RIV-2007-A-0117 Callaway DRP 139 DAYS

Concern 1 Assigned To: RPBB OI 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.

Action		Branch	Assigned	Planned	Completed
1	Acknowledgement Letter	ACES	10/19/2007	11/18/2007	11/15/2007
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.				
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 higher nuclear authority than Mr. Naslund. Callaway management has this information also. Concern 5- RPBB to provide basis for closure.				
5	Referral Letter	ACES	10/29/2007	12/03/2007	12/07/2007
	Refer Concerns 1 - 4, 6 - 9, to licensee for response. Refer Concern 10 for information only.				
6	Response to Referral	ACES	12/07/2007	01/23/2008	01/17/2008
	Licensee phoned and requested an extension (2-weeks) until 01/23/08.				
7	Review Submittal	RPBB	01/18/2008	02/01/2008	02/20/2008
8	Closure Memo	RPBB	11/26/2007		01/16/2008
	Provide basis for closure for Concern 5				
9	Response to Referral	ACES			02/19/2008
	Based upon discussions with RPBB, the licensee provided a supplemental response.				
10	Closure Letter	ACES	02/20/2008	02/29/2008	03/06/2008
11	File Closed	ACES			03/06/2008
12	Final QA Review	ACES	03/06/2008	04/04/2008	06/04/2008

Concern 2 Assigned To: RPBB OI Action: No
OI Report:

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.

Action	Branch	Assigned	Planned	Completed

Concern 3 Assigned To: RPBB OI Action: No
OI Report:

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?

Action	Branch	Assigned	Planned	Completed

Concern 4 Assigned To: RPBB OI Action: No
OI Report:

The following statement is attributed to (CNO/VP), "Engineers come and engineers go." A statement attributed to (VP - Engineering) was "engineers are a dime a dozen." Xxxx 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?

Action	Branch	Assigned	Planned	Completed

Concern 5 Assigned To: RPBB OI Action: No
OI Report:

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.

Action	Branch	Assigned	Planned	Completed

Concern 6 Assigned To: RPBB OI Action: No
OI Report:

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?

Action	Branch	Assigned	Planned	Completed

Concern 7 Assigned To: RPBB OI Action: No
OI Report:

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?

Action	Branch	Assigned	Planned	Completed

Concern 8 Assigned To: RPBB OI Action: No
OI Report:

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?

Action	Branch	Assigned	Planned	Completed

Concern 9 Assigned To: RPBB OI Action: No
OI Report:

CAR (b)(7)(C) **(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.**

Action	Branch	Assigned	Planned	Completed

Concern 10 Assigned To: RPBB OI Action: No
OI Report:

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.

Action	Branch	Assigned	Planned	Completed

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	Direct Inspection Activities	
A10304 Support for Allegations (Reactors)	AF	Allegation Followup
A10191 Support for Allegations (Materials)	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
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 (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 (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?

5. As already noted, CAR (b)(7)(C) had a component to it which concerned the inadequate resolution of an issue when earlier identified in the Corrective Action Process. CAR (b)(7)(C) 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 CAR (b)(7)(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.

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

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

What requirement/regulation governs this concern?

50.59

What records should the NRC review?

Mod package

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?

Yes

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

Not satisfied with management's response

CONCERN 2

Summary of Concern (be brief)

Inadequate staffing in the Fire Brigade - 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.

Fire Brigade can't be staffed w/o overtime

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)

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?

Yes,

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

Not satisfied with management' response

THIS DOCUMENT IDENTIFIES AN ALLEGER

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?

