



Callaway Plant

September 17, 2015

ULNRC-06244

U.S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, DC 20555-0001

10 CFR 50.73(a)(2)(iv)

Ladies and Gentlemen:

**DOCKET NUMBER 50-483  
CALLAWAY PLANT UNIT 1  
UNION ELECTRIC CO.  
RENEWED FACILITY OPERATING LICENSE NPF-30  
LICENSEE EVENT REPORT 2015-002-00  
MANUAL AUXILIARY FEEDWATER ACTUATION**

The enclosed licensee event report is submitted in accordance with 10CFR50.73(a)(2)(iv)(A) to report a manual actuation of the auxiliary feedwater system.

This letter does not contain new commitments.

Sincerely,

Barry L. Cox  
Senior Director, Nuclear Operations

Enclosure

ULNRC-06244  
September 17, 2015  
Page 2

cc: Mr. Marc L. Dapas  
Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region IV  
1600 East Lamar Boulevard  
Arlington, TX 76011-4511

Senior Resident Inspector  
Callaway Resident Office  
U.S. Nuclear Regulatory Commission  
8201 NRC Road  
Steedman, MO 65077

Mr. L. John Klos  
Project Manager, Callaway Plant  
Office of Nuclear Reactor Regulation  
U. S. Nuclear Regulatory Commission  
Mail Stop O-8B1  
Washington, DC 20555-2738

ULNRC-06244  
September 17, 2015  
Page 3

**Index and send hardcopy to QA File A160.0761**

**Hardcopy:**

Certrec Corporation  
4150 International Plaza Suite 820  
Fort Worth, TX 76109  
(Certrec receives ALL attachments as long as they are non-safeguards and may be publicly disclosed.)

**Electronic distribution for the following can be made via LER ULNRC Distribution:**

F. M. Diya  
D. W. Neterer  
L. H. Graessle  
B. L. Cox  
T. E. Herrmann  
S. A. Maglio  
T. B. Elwood  
Corporate Oversight  
Corporate Communications  
NSRB Secretary  
Performance Improvement Coordinator  
Resident Inspectors (NRC)  
STARS Regulatory Affairs  
Mr. John O'Neill (Pillsbury Winthrop Shaw Pittman LLP)  
Missouri Public Service Commission

**LICENSEE EVENT REPORT (LER)**  
(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to [infocollections.Resource@nrc.gov](mailto:infocollections.Resource@nrc.gov), and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

<b>1. FACILITY NAME</b> Callaway Plant Unit 1	<b>2. DOCKET NUMBER</b> 05000483	<b>3. PAGE</b> 1 OF 5
--	-------------------------------------	--------------------------

**4. TITLE**  
Manual Auxiliary Feedwater System Actuation

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
07	23	2015	2015	- 002 -	00	09	17	2015	FACILITY NAME	DOCKET NUMBER
									FACILITY NAME	DOCKET NUMBER

<b>9. OPERATING MODE</b>  1	<b>11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§:</b> (Check all that apply)									
	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
<b>10. POWER LEVEL</b>  100%	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)						
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)						
	<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER						
	<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A						

**12. LICENSEE CONTACT FOR THIS LER**

FACILITY NAME T.B. Elwood, Supervising Engineer, Regulatory Affairs and Licensing	TELEPHONE NUMBER (include Area Code) 314-225-1905
--	--

**13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT**

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

<b>14. SUPPLEMENTAL REPORT EXPECTED</b> <input checked="" type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input type="checkbox"/> NO	<b>15. EXPECTED SUBMISSION DATE</b> MONTH: 06, DAY: 15, YEAR: 2016
--	---

**ABSTRACT** (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

During plant cooldown in response to conditions reported to the NRC on July 23, 2015 in Event Notification 51253, Callaway was in Mode 3 (Hot Standby) and on the way to Mode 5 (Cold Shutdown). In accordance with cooldown procedures, Callaway was operating with one Main Feedwater Pump (MFP) when the pump speed unexpectedly lowered to 0 RPM. The pump was manually tripped in response to the condition. This led to a decrease in water level in the steam generators. Operators manually activated the Auxiliary Feedwater System to maintain water level in the steam generators. This system actuation is reportable per 10CFR50.73(a)(2)(iv)(A).

