APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-298/94-29

Operating License: DPR-46

Licensee: Nebraska Public Power District
P.O. Box 499
Columbus, Nebraska 68602-0499

Facility Name: Cooper Nuclear Station

Inspection At: Brownville, Nebraska

Inspection Conducted: November 14-18, 1994

Inspectors: D. B. Spitzberg, Ph.D., Senior Emergency Preparedness Analyst (Team Leader)
A. D. McQueen, Emergency Preparedness Analyst
R. A. Kopriva, Senior Resident Inspector

Accompanied by: G. Behtke, Comex Corporation
F. McManus, Comex Corporation

Approved: Blaine Murray 11/30/94
Blaine Murray, Chief, Reactor Inspection Branch Date

Inspection Summary

Areas Inspected: Routine, announced inspection of the licensee's performance and capabilities during an annual exercise of the emergency plan and implementing procedures. The inspection team observed activities in the Control Room (simulator), Technical Support Center, Operational Support Center, and the Emergency Operations Facility.

Results:

- The Control Room Simulator operating crew performed well during the exercise to detect and classify emergency conditions and to make initial notifications to offsite authorities (Section 3.1).

- An exercise weakness was identified for transmission of erroneous and conflicting information to offsite response agencies concerning status of radioactive releases (Section 3.1).

- The Technical Support Center was staffed and activated promptly and worked well as an organization. The challenges to the Technical Support Center analysts were limited by the weak scenario (Section 4.1).

- The Operational Support Center performed their emergency response activities in an effective, professional, and timely manner. Command, control, and communications in the facility were good. Response personnel were trained and familiar with their assigned responsibilities (Sections 5.1-5.2).

- The Emergency Operations Facility was staffed and activated promptly and demonstrated good command and control. Dose projections and protective action recommendations were appropriately made. Direct interfaces in the Emergency Operations Facility between the licensee, NRC, and state of Missouri response personnel were good. Field monitoring teams were effectively used to locate and track th3e plume (Section 6.1).

- The exercise scenario was identified as an exercise weakness, because it was found to be simplistic and minimally challenging, it contained numerous data errors and omissions, and it resulted in negative training in some areas (Section 7.1).

- An emergency preparedness weakness was identified involving errors contained in an Emergency Plan Implementing Procedure that is used for assessing Emergency Action Levels and fission product barrier status (Section 7.1).

- The licensee's exercise critique process was effective in identifying areas in need of corrective action (Section 8.1).

Summary of Inspection Findings:

- Exercise Weakness 298/9324-01 was closed (Section 9.1).
- Exercise Weakness 298/9429-01 was opened (Section 3.1).
- Exercise Weakness 298/9429-02 was opened (Section 7.1).
- Emergency Preparedness Weakness 298/9429-03 was opened (Section 7.1).

Attachment:

Attachment - Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS

During the week of November 14-18, 1994, the reactor was in cold shutdown for a maintenance outage.

2 PROGRAM AREAS INSPECTED (82301)

The licensee's annual emergency preparedness exercise began at 5:30 a.m. on November 16, 1994, thus meeting the criteria for an unannounced, off-hours exercise. Other participants in the exercise included NRC regional base and site teams, the states of Nebraska and Missouri, and county and local officials. The performances of state and local response organizations were evaluated by representatives of the Federal Emergency Management Agency (FEMA), which will issue a separate report.

The scenario consisted of three unrelated events which directly forced the escalation to Alert, Site Area Emergency, and General Emergency. The Alert was driven by a jet pump riser failure initiating event at 5:35 a.m. The riser failure caused localized fuel channel blockages resulting in about 20 percent gap release of fission products. The Site Area Emergency was driven by a small break in a recirculation line at 7:20 a.m. The General Emergency was driven by a reactor core isolation cooling steam line break outside containment. The reactor core isolation cooling steam line break was the source of offsite release via the standby gas treatment system and the elevated release point. The exercise was terminated at 11:30 a.m. shortly after the reactor core isolation cooling steam line was isolated.

The inspectors identified concerns during the course of the exercise, none of which were of the significance of a deficiency as defined in 10 CFR 50.54(s)(2)(ii). The identified concerns were characterized as an exercise weakness or as an area recommended for improvement. An exercise weakness is a finding that a licensee's demonstrated level of preparedness could have precluded effective implementation of the emergency plan in the event of an actual emergency. It is a finding that needs licensee corrective action. Other observations are documented which did not have a significant negative impact on overall performance during the exercise but still should be evaluated and corrected as appropriate by the licensee.