THIS DOCUMENT IDENTIFIES AN ALLEGER

ALLEGATION RECEIPT FORM

ALLEGER INFORMATION

Full Name:	Telephone:
Larry Criscione	Office: 000 - 000 - 0000
Mailing Address:	Home: 000 - 000 - 0000
1412 Dial Court Springfield, IL 65704 [Debra S. Katz Katz, Marshall & Banks, LLP]	Mobile: 000 - 000 - 0000

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 ☑ No

Referral ☑ Yes ☐ No	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? ☐ Yes ☑ No	Does the individual object to releasing their identity? ☐ Yes ☑ No

Regulations prohibit NRC licensees (including contractors and subcontractors) from discriminating against individuals who engage in protected activities (alleging violations of regulatory requirements, refusing to engage in practices made unlawful by statutes, etc.).

Does the concern involve discrimination? ☐ Yes ☑ No	Was the individual advised of the DOL process? ☐ 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 being 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 engaging in a protected activity?

THIS DOCUMENT IDENTIFIES AN ALLEGER

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

ARB DISPOSITION RECORD		Allegation Number: RIV-2007 -A-0117	
Facility Name: **Callaway Plant**		Docket Number: 50-483	
Responsible Division: DRP		ARB Date:	
Received Date 10/19/2007	30 Days 11/18/07	150 Days 3/17/08	180 Days 4/16/08
Purpose of the ARB:			
Basis for Another ARB:			

REFERRAL

Does Alleger Object to Referral ☐ Yes ☑ No ☐ N/A

If any of the following factors apply, an allegation shall not be referred to the licensee.

- ☐ Information cannot be released in sufficient detail to the licensee without compromising the identity of the alleger of confidential source.
- ☐ The licensee could compromise an investigation or inspection because of knowledge gained from the referral.
- ☐ The allegation is made against the licensee's management or those parties who would normally receive and address the allegation.
- ☐ The basis of the allegation is information received from a Federal or State agency that does not approve of the information being released in a referral.

ARB PARTICIPANTS

Chairman:			

Concern 1	Discipline Engineering	Reactor Department Code Engineering
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

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 for 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 1998 with damage remaining undetected until one of the valves failed in 1993.

Regulatory Requirement:

Test/Design Control

Safety Significance - N/A

Basis:

Valves no longer is service.

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 Date	Planned Date

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

Additional Comments

Concern 2	Discipline Engineering	Reactor Department Code Engineering
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

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.

Regulatory Requirement:

TS 5.4.1/Test Control

Safety Significance - N/A

Basis:

Valve no longer in service.

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 3	Discipline Engineering	Reactor Department Code Engineering
Responsible 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

Basis:
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	**RPBB**		

Comments:

Additional Comments

Concern 4	Discipline Chilling Effect	Reactor Department Code Engineering
Responsible Branch: RPBB	OI Case Number:	

Concern Description:
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 5	Discipline Safety Culture	Reactor Department Code 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 Requirement:

SCWE

Safety Significance - Normal

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?

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 6	Discipline Operations	Reactor Department Code Operations
Responsible Branch: RPBB	OI Case Number:	

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 and

one half years for Operations to fully staff the fire brigade?

Regulatory Requirement:
None

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?

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 7	Discipline Safety Culture	Reactor Department Code Operations
Responsible Branch: 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:

Safety Significance - Normal

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?

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 8	Discipline Corrective Action	Reactor Department Code Operations
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

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 re-classified and addressed prior to recurrence of an adverse condition?

Regulatory Requirement:

Safety Significance - Normal

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?

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 9	Discipline Corrective Action	Reactor Department Code Operations
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

CAR (b)(7)(C) (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.

Regulatory Requirement:
Criterion XVI

Safety Significance - Normal

Basis:
Problem may still be occurring.

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 10	Discipline Other	Reactor Department Code Modifications
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?

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

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-visiited.

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 alleger 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: <haf@nrc.gov>
Date: 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!!!

(b)(7)(C)

(b)(7)(C)

Ameren UE

Callaway Plant

AmerenUE
Callaway Plant

PO Box 620
Fulton, MO 65251

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

ULNRC 05469

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
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.

