ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

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License No.:	DPR 46
Report No.:	50-298/98-16
Licensee:	Nebraska Public Power District
Facility:	Cooper Nuclear Station
Location:	P.O. Box 98 Brownville, Nebraska
Dates:	June 8-11, 1998
Inspector(s):	Gail M. Good, Senior Emergency Preparedness Analyst, Team Leader Francis L. Brush, Resident Inspector, Callaway Michael P. Shannon, Senior Radiation Specialist
Observer:	John D. Hanna, Reactor Engineer
Approved By:	Blaine Murray, Chief, Plant Support Branch Division of Reactor Safety
Attachment:	Supplemental Information

EXECUTIVE SUMMARY

Cooper Nuclear Station
NRC Inspection Report 50-298/98-16

A routine, announced inspection of the licensee's performance and capabilities during the full-scale, biennial exercise of the emergency plan and implementing procedures was performed. The inspection team observed activities in the control room simulator, technical support center, operational support center, and emergency operations facility.

Plant Support

- Overall, performance was good. The control room (CR), technical support center (TSC), and emergency operations facility (EOF) successfully implemented essential emergency plan functions including classification, notification, protective action recommendations, and personnel accountability.

- The CR staff's performance was good. Emergency events were promptly recognized and classified, but CR staff and plant-wide announcements for event classifications and personnel accountability were not timely. Offsite event notifications were made within required times. Personnel accountability was correctly maintained. Operators promptly recognized changing plant conditions and took appropriate corrective actions. Communications between the CR and TSC were effective (Section P4.2).

- The TSC staff's performance was good. Emergency conditions were quickly recognized and classified. Briefings were thorough and included input from key center areas. Task priorities were assigned and reviewed at frequent intervals. Resources were well coordinated, and status boards were effectively used. Personnel accountability was well implemented and maintained (Section P4.3).

- The operational support center (OSC) staff's performance was satisfactory. The response to the fire was not completely correct because entry into the fire scene was made 7 minutes before the hoses were charged and respiratory protection equipment was not properly tested. OSC briefings were clear, concise, and center work priorities were relayed and updated to center personnel in a timely manner. Radiological job briefings provided inplant response teams with proper radiological information to maintain personnel exposures as low as reasonably achievable (ALARA). The manner in which teams were assigned, briefed, and dispatched, coupled with the level of activity (noise and distraction) in the OSC lead office area, detracted from the overall effectiveness of the center and caused minor delays in team dispatch. An exercise weakness was identified for the failure to implement proper radiological contamination controls in the TSC and OSC. Additionally, some station workers, including radiation protection personnel, did not demonstrate proper radiation protection practices when respiratory equipment and protective clothing were used (Section P4.4).

- The EOF staff's performance was good. Facility briefings were frequent and included input from key functional areas, such as operations, dose assessment, and offsite agency response teams. The release of nondesignated personnel was not well coordinated because personnel were released before the relief shift was notified of standby status and a security event was in progress. Changes in emergency classifications were promptly recognized and correctly declared with support from the TSC. Offsite agency notifications and protective action recommendations were correct and timely following changes in plant conditions. Dose assessment and field team control activities were well managed and executed to determine actual offsite impact. Interactions with state and NRC response teams were open and constructive (Section P4.5).

- The exercise objectives were appropriate to meet emergency plan requirements. Outdated information was referenced in the letter that forwarded the exercise objectives and indicated that the emergency preparedness staff was not keeping current with program area changes. The exercise scenario was sufficiently challenging to test onsite emergency response capabilities. The use of mock-ups, pictures, and staged props enhanced the exercise training value (Section P4.6).

- The critique process was strengthened by using a peer evaluation group made up of representatives from other sites (Section P4.7).

IV. Plant Support

P4 Staff Knowledge and Performance in Emergency Preparedness

P4.1 Exercise Conduct and Scenario Description (82301 and 82302)

The licensee conducted a full-scale, biennial emergency preparedness exercise on June 9, 1998. The exercise was conducted to test major portions of the onsite (licensee) and offsite emergency response capabilities. The licensee activated its emergency response organization and all emergency response facilities. The Federal Emergency Management Agency evaluated the offsite response capabilities of the states of Nebraska and Missouri, Nemaha and Richardson counties in Nebraska, and Atchison county in Missouri. The Federal Emergency Management Agency will issue a separate report.