Fault tree analysis and subsequent testing identified the most probable cause for the loss of the 'B' MFP is a software defect introduced during the software development process for the digital feedwater control system installed in 2013. However, further investigation and consultation with the software design firm for the control system is required to identify a definitive root cause. Thus, a supplemental LER will need to be submitted to update the root cause and corrective actions.

**LICENSEE EVENT REPORT (LER) U.S. NUCLEAR REGULATORY COMMISSION  
CONTINUATION SHEET**

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE	
Callaway Plant Unit 1	05000483	YEAR	SEQUENTIAL NUMBER	REV NO.	2	OF 5
		2015	- 002	- 00		

**NARRATIVE**

**1. DESCRIPTION OF STRUCTURE(S), SYSTEM(S) AND COMPONENT(S):**

The main feedwater system [EIIS System SJ] supplies feedwater to the secondary side of the steam generators [EIIS Component SG] in order to remove heat from the reactor coolant system (RCS) [EIIS System AB] during normal operations. The system consists of two main feedwater pumps (MFPs) [EIIS System SJ Component P] and one startup feedwater pump, which is only used for very low-power conditions.

The MFPs are controlled by a digital control system, which is operated via touch screen controls in the main control room.

The safety-related auxiliary feedwater (AFW) system [EIIS System BA] supplies feedwater to the steam generators to remove decay heat from the reactor coolant system upon the loss of the normal feedwater supply via either manual actuation or automatic response to an Auxiliary Feedwater Actuation Signal (AFAS). The auxiliary feedwater system may also be used following a reactor shutdown to cool the reactor coolant system to below approximately 350 degrees Fahrenheit and 400 psi gauge.

**2. INITIAL PLANT CONDITIONS:**

On July 23, 2015 at 0115, Callaway Plant operators initiated a shutdown required by Technical Specification (TS) 3.4.13, "RCS Operational Leakage," as reported to the NRC in Event Notification 51253. At 1357 Callaway was in Mode 3 (Hot Standby) and on the way to Mode 5 (Cold Shutdown). The plant was being operated per procedure with one MFP supplying feedwater flow to the steam generators. The startup feedwater pump was unavailable due to a fire protection requirement to have its breaker [EIIS Component BKR] in the racked out position.

**3. EVENT DESCRIPTION:**

On July 23, 2015, during a plant shutdown, main feedwater flow was lost to all four steam generators. A manual actuation of the auxiliary feedwater system was performed to prevent a reactor trip signal and AFAS. As described in Section 2 above, the plant was in Mode 3 at the time of the manual actuation.

Prior to the AFW manual actuation, the balance of plant operator was lowering the 'B' Main Feedwater Pump (MFP) speed manually per procedure via the pump's digital control board to regulate pump differential pressure (dP). After performing the manual speed decrease, the operator turned his attention to other main control board indications. A 'B'MFP vibration annunciator returned the operator's attention to the digital feedwater control indications at 1333. He noticed that the discharge valve position and pump speed demand went to 0 percent and 0 RPM respectively and the pump was

U.S. NUCLEAR REGULATORY COMMISSION

**LICENSEE EVENT REPORT (LER)**  
**CONTINUATION SHEET**

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE	
Callaway Plant Unit 1	05000483	YEAR	SEQUENTIAL NUMBER	REV NO.	3	OF 5
		2015	- 002	- 00		

**NARRATIVE**

coasting down. No pump trip alarms were received.

An equipment operator was dispatched to investigate the 'B' MFP and reported a metallic banging sound. This was later confirmed to be the main feedwater pump turbine 'B' low pressure steam line check valve. While the equipment operator was investigating the pump locally, the control room operator was able to control pump speed manually using both increase and decrease pushbutton commands. When the equipment operator reported to the control room that he heard an unusual noise at the pump, the decision was made to trip the pump at 1342.

The 'A' MFP had been tripped earlier during the plant down-power, per procedure. The startup feed pump is not maintained in a standby condition, so was unavailable. Therefore, following the 'B' MFP trip all main feedwater sources were unavailable. With none of the normal sources of main feedwater readily available and 'D' steam generator level approaching 23%, the decision was made to put the AFW system in service to establish makeup to the steam generators.

