 4 3 4 4 4 4 4 4 4 4
Springrield, IL 62/04	3. Septice Type Certified Mail Byeren Arter Registered Servin Recei	Loston Receipt for Merchandise
	4. Restricted Delivery? (Extra Fee)	□ Yes
Article Number Transfer from service label)	(©)	36-08
Form 3811, February 2004 Domestic F	Domestic Return Receipt	102595-02-M-1540

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OFFICE	RIV:SAC	C:RPBB	D:DRP 0	4
NAME	HAFreeman	VGGaddy	DDChamberlain	
	HOI	166	100	
DATE	02/23/2008	1/18/2008	3/6/2008	

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T=Telephone

E=E-mail

r=rax

bcc: Allegation File

SENDER: CCMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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 mailplece, or on the front if space permits. 	(b)(7)(C)	C. Date of Delivery
Mr. Lawrence Criscione 1412 Dial Court	If YES, enter delivery does the way of the w	\$ £
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UNITED STATES NUCLEAR REGULATORY COMMISSION

REGION IV 611 RYAN PLAZA DRIVE, SUITE 400 ARLINGTON, TEXAS 76011-4005

March 6, 2008

Mr. Lawrence Criscione 1412 Dial Court Springfield, IL 62704

SUBJECT: CALLAWAY ALLEGATION NO. RIV-2007-A-0117

Dear Mr. Criscione:

This refers to the November 16, 2007, letter from Mr. Harry A. Freeman, Senior Allegation Coordinator, to Ms. Debra S. Katz, Katz Marschall & Banks, LLP. This letter acknowledged receipt of the concerns you presented during an October 19, 2007, public meeting held to discuss performance issues at the Callaway Plant.

Since you presented your concerns in a public manner, the NRC decided to forward the concerns to the licensee and require that the licensee provide a formal response to each concern. The NRC has completed its review and followup of the licensee's response to your concerns. The enclosed "Resolution of Concerns" documents each of your concerns and summarizes the NRC resolution.

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 G. Gaddy, Chief, Reactor Projects Branch B, at 800-952-9677, Extension 141 or you can call Mr. Freeman at 800-952-9677, Extension 245, Monday - Friday between 8:00 a.m. and 4:30 p.m. Central time.

Sincerely,

Dwight D. Chamberlain, Director

Division of Reactor Projects

Enclosure:

Resolution of Concerns

CERTIFIED MAIL RETURN RECEIPT REQUESTED Callaway Allegation RIV-2007-A-0117, Concerns 1 – 4, and 6 – 10, were referred to AmerenUE by letter dated December 7, 2007. The licensee provided a response to this referral in Letter ULNRC 05469, dated January 17, 2008. The original response was revised and resubmitted in Letter ULNRC 05477, dated February 13, 2008, based on inspector questions. Based on our evaluation, the licensee did a thorough review using a person independent of the following concerns. The evaluation appears to be of sufficient depth to address the concerns raised. Because of the nature of the concerns, and since the investigator did not have an engineering background, the investigator requested technical assistance from various groups within the Callaway organization in order to assure that the details were technically accurate. The technical staff's evaluation of the licensee's response is included below.

Concern 1

Severely damaged A and B Train RHR suction relief valves were allowed to remain in service for 20 months. The valves were damaged in February 2004 and removed from service in October 2005. The valves were damaged due to an inadequate design of the Pressurizer Relief Tank common relief valve discharge header. A similar event had occurred in 1988 with damage remaining undetected until one of the valves failed in 1993.

Resolution 1

This concern is substantiated.

The licensee identified that the valves were found damaged during offsite testing in August 2006. A root cause team was initiated and determined that the disc assembly pins of the valves were broken as a result of a water hammer event on February 11, 2004, due to the combination of a safety injection (SI) actuation and the actuation of the power operated relief valves (PORVs). The valves were removed from service in October 2005.

Once identified, the licensee determined that the cold overpressure mitigation system had been inoperable from the time the valve pin failure in 2004 until the time the valves were physically replaced in 2005. This was subsequently reported as Licensee Event Report 2006-008. The inspectors verified this notification was made.

The licensee acknowledged that the cause of the damage was due to the design of the common relief valve discharge piping. The identified corrective action will change the common relief valve discharge piping configuration to the Pressurizer Relief Tank, removing a common header between RHR suction relief and the Pressurizer PORVs. This modification will be implemented during the next refueling outage. This outage is currently scheduled to begin October 2008. The inspectors will monitor the implementation of this modification.

In February 1988, a low steam line pressure safety injection automatically initiated after a plant trip, causing the PORVs to lift about a dozen times resulting in a similar water hammer transient as that that occurred in 2004 and subsequent disc assembly pin failure for one of the PORVs. The valves were removed in late 1992 and inspected. The apparent cause documented in CARS stated that the failure was due to disc chatter during testing. The root cause analysis performed following the 2004 event determined that the cause of the pin failure in 1988 was incorrect. The 2004 failure could have been prevented if the licensee had properly identified the root cause following the 1988 event.

Concern 2

Although the valves discussed in Concern 1 were removed from service in October 2005, they were not tested until August 2006, due to the licensee's test staggering method. Had the valves been tested sooner, the damage would have been identified earlier. Also, why did the plant reject the suggestion that the RHR system suction relief valves be tested on a staggered test basis so that instead of doing both valves during even numbers refueling outages, one valve would be tested every refueling outage.

Resolution 2

This concern was substantiated to the extent that the valves were removed from service in October 2005 and not tested until August 2006. However, it was not substantiated that the testing was delayed due to the staggered testing method. The valves are tested by the group method by removing both RHR suction valves every other refueling outage (once per 3 years) according to the standards prescribed in the American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance of Nuclear Power Plants, 2001, Ed., 2003 Addenda and the licensee's IST Plan. The ASME code specifies the test frequency for these valves and this was verified by the inspector. The licensee's response indicated they recognize that these valves are vulnerable to common mode failures, and have determined that both valves in the group will be tested simultaneously in subsequent outages because it is likely that a common mode failure could have the same impact on both valves.

Concern 3

During Fall 06, you met with the Plant Director and Design Engineering to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header at the first opportunity (spring 2007 refuel outage, Refuel 15). Despite acknowledgement of the problem, no one was assigned to work on a mod to correct the problem until December 2006. The mod to correct the problem was subsequently removed from Refuel 15. Since no one was assigned to work on the mod in September, October, and November 2006, is this an indication of inadequate design engineering staffing or is it an indication of inadequate design engineering experience?

Resolution 3

This concern was not substantiated.

Condition Report 200607188 was initiated August 30, 2006, to document the valve damage information. The inspector verified this report was written to document the failure. Following the CR's initiation, a root cause team was appointed and began meeting on September 12 to investigate the root cause. Following the root cause analysis, a design engineer was assigned full time on October 31, 2006, to perform an independent review of the team's findings and to model the dynamics of the transient for appropriate corrective action. Also in October 2006, the inspector verified that RFR was written to evaluate a possible design change. The licensee also reported that additional resources were made available to the assigned engineer upon his request. Two additional engineers completed the operability determinations and probabilistic risk assessment necessary to support the Operations Department in formulating remedial actions.

Concern 4

The following statement is attributed to Mr. Naslund (CNO/VP), "Engineers come and engineers go." A statement attributed to Mr. Herrmann, (VP – Engineering) was "engineers are a dime a dozen." Mr. Herrmann told an engineer that had been at the plant since construction days that "If you leave, I can have two engineers for the price of you." Based on these comments, does Callaway Plant value experienced engineers who are capable of properly assessing nuclear safety concerns?

Resolution 4

This concern was not substantiated.

No specific information describing the circumstances or the dates when the alleged statements were made were included. Both Mr. Naslund and Mr. Herrmann deny making the attributed statements with an intent to convey a lack of appreciation for Calllaway's engineering force. During interviews during the problem identification and resolution inspection in February 2008, no engineering personnel expressed a concern that they were not valued by licensee management.

Concern 5

On September 20, 2004, during an Event Review Team meeting following a September 18, 2004, fire on the communications corridor roof, equipment operators questioned the practice of using outside operators to staff the fire brigade. You were also concerned that this issue was not addressed. In November 2004, equipment operators expressed concern that this issue was being covered up. You were concerned that although the issue was discussed in the event review team, the issue is not included in the meeting minutes.

Resolution 5

This issue was partially substantiated.

In December 2007, the Callaway senior resident inspector and senior project engineer determined that the practice of assigning outside operators to the fire brigade had been previously addressed at the station. Two corrective action documents (CARs) had previously been generated. There were CARs 20048626 and 20040065. Operations department management response to these CARs was that the ongoing practice of assigning outside equipment operators to the fire brigade was an acceptable practice. The NRC subsequently determined that this practice was a violation of Technical Specification 5.4.1.d for failing to maintain the minimum number of fire brigade members on-site. This issue is documented in NRC Inspection Report 0500483/2005002.

The inspectors also verified that this issue was discussed during the November 2004 event review team. It is correct to state that although this topic was discussed during the event review team, the issue was not captured in the meeting minutes. The inspectors determined that there was no regulatory requirement governing inclusion of an issue in the meeting minutes/transcripts. Therefore, the inspectors concluded that the failure to include information in a summary where it was not required did not represent a cover-up of this issue.

Concern 6

Since removing the practice of requiring outside operators to support the fire brigade in Spring 2005, only one of six operating crews is able to staff all required watch stations w/o overtime.

RESOLUTION OF CONCERNS

RIV-2007-A-0117

Two crews are one equipment operators short, two crews are two equipment operators short, and one crew is three equipment operators short. Why has it taken two and one half years for Operations to fully staff the fire brigade?