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

January 18, 2008

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

FROM: Harry A. Freeman, Senior Allegation Coordinator

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

The licensee has replied to our December 7, 2007, referral related 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 February 1, 2008. Your response should address the concerns listed in the attached concerns list. Please provide a **brief/direct answer stating what was done and what was found**. State whether the concern was substantiated, unsubstantiated, 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 the 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 conclude that the response was not adequate, provide a recommendation for additional NRC action.

Should you have any questions, please call me.

Attachments:
As Stated

cc w/attachment:
Allegation File

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 B

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 February 26, 2008. The allegation is currently 123 days old. Your response should address the concerns listed in the attached concerns list. Please provide a **brief/direct answer stating what was done and what was found**. State whether the concern was substantiated, unsubstantiated, 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 the 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 conclude that the response was not adequate, provide a recommendation for additional NRC action.

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.

Ameren UE

CALLAWAY NUCLEAR PLANT
P. O. Box 620
Fulton, MO 65251

FAX No. (b)(7)(C)

Verification No.

Message Transmitted By:
(b)(7)(C)

Date: 2/13/08

Time: 11:30 ☒ A.M. ☐ P.M.

DO NOT USE RED INK OR PENCIL

TOTAL PAGES: 10

To: Mr. Harry Freeman
Company: NRC Region IV
Receiving FAX 817-276-6525
Verification No.

From:
Extension:

☐ Discard ☐ Mail to Receiving Party (Please provide address) ☐ Return to Sender

Instructions to Receiving Operator:

CA0021
01/21/98
N/A

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

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 (b)(7)(C) 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)(7)(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 (b)(7)(C) 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 (b)(7)(C) (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.

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.

FINAL QA REVIEW
RIV-2007-A-0117

Performed by: Eduardo D. Uribe Date: June 4, 2008

Y/N	NA	#	Audit Attribute	Comments
1.0	**RECEIVING ALLEGATIONS**			
Y		1.1	Allegations received were forwarded to ACES within 5 days.	
Y		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 CI 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	**ALLEGATION REVIEW BOARD**			
Y		2.1	Allegations were reviewed by an ARB within 30 days after the allegation was received in Region IV.	
Y		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.	
Y		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.	

FINAL QA REVIEW
RIV-2007-A-0117

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.	
	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	**ACKNOWLEDGING ALLEGATIONS**			
Y		3.1	Letters issued within 30 days	Ack. Letter was not sent to the individual
Y		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	**INSPECTIONS**			
	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	**ALLEGATION RESOLUTION DOCUMENTATION**			
Y		5.1	Allegation was resolved in a timely manner, given the circumstances of the issue(s).	
Y		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	

FINAL QA REVIEW
RIV-2007-A-0117

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	**PERIODIC STATUS/MANAGEMENT REVIEWS**			
	NA	6.1	Status letters were issued in writing every 6 months for cases open greater than 180 days	
	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	**LICENSEE REFERRALS**			
Y		7.1	Referral criteria are met.	
Y		7.2	Referral letters provide sufficient information for the licensee to resolve the issue.	
Y		7.3	Licensee evaluations are independent and thorough.	
Y		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	
Y	NA	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	**STATE REFERRALS**			
	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	

FINAL QA REVIEW
RIV-2007-A-0117

Y/N	NA	#	Audit Attribute	Comments
	NA		extraneous information	
	NA	8.6	Referral letter provide sufficient information for review of the issue(s).	
	NA	8.7	If CI objected to referral to the State, the referral was made, but a request not to send the issue to the licensee was made.	
	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	**OTHER GOVERNMENT 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 CI's name was not released without the CI'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	**DISCRIMINATION 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.	
	NA	10.6	OI synopses are transmitted to DOL participants as appropriate.	
11.0	**AMS/ALLEGATION FILE**			
Y		11.1	All documentation from the CI which identifies the CI is stamped "THIS DOCUMENT IDENTIFIES AN ALLEGER."	Email pages not stamped.

