ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-483/95-12

License: NPF-30

Licensee: Union Electric Company
P.O. Box 149
St. Louis, Missouri

Facility Name: Callaway Nuclear Plant

Inspection At: Steedman, Missouri

Inspection Conducted: October 17-20, 1995

Inspectors: Gail M. Good, Senior Emergency Preparedness Analyst (Team Leader)
Plant Support Branch

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Approved: Blaine Murray 11/24/95
Blaine Murray, Chief, Plant Support Date
Division of Reactor Safety

Inspection Summary

Areas Inspected: Routine, announced inspection of the licensee's performance and capabilities during the full-scale exercise of the emergency plan and implementing procedures. The inspection team observed activities in the control room (simulator), technical support center/operations support area, and emergency operations facility.

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Results:

Plant Support

- The control room staff properly detected, analyzed, and classified emergency events. Offsite agency notifications were prompt. Command and control and control room coordination were excellent. Use of the site-wide public address system to inform plant personnel of changing conditions was identified as a strength. The response to the security event was identified as an area for improvement (Section 2).

- Overall, the technical support center staff's performance was excellent. Emergency classifications and offsite agency notifications were timely, and facility command and control were excellent. Technical assessment and engineering support were also excellent. The plant staff was kept well informed of ongoing events; however, facility public address announcements could have been more frequent. The radiological protection staff functioned very well (Section 3).

- Overall, the operations support area staff performed well. Collocation of the operations support center with the technical support center enhanced communication flow and inplant emergency team formation, briefing, and dispatch. Emergency team briefings and team problem solving and discussions were excellent. An area for improvement involving visual methods to track dispatched emergency team members was identified (Section 4).

- The emergency operations facility's performance in the areas of command and control, communications, interactions with offsite officials, and recovery planning was excellent. An exercise weakness was identified for failure to make a timely protective action recommendation. Areas for improvement involving notifications and approval/content of press releases were identified. Dose assessment activities were satisfactorily performed. Interactions with offsite officials and field team coordination with the state were excellent (Section 5).

- The scenario was minimally challenging to test emergency response capabilities and demonstrate onsite exercise objectives. Exercise control was satisfactory (Section 6).

- The licensee's critique process was effective. Post-exercise facility critiques were excellent, and management involvement in the critique process was identified as a strength (Section 7).

Summary of Inspection Findings:

- Exercise Weakness 483/9512-01 was opened (Section 5).

Attachment:

- Attachment - Persons Contacted and Exit Meeting

DETAILS

1 PROGRAM AREAS INSPECTED (82301)

The scenario for the exercise was dynamically simulated using the Callaway Plant simulator. The initial conditions of the scenario included the plant at approximately 94 percent power. The oncoming operating crew was informed of the following conditions. At 4:01 a.m., a circulating water pump tripped which caused the plant to runback to 75 percent power. Following the runback, the licensee increased power at a rate of 10 percent per hour. Also, at 5:54 a.m., the chemical and volume control system letdown gamma detector alarmed indicating an increase in reactor coolant system activity. At 6:06 a.m., the detector hi-hi alarm annunciated and the power increase halted. The sky was clear with West-Southwest winds at 5 to 10 miles per hour. Daytime temperatures were predicted to be in the upper eighties and no weather changes were anticipated. The major events simulated were as follows:

- At 7:07 a.m., chemistry technicians informed the control room that reactor coolant activity was approximately 100 microcuries per gram dose equivalent iodine. At 7:15 a.m., the shift supervisor declared an unusual event.

- At 7:34 a.m., chemistry technicians informed the control room that the reactor coolant activity was approximately 320 microcuries per gram dose equivalent iodine. At 7:40 a.m., the shift supervisor declared an alert and initiated activation of the emergency response facilities.

- At 8:10 a.m., security detected unauthorized personnel in the protected area "Code Red."

- At 9:10 a.m., there was a tube rupture on the "C" steam generator. At 9:13 a.m., the operators determined that the leak was greater than 50 gallons per minute and tripped the reactor. At 9:16 a.m., the operators manually initiated safety injection. At 9:18 a.m., the emergency coordinator declared a site area emergency.

- At 9:31 a.m., due to high pressure, the "C" steam generator power operated relief valve opened and then closed approximately 4 minutes later. At 9:40 a.m., the emergency coordinator declared a general emergency.