3 CONTROL ROOM (82301-03.02)

The inspectors observed and evaluated the Control Room (simulator) staff as they performed tasks in response to the exercise. These tasks included detection and classification of events, analysis of plant conditions, implementation of corrective measures, notifications of offsite authorities, and adherence to the emergency plan and implementing procedures.

3.1 Discussion

The inspectors observed that the Control Room Simulator personnel performed their duties in a professional manner. The reactor operators were very quick

to identify changing plant parameters, even prior to alarms or annunciation. The shift supervisor performed well to assess and assimilate plant indications. Prompt and accurate classification of an Alert was made by the shift supervisor, along with activation of the site emergency pager call out.

Following the Alert classification, offsite notifications were completed within the required time, and the information provided was accurate with one exception. The licensee's initial Alert notification, completed at 5:56 a.m. to state and local response agencies, indicated that an airborne radioactive release was in progress. At 6:13 a.m., the licensee notified the NRC of the Alert. No information of a release occurring or having occurred was provided. The conflicting information provided by the licensee established the potential for major confusion among the response agencies. The transmission of erroneous and conflicting information concerning status of radioactive releases was identified as an exercise weakness (50-298/9429-01).

The inspectors observed that Control Room personnel used appropriate Emergency Operating Procedures, flow charts, and Emergency Plan Implementing Procedures. The operators were very attentive and aware of plant conditions and status. During the exercise, the following simulator anomalies were noted:

- Immediately following the reactor scram at 5:56 a.m., there appeared to be disparity between the full core display located on the 9-5 panel and the computer program for control rod location. The operators responded properly by initiating alternate rod insertion and recommenced control rod full in verification.

- At about 5:53 a.m., the inspectors noted an apparent anomaly with the off-gas timer. The inspectors noted that the operators promptly identified the initiation of the timer and kept track as the timer timed out. When the automatic actions did not take place when the timer should have timed out, the operators took appropriate actions to accomplish the activities.

Emergency direction, command, and control from the Control Room Simulator was good. A clear chain of command was established along with effective utilization of personnel. Effective repeat back commands were noted throughout the exercise. Communications within the Control Room Simulator and between the Control Room Simulator and the Technical Support Center were good. However, the inspectors noted that the shift supervisor did not provide many shift briefings and, when provided, they included little of the important information on response activities being conducted by the other Emergency Response Facilities. Also, the inspectors noted that Control Room personnel did not appear to be attentive to plant announcements originating from outside the Control Room Simulator.

3.2 Conclusion

The Control Room Simulator operating crew performed well during the exercise to detect and classify emergency conditions and to make initial notifications to offsite authorities. An exercise weakness was identified for transmission

of erroneous and conflicting information to offsite response agencies concerning status of radioactive releases.

4 TECHNICAL SUPPORT CENTER (82301-03.03)

The inspectors observed and evaluated the Technical Support Center staff as they performed the full range of tasks necessary to respond to the exercise scenario. These tasks included detection and classification of events, notification of federal, state, and local response agencies, analysis of plant conditions, formulation of corrective action plans, prioritizing mitigating actions, and formulating recovery and re-entry plans.

4.1 Discussion

The Technical Support Center was activated in a prompt and orderly fashion, and smooth transitions of Command and Control from the Control Room to the Technical Support Center, and later, from the Technical Support Center to the Emergency Operations Facility were executed. Cooper Nuclear Station had a combined Technical Support Center and Operational Support Center. Even though these two Emergency Response Facilities were combined in a single large room, the Technical Support Center and Operational Support Center directors were able to maintain a quiet and business-like environment throughout the exercise.

The Technical Support Center staff worked well as an organization to assess plant conditions and develop mitigation strategies. Because of the weak scenario as discussed in Section 7.1, the challenges provided to the Technical Support Center analysts were limited. The inspectors noted the following two areas of potential improvement in the performance of the Technical Support Center:

- At about 9:47 a.m., a repair team succeeded in terminating the radioactive steam release to the reactor building by shutting the Outboard Isolation Valve MO-16 on the reactor core isolation cooling steam line. The Technical Support Center management continued to place a high priority, however, on shutting isolation valve MO-15 as well. There appeared to be confusion in the Technical Support Center among some staff as to the fact that Valve MO-15 in the reactor core isolation cooling steam line is the inboard isolation valve physically located inside the drywell. Any efforts to mechanically shut the valve would have required an impossible entry to the drywell. Even checking the electrical breaker for the motor operated valve would have required another entry into what would have been a heavily contaminated reactor building. This priority was set without any apparent attempt to verify electrical continuity to the valve from the control room, or a serious consideration of the ALARA implications of another reactor building entry.