Resolution 6

This concern was substantiated to the extent that the Operations Department had staffed the operating crews to support the fire brigade using overtime. The use of overtime was within the appropriated work hours limits specified in station procedure APA-ZZ-00905, Limitations of Callaway Plant Staff Working Hours."

The licensee recognized that there were occasional vacancies in the Operations Department and recognized a legitimate business need to ensure adequate staffing for critical areas at Callaway. The licensee indicated they hire classes of operators rather than taking in single replacements due to the extent of training and qualifications needed to perform this work and try at all times to maximize their staffing efforts. The licensee stated that their business plan and staffing strategies were adequate to support the operational needs of the plant.

Concern 7

CAR 200408626 was written by Callaway personnel to address equipment operators concerns related to the fire brigade. CAR 200501985 was written following an NRC finding associated with inadequate staffing of the fire brigade. CAR 200408626 was screened as an Action Notice (lower significance). CAR 20050501985 was screened as an Adverse Condition (higher significance). The problem was assigned a low significance until an NRC finding was issued. Does Callaway Plant value the concerns and input of its employees into the corrective action process?

Resolution 7

This concern was substantiated.

The licensee reported that CAR 200408626 was written to evaluate the practice of using the outside operator as a member of the fire brigade, and was screened by the standards in place at that time. Since the CAR requested an evaluation as a result of a post job critique, the licensee's practice was to classify these low level concerns as Action Notices rather than Adverse Conditions and track them administratively as a means to answer questions, complete follow-up items, or evaluate improvement opportunities.

The following year, CAR 200509185 was initiated following an NRC concern and assigned a higher significance. The licensee acknowledges that the evaluation of CAR 200408626 was inadequate.

The licensee stated they encourage individuals to identify problems and values a culture that self identifies issues at lower and lower thresholds. Employees have many avenues for raising concerns, including using the software CARS application, submitting paper copies of CARS anonymously, discussing issues with supervision, using the ECP and approaching the NRC.

Callaway had included these options in training material and new employee indoctrination, and advertises these options in many forms around the site. The inspectors verified this information was available to plant employees.

Concern 8

CAR 200408626 and CAR 200400065 (documents that in January 2005 during a drill the primary equipment operators had to be used as a member of the hose team due to the length of time it took the outside equipment operator to arrive). Both these CARs were screened as Action Notices CARs. Due to the recent change in the CAP, these issues would now be assigned a higher significance. What is being done to ensure that inappropriately screened historical issues are now re-classified and addressed prior to recurrence of an adverse condition?

Resolution 8

This concern was substantiated. In response, the licensee indicated they had made considerable changes to their corrective action system. These changes included an evaluation of all open CAR documents at the time to rescreen to the appropriate significance category in accordance with the new corrective action system procedure. The change management plan addressed the need to review historical documents, but determined that historical issues did not present a current or on going threat to plant safety or operability. As such, it was believed that the changes to the CAP were adequately implemented and the licensee was satisfied with the scope of the change management plan for this issue. The inspectors concluded this was a reasonable approach.

Concern 9	
CAR (b)(C)	(documents inappropriate control of the qualification process for a main control
	tation) was assigned to the individual that manages this process. What can be
	e adverse conditions are not assigned to individuals who have a vested interest in hey are addressed?

was also assigned to the individual who failed to properly address the issue the first time.

Resolution 9

This concern was not substantiated. However, the licensee does acknowledge that it is their practice to assign issues to individuals in the organization that are bested suited to resolve the concern and remedy the situation.

Callaway's administrative procedure APA-ZZ-00500, Corrective Action Program, outlines responsibilities for the lead of any corrective document as follows:

3.3 Lead

- Coordinates overall response for assigned ADCN CAR in accordance with the requirements of the APA-ZZ-00500 appendix.
- Ensures cause of problem/concern is determined and Corrective Action(s) are implemented to resolve this issue.
- As required, assigns, revises, and monitors CAR actions, sub-actions and due dates.
- Ensures resolution of degraded or non-conforming conditions is completed at the first opportunity as defined in APA-ZZ-00500, Appendix 1, Operability and Functionality Determinations.

- Ensures all CAR Actions are completed and appropriate keywords, trend codes, components, locations, references, programs, and attachments have been added.
- Ensures quality response and proper closure of CAR.

Callaway uses a cross functional group called the CARS Screening Committee to determine the proper lead for identified issues. It is the licensee's practice to assign issues to those individuals within the organization who are best suited to resolve the concern and remedy the situation. This generally means that the technical concern raised in any CAR are evaluated against the technical competencies and functional duties of individuals available with the organization to ensure that the right people are assigned to problems are that important to the plant, and that issues presented are prioritized commensurate with the risks they present to personnel or plant safety. The inspectors concluded that the licensee does have appropriate processes in place to ensure adverse conditions are thoroughly evaluated.

Additionally Callaway's senior leadership meets daily to review corrective action requests that have been entered into the system. This group may elevate the significance of a CAR or reassign the lead based on their review and discussion. This ensures all corrective action documents are reviewed by site leadership. During discussion with licensee senior management, the inspectors verified those meetings take place on a daily basis.

Concern 10

A former shift supervisor was promoted to Assistant Operations Manager last year. However, this individual was onshift during the October 2003 event in which the crew left the control rods withdrawn following an inadvertent reactor shutdown; during an inadvertent safety injection in Feb 2004 and in Nov 2005 when poor decisions were made while synchronizing to the grid, resulting in a letdown isolation on low pressurizer level. Additionally, this individual vacations with the Operations Manager. Your client is concerned that Callaway Plant fills critical positions through cronyism.

Resolution 10

The NRC concluded that this concern was actually an opinion or criticism of the employment practices by a licensee; and therefore, were not within the NRC's regulatory jurisdiction. This concern was forwarded to the licensee for their information and action as they deemed appropriate.



· UNITED STATES NUCLEAR REGULATORY COMMISSION

REGION IV 611 RYAN PLAZA DRIVE, SUITE 400 ARLINGTON, TEXAS 76011-4005

December 7, 2007

Mr. Charles D. Naslund, Senior Vice President and Chief Nuclear Officer AmerenUE P.O. Box 620 Fulton, MO 65251

SUBJECT: ALLEGATION NO. RIV-2007-A-0117

Dear Mr. Naslund:

During the NRC public meeting held on October 19, 2007, the NRC received information related to activities at the Callaway Plant. This information was also relayed to you and members of your staff. Our review of that information has identified several concerns that require resolution. The enclosure provides specific details. We are providing this information as received and have not assessed its credibility or validity. The enclosure to this letter must be controlled as sensitive information and distribution limited to personnel having a legitimate "need-to-know."

We request that you conduct inspections or investigations as may be necessary to reasonably prove or disprove the issue. Please provide the results of your review to NRC, Region IV, ATTN: Harry Freeman, Senior Allegation Coordinator, within 30 days of the date of this letter and make records available for possible NRC inspection. Your response to this request should not be docketed, and the distribution of your response should be limited. Please note that Concern 9 is being provided for your information and action as you deem appropriate. No response to this concern is required.

We also request that your response contain no personal privacy, proprietary, or safeguards information. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you <u>must</u> specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.390(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

In order to help us assess the adequacy of your response, please provide the following information as appropriate: (1) the independence of the individual conducting the evaluation from the organization affected by the concern; (2) the qualifications of the evaluator in the specific functional area; (3) the depth and scope of the evaluation; (4) the root causes and any generic implications considered; and (5) any corrective actions planned or implemented.

Should you have any further questions concerning our requests, our role in this matter, or require additional time to accomplish this request, please contact Mr. Freeman at 817-860-8245.

Sincesely,

Division of Reactor Projects

Enclosure:

Statement of Concerns

Docket: 50-483 License: NPF-30 Allegedly:

Concern 1

5

Severely damaged A and B Train RHR suction relief valves were allowed to remain in service for 20 months. The valves were damaged in Feb 2004 and removed from service in Oct 2005. The valves were damaged due to an inadequate design of the Pressurizer Relief Tank common relief valve discharge header. A similar event had occurred in 1988 with damage remaining undetected until one of the valves failed in 1993.

Concern 2

N

Although the valves discussed in Concern 1 were removed from service in Oct 2005, they were not tested until August 2006, due to the licensee's test staggering method. Had the valves been tested sooner, the damage would have been identified earlier. Also, why did the plant reject the suggestion that the RHR system suction relief valves be tested on a staggered test basis so that instead of doing both valves during even numbers refueling outages, one valve would be tested every refueling outage.

Concern 3

N

During Fall 06, the concerned individual met with the Plant Director and Design Engineering to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header at the first opportunity (Spring 2007 refueling outage, Refuel 15). Despite acknowledgement of the problem, no one was assigned to work on a mod to correct the problem until Dec 2006. The mod to correct the problem was subsequently removed from Refuel 15. Since no one was assigned to work on the mod in Sep, Oct, and Nov 2006, is this an indication of inadequate design engineering staffing or is it an indication of inadequate design engineering experience?

Concern 4

A

The following comment is attributed to Mr. Naslund (CNO/VP), "Engineers come and engineers go." A statement attributed to Mr. Herrmann, (VP-Engineering) was "Engineers are a dime a dozen." Mr. Herrmann told an engineer that had been at the plant since construction days that "If you leave, I can have two new engineers for the price of you." Based on these comments, does Callaway Plant value experienced engineers who are capable of properly assessing nuclear safety concerns?