The exercise scenario was run using a normal shift staff with the CR simulator in an interactive mode. The exercise scenario began at 7:58 a.m. with the plant at 100 percent power. Normal weekday personnel were available for duties. The high pressure coolant injection pump was out of service.

At 8 a.m., the CR received a report of a fire in a lunch trailer located within the protected area. The fire brigade was promptly dispatched, and the shift supervisor declared a notification of unusual event at 8:10 a.m. based on a fire that lasted longer than 10 minutes.

At 8:48 a.m., the CR received a seismic alarm. The shift supervisor, acting as the emergency director, declared an alert at 8:53 a.m. based on the seismic monitor reading. The licensee commenced a plant shutdown at 9:07 a.m. in response to the seismic event and mobilized the emergency response organization.

At 10:27 a.m., a second seismic event occurred followed by a 10:31 a.m. report of a steam leak in the reactor building. Emergency responders determined the leak was from the reactor water cleanup system. The EOF emergency director declared a site area emergency at 10:31 a.m. based on a loss of two fission product barriers.

At 10:32 a.m., the CR operators scrammed the plant when the attempt to isolate the leak failed. A spurious Group 1 isolation signal closed the main steam isolation valves. Then, at 11:03 a.m., control rod drive Pump A failed. The CR operators started Pump B.

At 11:21 a.m., standby liquid control Pump A relief valve failed open, and, at 12:06 p.m., the reactor core isolation cooling pump failed. This condition prompted the EOF emergency director to declare a general emergency at 12:08 p.m. based on the loss of two of three fission product barriers with a potential loss of the third barrier.

At 12:17 p.m., reactor water level reached the top of active fuel and fuel failure resulted. An unmonitored release above Technical Specification limits commenced at 12:28 p.m.

via the turbine building ventilation system. The CR staff responded to other events and annunciators as required throughout the remainder of the exercise. At approximately 2:15 p.m., the exercise was terminated.

P4.2 Control Room (CR)

a. Inspection Scope (82301-03.02)

The inspectors observed and evaluated the CR shift staff as they performed tasks in response to the exercise scenario conditions. These tasks included event detection and classification, analysis of plant conditions, offsite agency notifications, internal and external communications, and adherence to the emergency plan and procedures. The inspectors reviewed applicable emergency plan sections and procedures, logs, and notification forms.

b. Observations and Findings

The CR staff was attentive to plant parameters, promptly recognized changing plant conditions, and took appropriate corrective actions. The notification of unusual event and alert conditions were correctly classified. State, local, and NRC notifications were made within the required time limits.

However, CR and plant-wide announcements for the emergency classification levels were not timely. Following the declaration of the notification of unusual event, the shift supervisor did not immediately announce the event declaration and assumption of emergency director duties to the CR staff. The staff was informed during a briefing about 30 minutes later. Plant-wide announcements for the alert, site area emergency, and general emergency occurred 11, 9, and 8 minutes, respectively, after declaration. The delayed alert announcement held-up the personnel accountability process and challenged the goal to complete the process within 30 minutes of event declaration.

Control room supervision held effective periodic briefings. Communications between the CR and TSC were generally good. There were two instances when incorrect plant status information was communicated to the TSC. In the first instance, the reactor water level data was immediately corrected. In the second, the incorrect main condenser vacuum status led to confusion on the release path into the turbine building.

Control room personnel exhibited good teamwork and coordination. Personnel accountability was maintained throughout the exercise.

c. Conclusions

The CR staff's performance was good. Emergency events were promptly recognized and classified, but CR staff and plant-wide announcements for event classifications and personnel accountability were not timely. Offsite event notifications were made within required times. Personnel accountability was correctly maintained. Operators promptly

recognized changing plant conditions and took appropriate corrective actions. Communications between the CR and TSC were effective.