- Emergency Plan Implementing Procedure 5.7.16, "Release Rate Determination," method for "Emergency Sampling for Release Rate Activity" (Section 8.6) was not used by either the Technical Support

Center or the Emergency Operations Facility dose assessment teams to determine the iodine fraction in the release from the elevated release point. The inspectors also noted that even if the licensee had used a sampling technique to determine iodine fraction, the existing dose projection programs in use by the licensee have no provision for the direct input of an iodine-noble gas ratio.

4.2 Conclusions

The Technical Support Center was staffed and activated promptly and worked well as an organization. The challenges to the Technical Support Center analysts were limited by the weak scenario.

5 OPERATIONAL SUPPORT CENTER (82301-03.05)

The inspectors evaluated the performance of the Operational Support Center staff as they performed tasks in response to the exercise. These tasks included activation of the Operational Support Center and its effectiveness in providing support to operations, including the coordination of emergency in-plant response teams.

5.1 Discussion

The Operational Support Center was activated in a timely, efficient manner. The Operational Support Center was properly equipped to perform its function. No indications of Operational Support Center staff prepositioning were observed prior to the facility's activation. The Operational Support Center was staffed with a sufficient number of individuals with appropriate expertise. Due to their integration and collocation, the Technical Support Center was able to keep directly informed of activities being implemented by the Operational Support Center. During staffing of the Operational Support Center, the inspectors noted that the facility sign-in sheets did not contain an entry space for arrival time. Such information could be useful for prolonged activations or for staff relief considerations. This was identified as an area for potential improvement.

The Operational Support Center section supervisors for chemistry/health physics, maintenance/instrumentation and control, and electrical exercised direct and personal command and control with technicians. The center exhibited good teamwork and coordination among the section supervisors. A detailed chronological log was kept by the chemistry/health physics supervisor indicating team radio updates and other activities under his purview. Location, tasks, and exposures of in-plant teams were adequately monitored by the chemistry/health physics supervisor. Operational Support Center habitability was confirmed and periodically assessed in conjunction with the Technical Support Center.

The Operational Support Center activities were adequately controlled by the controllers at the Operational Support Center; however, it was indicated by a licensee controller prior to the exercise that controllers were not specifically assigned to response teams, since there was no way to know how many or what types of teams would be dispatched. The only status board used

in the Operational Support Center was the team dispatch board, a cork board on which was posted copies of the Team dispatch/tracking form. It was observed that the tracking forms did not consistently contain all the information specified in Emergency Plan Implementing Procedure 5.7.15. The missing information related to such things as briefing and dispatch times and task objective. The tracking form entry omissions were identified as an area for potential improvement.

5.2 In-plant Teams

The inspectors accompanied in-plant teams, 8 and 13, to observe conduct of team response. Both teams exhibited good teamwork and coordination. The teams' activities were adequately controlled by the exercise controllers, and communication with the teams was effectively maintained by the Operational Support Center. Team personnel demonstrated proficiency in the use of equipment and proper concern for ALARA and contamination control. Although predispatch briefings for the in-plant teams were not documented in any detail and were not conducted in any structured manner, the teams were adequately briefed prior to departure. The health physics supervisor kept himself informed of radiological conditions in the plant and kept teams informed of this information as it related to their assignments. The teams observed implemented appropriate protective measures for the activity assigned.

Generally, the teams performed effectively; however, the following minor problems were noted for potential improvement.

- Team 8 was formed to obtain a Post-Accident Sampling System (PASS) sample. The Control Room had issued the team a key to the padlocks in the PASS panel allowing "jet pump" valve manipulation. Upon arrival to the PASS area, the team found that it had been issued the wrong key. A phone call to the Control Room identified the correct key. This error resulted in a preventable delay of several minutes in the acquisition of the PASS sample.

- As required by procedure (Cooper Nuclear Station Operations Manual Chemistry Procedure 8.4.1.1, Section 8.6.2), the Control Room was requested to open ". . . drywell equipment drain valves MO-92 and MO-93." The Control Room indicated that MO-93 was open, but that MO-92 was closed and was interlocked so that it could not be opened while MO-93 was open. A subsequent call back from the Control Room indicated there was a bypass switch in the control room which would permit them to take the action indicated by the procedure. A review of this procedure by the chemistry group after the exercise, concluded that the procedure could be improved by indicating the existence of the bypass switch option.