Concern 5

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Since removing the practice of requiring outside operators to support the fire brigade in Spring 2005, only one of six operating crews is able to staff all required watch stations w/o overtime. Two crews are one equipment operator short, two crews are two equipment operators short, and one crew is three equipment operators short. Why has it taken two and one half years for Operations to fully staff the fire brigade?

Concern 6

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Concern 7

CAR 200408626 and CAR 200400065 (documents that in Jan 2005 during a drill the primary equipment operator had to be used as a member of the hose team due to the length of time it took the outside equipment to arrive). Both these CARs were screened as Action Notices CAR. Due to recent changes in the CAP, these issues would now be assigned higher significance. What is being done to ensure that inappropriately screened historical issues are now reclassified and addressed prior to recurrence of an adverse condition?

CAR (documents inappropriate control of the qualification process for a main control room watch station) was assigned to the individual that manages this process. What can be done to ensure adverse conditions are not assigned to individuals who have a vested interest in not ensuring they are addressed?

CAR (b)(7)(C) was also assigned to the individual who failed to properly address the issue the first time.

Concern 9

A former shift supervisor was promoted to Assistant Operations Manager last year. However, this individual was onshift during the October 2003 event in which the crew left the control rods withdrawn following an inadvertent reactor shutdown; during an inadvertent safety injection in Feb 2004, and in Nov 2005 when poor decisions were made while synchronizing to the grid, resulting in a letdown isolation on low pressurizer level. However this individual vacations with the Operations Manager. How does Callaway ensure critical positions are filled by qualified candidates and not through cronyism?

Note: This concern is being provided for your information and action as you deem appropriate. No response to this concern is required.

bcc w/Statement of Concerns: Allegation File

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UNITED STATES NUCLEAR REGULATORY COMMISSION



611 RYAN PLAZA DRIVE, SUITE 400 ARLINGTON, TEXAS 76011-4005

NOV 16 2007

Ms. Debra S. Katz Katz, Marshall & Banks, LLP 1718 Connecticut Avenue, NW Sixth Floor Washington, DC 20009

SUBJECT: ALLEGATION NO. RIV-2007-A-0117

Dear Ms. Katz:

This letter refers to an October 19, 2007, e-mail your client sent to Mr. Vincent Gaddy, an NRC branch chief whose responsibilities include regulatory oversite of the Callaway Plant. In the attachment to the e-mail, your client expressed concerns related to Callaway Plant that he had presented during a public meeting. Enclosure 1 to this letter documents our understanding of your client's concerns. We will initiate actions to examine the facts and circumstances based on our understanding of those concerns. Therefore, if the summary of concerns is not accurate, we request that your client contact us so that we can correct any misunderstanding before we complete our review.

An evaluation of the technical concerns should normally be completed within 6 months, although complex issues may take longer. In resolving your client's concerns, the NRC intends to take all reasonable efforts not to disclose his identity. However, your client is not considered a confidential source unless an explicit request of confidentiality has been formally granted in writing.

We will advise you and your client when we have completed our review of this matter. Should you have any questions or comments during the interim regarding this matter, please call me Monday - Friday between 8:00 a.m. and 4:30 p.m. Central time at 800-952-9677, Extension 245.

Sincerely,

Harry A. Freeman

Senior Allegation Coordinator

Enclosure:

Statement of Concerns

CERTIFIED MAIL
RETURN RECIEPT REQUESTED



Concern 1

Severely damaged A and B Train RHR suction relief valves were allowed to remain in service for 20 months. The valves were damaged in February 2004 and removed for service in October 2005. The valves were damaged due to an inadequate design of the Pressurizer Relief Tank common relief valve discharge header. A similar event had occurred in 1988 with damage remaining undetected until one of the valves failed in 1993.

Concern 2

Although the valves discussed in Concern 1 were removed from service in October 2005, they were not tested until August 2006, due to the licensee's staggered test method. Had the valves been tested sooner, the damage would have been identified earlier. Also, your client is concerned the RHR system suction relief valves are tested on a staggered test basis so that both valves are tested during even numbers refueling outages versus one valve being tested every refueling outage.

Concern 3

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Concern 5

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Concern 6

Since removing the practice of requiring outside operators to support the fire brigade in Spring 2005, only one of six operating crews is able to staff all required watch stations without overtime. Two crews are one equipment operator short, two crews are two equipment operators short, and one crew is three equipment operators short. Your client is concerned it has taken two and one half years for Operations to fully staff the fire brigade.

Concern 7

CAR 200408626 was written by Callaway personnel to address equipment operators concerns related to the fire brigade. CAR 200501985 was written following an NRC finding associated with inadequate staffing of the fire brigade. CAR 200408626 was screened as Action Notice (lower significance). CAR 200501985 was screened as Adverse Condition (higher significance). The problem was assigned a low significance until an NRC finding was issued. Your client is concerned Callaway Plant does not value the concerns and input of its employees into the corrective action process.

Concern 8

CAR 200408626 and CAR 200400065 (documents that in Jan 2005 during a drill the primary equipment operator had to be used as a member of the hose team due to the length of time it took the outside equipment to arrive). Both these CARs were screened as Action Notices CAR. Due to recent changes in the CAP, these issues would now be assigned higher significance. Your client is concerned that inappropriately screened historical issues are not re-classified and addressed prior to recurrence of an adverse condition.

Concern 9

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Concern 10

A former shift supervisor was promoted to Assistant Operations Manager last year. However, this individual was onshift during the October 2003 event in which the crew left the control rods withdrawn following an inadvertent reactor shutdown; during an inadvertent safety injection in Feb 2004 and in Nov 2005 when poor decisions were made while synchronizing to the grid, resulting in a letdown isolation on low pressurizer level. Additionally, this individual vacations with the Operations Manager. Your client is concerned that Callaway Plant fills critical positions through cronyism.

D. Katz

bcc w/Statement of Concerns: Allegation File

via Certified Mail Mr. Lawrence Criscione 1412 Dial Court Springfield, IL 65704

via Regular Mail Mr. Lawrence Criscione 211 E. Dunklin Street Jefferson City, MO 65101

SENDER: COMPLETE THIS SECTION	COMPLETE HIS SECTION ON I FI WERY
Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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 malipiece, or on the front if space permits.	(b)(7)(C) B. Becahood to Called the Company of Délivery C. Dele of Délivery
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bcc w/Statement of Concerns: Allegation File

via Certified Mail Mr. Lawrence Criscione 1412 Dial Court Springfield, IL 65704

via Regular Mail Mr. Lawrence Criscione 211 E. Dunklin Street Jefferson City, MO 65101

-,	CERTIFIED MAIL NO (Domestic Mail Only: No Insurance For delivery information visit our webs	
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	Postage Certifled Fee Return Receipt Fee (Endorsement Required) Restricted Delivery Fee (Endorsement Required) Total Postage & Fees	Postmark Here
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SUNSI Review Completed: __JRG___ ADAMS: □ Yes No Initials: __JRG__ □ Publicly Available Non-Publicly Available Sensitive □ Non-Sensitive

Non Responsive Record

OFFICE	RIV:ACES	RC/TL	C:RPBB	D:DRS	D:DRP	SAC
NAME	JRGroom	KDFuller	VGGaddy	DChamberlain	ATHowell	HAFreeman
	/HAFreeman for RA/	/RA/	The same of the sa	/RKCaniano for RA/	/AVegel for RA/	JYW for
DATE	11/15/2007	11/16/2007	11/16/2007	11/16/2007	11/16/2007	11/16/2007

OFFICIAL RECORD COPY

T=Telephone

E=E-mail

F=Fax

ARB DISPOSITIO	N RECORD	Allegation N	lumber: RIV-2007 -A-0117
Facility Name: Callawa	y Plant	Docket Num	nber: 50-483
Responsible Division	: DRP	ARB D	Date: 10/29/2007
Received Date 10/19/2007	30 Days 11/18/2007	150 Days 03/17/2008	180 Days 04/16/2008
Purpose of the ARB:	Initial		ann ann an
Basis for Another ARB:	After RPBB's revi	ew of concerns 4 and 5	
		REFERRAL	The state of the s
Does Alleger Object to Re	ferral 🗆 Yes 🗹 N	o 🗆 N/A	
If any of the following factor	ors apply, an allegation s	shall not be referred to the lic	ensee.
Information cannot be alleger of confidential		etail to the licensee without co	ompromising the identity of the
The licensee could co	mpromise an investigati	on or inspection because of	knowledge gained from the referral.
address the allegation			s who would normally receive and
The basis of the allegathe information being r	ation is information recei released in a referral.	ived from a Federal or State	agency that does not approve of
	ARI	B PARTICIPANTS	
Chairman:			
AVegel	RCaniano	RDeese	CHolland
KFuller	JWalker	HFreeman	AFairbanks
ATGody	DPowers	MHaire	

Concern	1		Discipline		Reactor Depar	rtment Code
			Engineering		Engine	ering
Responsib	ole Branch:	RPBB		OI Case Number:		- Andrews
Contract of the Party of the Pa	Description:					
for 20 mo 2005. Th common	onths. The ne valves w relief valve	valves were dere dere damaged e discharge he	damaged in F d due to an ina	n relief valves were Feb 2004 and remo- adequate design of ilar event had occur ailed in 1993.	ved for service i the Pressurizer	in Oct Relief Tank
Regulator	y Requireme	ent:				
And in case of the last of the	Andreas Antonion and Antonion		s/Criterion XV	/1		
Safety Sig	nificance -	Select	A STATE OF THE STA			I was been about a state of the
Basis:			A CONTRACTOR OF STREET	的现在分词		15000000000000000000000000000000000000
Low Safe	ety Significa ection/maint		Conditions that	it caused damage h	nas not occurred	since the
Check if qu	uestion is a	pplicable to th	e concern.			
				impropriety or inade with NRC regulated a		

