APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-298/92-14

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: September 21 through 24, 1992

Inspectors: D. Blair Spitzberg (Team Leader)
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Accompanying Personnel: Bruce E. Vesper, Battelle Laboratories
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Approved: Blaine Murray 10/7/92
Blaine Murray, Chief, Facilities Inspection Programs Section — 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 team observed activities in the control room, technical support center, operational support center, and the emergency operations facility.

Results:

- The control room performed well during the exercise to detect and classify emergency conditions, and to make initial notifications to offsite authorities (paragraph 2).

- The Technical Support Center was efficiently activated and demonstrated good control over security and personnel accountability. A strength was noted in the area of the Technical Support Center turnover briefing. A

repeat exercise weakness was identified in the area of analysis and technical assessment of plant conditions (paragraph 3).

- The Operational Support Center was activated efficiently and performed its support functions well. The tracking of response teams had improved from previous exercises. The timeliness of fire fighting activities was an area recommended for improvement. A weakness was identified for failure to take steps to ensure Technical Support Center/Operational Support Center habitability during the release (paragraph 4).

- The Emergency Operations Facility was promptly and efficiently activated and maintained good accountability and security throughout the exercise. The licensee's working relationship with state representatives was very good. Three exercise weaknesses were identified in this area. A weakness was identified as a result of the failure to detect and classify General Emergency conditions promptly. The failure to approve notification messages properly and to complete the notification of offsite authorities in a timely manner was identified as a weakness. The third weakness involved the lack of clear guidance for resolving conflicting decisionmaking information generated by the two dose assessment programs (paragraph 5).

- The scenario and the conduct and preparation of the exercise was sufficient to test the demonstration of exercise objectives (paragraph 6).

- The inspection team found that the licensee's self-critique process had improved significantly since the previous exercise. Most of the significant findings identified by the NRC inspection team were also identified and similarly characterized by the licensee (paragraph 7).

Summary of Inspection Findings:

- Exercise Weakness 298/9112-01 was identified as a repeat weakness. Exercise Weaknesses 298/9214-01, 298/9214-02, 298/9214-03, and 298/9214-04 were opened.

- Exercise Weaknesses 298/9112-02, 298/9112-03, 298/9112-04, 298/9112-05, and 298/9112-06 were closed (paragraph 8).

Attachments:

Attachment 1 - Persons Contacted and Exit Meeting

DETAILS

1 PROGRAM AREAS INSPECTED (82301)

The licensee's annual emergency preparedness exercise began at 8 a.m. on September 22, 1992. The exercise involved partial participation by the states of Nebraska and Missouri. The NRC did not participate.

The exercise began during simulated power ascension with a fire in the diesel generator area requiring classification of an Alert. Approximately 1.5 hours after the fire, the scenario called for a failure of the digital Electro-Hydraulic Control system in conjunction with a turbine trip. At this point, turbine blades were severed from the low pressure turbine, penetrating the upper turbine casing and several circulating water tubes in the condenser. A simultaneous rod drop accident occurred which created a power excursion and the release of approximately 1 percent of fuel clad gap activity into the coolant. A main steam line isolation signal created by the coolant activity failed to close both main steam isolation valves on one steam line. This created conditions of a General Emergency with an uncontrolled release of the activity into the turbine building and then to the environment through the monitored turbine building ventilation system.

The inspection team observed licensee activities in the (simulator) Control Room, Technical Support Center, Operational Support Center, and the Emergency Operations Facility during the exercise. The inspection team evaluated the licensee's implementation of the emergency plan and procedures including emergency response organization staffing; emergency response facility activation, detection, classification and notification of offsite authorities; technical assessment; emergency communications; dose assessment; and formulation of protective action recommendations. Inspection findings are documented in the following paragraphs.

The inspection team identified various concerns during the course of the exercise; however, none were of the significance of a deficiency as defined in 10 CFR 50.54(s)(2)(ii). Each observed concern can be 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. Areas Recommended for Improvement are findings 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.

2 CONTROL ROOM (82301-03.02.b.1)

The inspection team observed and evaluated the Control Room staff in the simulator as they performed tasks in response to the exercise. These tasks included analysis of plant conditions, implementation of corrective measures, detection and classification of events, and notifications to offsite authorities.