- At 10:15 a.m., the "C" steam generator power operated relief valve reopened. Operators and maintenance technicians were unable to close the block valve to terminate the release.

- The remainder of the scenario consisted of efforts to terminate the release. At 12:18 p.m., efforts to close the block valve were successful, and the release was terminated.

2 CONTROL ROOM (82301-03.02)

The inspection team observed and evaluated the control room staff as they performed tasks in response to exercise events indicated by the simulator. These tasks included detection and classification of event-related conditions, detailed analysis of conditions, notification of licensee personnel, and notification of offsite authorities.

At 6:45 a.m., during the pre-shift briefing, the control room staff was informed that the chemical and volume control system letdown hi-hi alarm had annunciated and that chemistry had taken a reactor coolant system sample for analysis. Shortly after assuming the shift, chemistry informed the shift supervisor that reactor coolant system dose equivalent iodine was approximately 100 microcuries per gram. The shift supervisor briefed control room personnel on the situation and ordered power reduced at 30 percent per hour in preparation for the required technical specification shutdown. The shift supervisor and shift technical advisor also referred to Emergency Implementing Procedure EIP-ZZ-101, "Classification of Emergencies," and properly determined that the plant was in an unusual event. The shift supervisor declared the unusual event at 7:15 a.m. and assumed the responsibilities of the emergency coordinator.

At 7:34 a.m., chemistry informed the shift supervisor that the reactor coolant system chemistry activity was approximately 320 microcuries per gram. The emergency coordinator and shift technical advisor referred to Emergency Implementing Procedure EIP-ZZ-101 and correctly determined that the plant was in an alert. The shift supervisor declared the alert at 7:40 a.m. and initiated activation of the emergency response facilities.

Additionally, the shift supervisor directed that the shift technical advisor contact engineering to determine if the plant could be shutdown at 60 percent per hour without causing additional problems. The engineers stated that this would not be a problem. At 7:49 a.m., the shift supervisor ordered the rate of shutdown increased to 60 percent per hour. At 7:52 a.m., the shift supervisor held a briefing with control room personnel on the plant status and requested an off-shift reactor operator to assist in the shutdown.

At 8:04 a.m., the shift supervisor and shift technical advisor reviewed Emergency Implementing Procedure EIP-ZZ-101 to determine if any items might have been overlooked. No problems were noted. The technical support center was declared operational at 8:07 a.m., and the shift supervisor was relieved as emergency coordinator.

Offsite agency notifications made by the control room were prompt. The shift supervisor completed the initial notification forms, and the control room communicator notified the state and local authorities. Notifications for both the unusual event and alert were made well within the required time limits. Notifications to NRC were also prompt.

At 8:10 a.m., security declared a "Code Red" condition due to unauthorized personnel in the protected area. Response to the security event was identified as an area for improvement. Although the shift supervisor conducted a very good briefing on the event, there appeared to be minor communication problems between the control room and security. As examples, there appeared to be some confusion regarding what was taking place, what was required to clear the code red, and who was to make the "all-clear" site wide announcement. Moreover, during the period when everyone was asked to stay inside, the control room requested administrative support. The individual who responded to this request had to travel outside buildings to get to the control room. Considering the security event, this situation was not appropriate. The licensee acknowledged these observations.

During the shutdown, the shift supervisor discussed the ramifications of a reactor coolant system leak and reactor coolant system boron concentration requirements for various reactor modes with control room personnel.

At 9:10 a.m., the operators determined that there was a tube leak in the "C" steam generator and entered Operations Off-Normal Procedure OTO-BB-00001, "Steam Generator Tube Leak." After determining that the leak was greater than 50 gallons per minute, the operators tripped the reactor and initiated safety injection.

The shift supervisor's command and control during the entire exercise was excellent. The site-wide public address announcements were timely and informative. The use of this system to inform personnel of emergency classifications and changing plant conditions was identified as a strength. The shift supervisor was knowledgeable of plant conditions and conducted frequent briefings to ensure that all control room staff members were aware of events. The control room operators exhibited excellent coordination. Operators repeated-back orders, discussed issues with shift management, and were very prompt in recognizing plant conditions. The shift technical advisor, control room supervisor, and shift supervisor properly followed the emergency operating procedures to assess required actions.