5.3 Conclusions

The Operational Support Center performed their emergency response activities in an effective, professional, and timely manner. Command, control, and

communications in the facility were good. Response personnel were trained and familiar with their assigned responsibilities.

6 EMERGENCY OPERATIONS FACILITY (82301-03.04 & 03.07)

The inspectors observed the Emergency Operations Facility staff as they performed tasks in response to the exercise. These tasks included facility activation, classification of events, development and issuance of protective action recommendations, notification of federal, state, and local response agencies, dose assessment and coordination of field monitor teams, analysis of plant conditions, setting action priorities, and direct interactions with the NRC site team and the state response teams.

6.1 Discussion

The inspectors observed that the Emergency Operations Facility was activated in a timely manner, and the staff worked well as an organization. Notification of events to state and local emergency response agencies were promptly ordered by the Emergency Director and executed by the Emergency Operations Facility staff. The emergency director demonstrated the use of classification emergency action levels and protective action recommendation decisionmaking procedures. Classification levels and protective action recommendations were promptly communicated to the off site response agencies.

The Emergency Director and Emergency Operations Facility staff demonstrated a good understanding of plant systems and conditions. Briefings were routinely conducted throughout the exercise. Priorities and action items were established or updated during the briefings. Plant status briefings were conducted frequently which provided appropriate plant conditions and established action priorities for the Emergency Operations Facility staff. Status boards were maintained current and accurate during the exercise.

Communications between the on-site emergency response facilities were demonstrated. No major problems were noted. The inspectors observed that one phone linking the NRC site team with NRC headquarters failed to function properly. The licensee provided an alternate phone for use by the NRC.

Integration of the state of Missouri and the NRC site response teams was accomplished in an prompt and professional manner. The licensee properly briefed each site team and the teams then assumed their functional positions in the Emergency Operations Facility. Because of radiological concerns, the state of Nebraska elected to setup their response team operation from the alternate Emergency Operations Facility, located in Auburn, Nebraska, about 10 miles from the site. Radio communications were established between the site Emergency Operations Facility and the Nebraska team at the alternate Emergency Operations Facility. Following arrival and integration at the site Emergency Operations Facility, the NRC response team dispatched one team member to the alternate Emergency Operations Facility for direct liaison with the Nebraska team. Under such circumstances, the licensee should consider a similar option in order to provide direct face-to-face integration and/or liaison with the state officials. This was identified as an area of potential improvement.

Dose assessments based on plant conditions or release source terms, as appropriate, were accomplished before, during, and after the simulated release. The inspectors noted; however, that the printed dose projections from the CNS DOSE computer program did not reflect accurately the correct time the projection was executed. The time had to be handwritten on the printout. The result was that two, potentially confusing, times appeared on the dose projection printouts. The problem appeared to be with the use of the program edit function employed by the operator when changing one or two of the inputs to the assessment program. The computer time did not update when the edit mode was used. When a complete new data set was input, the computer updated the time on the printout properly. The operator used the edit mode, because it was faster than inputting complete data sets. This observation was identified as an area for potential improvement.

Field monitoring teams were dispatched to downwind stations prior to the release and were used effectively to locate and track the plume after the release began. A Missouri field team was used to augment and assist the site teams in plume detection and tracking.

6.2 Conclusions

The Emergency Operations Facility was staffed and activated promptly and demonstrated good command and control during the exercise. Dose projections and protective action recommendations were appropriately made. Direct interfaces in the Emergency Operations Facility between the licensee, NRC, and state of Missouri response personnel were good. Field monitoring teams were effectively used to locate and track the plume.

7 SCENARIO AND EXERCISE CONDUCT (82301)

The inspectors made observations during the exercise to assess the challenge and realism of the scenario and to evaluate the conduct of the exercise.

7.1 Discussion

The inspectors observed that the scenario for the 1994 exercise presented minimal technical challenge for a scenario which escalated to General Emergency. In addition, the scenario radiological data was not representative of the consequences associated with the sequence of unrelated system failures simulated. Although the scenario faults did not significantly affect meeting exercise objectives, they provided negative training in terms of what should be expected both radiologically and thermal-hydraulically during events of this nature. While most of the radiological data errors appeared to be the result of improper assumptions on the part of the scenario authors, some errors such as the minimal radiological impact in the reactor building following the reactor core isolation cooling steam line break were introduced to provide an exercise termination success path for the participants. The scenario was still undergoing significant revision on the evening before the exercise. The following specific scenario problems were among those noted which supported this apparent weakness:

- Radiological data in the exercise scenario was not realistic. Examples include:

  - The scenario initiating event at about 5:35 a.m. was an approximately 20 percent fuel gap release, caused by a jet pump failure obstructing fuel channel flow. The scenario data immediately increased containment radiation levels to over 2500 Rem/Hour. These high levels were unrealistic considering that no reactor coolant system leakage was occurring into containment.