2.1 Discussion

The inspection team noted that the scenario did not provide strong challenges for the evaluation of command and control of the shift operating crew. This was because the plant was simulated to be in startup when emergency initiating conditions occurred. This mode called for a nuclear engineer to be in the control room from the beginning of the exercise. In addition, the Site Manager, who was to become the Emergency Director, arrived in the control room 3 minutes after the first emergency initiating condition (diesel generator fire).

The inspection team observed that Control Room personnel performed their duties in a professional manner. The Shift Supervisor, in consultation with the Site Manager, detected and made a prompt classification of Alert following assessment of the diesel generator fire initiating event. The Site Manager relieved the Shift Supervisor as Emergency Director about 6 minutes after the Alert declaration. Accurate notifications to offsite authorities of the Alert classification were made promptly from the Control Room. During the attempt to establish initial contact with the State of Missouri, the speed dial feature twice failed to establish a telephone connection. The connection was subsequently established by using manual dialing. The inspectors recommended that the licensee improve the reliability of the speed dialing function.

The inspection team observed that Control Room personnel used appropriate Emergency Operating Procedures, flow charts, and Emergency Plan Implementing Procedures. Operators were generally attentive and aware of plant conditions and status. It was noted, however, that the Control Room staff did not detect the simulated rod drop accident. This later contributed to problems assessing the fuel boundary status (see paragraph 5.1). The Shift Supervisor and Control Room Supervisor maintained good control and supervision over the operating staff. The operators performed well in verifying the accuracy of information transmitted to the Technical Support Center. The reactor operators maintained positions at the control panels during important transients and evolutions and notified the Control Room Supervisor when leaving the panels on other occasions.

The inspectors observed emergency direction, command, and control from the Control Room to determine whether clear chains of command were established and whether personnel were utilized effectively. Good command and direction was observed in the Control Room. Reactor operators and Control Room staff were used effectively. Communications both within the Control Room and between the Control Room and the Technical Support Center were good. The inspectors noted, however, that the practice of using repeat back commands was inconsistent. It was also noted that the status board in the Control Room was not used to post emergency information.

2.2 Conclusions

The control room performed well during the exercise to detect and classify emergency conditions and to make initial notifications to offsite authorities.

3 TECHNICAL SUPPORT CENTER (82301-03.02.b.2)

The inspectors observed the operation of the Technical Support Center from activation through termination of the exercise. The inspectors evaluated staffing, command and control, technical assessment and support of operations, classifications and notifications, dose assessment, formulation of protective action recommendations, and adherence to the emergency plan and implementing procedures.

3.1 Discussion

The inspectors observed that the Technical Support Center was activated promptly and efficiently following the declaration of Alert. The process of turnover by the Technical Support Center Director was noted to be strong with complete and accurate information conveyed and understood by the Technical Support Center Director before he assumed his duties. Security and personnel accountability was maintained in the Technical Support Center throughout the exercise.

The inspection team followed the activities of the Technical Support Center management team and technical assessment personnel in their response to scenario data and known plant conditions in order to evaluate the effectiveness of technical decisionmaking and direction. The inspectors noted the following examples of weak analysis and technical assessment of plant conditions:

- Despite multiple indications received in the Control Room, the assessment staff did not pursue and properly analyze or diagnose the condition of the turbine/generator following the severing of turbine blades and the resultant damage. At 10:45 a.m., the main turbine tripped and the Control Room reported a problem with the Digital Electro-Hydraulic system. Following the trip, one main steam line failed to isolate. Plant indications following the trip included turbine/generator overspeed; high turbine vibrations, high conductivity in the hotwell, turbine building sumps filling, and verbal reports of hissing sounds from the turbine deck. At the time, the assessment staff was distracted by problems with the main steam system; however, the outboard main steam isolation valve on the affected steam line was closed about 11:27 a.m. The assessment and response to events involving the turbine/generator were delayed such that the sumps were not secured until 1:18 p.m., condensate was not secured until 1:26 p.m., and the water boxes on the condenser were not secured until 1:46 p.m. The delays in analyzing and responding to these conditions allowed contaminated primary coolant to flow unchecked into the turbine building, thus aggravating the radiological conditions.

- From about 10:45 to 11:21 a.m., the Main Steam Line C remained unisolated. At 11:21 a.m., the Control Room received multiple indications that the steam line isolation valve had closed. It was reported to the Technical Support Center at 11:33 a.m. that the Control Room questioned whether the main steam isolation valve had closed. From

this time until after 12:20 p.m., considerable effort was expended by the Control Room and Technical Support Center to close the turbine reheat and stop valves. These efforts included the dispatching of Operational Support Center teams to depressurize the nitrogen header and to manipulate the Digital Electro-Hydraulic system. The failure to analyze this plant condition properly diverted the operating and emergency staffs from diagnosing actual plant conditions having higher priorities.