P4.3 Technical Support Center (TSC)

a. Inspection Scope (82301-03.03)

The inspectors observed and evaluated the TSC staff as they performed tasks necessary to respond to the exercise scenario conditions. These tasks included staffing and activation, accident assessment, NRC notifications, personnel accountability, facility management and control, internal and external communications, assistance and support to the CR, and prioritization of mitigating actions. The inspectors reviewed applicable emergency plan sections, procedures, position instruction manual checklists, and logs.

b. Observations and Findings

The TSC was promptly activated 24 minutes after the alert declaration. The TSC was staffed with the appropriate number of personnel with the requisite expertise for the positions assigned.

Plant conditions were analyzed and evaluated in a timely and effective manner. The TSC staff held effective discussions and briefings. The staff determined the appropriate response to emerging issues. The TSC staff discussed their conclusions with the other emergency response facilities.

The TSC director conducted thorough briefings with the TSC and OSC staffs. During internal discussions and briefings, the TSC staff assigned and reviewed task priorities. This practice contributed to a very good use of available resources. OSC teams were reassigned as necessary to address emerging issues.

Personnel accountability in the TSC was well implemented and maintained. Licensee security personnel were proactive in ensuring personnel logged in and out of the TSC.

The TSC staff used status boards effectively to track task priorities and plant historical status. The displays driven by the simulator computer provided real-time plant parameter values which allowed TSC personnel to make timely decisions when responding to changing plant conditions.

c. Conclusions

The TSC staff's performance was good. Emergency conditions were quickly recognized and classified. Briefings were thorough and included input from key center areas. Task priorities were assigned and reviewed at frequent intervals. Resources were well coordinated, and status boards were effectively used. Personnel accountability was well implemented and maintained.

P4.4 Operational Support Center (OSC)

a. Inspection Scope (82301-03.05)

The inspectors observed and evaluated the OSC staff as they performed tasks in response to the exercise scenario conditions. These tasks included fire brigade response, facility activation and staffing, emergency response team dispatch, and response to CR and TSC requests. The inspectors reviewed applicable emergency plan sections, procedures, logs, position instruction manual checklists, and forms.

b. Observations and Findings

Prior to OSC activation, the inspectors observed the licensee's response to a fire in the lunch trailer. In general, the fire brigade leader demonstrated good command and control of the fire scene. Team members wore appropriate fire protection clothing and were assigned job responsibilities in a timely manner. However, several problems were noted with the fire brigade's response. First, one team entered the trailer without a charged fire hose. The direction to simulate charging the hose came 7 minutes later. Second, although three-part communications were good during the fire response, on two occasions the CR simulator operator attempted to complete a radio check with the fire brigade leader, but the operator did not acknowledge the fire brigade leader's radio check, nor did the fire brigade leader followup with the operator. Third, none of the fire brigade members performed a negative pressure test after donning the respiratory face piece.

The OSC was promptly activated after the CR emergency director announced the alert classification. Upon arrival, the functional area leads listed craft personnel on the personnel status control board. Due to an emergency preparedness oversight, there was no space on the board to list onsite operations personnel. The emergency preparedness manager stated that the oversight was scheduled to be corrected and confirmed that operations personnel were tracked as inplant response team members.

The OSC supervisor demonstrated good oversight during the exercise by effectively communicating job center priorities and equipment status to all OSC personnel. OSC personnel correctly used three-part communications when issuing directions. Repair teams were appropriately assigned according to the priority status board.

For ALARA purposes, the OSC leads generally ensured that inplant response teams consisted of the minimum amount of appropriate personnel necessary to accomplish assigned tasks (based on expertise). However, when Team 9 entered the power block to trouble shoot and attempt to close reactor water clean-up Motor Operated Valves 15 and 18, one of the three team members could not achieve a proper respiratory equipment seal because of facial hair that interfered with the respirator sealing surface. Following a discussion between the team's electrical maintenance technician and OSC lead personnel, a decision was made to accomplish the job with the remaining two team members. The inspectors concluded that, in addition to the ALARA concerns (sending

two people when three were initially identified as necessary), this task was not thoroughly assessed by the OSC leads prior to assigning team members (assigning someone with a beard).