FINAL QA REVIEW
RIV-2007-A-0117

Y/N	NA	#	Audit Attribute	Comments
Y	JLW	[redacted]	AMS is accurate and correctly indicates concerns, follow-up and disposition. A "file closed" entry was made in AMS.	
Y	JLW	[redacted]	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.	
	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	JLW	[redacted]	E-mail responsible branch that file is closed.	

L. Criscione RIV-2007-A-0117

bcc:
Allegation File

SENDER: COMPLETE THIS SECTION

- 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 mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Lawrence Criscione
1412 Dial Court
Springfield, IL 62704

7-A-0117

2. Article Number (Transfer from service label) (b)(7)(C)

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature (b)(7)(C) ☒ Agent ☐ Addressee

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

MAR 11 2008 USPS

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

3-6-08

(b)(7)(C)

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Total Postage & Fees	$

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Sent To: Lawrence Criscione
Street, Apt. No.; or PO Box No.
City, State, ZIP+4

PS Form 3800, August 2006 See Reverse for Instructions

SUNSI Review Completed: HAF ADAMS: ☐ Yes ■ No Initials: HAF
☐ Publicly Available ■ Non-Publicly Available ■ Sensitive ☐ Non-Sensitive
DOCUMENT NAME: Non Responsive Record
Non Responsive Record

OFFICE	RIV:SAC	C:RPBB	D:DRP		
NAME	HAFreeman	VGGaddy	DDChamberlain		
	/RA/	VGG	DDC		
DATE	02/23/2008	2/28/2008	3/6/2008		

OFFICIAL RECORD COPY T=Telephone E=E-mail F=Fax

L. Criscione

RIV-2007-A-0117

bcc:
Allegation File

SENDER: COMPLETE THIS SECTION

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1. Article Addressed to:

Mr. Lawrence Criscione
1412 Dial Court
Springfield, IL 62704

7-4-0117

COMPLETE THIS SECTION ON DELIVERY

A. Signature: X (b)(7)(C)
Agent ☐ Addressee

B. Received by (Printed Name) (b)(7)(C) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

MAR 11 2008

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

3-6-08

(b)(7)(C)

Article Number (Transfer from service label) 7004 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

(b)(7)(C)

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Total Postage & Fees	$

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Street, Apt. No.; or PO Box No.:
City, State, ZIP+4:

PS Form 3800, August 2006 See Reverse for Instructions

SUNSI Review Completed: HAF ADAMS: ☐ Yes ■ No Initials: HAF
☐ Publicly Available ■ Non-Publicly Available ■ Sensitive ☐ Non-Sensitive
DOCUMENT NAME: Non Responsive Record
(b)(7)(F), (b)(8), Non

OFFICE	RIV:SAC	C:RPBB	D:DRP		
NAME	HAFreeman	VGGaddy	DDChamberlain		
	HAF	VGG	DDC		
DATE	02/23/2008	2/28/2008	3/6/2008		

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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

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 (b)(7)(C) 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 (b)(7)(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?

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.

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)(7)(C) (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.

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 must 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.

Sincerely,

Arthur T. Howell III, Director
Division of Reactor Projects

Enclosure:
Statement of Concerns

Docket: 50-483
License: NPF-30

Allegedly:

Concern 1 S

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 N

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 9

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 4

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?

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 re-classified and addressed prior to recurrence of an adverse condition?

Concern 8

CAR (b)(7)(C) (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

SUNSI Review Completed: HAF ADAMS: ☐ Yes ■ No Initials: HAF
☐ Publicly Available ■ Non-Publicly Available ■ Sensitive ☐ Non-Sensitive
DOCUMENT NAME: Non Responsive Record
Non Responsive Record

OFFICE	RIV:SAC	C:RPBB	D:DRP	
NAME	HAFreeman	VGGaddy	ATHowell	
		/RA/ for VGG		
DATE	11/30/2007	12/4/2007	12/7/2007	

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

COPY

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,

/for/ Judith Walker

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

During Fall 06, your client 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 modification to correct the problem until December 2006. The modification 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, your client is concerned this is an indication of inadequate design engineering staffing or is it an indication of inadequate design engineering experience.