- Widely differing assessments of fuel damage led to delays in assessing actual plant conditions and in detecting General Emergency conditions. From approximately 10:55 a.m. when the Technical Support Center was informed that the main steam line radiation monitors had risen from 300 mR/h to 9500 mR/h, the Technical Support Center was receiving information that the fuel had suffered some cladding damage. At 11:16 a.m., the Technical Support Center noted that the radiation levels in the turbine building were less than expected and at 11:20 a.m., it reported that fuel cladding damage was less than 1 percent. At 11:22 a.m., the Technical Support Center Health Physics/Chemistry Coordinator reported that the Atmospheric Dose Assessment Model (ADAM) dose assessment program had predicted a General Emergency, but the management team determined that ADAM was incorrect. At 12:47 p.m., the results of a core damage assessment based on coolant sample activity was given to the Technical Support Center director showing 34 to 35 percent clad damage. In addition, the assessment of loss or potential loss of the fuel boundary fission product barrier was not made during the exercise despite the scenario calling for release of 1 percent of fuel gap activity. (For related discussion, see paragraph 5.1). The conflicting assessments of fuel damage caused confusion as to actual plant conditions. This delayed the declaration of the General Emergency and the recommendation of protective actions.

  The analysis and technical assessment of plant conditions was identified as a repeat exercise weakness first identified during the 1991 emergency exercise (298/9112-01).

3.2 Conclusions

The Technical Support Center was efficiently activated and demonstrated good control over security and personnel accountability. A strength was noted in the area of the Technical Support Center turnover briefing. A repeat exercise weakness was identified in the area of analysis and technical assessment of plant conditions.

4 OPERATIONAL SUPPORT CENTER (82301-03.02.b.4)

The inspectors evaluated the performance of the Operational Support Center staff as they performed tasks in response to the exercise to determine whether the Operational Support Center would be effective in providing emergency support to operations.

4.1 Discussion

In the month preceding the exercise, the licensee had implemented changes in the operation of the Operational Support Center. The most significant change involved combining the three Operational Support Centers in use previously into a single Operational Support Center which was within the Technical Support Center envelope. This change in the Emergency Plan and Emergency Plan Implementing Procedures had not been transmitted to NRC prior to the exercise and will, therefore, not be evaluated until such time as the change is reflected in the emergency plan.

The inspection team observed that activation of the Operational Support Center was prompt and personnel accountability and security of the facility was good. A strength was noted in that Operational Support Center response teams used available support equipment in those situations in which it would have been required in the event of an actual emergency. For instance, self-contained breathing apparatus were used by responders to the fire, as well as those who would have entered the turbine building. This play allowed the responders to cope with the communications and logistics problems that accompany such activities.

The tracking of survey and repair teams had improved since previous exercises with the radio operator keeping close attention on the location of the teams. Some players, however, appeared somewhat unfamiliar with the new tracking system. Radiation monitoring of the plant interior and the protected areas were performed early on, and in a relatively continuous manner.

The inspectors observed the licensee's response to the simulated fire in the diesel generator area and noted that while the fire brigade arrived on the scene promptly, it was 18 minutes (from 9:46 to 10:04 a.m.) before hoses had been broken out and applied to the fire. Even allowing several minutes for the transition from the diesel generator spaces to the area where the fire simulation was located, the inspectors concluded that the timeliness of fighting the fire was an area for improvement.

The inspectors noted that the combined Technical Support Center/Operational Support Center did not take steps to ensure habitability when the release from the turbine building was taking place. The facility must actively close the door to the facility and manually switch the ventilation from bypass to High Efficiency Particulate Air Filter (HEPA) filtration. Neither were observed to take place during the exercise. A continuous air monitor was placed in the room, ostensibly to provide early detection of airborne radioactivity; however, placement was so far from the door and major circulation areas that the continuous air monitor would likely have detected alarm levels only after the facility had exceeded habitability limits. Failure to take steps to ensure Technical Support Center/Operational Support Center continued habitability during a release was identified as an exercise weakness (298/9214-01).

4.2 Conclusions

The Operational Support Center was activated efficiently and performed its support functions well. The tracking of response teams had improved from previous exercises. The timeliness of fire fighting activities was an area recommended for improvement. A weakness was identified for failure to take steps to ensure Technical Support Center/Operational Support Center habitability during the release.