Following the procedure for a manual AFW actuation, the operators manually closed all four AFW Discharge Control Valves (ALHV0005, ALHV0007, ALHV0009, and ALHV0011) to prevent unnecessary water hammer and thermal shock in the steam generators. When the operators attempted to reopen ALHV0011, the valve did not respond. After no response was received, the operator reduced the valve demand to 0% on the main control board. An equipment operator was dispatched to the valve to manually open the valve. The operator locally opened ALHV0011. After this local action, control was restored from the main control board.

**4. ASSESSMENT OF SAFETY CONSEQUENCES:**

The actual and potential safety consequences of the loss of the Main Feedwater system are not significant, as Main Feedwater is not a safety-related system. By design, the safety-related Auxiliary Feedwater system performs the credited function of supplying feedwater to the steam generators in the event of a postulated accident. In addition, the deterministic Accident Analysis includes evaluation of an assumed or postulated complete loss of feedwater supply from the Main Feedwater system to the steam generators. Thus, the loss of Main Feedwater delivery leading to the manual AFW actuation was consistent with the results contained in the Accident Analysis of record.

When called upon for this event, the Auxiliary Feedwater system was able to perform its specified safety function despite the anomalous behavior of the ALHV0011 valve. (The ALHV0011 issue, which itself is not reportable, was subsequently corrected). Postulating reasonable and credible alternative conditions, including normal plant operating conditions (Mode 1) and accident conditions, would have no impact on the significance of loss of Main Feedwater as these conditions are accounted for in the Accident Analysis of record.

**LICENSEE EVENT REPORT (LER) U.S. NUCLEAR REGULATORY COMMISSION  
CONTINUATION SHEET**

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE	
Callaway Plant Unit 1	05000483	YEAR	SEQUENTIAL NUMBER	REV NO.	4	OF
		2015	- 002	- 00		

**NARRATIVE**

**5. REPORTING REQUIREMENTS:**

This LER is submitted pursuant to 10 CFR 50.73(a)(2)(iv)(A) to report an Auxiliary Feedwater system actuation.

Specifically, 10 CFR 50.73(a)(2)(iv) states in part, "The licensee shall report:

(A) Any event or condition that resulted in manual or automatic actuation of any of the systems listed in paragraph (a)(2)(iv)(B) of this section...

(B) The systems to which the requirements of paragraph (a)(2)(iv)(A) of this section apply are:

(6) PWR auxiliary or emergency feedwater system."

The auxiliary feedwater system was manually actuated in response to a decrease in water level in the steam generators following the MFP trip. This fulfills the reporting requirement of 10 CFR 50.73(a)(2)(iv)(A) due to actuation of the system specified in 10 CFR 50.73(a)(2)(iv)(B)(6).

**6. CAUSE OF THE EVENT:**

The manual actuation of the auxiliary feedwater system was necessitated by the manual trip of the 'B' MFP. Following the event, the main feedwater digital control touchscreen from the main control room was replaced. The touchscreen removed from the plant was tested and the failure has not recurred. It is not likely that the touchscreen was the cause of this event. The most likely cause is a software malfunction. The software malfunction has only occurred one time and has yet to be re-created in the test system.

Fault tree analysis and subsequent testing identified the most probable cause for the loss of the 'B' MFP is a software defect introduced during the software development process for the digital feedwater control system installed in 2013. However, further testing and consultation with the software design firm for the control system is required to identify a definitive root cause. Since these tests cannot be performed with the plant online, the testing is currently scheduled during the upcoming refueling outage in April 2016.

**7. CORRECTIVE ACTIONS:**

Since a definitive root cause analysis is delayed until the upcoming refueling outage, correction actions have not been developed. Upon further investigation, these actions will be developed and submitted in a supplemental report. A communication has been issued to all operators to notify all crews of this condition.

U.S. NUCLEAR REGULATORY COMMISSION

**LICENSEE EVENT REPORT (LER)  
CONTINUATION SHEET**

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE	
Callaway Plant Unit 1	05000483	YEAR	SEQUENTIAL NUMBER	REV NO.	5	OF 5
		2015	-	002		

**NARRATIVE**

**8. PREVIOUS SIMILAR EVENTS:**

An Operating Experience (OE) review for Callaway since the main feedwater digital control system was installed in 2013 revealed no other manual actuations of the auxiliary feedwater system due to failure of MFPs or their associated digital control system.