3 TECHNICAL SUPPORT CENTER (82301-03.03)

The inspection team observed and evaluated the technical support center staff as they performed the 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; and prioritization of mitigating actions. The licensee's technical support center and operations support center were collocated; independent command and control structures were not maintained. The latter facility is now referred to as the operations support area.

The technical support center was rapidly activated following the alert declaration. Personnel began to arrive at the facility 2 minutes after the alert declaration. The facility was declared operational at 8:07 a.m.

Incoming responders made extensive usage of Emergency Implementing Procedure EIP-ZZ-00240, "Technical Support Center Operations," and associated checklists.

Immediately following the alert declaration, the control room requested the technical support center to activate the emergency response data system. The activation sequence was simple and user-friendly such that the procedure was not utilized nor needed.

Status boards were rapidly filled-in and maintained current throughout the exercise. Board plotters effectively and efficiently utilized computer system printouts formatted to match the reactor status board to perform board updates. The small letters made the board difficult to read from a distance. The technical support center had a dedicated individual who maintained a highly detailed facility log. Notations were taken in shorthand and later transcribed into the log.

Technical support center personnel were aware that timely assumption of burdens from the control room was important. Communications, emergency coordinator, and technical assessment responsibilities were promptly assumed. A site-wide announcement was made when the technical support center was declared operational.

Two offsite monitoring teams were assembled, properly briefed, and sent to the central processing facility to await dispatch. When the security event was declared, offsite monitoring teams were properly advised to remain at the central processing facility.

Command and control of the facility were excellent. The emergency coordinator effectively directed technical support center staff in responding to the emergency. Periodically, the emergency coordinator would call key coordinators to the conference room for a status meeting. Meetings were appropriately detailed and kept to 10 minutes in length.

Communication within the facility was excellent. Repeat-backs of comments by the emergency coordinator were frequent. Plant public address announcements were excellent, providing event classifications, reasons for the classifications, facility activations, and other information. Periodic technical support center public address system announcements were made to keep personnel aware of ongoing events and plant status; however, as an area for improvement, the facility announcements could have been more frequent.

During the exercise, the technical support center/emergency coordinator properly classified emergency events. Emergency action levels were continuously reviewed by several groups in the facility. Condition changes which would lead to emergency action level changes were anticipated. The decision to escalate to the site area emergency was properly made at 9:18 a.m., based upon high reactor coolant activity and steam generator tube leakage. Evacuation of non-essential personnel was properly directed following the declaration of the site area emergency. Evacuation routes were

chosen to keep personnel out of the potential path of a release plume, even though no release was in progress at that time. Accountability was conducted utilizing Emergency Implementing Procedure EIP-ZZ-00230, "Accountability."

The decision to escalate to the general emergency classification was rapidly made following the opening of the "C" steam generator power operated relief valve, providing a release pathway. Although the valve closed within 4 minutes, technical support center staff properly decided to remain in the general emergency status based upon plant conditions.

Technical assessment of plant conditions was excellent. Technical assessment personnel were aware when pressure was approaching the setpoints for the steam generator power operated relief valve. They were also aware that control room personnel were implementing emergency operating Procedure E-3, "Steam Generator Tube Rupture," and proactively looked ahead to actions that the procedure would require operators to take. They likewise anticipated radiation level increases when the reactor heat removal system was initiated.

The technical support center made timely offsite agency notifications following emergency declarations. The emergency operations facility experienced problems with the "blue phone," utilized for communications (notifications) with the state and counties. At the emergency operations facility's request, the technical support center retained notification responsibilities until this problem was rectified. The emergency coordinator properly delayed the transfer of notification responsibilities to the emergency operations facility until after the initial notifications for the general emergency declaration were completed. The communicator utilized a "transferring/assuming communications" form during turnover of communications to the emergency operations facility.

At 10:16 a.m. a plant announcement indicated that the faulted "C" steam generator power operated relief valve had failed open. At 10:23 a.m., the emergency coordinator called the recovery manager in the emergency operations facility and recommended upgrading the protective action recommendations based on the proceduralized plant conditions flowchart. This protective action recommendation is discussed further in Section 5 below.