5 EMERGENCY OPERATIONS FACILITY (82301-03.02.b.3)

The inspection team observed the Emergency Operations Facility staff as they performed tasks in response to the exercise. These tasks included activation of the Emergency Operations Facility, accident assessment and classification, off-site dose assessment, protective action decision making, notifications and interactions with field monitoring teams.

5.1 Discussion

The inspectors observed that the Emergency Operations Facility was activated within time limits specified in the Emergency Plan Implementing Procedures. The Emergency Operations Facility Director used appropriate activation procedures and kept abreast of activation requirements using checklists. Personnel accountability was maintained in the Emergency Operations Facility. Security measures to prevent unauthorized access were excellent.

The licensee's emergency management team and staff established a close working relationship with the state representatives located in the Emergency Operations Facility. Joint briefings and discussion were held frequently to discuss plant status and plans of action. Protective action recommendations made by the licensee were carefully explained to the state representatives.

Classification of the General Emergency was delayed approximately 1 hour even though scenario conditions indicated General Emegency conditions were clearly present. The following are observations related to the failure to promptly classify the General Emergency:

- At 11 a.m. the ADAM dose assessment program indicated that a General Emergency condition existed. Based on Emergency Action Levels 1.4.1 and 1.4.2, a General Emergency should have been declared based on the ADAM dose projections exceeding specified whole-body and thyroid dose rates at the site boundary. The Emergency Director instead, decided not to declare a General Emergency at that time because of spurious information regarding plant conditions given to the Emergency Operations Facility staff by the Technical Support Center (see paragraph 3.1). The General Emergency was finally declared at 12:02 p.m.

- From 10:45 a.m. until 2 p.m., the Control Room and Technical Support Center staff were presented with numerous plant conditions indicating that fuel cladding failure had occurred with simultaneous loss of the primary coolant boundary and containment as follows:

- A scram signal was generated from the main steam line radiation monitor trip because of radiation levels that were three times higher than normal full power levels.

- Primary containment radiation levels increased significantly.

- Secondary containment radiation levels increased well above their normal levels.

- Turbine building area radiation levels and turbine building exhaust radiation levels were extremely high.

- Coolant activity levels were high.

Emergency Plan Implementing Procedure 5.7.1, "Emergency Classification", requires a General Emergency classification be declared with loss of any two of three fission product barriers with the potential for loss of the third. The three fission product barriers are defined as: (1) fuel cladding, (2) primary coolant boundary, and (3) primary containment. To determine fuel cladding loss, Attachment 3 of the procedure specifies utilization of any of only three indicators: (1) steam jet air ejector offgas activity, (2) reactor coolant sample activity, or (3) drywell radiation monitor readings. In order to assess the potential loss of the fuel cladding fission product boundary, the procedure specifies monitoring for degrading trends in the same indicators used to determine loss. During the scenario, steam jet air ejector offgas was isolated, and the leak was bypassing drywell radiation monitors. In order to utilize the coolant sample activity indicator, a coolant sample must be obtained and analyzed, a process which can take up to 2 hours. The inspectors concluded that in accident conditions such as presented by the scenario, a rapid determination of fuel cladding loss or potential loss would not have been likely using only the three indicators specified in Emergency Plan Implementing Procedure 5.7.1, Attachment 3.

The scenario involved fuel clad damage starting about 11 a.m. Because of the limitations of the defined indicators under the plant conditions encountered during this exercise, the General Emergency was not declared as expected by the scenario developers on the basis of fission product barriers status. Instead the General Emergency classification was delayed until about 1 hour after the fuel clad damage had occurred and was only then declared with the assessment of actual radiological conditions at the site boundary.

The failure to detect and classify general emergency conditions promptly was identified as an exercise weakness (298/9214-02).

Following the declaration of the General Emergency, the inspectors noted that notifications to offsite authorities were not completed in a timely manner. According to the notification message documentation, the initial notifications of offsite authorities of the General Emergency were completed after 12:28 p.m. or about 26 minutes after the General Emergency Declaration at 12:02 p.m. This was contrary to the notification timeliness criteria specified in 10 CFR Part 50, Appendix E.IV.D.3, Emergency Plan Implementing Plans 5.7.5, "General Emergency" and 5.7.6, "Notification," which state that

initial notifications of state and local government agencies shall be made within 15 minutes of the emergency declaration.