▼ Is the validity	y of the issue unknown	wn?		
	ements are checked, the is		Assigned Date	Planned Date
Refer to License	e for Response	ACES	10/29/2007	Flamed Date
Comments:	RPBB to review	response.		
Additional Comm	ents			4 4 14

Concern	2		Discipline		Reactor Department Code
			Engineering		Engineering
Responsib	le Branch:	RPBB	OI C	Case Number:	
Secretary and property of the second	escription:	在 時期間標準	海路 海 (多)		
were not valves be plant reje staggere	tested until een tested s ect the sugg d test basis	August 2006, of sooner, the dam jestion that the last so that instead	due to the licens nage would have RHR system su	see's test stagge e been identified ction relief valve alves during eve	ervice in Oct 2005, they ering method. Had the d earlier. Also, why did the es be tested on a en numbers refueling
Regulator	y Requireme	ent:			
TS 5.4.1/	Test Contro	ol			
Safety Sig	nificance -	Select			
	ty Significa ection/maint		nditions that cau	ised damage ha	as not occurred since the
☑ Is it a ☑ Is the ☑ Is the	declaration, impropriety validity of th		ssertion of impro associated with N n?		
Action			Assigned Bra	anch Assigned D	ate Planned Date
	icensee for i	Response	ACES	10/29/2007	
Refer to L	CONTRACTOR AND ADDRESS OF THE PARTY OF THE P	DDD to milau s	esnonse	Mileston Committee of the Committee of t	
Commen	ts: R	PBB to review r	COPOLICO.		
PULL MANY STREET,	rs: R	PDD to review r	оороноо:		

Concern	3	D	iscipline	Reactor Department Code
		En	ngineering	Engineering
Responsibl	e Branch:	RPBB	OI Case Number:	V 10 2 884 1000 V 104 R 10 W 104 W 104
Concern De	escription:			

During Fall 06, the concerned individual met with the Plant Director and Design Engineering to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header at the first opportunity (Spring 2007 refueling outage, Refuel 15). Despite acknowledgement of the problem, no one was assigned to work on a mod to correct the problem until Dec 2006. The mod to correct the problem was subsequently removed from Refuel 15. Since no one was assigned to work on the mod in Sep, Oct, and Nov 2006, is this an indication of inadequate design engineering staffing or is it an indication of inadequate design engineering experience?

Regulatory Requirement:

Criterion XVI

Safety Significance - Select...

Basis:

Low Safety Significance- Inadequate staffing/experience could eventually adversely affect engineering performance.

Check if question is applicable to the concern.

- ▼ Is it a declaration, statement, or assertion of impropriety or inadequacy?
- ▼ Is the impropriety or inadequacy associated with NRC regulated activities?
- ✓ Is the validity of the issue unknown?

If all of the above statements are checked, the issue is an allegation.

Action		Assigned Branch	Assigned Date	Planned Date
Refer to License	ee for Response	ACES	10/29/2007	
Comments:	RPBB to review	response.	ADDESIMANO GEORGIA SI DAS TOTA	DALES I RESERVED DE MAI VERSEN

Additional Comments

Concern	4		Discipline	Reactor Department Code
		2	Chilling Effect	Engineering
Responsibl	e Branch:	RPBB	OI Case Numbe	er:
Concern D	escription			NO SOLETION OF THE CONTRACTOR
are a dime constructi you." Bas capable o	e a dozer on days t sed on the f properly	n." Mr. Herrmann hat "If you leave, ese comments, do assessing nucle	told an engineer that had I can have two new engin	
Regulatory	and the state of t	ient:		
Criterion >	ΚVI			
Safety Sign	nificance -	Select		

Basis:

Safety Significance is Low- Basis: Potential chilling environment.

Check if question is applicable to the concern.

Is it a declaration, statement, or assertion of impropriety or inadequacy?

If all of the above stater	ments are thecked, the			
Action Other (Describe)	appendiction (see a	Assigned Branch RPBB	Assigned Date 10/29/2007	Planned Date 11/13/2007
Comments:	A STATE OF THE STA	COVERNO DE LA VILLE DE LA COLLEGA	APPENDING TO SERVICE OF THE SERVICE	SECTION OF THE PARTY OF THE
Comments.	HARR to Levie	w concern again for cla	rification before	reterring.
Action		Assigned Branch	Assigned Date	Planned Date
Other (Describe)	es de la companya de	ACES	harts in the same of the	MATERIAL STREET
Comments:	Bring back to A	ARB after RPBB's revie	w.	
Additional Comme	nts			180 Fig. 98 (1900)
Concern 5	(Market State of the State of t	Discipline	Reac	tor Department Co
Concern <u>5</u>	ALLEY MAN TANK	CONTRACTOR OF STREET AND STREET AND ADDRESS OF THE PARTY ADDRE	With the property of the prope	CAMPUS SECTIONS CONTRACTOR AND ADMINISTRA
		Safety Culture		Operations
Responsible Branci Concern Descriptio On Sept 20, 2004 fire on the commu	on: 4, during an Ever unications corrid	Safety Culture OI Case N or Review Team meetin or roof, equipment oper	umber: g following a Se	eptember 18, 200 d the practice of
Responsible Branch Concern Description On Sept 20, 2004 fire on the commu using outside ope equipment operations was discuss minutes.	on: 4, during an Ever unications corride erators to staff the tors expressed c sed in the event	Safety Culture OI Case N ot Review Team meetin	g following a Serators questione ue was not addrivas being cover	eptember 18, 200 d the practice of essed. In Nov 20 ed up. Although
Responsible Branch Concern Description On Sept 20, 2004 fire on the commusing outside operate operate was discussed in the community of the co	on: 4, during an Ever unications corride erators to staff the tors expressed c sed in the event	Safety Culture OI Case N or Review Team meetin or roof, equipment oper e fire brigade. This issue w	g following a Serators questione ue was not addrivas being cover	eptember 18, 200 d the practice of essed. In Nov 20 ed up. Although
Responsible Branch Concern Description On Sept 20, 2004 fire on the commusing outside operate operate was discussed in the commusion of the commusion of the commusion of the commusion of the community of the co	on: 4, during an Ever unications corride erators to staff the tors expressed c sed in the event ement:	Safety Culture OI Case N or Review Team meetin or roof, equipment oper e fire brigade. This issue w	g following a Serators questione ue was not addrivas being cover	eptember 18, 200 d the practice of essed. In Nov 20 ed up. Although
Responsible Branch Concern Description On Sept 20, 2004 fire on the commusing outside operate operate operate was discussed in the community of the community o	on: 4, during an Ever unications corride erators to staff the tors expressed c sed in the event ement:	Safety Culture OI Case N or Review Team meetin or roof, equipment oper e fire brigade. This issue w	g following a Serators questione ue was not addrivas being cover	eptember 18, 200 d the practice of essed. In Nov 20 ed up. Although
Responsible Branch Concern Description On Sept 20, 2004 fire on the communication outside open equipment operations was discussed in the communication of th	A, during an Ever unications corride erators to staff the tors expressed corride exact in the event ement: Normal s applicable to the on, statement, or ety or inadequacy of the issue unknown	Safety Culture OI Case Note that Review Team meeting or roof, equipment oper e fire brigade. This issue we review team, the issue we review team, the issue on the concern. The concern is assertion of impropriety associated with NRC region?	g following a Serators questione ue was not addrives being covered is not included in a continuous or inadequacy?	eptember 18, 200 d the practice of essed. In Nov 20 ed up. Although n the meeting
Responsible Branch Concern Description On Sept 20, 2004 fire on the commusing outside operation of the communication of the communicati	A, during an Ever unications corride erators to staff the tors expressed corride exact in the event ement: Normal s applicable to the on, statement, or ety or inadequacy of the issue unknown	Safety Culture OI Case Note that Review Team meeting or roof, equipment oper e fire brigade. This issue we review team, the issue we review team, the issue on the concern. The concern is assertion of impropriety associated with NRC region?	g following a Serators questione ue was not addrivas being covere is not included in or inadequacy?	eptember 18, 200 d the practice of essed. In Nov 20 ed up. Although n the meeting

Assigned Branch Assigned Date 11/13/2007

Planned Date

Action

No Further Action

Comments:	Bring back to ARB after RPB's review.
Additional Comm	nents

Concern	6		Discipline Operations		Reactor Department Code Operations
Responsib	ole Branch:	RPBB		ase Number:	America
Concern [Description:				
Spring 20 overtime operators	005, only on Two crews s short, and	e of six opera s are one equ one crew is t	ating crews is able uipment operator s	to staff all requishort, two crews perators short.	rt the fire brigade in ired watch stations w/o are two equipment Why has it taken two and
Regulator Criterion	y Requireme XVI	nt:			
Safety Sig	nificance -	N/A			
Basis: Using OT	f, fire brigad	e is fully staf	fed.		
Check if q	uestion is ap	plicable to the	e concern.		
☐ Is the ☐ Is the	impropriety validity of th	or inadequacy e issue unkno	r assertion of impro y associated with N own? Issue is an allegation.		September 1990
Action			Assigned Bra	nch Assigned Da	ate Planned Date
Refer to L	icensee for R	lesponse	ACES	10/29/2007	
Commen	ts: RF	PBB to review	v response.		
Additional	Comments		- 4		

Concern 7		Discipline Reactor Department Co
	Si	afety Culture Operations
Responsible Branch:	RPBB	OI Case Number:
Concern Description:		
associated with inac as Action Notice (lo (higher significance	dequate staffing o wer significance) . The problem wa	CAR 200501985 was written following an NRC findin f the fire brigade. CAR 200408626 was screened. CAR 200501985 was screened as Adverse Conditions as assigned a low significance until an NRC finding we concerns and input of its employees into the

Safety Significance -	Select			
Basis:			13.44/13/44/19	建
Safety Significance-	low.			
Check if question is ap	plicable to the	concern.		
	or inadequacy	assertion of improprie associated with NRC r wn?		
Is the impropriety	or inadequacy e issue unkno	associated with NRC nwn?		
☑ Is the impropriety o ☑ Is the validity of the	or inadequacy e issue unkno	associated with NRC nwn?	Assigned Date	
Is the impropriety of Is the validity of the	or inadequacy e issue unkno are checked, the is	associated with NRC nwn?	egulated activitie	es?