With some exceptions, response teams demonstrated good proficiency, expertise, and radiological control practices in carrying out assigned tasks. Teams retrieved the necessary tools, materials, and radiological supplies needed to accomplish assigned tasks. However, some workers, including radiation protection personnel, did not inspect anticontamination clothing for tears or holes prior to donning the items, and one of three workers assigned to wear respiratory equipment for radiological work did not perform a negative pressure check after donning the respirator face piece. One operator reported to the OSC for a job assignment but did not bring the necessary personnel safety equipment needed for the task (respirator eye glass inserts). The team was delayed because it had to go to the operations relief office to obtain the needed personnel safety equipment prior to reporting to the assigned task location. One radiation protection technician assigned field job coverage walked passed two continuous air monitors in the reactor building without checking the continuous air monitor chart recorders to determine airborne trends in the area.

Good communications were maintained between the field teams and the OSC leads. The OSC radiation protection lead informed the field teams when there was a change in radiological or plant equipment conditions. Radiation protection personnel assigned to field teams kept the OSC radiation protection lead informed of the radiological conditions in task work areas and traversed routes. When conditions were different than expected, the OSC supervisor was promptly and clearly informed.

Good team briefings were conducted prior to dispatch from the OSC. Maintenance and radiation protection OSC leads provided the teams with the appropriate information to properly assess and perform assigned tasks expeditiously and in a radiologically safe manner. Engineering personnel were consulted when appropriate.

However, the manner in which teams were assigned, briefed, and dispatched detracted from the OSC's overall effectiveness and caused minor delays. For example, Team 5 was unnecessarily delayed because a team briefing was not conducted in a timely manner. Team 5 was assigned an OSC Priority 1 task to perform a walkdown of the emergency core cooling system to identify system leaks. It took more than 30 minutes to brief the team prior to dispatch. The radiological briefing was delayed because the OSC radiation protection lead was handling multiple tasks, such as debriefing field teams, assigning radiation protection team members, and monitoring current radiological information. The team was also delayed because one team member did not have the necessary safety equipment (the aforementioned individual without the eye glass inserts). Minor delays also occurred because the OSC lead groups had to coordinate with one another to assign team numbers. There did not appear to be a system to easily keep track of the next available team number.

Similarly, the level of activity in the OSC lead office area detracted from the center's overall effectiveness. For example, OSC lead job assignment briefings were generally held in the OSC lead office area. This practice distracted other OSC leads who were obtaining direction from the OSC supervisor or conducting field team debriefs. Also, operations personnel discussed activities and performed turnovers in the OSC lead office, rather than the OSC personnel assembly area. Again, this practice was distracting and added to the noise levels.

Radiological contamination controls were not properly implemented in the TSC and OSC (the two facilities are collocated). Inspectors observed the following sequence:

- At 11 a.m., about 15 minutes after initial contamination controls were established (personnel contamination monitor activation/frisker placement nearby on the floor), the trouble light on the personnel contamination monitor illuminated, indicating the monitor was out of service.

- At about 12:10 p.m., a team of three, including a radiation protection technician, entered the TSC/OSC without using the personnel monitoring equipment to check for contamination.

- At 12:15 p.m., the TSC radiation protection coordinator noted the condition of the personnel contamination monitor but took no actions to either correct the monitor problem or to inform the TSC/OSC staff of the need to use the frisker.

- Between approximately 12:15 and 1 p.m., at least five more workers bypassed the personnel contamination monitoring equipment, and again, at least one of the five workers was a radiation protection technician.

- At 1:08 p.m., the OSC supervisor finally announced to the OSC personnel that the personnel contamination monitor was out-of-service and that all personnel entering the TSC/OSC were required to perform a manual frisk prior to entering the centers.

- A contamination survey was finally conducted at 1:10 p.m., after an OSC worker informed radiation protection personnel that some people did not use the contamination equipment prior to entering the TSC/OSC. Inspectors questioned the appropriateness of the habitability survey procedure since only airborne and area radiation readings were initially specified, even after contamination controls were established outside the TSC/OSC door.