In addition to the untimely General Emergency notification, the inspectors noted that the initial notification message forms (EPIP 5.7.6, Attachment 1) were not signed by the Emergency Director for either the Site Area Emergency or General Emergency notification messages. Instead, these forms had been signed and approved by other individuals within the emergency response organization. This was contrary to Procedure EPIP 5.7.6, "Notification," paragraph 8.1.1.2, which requires that the Emergency Director approve and sign the message form.

The failure of the licensee to approve initial notification messages properly to state and local government agencies and the failure to complete the initial notification process in a timely manner was identified as an exercise weakness (298/9214-03).

The inspectors observed the licensee's staff performing dose assessments in the Emergency Operations Facility to determine whether reliable information was being disseminated regarding the radiological consequences of the release. The method used for making dose assessments and dose projections was based on two different computer programs (ADAM and CNS DOSE). Although the written Procedure 5.7.17, "Dose Assessment," states in paragraph 2.2 that the CNS DOSE program is the primary on-shift dose projection method, the Radiation Protection Manager and other staff members appeared to give equal weight to both computer programs for emergency classification decisions. The ADAM computer results were based on a puff release, and the CNS DOSE were based on a linear Gaussian model. For scenarios such as this exercise, these two computer programs exhibit little correlation and, in fact, yielded contradictory results. For example, at 11 a.m. the ADAM program clearly indicated General Emergency conditions while the CNS DOSE program under the same assumptions for release rate and duration, and no core damage, projected doses below the General Emergency threshold. As a consequence, decisionmakers delayed classifying the General Emergency condition until 12:02 p.m., that is 1 hour after conditions warranted this declaration. At the time of the General Emergency classification, the decision for the declaration was based on the results of CNS DOSE results and hand calculations.

The inspectors concluded there was nothing wrong in having two independent dose assessment and projection methods. However, the absence of clear guidance and criteria as to when to use and how to interpret conflicting results between different computer programs contributed to the difficulties in decisionmaking. This can prevent the licensee from making accurate and prompt protective actions recommendations as demonstrated during this exercise. The use of two dose assessment programs for decisionmaking purposes without clear guidance on reconciling conflicting results was identified as an exercise weakness (298/9214-04).

5.2 Conclusions

The Emergency Operations Facility was promptly and efficiently activated and maintained good accountability and security throughout the exercise. The

licensee's working relationship with state representatives was strong. Three exercise weaknesses were identified in this area. A weakness was identified as a result of the failure to detect and classify General Emergency conditions promptly. The failure to approve notification messages properly and to complete the notification of offsite authorities in a timely manner was identified as a weakness. The third weakness involved the lack of clear guidance for resolving conflicting decisionmaking information generated by the two dose assessment programs.

6 SCENARIO AND EXERCISE CONDUCT (82301)

6.1 Discussion

The inspection team made observations during the exercise to assess the challenge and realism of the scenario and to evaluate the conduct of the exercise. The scenario provided sufficient challenge to exercise response activities in each of the exercise objectives. Realism was enhanced by utilizing the control room simulator in the dynamic mode to model the accident sequence. As discussed in paragraph 2.1, the scenario lacked significant challenge in testing the command and control of the shift crew. In addition, the time between the Alert and the events leading to the General Emergency were such that the Emergency Response Facilities could be fully staffed, activated, and prepared for the more significant events to follow. Despite these drawbacks, the scenario and conduct of the exercise permitted a good demonstration of the licensee's overall emergency response capabilities.

The following observations related to the scenario, and the conduct of the exercise were identified as areas for improvement:

- NRC evaluators were denied access to observation locations by security personnel early in the exercise. The licensee should review security arrangements for NRC exercise evaluators to prevent recurrence of these conditions in future exercises.

- Signs were posted in the Control Room before the exercise started directing personnel to use data sheets to obtain radiation monitor data. This was prompting in that the signs should only have been posted at the time the operators went to access the data.

- The scenario did not yield the conspicuous indication of the rod drop accident which was anticipated by the scenario developers to give indications of fuel damage.

6.2 Conclusions

The scenario and the conduct and preparation of the exercise was sufficient to demonstrate the exercise objectives.