Concern	8	Life and Association and Assoc	Discipline rrective Action	Reactor Department Code Operations
Responsib	le Branch	: RPBB	OI Case Number:	
equipmentook the c CAR. Du significan	nt operate outside e le to rece ce. Wha	or had to be used a quipment to arrive) ent changes in the (at is being done to a		w be assigned higher screened historical issues
Regulatory Criterion	Require			
Safety Sig	nificance	- Select		
				当然在对于私生,但是这种企业的
Basis:	The state of the state of	•		
Basis: Safety Sig	gnificanc	e- Low		to the second
Safety Sig		e- Low applicable to the co	oncern.	
Safety Signature Check if quality Is it a	uestion is	applicable to the co	sertion of impropriety or inad	
Safety Signature Check if quality Is it a	uestion is	applicable to the co		
Safety Signature Check if qualify Is it a given by Is the i	declaration is	applicable to the co	sertion of impropriety or inad	

Action

Comments:

Refer to Licensee for Response

RPBB to review response.

Assigned Branch Assigned Date
ACES 10/29/2007

Planned Date

Additional Comments

Concern 9		Discipline	Reac	tor Department Code
	9	Corrective Action		Operations
Responsible Branch	: RPBB	OI Case	Number:	
Concern Descriptio	n:			A STATE OF THE STATE OF
control room water can be done to er interest in not ens	h station) was as sure adverse co- uring they are ac	Idressed?	ual that manages gned to individual	
Regulatory Require Criterion XVI	ment:		STEP HE WAS IN WHAT	
Safety Significance	- Select			
Basis:				
Safety Significance	e- Low Proble	m may still be occur	ring.	
Check if question is	applicable to the	concern.		
▼ Is it a declaration	on, statement, or	assertion of improprie	tv or inadequacy?	
		associated with NRC r		
☑ Is the validity of				
If all of the above stateme	ents are checked, the is	sue Is an allegation.		
Action		Assigned Branch	Assigned Date	Planned Date
Refer to Licensee for	or Response	ACES	10/29/2007	
Comments:	RPBB to review	response.	THE RESERVE THE PROPERTY OF THE PARTY OF THE	
Additional Commen	is			20 - 2 10 - 2

Concern 10	Disciplin	ie l	Reactor Department Code
	Other		Modifications
Responsible Branch:	Select	OI Case Number:	
Concern Description:		对于是一种基础的	
IDDIVIDUAL WAS OBSDI		13 AVANT IN WAICH THA CE	ew left the control rods

None			
Safety Significance - N/A			
Basis:			A SUSSILIVE CONTRACTOR
Check if question is applicable to the co	oncern.		
		4	
			
Is it a declaration, statement, or as			
▼ Is the impropriety or inadequacy as	ssociated with NRC re		
	ssociated with NRC re		
▼ Is the impropriety or inadequacy as	ssociated with NRC ren?		
✓ Is the impropriety or inadequacy as✓ Is the validity of the issue unknown	ssociated with NRC ren?	egulated activities	
Is the impropriety or inadequacy as Is the validity of the issue unknown fall of the above statements are checked, the issue	ssociated with NRC renal ren	egulated activities	s?

ALLEGATION RECEIPT FORM Allegation Number: RIV-2007-A-0117

Received By: Vincent Gaddy	Receipt Date: 10/19/2007	
Receipt Method: E-mail	Other Method	
	FACILITY	
Facility Name: Callaway Plant	\$	
Location: MO		
Docket(s): 50-483		
General Discussion:		

	CONCERN 1
1.5	Concern (be brief) ddress a known deficiency in the PRT during Refuel 15 - for specific see attached email
section of th	em specifics. What is the concern, when did it occur, who was involved, etc. If the concern involves discrimination, fill in the last e form. ect deficiency was not implemented
	potential safety impact? Is this an ongoing concem?
What require 50.59	ement/regulation governs this concern?
What record	s should the NRC review?
What other i	ndividuals could the NBC contact for information?
Was the con	cem brought to management's attention? If so, what actions have been taken, if not, why not?
	concern brought to the NRC's attention? I with management's response

CONCERN 2
mmary of Concern (be brief) adequate staffing in the Fire Brigade - for specifics see attached email
tain concern specifics. What is the concern, when did it occur, who was involved, etc. If the concern involves discrimination, fill in the last tion of the form. Brigade can't be staffed w/o overtime
at is the potential safety impact? Is this an ongoing concem? one, as long as OT is allowed. Currently being satisfied w OT.
at requirement/regulation governs this concern? sense condition 5c
at records should the NRC review? Rs 200400065, 200408626, 200501985, 200502693
at other individuals could the NRC contact for information?
s the concern brought to management's attention? If so, what actions have been taken, if not, why not?
y was the concern brought to the NRC's attention? t satisfied with management' response

CONCERN 3

Summary of Concern (be brief)

Cronyism in the Operations Department - for specifics see attached email

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.

Individual promoted to Asst Ops Manager based relationship to Ops Manager, not qualifications

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

What requirement/regulation governs this concern?

What records should the NRC review?

What other individuals could the NRC contact for information?

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

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

ALLEGATION RECEIPT FORM

ALLEGER IN	FORMATION			
Employer: AmerenUE/Callaway Plant	Relationship to Facility: Licensee Employee			
Occupation:	Ops Department			
Preference for method and time of contact.	Was the individual advised of identity protection?			
Method Telephone Other Method	F			
Time Select Select Comments	Yes V No			
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 follow-up.				
Does the individual object to the referral?	Does the individual object to releasing their identity?			
☐ Yes ☑ No	Yes ✓ No			
Regulations prohibit NRC licensees (including contractors and subcontractivities (alleging violations of regulatory requirements, refusing to engi	actors) from discriminating against individuals who engage in protected age in practices made unlawful by statutes, etc.).			
Does the concern involve discrimination?	Was the individual advised of the DOL process?			
Γ Yes ▼ No	Γ Yes ▼ No			
What was the protected activity? When did it occur?				
Who in management/supervision was aware of the protected activity? When did they become aware? How were they aware? Licensee management (CNO, VP engr, Plant director) all copied on the attached email.				
What adverse actions have been taken (termination, demotion, not bein	g selected for position)? When did it occur?			
What was managements reason for the adverse action?				
Why does the individual believe the actions were taken as a result of en	gaging in a protected activity?			

The first issue I wish to address is the reason why Callaway was unable to address the known design deficiencies in the Pressurizer Relief Tank during Refueling Outage 15.

On February 11, 2004 the operating crew at Callaway Plant increased the Reactor Coolant System pressure above the Safety Injection Signal block permissive reset point before Steam Header Pressure was above the Steam Line Pressure Safety Injection set point. This caused all six pumps in the Emergency Core Cooling System to start and inject water into the core. As water was injected into the core, the pressure in the Pressurizer rose until it exceeded the lift set point of the Pressurizer Power Operated Relief Valves. Over the next 15 minutes, the Power Operated Relief Valves lifted about a dozen times. With each lift, radioactive steam at greater than 2300 psig and greater than 600°F was evacuated from the Pressurizer into the Common Relief Valve Discharge Header of the Pressurizer Relief Tank.

Because of an, at the time, unknown, inadequate system design, the pressure transient in the header caused by the high enthalpy steam induced a water hammer event which significantly damaged both the 'A' and 'B' train Residual Heat Removal system Suction Relief Valves. The assembly pin of one of the valves was sheared into eight pieces and for the other valve the pin was broken into three pieces. The fact that these valves were severely damaged went unrecognized at the time; the damage was not discovered for more than 31 months. For 20 of the 31 months, the valves remained in the system. A similar event had occurred in 1988 with the damage remaining undetected until one of the valves failed while raising Reactor Coolant System Pressure in 1993.

Because these valves are not tested on a staggered test basis, their inability to perform their design function was not noticed for an entire 18 month fuel cycle. (A staggered test basis means that for components with a certain test frequency, which in this case is 36 months, the testing of the two trains would be staggered such that one train would be tested during the middle of the other train's test frequency. If these valves had been on a staggered test basis, then during Refueling Outage 13 in the Spring of 2004 one valve would have been removed and tested and then 18 months later during Refueling Outage 14 in the Fall of 2005 the opposite train's valve would have been removed and tested. Because a staggered test basis was not in affect at the time, no valves were removed during the Spring of 2004, but instead both valves were removed during the Fall of 2005.)