Concern 4

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, your client is concerned that Callaway Plant does not value experienced engineers who are capable of properly assessing nuclear safety concerns.

Concern 5

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. Your client is concerned that this issue was not addressed. In Nov 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, the issue is not included in the meeting minutes.

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

CAR (b)(7)(C) (documents inappropriate control of the qualification process for a main control room watch station) was assigned to the individual that manages this process. Your client is concerned that adverse conditions are 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 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.

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 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 mailpiece, or on the front if space permits.

1. Article Addressed to:
Ms. Debra S. Katz
Katz, Marshall & Banks, LLP
1718 Connecticut Avenue, NW
Sixth Floor
Washington, DC 20009

7-A-0117

Article Number
(Transfer from ser... (b)(7)(C)

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(b)(7)(C)

(b)(7)(C)

C. Date of Delivery 11/15/07

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☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

11/16/07

3 Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

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
	JRG for	KDF	VGG			
DATE	11/15/2007	11/16/2007	11/16/2007	11/16/2007	11/14/2007	11/ /2007

OFFICIAL RECORD COPY T=Telephone E=E-mail F=Fax

D. Katz

RIV-2007-A-0096

NOV 16 2007

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

(b)(7)(C)

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Street, Apt. No.; or PO Box No. 1718 Connecticut Ave, NW
City, State, ZIP+4 Washington, DC 20009

PS Form 3800, June 2002 See Reverse for Instructions

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/	/RA/	/RKCaniano for RA/	/AVegel for RA/	JLW 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 DISPOSITION RECORD			Allegation Number: RIV-2007 -A-0117
Facility Name: Callaway Plant		Docket Number: 50-483	
Responsible Division: DRP		ARB Date: 10/29/2007	
Received Date	30 Days	150 Days	180 Days
10/19/2007	11/18/2007	03/17/2008	04/16/2008
Purpose of the ARB:	Initial		
Basis for Another ARB:	After RPBB's review of concerns 4 and 5.		

REFERRAL

Does Alleger Object to Referral ☐ Yes ☑ No ☐ N/A

If any of the following factors apply, an allegation shall not be referred to the licensee.

- ☐ Information cannot be released in sufficient detail to the licensee without compromising the identity of the alleger of confidential source.
- ☐ The licensee could compromise an investigation or inspection because of knowledge gained from the referral.
- ☐ The allegation is made against the licensee's management or those parties who would normally receive and address the allegation.
- ☐ The basis of the allegation is information received from a Federal or State agency that does not approve of the information being released in a referral.

ARB PARTICIPANTS

Chairman:			
AVegel	RCaniano	RDeese	CHolland
KFuller	JWalker	HFreeman	AFairbanks
ATGody	DPowers	MHaire	

Concern 1	Discipline: Engineering	Reactor Department Code: Engineering
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

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 for 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.

Regulatory Requirement:

Design Control/Corrective Actions/Criterion XVI

Safety Significance - Select...

Basis:

Low Safety Significance- Basis: Conditions that caused damage has not occurred since the last inspection/maintenance.

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 2	Discipline	Reactor Department Code
	Engineering	Engineering

Responsible Branch: RPBB | OI Case Number:

Concern Description:

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.

Regulatory Requirement:

TS 5.4.1/Test Control

Safety Significance - Select...

Basis:

Low Safety Significance- Basis: Conditions that caused damage has not occurred since the last inspection/maintenance.

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 3	Discipline	Reactor Department Code
	Engineering	Engineering

Responsible 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:
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 Licensee for Response	ACES	10/29/2007	

Comments: RPBB to review response.

Additional Comments

Concern 4	Discipline	Reactor Department Code
	Chilling Effect	Engineering

Responsible Branch: RPBB | OI Case Number:

Concern Description:
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:
Criterion XVI

Safety Significance - 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?