- Between about 1:15 and 1:45 p.m., three more people entered the TSC/OSC without using the contamination monitoring equipment. One security officer noted the personnel contamination monitor was out-of-service and paged radiation protection, via GAITRONICS, to get direction on how to enter the TSC/OSC. This action was appropriate. Although the individual contacted was not participating in

the exercise, the response given was incorrect (the officer was told to bypass the contamination monitoring equipment).

The failure to implement proper radiological contamination controls in the TSC and OSC was identified as an exercise weakness due to the potential disruption to the response effort that would have occurred if the TSC and OSC personnel and facilities became contaminated (50-298/98016-01).

c. Conclusions

The OSC staff's performance was satisfactory. The response to the fire was not completely correct because entry into the fire scene was made 7 minutes before the hoses were charged and respiratory protection equipment was not properly tested. The OSC was promptly activated with appropriate personnel. OSC briefings were clear, concise, and center work priorities were relayed and updated to center personnel in a timely manner. Status boards were effectively used to maintain job priority focus. Radiological job briefings provided inplant response teams with proper radiological information to maintain personnel exposures ALARA. The manner in which teams were assigned, briefed, and dispatched, coupled with the level of activity (noise and distraction) in the OSC lead office area, detracted from the overall effectiveness of the center and caused minor delays in team dispatch. An exercise weakness was identified for the failure to implement proper radiological contamination controls in the TSC and OSC. Additionally, some station workers, including radiation protection personnel, did not demonstrate proper radiation protection practices when respiratory equipment and protective clothing were used.

P4.5 Emergency Operations Facility (EOF)

a. Inspection Scope (82301-03.04)

The inspectors observed the EOF's staff as they performed tasks in response to the exercise scenario. These tasks included facility activation, emergency classification, notification of state and local response agencies, development and issuance of protective action recommendations, dose projections, field team control, and direct interactions with offsite agency response personnel. The inspectors reviewed applicable emergency plan sections and procedures, position instruction manual checklists, forms, dose projections, and logs.

b. Observations and Findings

The EOF was promptly staffed and systematically activated following the 8:53 a.m. alert declaration. Upon arrival, personnel established an accountability control point at the facility entrance, retrieved and implemented position instruction manual checklists, established communications with counterparts, synchronized the clock, and determined facility habitability. At 9:28 a.m., following a turnover with the CR, the EOF assumed

emergency director duties (emergency classification, offsite agency notifications, and protective action recommendations).

Coincident with the alert declaration, the CR initiated the site personnel and assembly process. Following EOF activation and accountability process completion, the EOF emergency director authorized the release of non-designated personnel. However, the decision to release non-designated personnel was not effectively coordinated. First, the decision to keep Team 1 in standby was not made until after personnel were released. As a result, the logistics coordinator would have had to call all Team 1 personnel to communicate the standby status. Second, personnel were released during the simulated security event (a potentially armed and disgruntled former employee made an unauthorized/forced, site entry and had not been apprehended). Under some circumstances (e.g., security events and severe weather conditions), judgement may be needed regarding plant personnel movement.

Management oversight in the EOF was good. Briefings were frequent and comprehensive. Facility members were given prior notice to prepare, and all facility personnel, with the exception of the dose assessment staff, participated in the briefings. The briefings included input from operations, radiation protection, logistics, and state personnel. Early on, the briefings included a discussion of facility priorities; however, this practice waned as the exercise progressed. The EOF log (captured electronically via a word processor/overhead projector) was meticulously maintained with above average detail.

The EOF emergency director, with support from the TSC, promptly recognized and classified emergency conditions. Both the site area and general emergencies were classified within minutes of initiating conditions that warranted event escalation. Corresponding offsite agency notifications were made within required time limits. The offsite communicator's persistence in obtaining information to complete the notification forms contributed to the timely notifications. However, noise levels in the EOF, due to all the people and the different conversations, hampered the offsite communicator's ability to make some offsite agency notifications. Toward the end of the exercise, the offsite communicator appeared to have difficulty hearing the offsite agency representatives during notification calls.