We unknowingly had two damaged valves in the system during the entire 18 months of fuel cycle 14. In October 2005, both Residual Heat Removal system suction relief valves were removed from the system; this was 20 months after they had been damaged. Because the testing of these valves has been contracted out to an off-site facility, the valves were not tested until August 2006; this was 31 months after they had been damaged. On September 12, 2006 the Root Cause team for CARS 200607188 met to determine what caused the valves to be damaged. I was the Operations representative on that team. During the first week, I proposed that both Residual Heat Removal system suction relief valves may have been damaged due to a back pressure transient on the Pressurizer Relief Tank common relief discharge header during the February 2004 Safety Injection. By the end of the second week the team had enough evidence to prove this proposition. On September 22, 2006 a Night Order was issued to the Operating crews warning them that if a Pressurizer Power Operated Relief Valve were to lift from Normal Operating Pressure, it would be likely that neither Residual Heat Removal system suction relief valves would be capable of performing their function.

During every autumn month in 2006 I personally met with Fadi Diya and with Tim D. Hermann of the Design Engineering group to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header by the first opportunity; the first opportunity being Refueling Outage 15 during the Spring of 2007. Despite their acknowledgement of the problem, no one was assigned to modify the piping design until December 2006. In late March 2007, more than six months after the inadequate design was noted, the modification package to correct the design deficiencies was removed from Refueling

Outage 15.

I have several questions regarding this issue. The first set is with regard to being unable to prepare the modification package to correct the inadequate piping design in a six month time frame:

- 1. Is the fact that no one was assigned to the task of preparing the modification package during the months of September, October and November an indication that the staffing level of the Design Engineering group is insufficient?
- 2. Is the fact that a critical design modification could not be performed in six months an indication the experience level of the Design Engineering group is insufficient?
- 3. Several engineers at Callaway Plant have complained to me in recent weeks regarding statements made by Mr. Naslund and Mr. Herrmann. A statement attributed to Mr. Naslund was "Engineers come, engineers go." A statement attributed to Mr. Herrmann was "Engineers are a dime a dozen." Supposedly Mr. Herrmann recently told an engineer who had been at the plant since construction days that "If you leave, I can have two new engineers for the price of you." In light of these comments, does Callaway Plant value experienced engineers who are capable of properly assessing and addressing nuclear safety concerns?
- 4. The next question I have is why the Residual Heat Removal system suction relief valves, which were removed from the system in October 2005 were not tested until 10 months later in August 2006. What necessitated the 10 month delay?
- 5. The next question I have is why the plant rejected the suggestion that the Residual Heat Removal system Suction Relief Valves be tested on a Staggered Test Basis so that instead of doing both valves during even number Refueling Outages, one valve would be done in every Refueling Outage. Had a Staggered Test Basis plan been in affect during Refueling Outage 13, then one of the damaged valves would have been removed an entire fuel cycle earlier and the degraded condition of the other valve (the valve still in the system) would have been known prior to using it for the Cold Overpressure Mitigation System during the first half of Refueling Outage 14. In response to this request, the company has stated the following:

Testing on a staggered schedule is not recommended because if the removed valve has indications of degradation, the same must be assumed of the installed valve which will require immediate replacement because the internal condition of the valve cannot be determined with the valve in service. The current test frequency of both valves every other refueling outage is the preferred method because both valves are tested at the same time and as such a failure of one valve does not question the operability or material condition of the installed certified valves. As such a Tech Spec Action statement entry is not required.

The statement just read is interpreted by me to state that Callaway Plant would prefer not to have an indication that a valve installed in the system is degraded because then they could possibly have to take the plant off-line to fix the degraded valve (thereby losing some revenue from electricity generation). In other words, we would rather have two unknown degraded valves for an extra 18 months than one known degraded valve for 18 months because we would have to take action to correct a known degraded valve. If this is not a fair summary of the response, please let me known how I should be interpreting this response.

The next issue I wish to address is adequate staffing of the Fire Brigade.

In January 2004 an unannounced fire drill was conducted at Callaway Plant. In CAR 200400065, the Fire Marshall documented in the drill critique comments that due to the length of time it took the Outside Operator to arrive, the crew used the Primary Equipment Operator on a hose team. At the time, the Primary Equipment Operator was credited as the Safe Shutdown Operator required by the Final Safety Analysis Report and was therefore not eligible to be on the Fire Brigade.

On September 18, 2004 there was a small fire on the Communications Corridor roof. An Event Review Team meeting was held on September 20, 2004 to analyze the response of the Fire Brigade to this fire. This meeting was attended by the Equipment Operators who were manning the Fire Brigade on the day of the fire. Twice during the meeting there were discussions which lasted several minutes concerning the use of the Outside Operator in staffing the Fire Brigade. The Leader of the meeting at one point stated that the issue (of using the Outside Operator on the Fire Brigade) should be address in the response to the Callaway Action Request which was tracking the issue. This issue was actually never addressed in the response to either of the two Callaway Action Requests documenting the event (CAR 200407284 or CAR (b)(7)(C)) nor did it appear in the meeting minutes from the Event Review Team meeting at which the discussion occurred.

In November 2004 I attended Fire Brigade Training with the crew which fought the Communications Corridor roof fire. Their supervisors were not present at the training and I was the only salaried person from Operations in attendance. The equipment operators expressed a concern that issues brought up during the Event Review Team meeting in September were being covered up by the company. The specific issue was using the Outside Operator for a Fire Brigade assignment. I informed the operators that my experience was the ERT minutes are typically a verbatim transcription of the meeting and I doubted that anything said at the meeting would not appear in the meeting minutes (I was wrong on this issue. ERT minutes are only sometimes verbatim transcriptions and are more often summaries). I took an action from the training session to investigate the matter and if necessary to generate a Callaway Action Request to address the operators' concerns.

I was able to obtain the tape of the September ERT meeting from a clerk in the Performance Improvement department. I wrote CAR 200408626 to address the Equipment Operators' concerns and attached a partial transcription of the ERT minutes to that CAR. While writing CAR 200408626 I was challenged by my supervisor that the union operators were merely using the issue of not assigning the Outside Operator to the Fire Brigade in order to force the company to allot more overtime. I continued writing CAR 200408626 anyway and when I was finished it my supervisor told me the issue would merely be answered the same way it had been answered in the past.

Despite my request that CAR 200408626 be screened as an Adverse Condition, it was assigned to my supervisor by the CAR Screening Committee as an Action Notice. With the exception of one minor side issue (the whereabouts of the Fire Brigade trainers during the September 2004 ERT meeting), CAR 200408626 was answered the same day it was screened with no further consideration of the issues in light of the experiences from the September 2004 fire.

In early 2005, the US NRC Senior Resident Inspector at Callaway Plant (Michael Peck) took up the issue of the Outside Operator being credited for the Fire Brigade. That resulted in CAR 200501985 being written by the Department Performance Coordinator of Operations. Because of the NRC Resident's attention to the issue, CAR 200501985 was screened as an Adverse Condition and ultimately resulted in the discontinuance of assigning the Outside Operator to the Fire Brigade.

Upon learning about CAR 200501985, I wrote CAR 200502693 concerning how the issue of assigning the Outside Equipment Operator to the Fire Brigade was brought to the attention of

Operations Management in both September and November 2004 and could have been addressed in house, thus avoiding a NRC finding.

CAR 200502693 was discussed with the entire "chain of command" of the Performance Improvement department up to and including the Senior Vice President of Nuclear. No changes to the Corrective Action Process were made as a result of CAR 200502693 but some of the suggested changes were made late in 2005 due to industry benchmarking.

In October 2006, CAR (b)(7)(C) was assigned to the same supervisor who had answered CAR 200408626 regarding the use of the Outside Operator on the Fire Brigade. CAR (b)(7)(C) contained the wording of the NRC's violation from the first quarter 2005 concerning inadequate Fire Brigade staffing. The main focus of the violation was that for a significant amount of time during the first quarter of 2005 Callaway Plant failed to maintain the required five Fire Brigade members on site. At the end of the violation, the issue was tied to the "crosscutting" issue of inadequate Problem Identification & Resolution. In the Closure statement of CAR (b)(7)(C) the supervisor makes an inane argument that the tie to the "crosscutting" issue in PI&R is not valid because CAR 200400065 and CAR 200408626 were screened as Action Notices (now replaced with "Business Tracking") and were therefore outside the Corrective Action Process.

This argument was inane because I sent CAR 200408626 to screening as an Adverse Condition and stated in the Description (with reasons provided) that it was an Adverse Condition; yet, it was screened as an Action Notice anyway. Although it can be argued that the standards were different in 2004, this argument is itself inane since the screening of CAR 200501985 (due to NRC attention) as an Adverse Condition proves CAR 200408626 was inappropriately screened. Regardless, by October 2006 CAR 200400065 and CAR 200408626 would have both met the criteria of Adverse Condition and so claiming they were outside the Corrective Action Process is merely unproductive quibbling designed to avoid acceptance of a valid comment from the NRC.

I have several questions regarding the above events:

- 1. Since the Spring of 2005 Operations has adopted the practice of not assigning the Outside Operator to the Fire Brigade. Currently only one of the six operating crews is able to staff all the required watch stations and Fire Brigade positions without using overtime. Two of the crews one Equipment Operator short. Two of the crews are two Equipment Operators short and one of the crews is short three equipment operators. Is there a reason that after more than two and one half years Operations has not staffed the Equipment Operator ranks to the point that all the crews can support the required watch stations as well as the Fire Brigade?
- 2. Many Equipment Operators at the plant believe the company attempted to cover up the issue of assigning the Outside Operator to the Fire Brigade during the September 2004 Event Review Team meeting. Can you explain why this issue did not appear in the meeting minutes?
- 3. CAR 200408626 was written to address the concerns of craft personnel whereas CAR 200501985 was written concerning the same issue but to address the concerns of the NRC Resident Inspector. CAR 200408626 was screened an Action Notice and essentially dismissed in hours whereas CAR 200501985 was screened an Adverse Condition and received an Apparent Cause investigation. Does Callaway Plant value the concerns and input of its craft personnel into the Corrective Action Process?
- 4. CAR 200408626 and CAR 200400065 would be screened as Adverse Conditions by the current criteria applied at Callaway Plant, yet in recent documents (e.g. CAR (**)(**)(**)) from October 2006) we still discount these documents during our analysis because they were screened as Action Notices at the time. What is being done to ensure important issues brought to our attention in the past but not appropriately addressed due to our low

standards at the time are now re-classified and addressed prior to the recurrence of an adverse condition?