  - A simulated break in a recirculation line at about 7:20 a.m. resulted in containment radiation increases from around 2500 Rem/Hour up to 3200 Rem/Hour. In reality, this would have been the point in the scenario during which the major containment radiation increase would have been observed (i.e., an increase from an initial value of about 100 Rem/Hour to a value of about 2,000 to 10,000 Rem/Hour).

  - A simulated break in the reactor core isolation cooling steam line at about 9 a.m. was not accompanied by major increases in the reactor building radiation levels. Area radiation monitor data for the lower levels of the reactor building in the vicinity of the break were only increased to unrealistically low values of less than 1 Rem/Hour. One of these increases, in the Torus Room area, was added the evening before the exercise as a result of the NRC inspectors pointing out the existence of an area radiation monitor in the area, and suggesting that it would be significantly affected by the reactor core isolation cooling steam line break.

  - No Continuous Air Monitor System data was available for the reactor building, even after this lack of data was pointed out by the NRC inspectors the day before the exercise. The simulator performance reflected the consequences of not providing scenario data for the Continuous Air Monitor System following the reactor core isolation cooling line break. Reactor building pressure increased to +0.1" H_2O and the reactor building floor drain sump began to fill. These indications caused exercise participants to request Continuous Air Monitor System data.

  - The main steam line monitor data immediately following the gap release at 5:35 a.m., but prior to main steam line isolation and scram at about 5:55 a.m., was ramped up to 10,000 mrem/hour. This scenario data modification was made the evening before the exercise. These values would be indicative of fuel gap failure more on the order of 50 percent than the intended 20 percent.

  - The scenario time line duration for release to atmosphere via the reactor core isolation cooling steam line and the Standby Gas Treatment system was too short (about 25 minutes) to allow the state participants to conduct independent analysis for the purpose of concurring in licensee protective action recommendations.

Scenario controllers had to artificially delay Operational Support Center Team 12 during the exercise in order to provide the extra time needed for the states to meet their exercise objectives.

- Changes to the scenario radiological data continued past 4 p.m. the evening before the exercise. In the course of several queries of the licensee and licensee support contractors as to the origin and basis for the radiological data, no consistent explanation was received. It appeared to the inspectors that the scenario radiological data was developed by several different parties in a disjointed or ad hoc fashion.

- The exercise scenario was simplistic, contained step changes in data nearly identically matching Emergency Action Level trigger points, and provided minimal challenge to Technical Support Center, Operational Support Center, and Emergency Operations Facility analysts. For example, only one major repair task was posed by the scenario. In-plant radiological conditions were not challenging for in-plant teams dispatched by the Operational Support Center because of the minimal and unrealistic radiological impact in the reactor building of the reactor core isolation cooling steam line break. Also, no protective action decisions beyond the initial, automatic protective action recommendations were forced by scenario conditions.

- Unlike other scenarios, the three major events leading to the General Emergency were simple events which were totally unrelated (a recirculation loop jet pump riser failure, a recirculation line break, and a reactor core isolation cooling steam line break).

- The NRC inspectors were unable to receive reliable responses to several technical questions concerning the scenario posed to the licensee after the team's arrival.

The exercise scenario contained numerous significant data errors and omissions, was simplistic, provided minimal challenges, and in some areas, negative training. As a result, the scenario was identified as an exercise weakness (50-298/9429-02).

Because of recent changes to the NRC inspection program for emergency exercises, exercises in the future will be fully evaluated by the NRC every 2 years instead of annually as in the past. Because of this, the use of fully developed, accurate, and challenging scenarios assumes greater importance in the NRC's on-going evaluation process of emergency preparedness.

In reviewing the scenario prior to the exercise, the inspectors noted errors in Emergency Plan Implementing Procedure 5.7.1, "Emergency Action Levels," used for accident classification. The errors identified were the following:

- The criteria on page 94 for determining "Fuel Cladding Loss" contained mixed references to both SBGT and SJAE exhaust. The criteria should only refer to SJAEs.