7 LICENSEE SELF-CRITIQUE (82301-03.02.b.12)

The inspectors observed and evaluated the licensee's formal self-critique on September 24, 1992, to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

7.1 Discussion

The licensee presented a summary list of weaknesses, improvement items, and observations. Licensee management representatives stated that all weaknesses and improvement items would be tracked and corrected. The licensee's major self-critique findings are summarized below with their characterization listed in parentheses:

- Response teams dispatched into plant areas did not follow proper ALARA principles (weakness).
- Initial notifications included incomplete data, were not timely, and problems were noted with the speedial (weakness).
- General Emergency was not declared as indicated (weakness).
- The scenario did not support the fuel damage criteria for the General Emergency classification (weakness).
- An offsite monitoring team spent too much time in the plume (weakness).
- Core damage program caused confusion (improvement item).
- Emergency Action Levels on fission product barrier loss or potential loss are in need of review (improvement item).
- ADAM and CNS-DOSE program results did not correlate (improvement item).

7.2 Conclusions

The inspection team found that the licensee's self-critique process had improved significantly since the previous exercise. Most of the significant findings identified by the NRC inspection team were also identified and similarly characterized by the licensee.

8 FOLLOWUP (92701)

(Open) Exercise Weakness (298/9112-C1): This weakness was for several examples of weak technical assessment from the Technical Support Center. The licensee's corrective actions included commitments to revise procedures used for core damage assessment, revising Technical Support Center Director's checklist to prompt formation of multi-disciplined teams, issuing radios to technicians in the Technical Support Center to provide more timely radiological data, revising status boards to focus more on assessment, and to

enhance Technical Support Center drills. The inspectors verified that the corrective actions committed to had been implemented, however, similar findings to those identified during the 1991 exercise were again identified during the current exercise (see paragraph 3.1).

(Closed) Exercise Weakness (298/91[illegible]-02): This weakness pertained to several examples of poor command and control in the Control Room and Technical Support Center. The inspectors reviewed new guidelines committed to by the licensee which provide detailed information for training and evaluation of command and control to ensure uniformity. During this exercise, command and control was observed to have improved in the Control Room and Technical Support Center indicating that this weakness had been satisfactorily addressed.

(Closed) Exercise Weakness (298/9112-03): This weakness was for several examples of weak coordination, control, and radiological practices of in-plant repair and survey teams. The licensee had implemented new methods of identifying and tracking repair and survey teams which proved to be effective during this year's exercise.

(Closed) Exercise Weakness (298/9112-04): This weakness was identified based on two observations involving weak assessment of offsite radiological consequences of the release. The first part, involving the assessment of the status of the release filtration was observed to have been corrected during this exercise. The second portion of this weakness related to the lack of efforts to correlate initial dose rate projections with field monitoring results. The inspectors noted that licensee procedures were followed to correlate dose rate projections with field monitoring results.

(Closed) Exercise Weakness (298/9112-05): This weakness related to several observations of poor controller and exercise preparation. During this exercise, the inspection team observed some instances of scenario problems and one minor case of prompting; however, none of these were deemed significant enough to effect the demonstration of exercise objectives. In addition, improvement was noted in the specific areas focused upon by this weakness.

(Closed) Exercise Weakness (298/9112-06): This item related to a weak self-critique process. Based on the inspection team's evaluation of the licensee's self-critique following this exercise, significant improvement was noted in the licensee's capability to identify areas in need of corrective action. Many of the NRC inspection team weaknesses were identified in some form during the licensee's critique.

ATTACHMENT 1

1. PERSONS CONTACTED

1.1 Licensee Personnel

M. Dean, Supervisor, Licensing and Safety
J. Flaherty, Manager, Engineering
*R. Gardner, Plant Manager
*R. Hayden, Coordinator, Emergency Preparedness
*G. Horn, Manager, Nuclear Power Group
*J. Kelsay, Emergency Preparedness Specialist
*M. Krumland, Supervisor, Emergency Preparedness
*L. Linder, Emergency Preparedness Specialist
*F. Mace, Senior Manager, Site Support
*J. Meacham, Site Manager
*H. Parris, Vice President, Production
*S. Peterson, Senior Manager, Operations
*G. Smith, Manager, Quality Assurance
*R. Wilbur, Division Manager, Nuclear Engineering and Construction
*V. Wolstenholm, Division Manager, Quality Assurance
M. Young, Supervisor, Maintenance

1.2 NRC Personnel

*R. Kopriva, Senior Resident Inspector
*W. Walker, Resident Inspector

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

The inspection team met with the licensee representatives indicated in Section 1 of this attachment on September 24, 1992, and summarized 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.