5. As already noted, CAR (E)(T)(C) had a component to it which concerned the inadequate resolution of an issue when earlier identified in the Corrective Action Process. was assigned to the individual who failed to properly address the issue the first time, and he successfully (in terms of being allowed to close CAR 60000 claimed that the issue had been appropriately addressed when it had first appeared due to the way it was inaccurately categorized as not being an Adverse Condition. This appears like the "Fox guarding the hen house." This more recently occurred in an unrelated topic identified in CAR (b)(C)(C) That CAR, which documented inappropriate control of the qualification process for a Main Control Room watch station, was assigned to the individual who inappropriately managed the process. Again, in another case of the "Fox guarding the hen house" that individual unsurprisingly closed the CAR to no inappropriate activity had occurred. What can we do at Callaway Plant to ensure Adverse Conditions are not assigned to individuals who have a vested interest in not ensuring they are addressed?

The third issue I wish to address involves "cronyism" in the Operations Department at Callaway Plant.

There is a former Shift Manager who last year was promoted to an Assistant Operations Manager position at Callaway Plant. This individual was consistently ranked as the top performing Shift Manager despite having been involved in some very significant incidents at Callaway which primarily resulted from a failure in supervisory oversight. In October 2003 his crew inexplicably left the control rods withdrawn following an inadvertent reactor shutdown (CAR 200702606). In February 2004 his crew caused an inadvertent Safety Injection to occur during a plant heat up (CAR (b)(7)(C) In November 2005 his crew made several significantly poor decisions while synchronizing the main generator to the Electric Grid, causing a severe temperature and pressure transient in the Reactor Coolant System which resulted in the isolation of the Letdown system on low Pressurizer level (CAR 200704820). However, this same individual has been known to vacation with the Operations Manager. How does Callaway Plant ensure that critical positions are filled by qualified candidates and not through a system of cronyism?

I have several other issues which I would like to address, however their investigations are still in progress with both the internal Callaway Plant Quality Assurance organization and externally with the Nuclear Regulatory Commission. Although I am not satisfied with the progress of these investigations, since they are not yet closed I do not believe it necessary to address them in this forum at this time. I would like to thank the Nuclear Regulatory Commission and the company for their time and would like to offer that I am available to discuss any of these concerns in further detail. I believe that most concerned parties know how to contact me.

ARB DISPOSITIO	ON RECORD	Allegation N	umber: RIV-2007 -A-0117
Facility Callaw Name:	ay Plant	Docket Num	nber: 50-483
Responsible Division	on: DRP	ARB D	Pate: 11/26/2007
Received Date 10/19/2007	30 Days 11/18/2007	150 Days 03/17/2008	180 Days 04/16/2008
Purpose of the ARB:	Followup after Ri	PBB reviews Concerns 4	and 5.
Basis for Another ARB:		A	
		REFERRAL	
Does Alleger Object to F	Referral T Yes V	lo 「N/A	* CASE OF THE CONTROL OF THE CASE OF THE C
If any of the following fac	ctors apply, an allegation	shall not be referred to the lic	ensee.
alleger of confidential The licensee could of The allegation is material address the allegation The basis of the alle	al source. compromise an investigation de against the licensee's on. gation is information rece g released in a referral.	ion or inspection because of l management or those parties ived from a Federal or State	knowledge gained from the referral. Is who would normally receive and agency that does not approve of
	AR	B PARTICIPANTS	
Chairman:	The state of the state of		
AVegel	RCaniano	MShannon	DWhite
VGaddy	JWalker	HFreeman	CMaier
JGroom	MVasquez		
	10 To 10 10 To 10		

Concern 1		Discipline 2	Reactor Department Code
		Engineering	Engineering
Responsible Bran	ch: RPBB	OI Case Numbe	r:
for 20 months. 2005. The valve common relief v	ged A and B Train Rh The valves were dan es were damaged du alve discharge head	naged in Feb 2004 and re ie to an inadequate desigi	ere allowed to remain in service moved for service in Oct n of the Pressurizer Relief Tank ocurred in 1988 with damage
Regulatory Requi	rement: Corrective Actions/C		
Safety Significand	the state of the second second second second		***************************************
Basis:			
Low Safety Sign last inspection/n		ditions that caused damag	ge has not occurred since the
Check if question	is applicable to the co	oncern.	
		sertion of impropriety or in	1

If all of the above statements are checked, the issue is an allegation.

Action
Assigned Branch
Refer to Licensee for Response
Comments:

RPBB to review response.

Additional Comments

Concern	2		Discipline Engineering	274	Reactor Department Code Engineering
Responsible i	Branch:	RPBB		Case Number:	
Concern Desc	ription:				
were not tes valves been plant reject t staggered te	ted unti tested he sug st basis	I August 2006, sooner, the da gestion that the sooner that the	due to the licer mage would have RHR system s	nsee's test stag ve been identifi action relief va valves during o	service in Oct 2005, they gering method. Had the led earlier. Also, why did the lives be tested on a even numbers refueling
Regulatory Re TS 5.4.1/Tes	of a simplification of	ACCOUNT OF THE PERSON OF THE P			4 13 14 S
Safety Signifi	cance -	Select	We die of commence of the o	the same of the sa	the same time to the same safe of the supplementary and the supplementary and the same safe same safe of the safe safe safe safe safe safe safe saf
Basis: Low Safety S last inspection			onditions that ca	aused damage	has not occurred since the
Check if ques	tion is a	pplicable to the	concern.	era	The state of the s
☑ Is the imp ☑ Is the vali	ropriety dity of t	or inadequacy he issue unkno			
If all of the above	statement	s are checked, the i	ssue is an allegation.		
Action				Assigned	Chief Processes Till weeken spiller and the surround has a violent completion as 100 Articles and 100 Colors an
Refer to Lice Comments:		PBB to review	ACES response.	10/29/200	U 7
Additional Cor	nments				

Concern	3	Wascourt day Advisor (1995) which was a second	Discipline Engineering	Reactor Department Code Engineering
Responsible E	Branch	RPBB	OI Case Number:	
Concern Desc	riptio	n:		

During Fall 06, the concerned individual met with the Plant Director and Design Engineering to emphasize the need to correct the inadequate design of the Pressurizer Relief Tank common relief valve discharge header at the first opportunity (Spring 2007 refueling outage, Refuel 15). Despite acknowledgement of the problem, no one was assigned to work on a mod to correct the problem until Dec 2006. The mod to correct the problem was subsequently removed from Refuel 15. Since no one was assigned to work on the mod in Sep, Oct, and Nov 2006, is this an indication of inadequate design engineering staffing or is it an indication of inadequate design engineering experience?

Regulatory Requirement:

Criterion XVI

Safety Significance - Select...

arety Significance - Select

Low Safety Significance- Inadequate staffing/experience could eventually adversely affect engineering performance.

Check if question is applicable to the concern.

- ✓ Is it a declaration, statement, or assertion of impropriety or inadequacy?
- ▼ Is the impropriety or inadequacy associated with NRC regulated activities?
- Is the validity of the issue unknown?

If all of the above statements are checked, the issue is an allegation.

Action Assigned Branch Assigned Date Planned Date

Refer to Licensee for Response ACES 10/29/2007

Comments: RPBB to review response.

Additional Comments

Concern	4		Discipline	Reactor Department Code
		C	hilling Effect	Engineering
Responsible	e Bran	ch: RPBB	OI Case Number:	
Concern De	script	ion:		The Control of the Control
The follow	ina co	mment is attributed t	o Mr. Nashind (CNOVP) "Fi	ngineers come and

The following comment is attributed to Mr. Naslund (CNO/VP), "Engineers come and engineers go." A statement attributed to Mr. Herrmann, (VP-Engineering) was "Engineers are a dime a dozen." Mr. Herrmann told an engineer that had been at the plant since construction days that "If you leave, I can have two new engineers for the price of you." Based on these comments, does Callaway Plant value experienced engineers who are capable of properly assessing nuclear safety concerns?

Regulatory Requirement:

SCWE

Safety Significance - Select...

Racic

Safety Significance is Low-Basis: Potential chilling environment.

Check if question is applicable to the concern.

☑ Is it a declaration, statement, or assertion of impropriety or inadequacy?

▼ Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? If all of the above statements are checked, the issue is an allegation. - Assigned Branch Assigned Date Planned Date Other (Describe) 10/29/2007 11/13/2007 RPBB Comments: RPBB to review concern again for clarification before referring. Action Assigned Branch Assigned Date Planned Date 11/26/2007 Refer to Licensee for Response ACES Comments: Action Assigned Branch Assigned Date Review Licensee Response Comments: Additional Comments Refer to licensee. There is no higher nuclear authority than Mr. Naslund. Callaway management has this information also. Concern 5 Discipline Reactor Department Code Safety Culture **Operations** Responsible Branch: RPBB OI Case Number: Concern Description: On Sept 20, 2004, during an Event Review Team meeting following a September 18, 2004. fire on the communications corridor roof, equipment operators questioned the practice of using outside operators to staff the fire brigade. This issue was not addressed. In Nov 2004, equipment operators expressed concern that this issue was being covered up. Although the issue was discussed in the event review team, the issue is not included in the meeting minutes. Regulatory Regulrement: SCWE Safety Significance -Normal

Check if question is applicable to the concern.