Dose assessment activities were performed well in the technical support center. Dose assessment personnel used management action guides for nuclear emergencies, Version 17.1, a personal computer based program for dose calculations. The program was versatile and user-friendly. Dose assessment personnel properly obtained release duration estimates for dose calculations from the technical assessment group. When radioiodine levels increased, the management action guides for nuclear emergencies program automatically reminded the user to issue potassium iodide to field team members. The recommendation to issue potassium iodide to offsite monitoring teams was referred to the emergency operations facility.

Dose calculations were performed for the team sent to close steam generator power operated valve Block Valve ABV29. Facility personnel determined that dose extensions or even modification of the Merlin-Gerin electronic dosimeters alarm setpoints would not be necessary.

Technical support center and emergency operations facility technical assessment personnel jointly developed a list of engineering items to be considered upon entry into the recovery phase of the emergency response. A teleconference between the two facilities was held to evaluate the proceduralized criteria for declaring the recovery phase. The facilities properly determined that the four criteria for entering the recovery phase had been met. As an area for improvement, the inspectors noted that Emergency Implementing Procedure EIP-ZZ-00260, "Event Closeout/Plant Recovery," did not address the likely needs of the NRC (e.g., refraining from repair of any failed equipment not necessary for plant safe shutdown and retention of all records).

4 Operations Support Area (82301-03.05)

The inspectors evaluated the performance of the operations support area staff as they performed tasks in response to the exercise. These tasks included functional staffing, providing support to operations, and inplant emergency response team coordination. The licensee's technical support center and operations support center were collocated; independent command and control structures were not maintained. The latter facility was now referred to as the operations support area.

The operations support area was promptly staffed and declared operational following the Alert declaration (within approximately 20 minutes). The area was rapidly and efficiently set up in preparation for team formation and dispatch. Very good communications were displayed between the operations support coordinator and support staff, and technical support center personnel.

Inplant emergency teams were formed in response to requests from the technical support center and control room. Emergency team members were provided excellent briefings prior to dispatch into the plant. The scope and depth of the briefings were appropriate. Members of the two teams dispatched from the operations support area were briefed on assigned tasks, appropriate routes, tools, potential hazards, communications methods and frequency, and radiological concerns. Excellent plant announcements provided current emergency conditions. The emergency teams were able to hear and understand the informative announcements throughout the plant.

Problem solving and discussions by the two inplant emergency teams dispatched from the operations support area were excellent. The diesel generator team actually drew tools and materials from the warehouse, fabricated appropriate piping and sealing materials in the workshop, and provided a temporary fix in a timely manner. The power operated relief valve block valve emergency team described multiple methods to close the valve. The team selected a method that was extremely practical and timely.

Inplant emergency teams periodically communicated with the operations support supervisor. Radiological conditions, equipment status, and progress of repair efforts were properly reported to the operations support area.

The collocation of the operations support center with the technical support center provided for enhanced information flow between the facilities. Emergency task priorities were well coordinated and information exchanged between personnel was continuous and immediate. Emergency team members communicated directly with operations support area and technical support center personnel prior to dispatch and upon return. The direct communication had a positive effect on the teams' understanding of assigned tasks and expected actions.

As an area for improvement, the operations support area sign-in board did not indicate emergency team members dispatched from the facility. Although the operations support coordinator appeared to know the names of dispatched emergency team members, these individuals were not tracked (visually) on any status boards (paper methods were used). If more than two emergency teams had been dispatched into the plant, accountability, access control, and emergency team personnel availability would have been more difficult to determine.

Good radiological practices were demonstrated by the block valve emergency team: low dose rate areas were used, survey meters were properly used on entering areas of unknown dose rates, and dosimetry was appropriately obtained and used.

5 EMERGENCY OPERATIONS FACILITY (82301-03.04)

The inspectors observed the emergency operations facility's staff as they performed tasks in response to the exercise. These tasks included facility activation, development and issuance of protective action recommendations, notification of state and local response agencies, dose assessment and coordination of field monitoring teams, analysis of plant conditions, and direct interactions with offsite agency response teams.

The emergency operations facility was promptly staffed after the alert declaration. Upon arrival, personnel immediately readied the facility, obtained necessary procedures and forms, synchronized clocks, and established communication links. As discussed in Section 3 above, the transfer of emergency coordinator duties was delayed due to the malfunction of the emergency operations facility's "blue phone" and the timing of the general emergency declaration (the technical support center retained this responsibility until the general emergency initial notifications were completed). Emergency coordinator, dose assessment, protective action recommendations, and offsite agency notification responsibilities were transferred at 9:52 a.m. when the emergency operations facility was declared operational. The transfer of responsibilities was conducted in a systematic manner.