Protective action recommendations were correctly formulated and communicated to offsite authorities in a timely manner. Following the general emergency declaration, a default 2-mile radius/5-mile downwind evacuation was correctly recommended. When a change in release rate and a wind shift caused additional downwind sectors to be affected, the dose assessment staff correctly recommended that the emergency director authorize an upgrade in protective action recommendations.

Dose assessment and field team control activities were well managed and controlled to support protective action recommendations. Numerous dose projections were calculated based on plant conditions. The dose assessment staff quickly computed new dose projections when plant conditions changed. Dose calculations compared well to offsite

field monitoring team samples. There was very good coordination between the utility and state offsite monitoring teams. Offsite monitoring team doses were closely monitored, and when the decision was made to issue potassium iodide, the field teams were promptly notified.

Although information released from the EOF was usually accurate, on two occasions, review and approval of information released from the EOF was insufficient to prevent the release of inaccurate information. First, release rate information and projected integrated doses communicated to offsite agencies in Notification Report 10 were not consistent with existing conditions. The release rate was one quarter of the actual value. A correction was made about 40 minutes later. The errors did not appear to affect offsite dose projections and protective action decision making but could have under different circumstances. Second, Press Release 6.1 contained inaccurate information concerning the technical specification release start time (12:35 versus 12:28 p.m.). This type of error could cause the pubic to question the credibility of utility emergency responders.

Interactions with state and NRC response team members who were stationed in the EOF were open and constructive. Upon arrival, state and NRC representatives were briefed on plant conditions and prognosis. The state's input was appropriately solicited during briefings.

c. Conclusions

The EOF staff's performance was good. Facility briefings were frequent and included input from key functional areas, such as operations, dose assessment, and offsite agency response teams. The release of non-designated personnel was not well coordinated because personnel were released before the relief shift was notified of standby status and a security event was in progress. Changes in emergency classifications were promptly recognized and correctly declared with support from the TSC. Offsite agency notifications and protective action recommendations were correct and timely following changes in plant conditions. Review and approval of information released from the EOF was insufficient on two occasions to prevent the release of inaccurate information: (1) an incorrect release start time was included in one press release, and (2) incorrect release rate and dose projection data was included on one offsite agency notification report. Dose assessment and field team control activities were well managed and executed to determine actual offsite impact. Interactions with state and NRC response teams were open and constructive.

P4.6 Scenario and Exercise Control

a. Inspection Scope (82301 and 82302)

The inspectors evaluated the exercise to assess the challenge and realism of the scenario and exercise control.

b. Observations and Findings

The licensee submitted the exercise objectives and scenario for NRC review on March 9 and April 24, 1998, respectively. The exercise objectives were appropriate to meet emergency plan requirements (reference NRC letter dated April 20, 1998); however, the corresponding letter (March 9, 1998) referenced outdated information contained in a February 9, 1984, letter from the NRC. The information concerning exercise objectives and scenario submittal dates was superseded by NRC Administrative Letter 94-16, "Revision of NRC Core Inspection Program for Annual Emergency Preparedness Exercise," dated November 30, 1994. Referencing outdated information indicated that the station emergency preparedness staff was not keeping current with program area changes. The exercise scenario was sufficiently challenging to test onsite emergency response capabilities.

Several mock-ups, pictures, and staged props were developed to enhance the training value of the exercise.

c. Conclusions

The exercise objectives were appropriate to meet emergency plan requirements. Outdated information was referenced in the letter that forwarded the exercise objectives and indicated that the emergency preparedness staff was not keeping current with program area changes. The exercise scenario was sufficiently challenging to test onsite emergency response capabilities. The use of mock-ups, pictures, and staged props enhanced the exercise training value.

P4.7 Licensee Self Critique

a. Inspection Scope (82301-03.13)

The inspectors observed and evaluated the licensee's post-exercise facility critiques and the formal management critique on June 11, 1998, to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

b. Observations and Findings

Post-exercise critiques in the CR simulator, TSC, OSC, and EOF were thorough, open, and very self critical. However, the post-exercise critiques were considered incomplete because controllers did not provide immediate feedback to participants. In addition, some CR and OSC participants were not present for the critiques. An operator and a radiation protection technician did not attend the CR critique, and operations personnel did not attend the OSC critique. Participants in all facilities made a sincere effort to identify areas where performance/processes could be improved.