▼ Is it a declaration, statement, or assertion of impropriety or inadequacy?

▼ Is the impropriety or inadequacy associated with NRC regulated activities?

Is the validity of the issue unknown?

If all of the above statements are checked, the issue is an allegation.

Action	Assigned Bran	nch Assigned Date Planned Date
Other (Describe)	RPBB	10/22/2007
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Action	Assigned Branc	h Assigned Date	Planned Date
Provide Basis for Closure	RPBB	11/26/2007	

Additional Comments

This was the subject of a previously closed allegation (confirmed by Deese). The allegation of a cover-up appears to be a stretch. The cognizant supervisor had already made up his mind on the use of the outside equipment operator (he was wrong and we issued a violation afterward) in the fire brigade and could have easily dismissed it for that reason. No merit is seen in pursuing the potential cover-up aspect.

Concern Description: Since removing the practice of requiring outside operators to support the fire brigade in Spring 2005, only one of six operating crews is able to staff all required watch stations w/o overtime. Two crews are one equipment operator short, two crews are two equipment operators short, and one crew is three equipment operators short. Why has it taken two are one half years for Operations to fully staff the fire brigade? Regulatory Requirement: Criterion XVI Safety Significance: N/A Basis: Using OT, fire brigade is fully staffed. Check if question is applicable to the concern. Is it a declaration, statement, or assertion of impropriety or inadequacy? Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? fall of the above statements are checked, the issue is an allegation. Action Assigned Branch Assigned Date: Planned Date Refer to Licensee for Response	Concern <u>6</u>		Discipline Operations		Reactor Department Code Operations
Spring 2005, only one of six operating crews is able to staff all required watch stations w/o overtime. Two crews are one equipment operator short, two crews are two equipment operators short, and one crew is three equipment operators short. Why has it taken two are one half years for Operations to fully staff the fire brigade? Regulatory Requirement: Criterion XVI Safety Significance N/A Basis: Using OT, fire brigade is fully staffed. Check if question is applicable to the concern. Is it a declaration, statement, or assertion of impropriety or inadequacy? Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? f all of the above statements are checked, the issue is an allegation. Assigned Branch Assigned Date Planned Date Refer to Licensee for Response ACES 10/29/2007	Responsible Branch	: RPBB		ase Number:	A STATE OF THE STA
Spring 2005, only one of six operating crews is able to staff all required watch stations w/o overtime. Two crews are one equipment operator short, two crews are two equipment operators short, and one crew is three equipment operators short. Why has it taken two are one half years for Operations to fully staff the fire brigade? Regulatory Requirement: Criterion XVI Safety Significance NVA Basis: Using OT, fire brigade is fully staffed. Check if question is applicable to the concern. Is it a declaration, statement, or assertion of impropriety or inadequacy? Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? If all of the above statements are checked, the issue is an allegation. Assigned Branch Assigned Date Planned Date Refer to Licensee for Response ACES 10/29/2007	Concern Description	n:			
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Using OT, fire brigade is fully staffed. Check if question is applicable to the concern. Is it a declaration, statement, or assertion of impropriety or inadequacy? Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? fall of the above statements are checked, the issue is an allegation. Action Assigned Branch Assigned Date: Planned Date Refer to Licensee for Response ACES 10/29/2007	ALCOHOLOGICAL CONTRACTOR SERVICES CONTRACTOR	nent:			
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Using OT, fire brigade is fully staffed. Check if question is applicable to the concern. Is it a declaration, statement, or assertion of impropriety or inadequacy? Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? If all of the above statements are checked, the issue is an allegation. Action Assigned Branch Assigned Date Planned Date Refer to Licensee for Response ACES 10/29/2007	Basis:	(A) (4) (A)			
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Is the impropriety or inadequacy associated with NRC regulated activities? Is the validity of the issue unknown? If all of the above statements are checked, the issue is an allegation. Action Assigned Branch Assigned Date Planned Date Refer to Licensee for Response ACES 10/29/2007	Check if question is	applicable to the c	oncern.		
Refer to Licensee for Response ACES 10/29/2007	☐ Is the improprie	ty or inadequacy as the issue unknown	ssociated with Ni n?		
Refer to Licensee for Response ACES 10/29/2007	Action		Assigned Bra	nch Assigned D	ate : Planned Date
Comments: RPRR to review response		r Response		Control for A long times & time	
	Comments:	RPRR to review re	esnonse		a remarkable so with a second
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Concern	7	Di	scipline	Reactor Department Code
		Safe	ty Culture	<u>Operations</u>
Responsible	e Brand	h: RPBB	OI Case Number:	

Concern Description:

CAR 200408626 was written by Callaway personnel to address equipment operators concerns related to the fire brigade. CAR 200501985 was written following an NRC finding associated with inadequate staffing of the fire brigade. CAR 200408626 was screened as Action Notice (lower significance). CAR 200501985 was screened as Adverse Condition (higher significance). The problem was assigned a low significance until an NRC finding was issued. Does Callaway Plant value the concerns and input of its employees into the corrective action process?

Regulatory Requirement:

TS 5.4.1/Fire Protection Program

Safety Significance - Select...

Basis:

Safety Significance- low.

Check if question is applicable to the concern.

- ▼ Is it a declaration, statement, or assertion of impropriety or inadequacy?
- ▼ Is the impropriety or inadequacy associated with NRC regulated activities?
- ✓ Is the validity of the issue unknown?

If all of the above statements are checked, the issue is an allegation.

Action	Assigned B	ranch Assigned Date Planned Date
Refer to Licensee for Response	ACES	10/29/2007
Comments: RPBB to review		

Additional Comments

Concern	8 <u>C</u> c	Discipline prrective Action	Reactor Department Code Operations
Responsible E	ranch: RPBB	OI Case Number:	
equipment o took the outs CAR. Due to significance.	perator had to be used a side equipment to arrive o recent changes in the What is being done to		ow be assigned higher screened historical issues
Regulatory Re Criterion XV	quirement:		
the development of the second of the second	cance - Select	And the second s	
Safety Signific			

▼ Is it a declaration, statement, or assertion of impropriety or inadequacy?

▼ Is the impropriety or inadequacy associated with NRC regulated activities?

Action	Assigne	Branch Assigned Date	Planned Date
Refer to Licensee for Respons	se ACES	10/29/2007	1

/ * \	Discipline Corrective Action		Reactor Department Code Operations	
Responsible Branch:	RPBB	OI	Case Number:	ALA.
control room watch can be done to ensu interest in not ensur	station) was ass are adverse con ing they are add	signed to the in aditions are not dressed?	dividual that ma assigned to ind	tion process for a main anages this process. What ividuals who have a vested properly address the issue
Regulatory Requireme Criterion XVI	ent:			
Safety Significance - Basis: Safety Significance-		m may still be o		机燃烧剂 沙
Check if question is ap ✓ Is it a declaration, ✓ Is the impropriety ✓ Is the validity of the	statement, or a	essertion of impressociated with I	opriety or inade	
if all of the above statements				
Action Refer to Licensee for	作。2015年第4日 年	Assigned Br	anch Assigned 10/29/2007	And many property and the second

Concern	10		Olscipline Other	Reactor Department Code Modifications	
Responsibl	e Brar	och: Select	OI Case Number:		
Concern De	escript	ion:			

		1	
A former shift supervisor was promo individual was onshift during the Oct withdrawn following an inadvertent refeb 2004, and in Nov 2005 when poresulting in a letdown isolation on low with the Operations Manager. How qualified candidates and not through	ober 2003 event in eactor shutdown; di or decisions were n w pressurizer level. does Callaway ensi	which the crew le uring an inadverte nade while synch However this ind	oft the control rods ent safety injection in ronizing to the grid, lividual vacations
Regulatory Requirement:			
Safety Significance - NA			The state of the s
Basis:			
Check if question is applicable to the co	oncern.		
✓ Is it a declaration, statement, or as✓ Is the impropriety or inadequacy as✓ Is the validity of the issue unknown	sociated with NRC r		?
If all of the above statements are checked, the issue	e is an allegation.		
Action	Assigned Branch	Assigned Date 10/29/2007	Planned Date
Forward to Licensee for Information	ACES		
Comments:			A PHILIPPIN A STATE OF

Additional Comments

(AALLEUM IIUN -

From:

Richard W Deese

To:

R4ALLEGATION

Date:

Wed, Nov 14, 2007 12:15 PM

Subject:

SENSITIVE ALLEGATION MATERIAL ******* RIV-2007-A-0117

Concerns 4 & 5 were assigned to be re-visited.

Concern 4 recommendation:

Refer to licensee. There is no higher nuclear authority that Mr. Naslund. Callaway management has this information also. Let's see what they say or do. If we do not like their response, we can Re-ARB.

Concern 5 recommendation:

No action. This was the subject of a previously closed allegation (confirmed by Deese). The allegation of a cover-up appears to be a stretch. The cognizant supervisor had already made up his mind on the use of the outside equipment operator (he was wrong and we issued a violation afterward) in the fire brigade and could have easily dismissed it for that reason. No merit is seen in pursuing the potential cover-up aspect.

CC:

Gaddy, Vincent