Command and control in the emergency operations facility were excellent. Briefings were frequently conducted to keep facility personnel informed of changing conditions. Input from functional area coordinators was solicited during the briefings. Status boards were useful and effectively maintained.

Communications and interactions between facility personnel were excellent. Repeat-backs were frequently used to ensure proper exchange of information. Emergency operations facility staff worked well as a team. The offsite liaison coordinator provided excellent support to the recovery manager and other facility personnel.

The emergency operations facility did not make a timely protective action recommendation following the 10:16 a.m. failure of the "C" steam generator power operated relief valve (start of the major release). The corresponding change in the protective action recommendations (evacuation of 2-mile radius and affected sectors to 5 miles) was not communicated to offsite officials until 10:38 a.m. (about 22 minutes later). The technical support center had previously issued an automatic shelter protective action recommendation in conjunction with the general emergency declaration.

Several factors contributed to the delay in the protective action recommendation. First, there was a lengthy discussion between the technical support center and emergency operations facility regarding the appropriate protective action recommendation. The discussions were prompted by the difference between the procedurally derived plant condition and dose assessment protective action recommendations. Based on plant conditions, the procedure indicated that evacuation should be recommended for a 5-mile radius and 10 miles downwind (affected sectors). Based on dose assessment, the procedure indicated that evacuation should be recommended for a 2-mile radius and 5 miles downwind. The discussions were further complicated because the plant conditions did not appear to meet the procedural (Emergency Implementing Procedure EIP-ZZ-00212, "Protective Action Recommendations") entry requirements to get to protective action recommendations beyond 5 miles. The procedural entry requirements appeared incomplete. Both recommendations (plant conditions/dose assessment) were discussed with the appropriate state official who was located in the emergency operations facility. A decision was made to issue the latter recommendation. Second, Emergency Implementing Procedure EIP-ZZ-00201, "Notifications," did not specifically state that a change in protective action recommendations should be treated as an initial notification (i.e., required to be made within 15 minutes of recognition). As a result, there did not appear to be an urgency associated with the communication of the expanded recommendation. Third, there appeared to be a reluctance to issue protective action recommendations based on plant conditions when dose projections resulted in less severe recommendations. This response was not consistent with current federal guidance published in the environmental protection agency protective action guides (EPA-400). The failure to make a timely protective action recommendation was identified as an exercise weakness (483/9512-01). The licensee acknowledged these comments and confirmed the need to revise the procedural guidance.

With the exception of the preceding notification involving the protective action recommendation, notifications made by the emergency operations facility were satisfactory. Two areas for improvement were identified. First, the event notification form (Attachment 1 to Emergency Implementing Procedure EIP-ZZ-00201) does not reference proper 10 CFR Part 20/EPA-400 dose values. The form still refers to whole body and thyroid doses versus total effective dose equivalent and thyroid committed dose equivalent. Second, on one occasion, an emergency operations facility communicator inappropriately added additional information to the notification form after the form had been signed by the recovery manager (plume arrival time). In response, the licensee stated that the additional information was discussed (later) with the recovery manager.

Press releases prepared by the emergency operations facility were satisfactory. Areas for improvement were identified concerning review/approval and content. Regarding review/approval, the inspectors observed that a formal method to document that press releases had been approved (signature/initials) was not used during the exercise. All press releases appeared to be reviewed. The licensee indicated that such a method had been used in the past. Regarding the content, the basis for the general emergency classification as stated in Press Release No. 4 appeared incorrect. The release stated that the event was declared due to a loss of two fission product barriers with a probable loss of the third. The general emergency was declared due to a loss of all three fission product barriers. Moreover, Press Release Nos. 4 and 5 incorrectly stated that conditions at the plant were stable.

Dose assessment activities were satisfactorily performed in the emergency operations facility. Numerous dose projections were computed during the exercise using effluent monitor data and field team results. Coordination with the technical assessment group was excellent. Habitability of the emergency operations facility was properly considered.

Interactions with offsite officials was excellent. Offsite agency representatives were included in utility briefings. Field team coordination with the state was excellent.