☐ 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
Other (Describe)	**RPBB**	10/29/2007	11/13/2007
Comments:	RPBB to review concern again for clarification before referring.		

Action	Assigned Branch	Assigned Date	Planned Date
Other (Describe)	**ACES**		
Comments:	Bring back to ARB after RPBB's review.		

Additional Comments

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 Requirement:

SCWE

Safety Significance - Normal

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?

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

Action	Assigned Branch	Assigned Date	Planned Date
Other (Describe)	**RPBB**	10/22/2007	
Comments:	RPBB to Review past history of previous allegation related to this issue.		

Action	Assigned Branch	Assigned Date	Planned Date
No Further Action	**ACES**	11/13/2007	

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

Additional Comments

Concern	6	Discipline	Reactor Department Code
		Operations	Operations

Responsible Branch:	RPBB	OI Case Number:	

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 and 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?

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	7	Discipline	Reactor Department Code
		Safety Culture	Operations

Responsible Branch:	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 Branch	Assigned Date	Planned Date
Refer to Licensee for Response	ACES	10/29/2007	

Comments: RPBB to review response.

Additional Comments

Concern	8	Discipline	Reactor Department Code
		Corrective Action	Operations

Responsible Branch: RPBB | OI Case Number:

Concern Description:
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 re-classified and addressed prior to recurrence of an adverse condition?

Regulatory Requirement:
Criterion XVI

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 Branch	Assigned Date	Planned Date
Refer to Licensee for Response	ACES	10/29/2007	

Comments: RPBB to review response.

Additional Comments

Concern 9	Discipline: Corrective Action	Reactor Department Code: Operations
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

CAR (b)(7)(C) (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.

Regulatory Requirement:

Criterion XVI

Safety Significance - Select...

Basis:

Safety Significance- Low Problem may still be occurring.

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 10	Discipline: Other	Reactor Department Code: Modifications
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?

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

Action	Assigned Branch	Assigned Date	Planned Date
Forward to Licensee for Information	**ACES**	10/29/2007	

Comments:

Additional Comments

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

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

What requirement/regulation governs this concern?
50.59

What records should the NRC review?
Mod package

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?
Yes

Why was the concern brought to the NRC's attention?
Not satisfied with management's response

CONCERN 2

Summary of Concern (be brief)
Inadequate staffing in the Fire Brigade - 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.
Fire Brigade can't be staffed w/o overtime

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)

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?
Yes,

Why was the concern brought to the NRC's attention?
Not satisfied with management' response

THIS DOCUMENT IDENTIFIES AN ALLEGER

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 INFORMATION

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 ☑ No
Referral ☑ Yes ☐ No	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? ☐ Yes ☑ No	Does the individual object to releasing their identity? ☐ Yes ☑ No
Regulations prohibit NRC licensees (including contractors and subcontractors) from discriminating against individuals who engage in protected activities (alleging violations of regulatory requirements, refusing to engage in practices made unlawful by statutes, etc.).	
Does the concern involve discrimination? ☐ Yes ☑ No	Was the individual advised of the DOL process? ☐ Yes ☑ No
What was the protected activity? When did it occur? I	
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 being 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 engaging in a protected activity?	

THIS DOCUMENT IDENTIFIES AN ALLEGER

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 (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?

5. As already noted, CAR (b)(7)(C) had a component to it which concerned the inadequate resolution of an issue when earlier identified in the Corrective Action Process. CAR (b)(7)(C) 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 (b)(7)(C)) 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)(7)(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 DISPOSITION RECORD		Allegation Number: RIV-2007 -A-0117	
Facility Name: Callaway Plant		Docket Number: 50-483	
Responsible Division: DRP		ARB Date: 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 RPBB reviews Concerns 4 and 5.		
Basis for Another ARB:			

REFERRAL

Does Alleger Object to Referral ☐ Yes ☑ No ☐ N/A

If any of the following factors apply, an allegation shall not be referred to the licensee.