During the June 11, 1998, management critique, the emergency preparedness manager presented the preliminary exercise findings. Several strengths and one exercise

weakness were identified by the licensee's evaluation team (discussed below). The strengths included the integration of the NRC site team, facility logkeeping, and the functioning of the TSC. The weakness involved the failure to implement contamination controls in the TSC and OSC (the same issue identified by the NRC inspection team).

In addition to the Cooper Nuclear Station evaluators and controllers, a peer evaluation was performed by representatives from other sites (South Texas Project, Washington Nuclear Project, and Brunswick). The addition of the peer evaluation group added depth to the licensee's critique process. A participant debrief of all exercise evaluation results was scheduled for June 16, 1998.

c. Conclusions

The critique process was strengthened by using a peer evaluation group made up of representatives from other sites.

P8 Miscellaneous Emergency Preparedness Issues (92904)

(Closed) Inspection Followup Item 50-298/96022-01: Exercise weakness for failure to continually maintain personnel accountability in the CR and TSC. During the 1996 biennial exercise, participants entered and exited the CR and TSC without signing the accountability log as required. The inspectors did not observe any accountability concerns in the CR or TSC during this exercise. Personnel logged in and out of the facilities as required. Security personnel were proactive in ensuring that accountability was maintained.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on June 11, 1998. The licensee acknowledged the facts presented. No proprietary information was identified.

The Federal Emergency Management Agency conducted a public meeting at the Cooper Nuclear Station auditorium on June 10, 1998. Representatives from the Federal Emergency Management Agency and NRC provided a brief discussion of preliminary exercise results.

ATTACHMENT

SUPPLEMENTAL INFORMATION

PART I LIST OF PERSONS CONTACTED

Licensee

J. Bednar, Emergency Preparedness Coordinator
T. Brown, Manager, Emergency Preparedness
P. Caudill, Senior Manager, Engineering
C. Gaines, Manager, Maintenance
W. Green, Shift Technical Engineer
M. Hale, Acting Senior Manager, Site Support
M. Hamm, Manager, Security
L. Hodges, Assistant to the Vice President
B. Houston, Manager, Licensing
J. Kelsay, Emergency Preparedness Coordinator
M. Peckham, Plant Manager
J. Pelletier, Assistant to the Vice President
B. Pergerson, Emergency Preparedness Coordinator
A. Shiever, Manager, Operations
C. Sunderman, Emergency Preparedness Coordinator
D. VanDerKamp, Assistant Manager, Operations

NRC

B. Murray, Chief, Plant Support Branch

LIST OF INSPECTION PROCEDURES USED

IP 82301	Evaluation of Exercises at Power Reactors
IP 82302	Review of Exercise Objectives and Scenarios for Power Reactors
IP 92904	Followup - Plant Support

LIST OF ITEMS OPENED AND CLOSED

Opened

50-298/98016-01	IFI	Exercise weakness - Failure to implement proper contamination controls in the TSC and OSC (Section P4.4)

Closed

50-298/96022-01	IFI	Exercise weakness - Failure to continually maintain personnel accountability in the CR simulator and TSC (Section P8)

LIST OF DOCUMENTS REVIEWED

Emergency Plan Implementing Procedures

5.7.1	Emergency Classification	Revision 23
5.7.2	Shift Supervisor EPIP	Revision 11
5.7.6	Notifications	Revision 25
5.7.7	Activation of TSC	Revision 23
5.7.8	Activation of OSC	Revision 16
5.7.9	Activation of EOF	Revision 18
5.7.10	Personnel Assembly and Accountability	Revision 20
5.7.15	OSC Team Dispatch	Revision 14, C1
5.7.17	Dose Assessment	Revision 21.1
5.7.20	Protective Action Recommendations	Revision 12

Other Procedures

5.4.1	General Fire Protection	Revision 30

Other Documents

Cooper Nuclear Station Emergency Plan, Revision 32
Position Instruction Manual checklists for various TSC, OSC, and EOF positions