As discussed in Section 3, the technical support center and emergency operations facility jointly participated in recovery discussions and the development of an engineering list. The recovery discussions were detailed and thorough.

6 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.

The inspectors determined that the exercise scenario was minimally challenging to test emergency response capabilities and demonstrate onsite exercise objectives. Specific examples included the following areas: operations,

event classification, radiation protection (challenges to inplant response teams), formulation and prioritization of mitigating actions, and dose assessment (meteorology). Event classifications were straight-forward, requiring little assessment. Only two emergency teams were dispatched from the operations support area, and neither team was taxed by the radiological conditions (high radiation, contamination, or airborne contamination). Dose assessment activities could have been more challenging if atmospheric conditions (stability class, wind speed, and wind direction) had not remained constant throughout the exercise.

Exercise control was satisfactory. Although use of the simulator in the dynamic mode enhanced realism, control room simulator personnel decided to reduce reactor power at 1 percent per minute. This rate was much faster than planned by the scenario developers, but the controllers did not prevent the increased power reduction rate. In order to maintain the integrity of the scenario and its accompanying data, controller intervention may be appropriate. Moreover, digressing from the planned scenario could affect demonstration of offsite objectives.

Two other minor observations were made regarding controller performance. First, a controller left a scenario book open even though participants were in the area. At the request of the inspector, another controller asked the first controller to close the book and to not "chit-chat" with participants. Second, the controller for the power operated relief valve emergency team became separated from the team for about 11 minutes. The team had to wait in a hot (temperature) plant location until he returned.

As an area for improvement, scenario developers should strive to generate reasons for scenario events. The lack of a cause for the fuel clad damage in the scenario was confusing to some players in the technical support center.

7 LICENSEE SELF-CRITIQUE (82301-03.13)

The inspectors observed and evaluated the licensee's post-exercise facility critiques and reviewed the licensee's draft critique report to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

The inspectors determined that the post-exercise facility critiques were excellent. Comments were solicited from players, and controllers/evaluators presented their preliminary exercise observations. The controllers/evaluators met the next morning to compile and discuss the observed critique items. A draft critique report was generated during this meeting. Copies of the draft report were provided to the inspectors for review. The report included action items, improvement opportunities, and positive comments. Since the licensee's controller/evaluator organization included management personnel, a formal management critique was not conducted. Management involvement in the exercise critique process was considered a strength.

ATTACHMENT

1 PERSONS CONTACTED

1.1 Licensee Personnel

*D. Schnell, Senior Vice President, Nuclear
*R. Affolter, Manager, Callaway Plant
*G. Belchik, Supervisor, Planning
*G. Czeschin, Superintendent, Training
*S. Crawford, Supervisor, Radiation/Chemistry, Emergency Preparedness
*M. Evans, Superintendent, Health Physics
*M. Faulkner, Supervisor, Radiation/Chemistry, Emergency Preparedness
*T. Herrmann, Supervisor, Design Engineering
*K. Kuechenmeister, Superintendent, Design Engineering
*R. Lamb, Superintendent, Operations
*J. Laux, Manager, Quality Assurance
*D. Lewis, Supervisor, Radiation/Chemistry, Training
*J. Neudecker, Supervisor, Emergency Preparedness
*J. Patterson, Shift Supervisor
*J. Peevy, Emergency Preparedness and Organizational Support
*G. Pendergraff, Engineering Evaluator
*R. Reidmeyer, Engineer, Quality Assurance
*R. Roselius, Superintendent, Chemistry/Radwaste
*A. White, Senior Training Supervisor

1.2 Other Personnel

*K. Craighead, Engineering Specialist III, Emergency Planning, Wolf Creek Nuclear Operating Corporation
*J. Weeks, Assistant to the Vice President, Plant Operations, Wolf Creek Nuclear Operating Corporation
*B. Winzenried, Engineer III, Emergency Planning, Wolf Creek Nuclear Operating Corporation

1.3 NRC Personnel

*D. Passehl, Senior Resident Inspector

*Denotes those present at the exit meeting

2 EXIT MEETING

An exit meeting was conducted on October 20, 1995. During this meeting, the inspectors reviewed the scope and findings of the report. The licensee did not identify as proprietary any of the materials provided to, or reviewed by, the inspection team during the inspection.