- On pages 94-95, the procedure misinterpreted reference documents General Electric NEDO 22215, and the graphs in Section 6 of the NRC "Response Technical Manual" for equating containment radiation levels to percent fuel cladding failure. The error was a failure to recognize that the referenced curves are only applicable in situations where a gap release is combined with a significant reactor coolant system leak or failure. The Emergency Plan Implementing Procedure, as written, uses containment radiation monitors to nonconservatively determine cladding failure in a non-LOCA situation. In a related matter, the licensee referenced NEDO 22215 as the source for the core damage assessment section (Attachment 7) of Emergency Plant Implementing Procedure 5.7.17, "Dose Assessment". The formulas in Attachment 7 are not found in the NEDO document.

The improper use of containment radiation monitors described in Emergency Plan Implementing Procedure 5.7.1 for assessment of fission product barrier potential loss and loss, and for Core Damage Estimate was identified as an emergency preparedness weakness (50-298/9429-03).

In addition to the errors which the above misconceptions introduced to the Emergency Plan Implementing Procedures (i.e., using containment radiation readings as indicative of only fuel cladding barrier failure, versus both cladding and reactor coolant system failure), the same misconceptions were found among all scenario authors and exercise participants. Therefore, the weakness encompasses both procedure errors as well as a training issue.

7.2 Conclusions

The exercise scenario was identified as an exercise weakness, because it was found to be simplistic and minimally challenging, it contained numerous data errors and omissions, and it provided avoidable negative training in some areas. An emergency preparedness weakness was identified during the inspection for errors contained in an Emergency Plan Implementing Procedure that is used for assessing Emergency Action Levels and fission product barrier status.

8 LICENSEE SELF-CRITIQUE (82301)

The inspectors evaluated the licensee's formal self-critique which was held on November 18, 1994, to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

8.1 Discussion

The licensee's formal critique was well prepared and involved the input of exercise participants, controllers and evaluators, and licensee management, Critique findings were properly characterized according to their significance. The licensee's critique identified the following four weaknesses:

- The initial state and local notification at the Alert incorrectly identified an airborne release in progress.

- Emergency Plan Implementing Procedures provided incomplete guidance on duties and responsibilities of the Emergency Response Organization.

- Recurring licensee-identified improvement items had not been effectively addressed.

- Weak scenario.

The licensee independently identified two of the weaknesses that were also identified by the NRC team. Other, less significant findings made by the licensee were similar to NRC team observations as noted in this report.

8.2 Conclusions

The licensee's exercise critique process was effective in identifying areas in need of corrective action. There was good agreement between licensee-identified and NRC-identified weaknesses.

9 FOLLOWUP ON PREVIOUS INSPECTION FINDINGS

(Closed) Exercise Weakness 8/9324-01: Failure to ensure that a response team member was qualified for respiratory protection.

During the 1994 exercise, Operations Support Center health physics personnel systematically verified respiratory protection qualifications for all personnel designated for assignment to in-plant response teams. In one instance, a team member had to be replaced due to lack of respirator qualification.

ATTACHMENT

1 PERSONS CONTACTED

1.1 Licensee Personnel

*R. Beilke, Radiological Manager
*J. Dutton, Nuclear Training Manager
*R. Gardner, Maintenance Manager
*J. Gausman, Engineering Manager
*R. Gibson, Quality Assurance Auditor
*R. Hayden, Coordinator, Emergency Preparedness
*J. Herron, Plant Manager
*G. Horn, Vice President, Nuclear
*J. Kelsay, Emergency Preparedness Specialist
*M. Krumland, Supervisor, Emergency Preparedness
*E. Mace, Operations Manager
*J. Mueller, Site Manager

1.2 NRC Personnel

*T. Kim, Reactor Engineer, Office of Nuclear Reactor Regulation

1.3 Other Personnel

*P. Brown, Entek Solutions (licensee contractor)
*J. Everitt, Entek Solutions
*D. Landahl, OSSI (licensee contractor)
*D. Lynch, Midwest Power
*J. Parker, Midwest Power
*J. Sanford, Entek Solutions
*S. Stoll, Entek Solutions
*J. Toresdahl, Entek Solutions
*W. Turnbull, Midwest Power

The inspectors also held discussions with and observed the actions of other station and corporate personnel.

*Denotes those present at the exit interview

2 EXIT MEETING

An exit meeting was conducted on November 18, 1994, to review the scope and findings of the inspection as presented in this report. The licensee did not identify as proprietary any of the materials provided to, or reviewed by, the inspectors during the inspection.