- ☐ Information cannot be released in sufficient detail to the licensee without compromising the identity of the alleger of confidential source.
- ☐ The licensee could compromise an investigation or inspection because of knowledge gained from the referral.
- ☐ The allegation is made against the licensee's management or those parties who would normally receive and address the allegation.
- ☐ The basis of the allegation is information received from a Federal or State agency that does not approve of the information being released in a referral.

ARB PARTICIPANTS

Chairman:			
AVegel	RCaniano	MShannon	DWhite
VGaddy	JWalker	HFreeman	CMaier
JGroom	MVasquez		

Concern 1	Discipline Engineering	Reactor Department Code Engineering
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

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 for 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.

Regulatory Requirement:

Design Control/Corrective Actions/Criterion XVI

Safety Significance - Select...

Basis:

Low Safety Significance- Basis: Conditions that caused damage has not occurred since the last inspection/maintenance.

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 2	Discipline: Engineering	Reactor Department Code: Engineering

Responsible Branch: RPBB | OI Case Number:

Concern Description:

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.

Regulatory Requirement:

TS 5.4.1/Test Control

Safety Significance - Select...

Basis:

Low Safety Significance- Basis: Conditions that caused damage has not occurred since the last inspection/maintenance.

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 3	Discipline: Engineering	Reactor Department Code: Engineering

Responsible 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:
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 Licensee for Response	ACES	10/29/2007	

Comments: RPBB to review response.

Additional Comments

Concern 4	Discipline	Reactor Department Code
	Chilling Effect	Engineering

Responsible Branch: RPBB | OI Case Number:

Concern Description:
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...

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?

☑ 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
Other (Describe)	RPBB	10/29/2007	11/13/2007
Comments:	RPBB to review concern again for clarification before referring.		

Action	Assigned Branch	Assigned Date	Planned Date
Refer to Licensee for Response	ACES	11/26/2007	
Comments:			

Action	Assigned Branch	Assigned Date	Planned Date
Review Licensee Response	RPBB		
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 Requirement:
SCWE

Safety Significance - Normal

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?

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

Action	Assigned Branch	Assigned Date	Planned Date
Other (Describe)	RPBB	10/22/2007	

Comments:	RPBB to Review past history of previous allegation related to this issue.

Action	Assigned Branch	Assigned Date	Planned Date
Provide Basis for Closure	**RPBB**	11/26/2007	
Comments:			

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 6	Discipline Operations	Reactor Department Code Operations
Responsible Branch: RPBB	OI Case Number:	

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 and 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?

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 7	Discipline Safety Culture	Reactor Department Code Operations
Responsible Branch: 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 Branch	Assigned Date	Planned Date
Refer to Licensee for Response	ACES	10/29/2007	

Comments: RPBB to review response.

Additional Comments

Concern 8	Discipline: Corrective Action	Reactor Department Code: Operations
Responsible Branch: RPBB	OI Case Number:	

Concern Description:

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 re-classified and addressed prior to recurrence of an adverse condition?

Regulatory Requirement:

Criterion XVI

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 Branch	Assigned Date	Planned Date
Refer to Licensee for Response	ACES	10/29/2007	

Comments: RPBB to review response.

Additional Comments

Concern 9	Discipline: Corrective Action	Reactor Department Code: Operations

Responsible Branch: RPBB | OI Case Number:

Concern Description:

CAR (b)(7)(C) (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.

Regulatory Requirement:

Criterion XVI

Safety Significance - Select...

Basis:

Safety Significance- Low Problem may still be occurring.

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 10	Discipline: Other	Reactor Department Code: Modifications

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?

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

Action	Assigned Branch	Assigned Date	Planned Date
Forward to Licensee for Information	ACES	10/29/2007	

Comments:

Additional Comments

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-visiited.

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