UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

July 12, 2001

EA-00-220
EA-01-154

J. H. Swailes, Vice President of
Nuclear Energy
Nebraska Public Power District
P.O. Box 98
Brownville, Nebraska 68321

SUBJECT: NRC INSPECTION REPORT NO. 50-298/01-04

Dear Mr. Swailes:

On June 27, 2001, the NRC completed an inspection at your Cooper Nuclear Station. The enclosed report presents the results of that inspection which were discussed onsite on April 17, 2001, and in telephone conversations on May 29 and 30 and June 27, 2001, with you and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspector reviewed selected procedures and records, observed activities, and interviewed personnel. The inspection consisted of a review of the implementation of the onsite emergency preparedness program and supplemental inspection for a finding of low to moderate safety significance that was identified in an earlier inspection (Inspection Report 50-298/00-16) (EA-00-220). Findings identified during the inspection are discussed in detail in the enclosed inspection report.

Based on the results of the supplemental inspection, we concluded that your staff performed an adequate evaluation of the causes associated with the failure of your formal exercise critique process to identify performance problems related to a risk-significant emergency planning standard. Additionally, we concluded that appropriate corrective actions were identified by your staff to address the root and contributing causes. Due to your acceptable performance in addressing the critique process failure, the White finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program."

In addition, the enclosed inspection report discusses a different issue that appears to have low to moderate safety significance. As described in Section 1EP5.b of this report, corrective actions implemented to prevent recurrence of a dose assessment performance weakness identified during the August 29, 2000, biennial exercise were not fully effective in that they were narrowly focused. As a result, the performance weakness was repeated during an April 11, 2001, drill. This issue was assessed using the Emergency Preparedness Significance

Determination Process as a potentially safety significant finding that was preliminarily determined to be White; i.e., an issue with some increased importance to safety, which may require additional NRC inspection. The issue has a low to moderate safety significance because it represented a failure to correct a performance weakness associated with a risk significant emergency preparedness planning standard.

The issue also appears to be an apparent violation of NRC requirements and is being considered for escalated enforcement action (EA-01-154) in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. The current Enforcement Policy is included on the NRC's website at www.nrc.gov/OE.

Before the NRC makes a final decision on this matter, we are providing you an opportunity to request a Regulatory Conference where you would be able to provide your perspectives on the significance of the finding, the bases for your position, and whether you agree with the apparent violation. If you choose to request a Regulatory Conference, we encourage you to submit your evaluation and any differences with the NRC evaluation at least one week prior to the conference in an effort to make the conference more efficient and effective. If a conference is held, it will be open for public observation. The NRC will also issue a press release to announce the conference.

Please contact Ms. Gail Good at (817) 860-8215 within seven days of the date of this letter to notify the NRC of your intentions. If we have not heard from you within 10 days, we will continue with our significance determination and enforcement decision and you will be advised by separate correspondence of the results of our deliberations on this matter.

Since the NRC has not made a final determination in this matter, no Notice of Violation is being issued for this inspection finding at this time. In addition, please be advised that the number and characterization of apparent violations described in the enclosed inspection report may change as a result of further NRC review.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/
Arthur T. Howell III, Director
Division of Reactor Safety

Docket: 50-298
License: DPR-46

Enclosure:
NRC Inspection Report No.
50-298/01-04

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket No: 50-298

License No: DPR-46

Report No: 50-298/2001-04

Licensee: Nebraska Public Power District

Facility: Cooper Nuclear Station

Location: P. O. Box 98
Brownville, Nebraska

Dates: April 9 - June 27, 2001

Inspector: William A. Maier, Senior Emergency Preparedness Inspector

Approved by: Gail M. Good, Chief
Plant Support Branch
Division of Reactor Safety

SUMMARY OF FINDINGS

Cooper Nuclear Station
NRC Inspection Report 50-298/2001-04

IR 05000298-01-04, on 04/09 - 06/27/2001, Nebraska Public Power District, Cooper Nuclear Station. Alert and notification system testing, emergency response organization augmentation, emergency action level and emergency plan changes, correction of emergency preparedness weaknesses and deficiencies, performance indicator verification, supplemental inspection for one white inspection finding in the reactor safety strategic performance area.

The inspection combined both baseline and supplemental inspection effort and was performed by a region-based emergency preparedness inspector. One apparent violation was identified during the baseline inspection. The significance is still being determined but has preliminarily been assessed as White. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using IMC 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html.

Cornerstone: Emergency Preparedness

A. Inspector Identified Findings

TBD. Corrective actions implemented to prevent recurrence of a dose assessment performance weakness identified during the August 29, 2000, biennial exercise were not fully effective in that they were narrowly focused. The dose assessment team failed to recognize a degraded core condition and to revise its dose projections for the degraded condition. As a result, protective action recommendations were not upgraded. Corrective actions for the performance weakness concentrated on procedural inconsistencies that contributed to the failure and did not sufficiently recognize the need for additional personnel training. As a result, the performance weakness was repeated during an April 11, 2001, drill. This was an apparent violation of 10 CFR Part 50, Appendix E, Paragraph IV.F.2.g. This issue was entered into the licensee's corrective action program as RCR 2001-0331.

This finding was preliminarily determined to have low to moderate safety significance (White) using the Emergency Preparedness Significance Determination Process because it represented a failure to correct a performance weakness associated with a risk-significant emergency preparedness planning standard. The failure to use a degraded core in dose calculations had a credible impact on safety because it resulted in incorrect protective action recommendations which could have caused offsite populations to receive unnecessary radiation dose.

B. Supplemental Inspection Findings

A supplemental inspection was performed by the NRC to assess the licensee's evaluation associated with the failure of the formal critique process to identify a dose

assessment performance weakness during the 2000 biennial emergency preparedness exercise. The weakness caused the issuance of incorrect protective action recommendations for offsite populations. This performance issue was previously characterized as having low to moderate risk significance (White) in NRC Inspection Report 50-298/2000-16. During this supplemental inspection performed in accordance with Inspection Procedure 95001, the inspector determined that the licensee performed an adequate evaluation of the critique failure. The licensee's evaluation identified the primary root cause of the performance issue to be the lack of a performance standard in the dose assessment area for a risk-significant emergency planning standard and identified contributing causes to be the time constraint to prepare the exercise report and the failure of the dose assessment evaluator to attend either the controller training or the pre-exercise brief. The licensee has taken actions to address these causes. The licensee has revised its drill and exercise manual to require inclusion of performance standards for all risk-significant planning standard activities for use by controllers and evaluators, specified the performance of an independent technical review of risk-significant planning standard activities during post-drill critique periods, enforced attendance at pre-exercise briefs, implemented an evaluator training module, and revised the drill evaluator checklists to explicitly identify areas for evaluators to observe and criteria for evaluation. The licensee provided training to its evaluators on the above changes.

Due to the licensee's acceptable performance in addressing the critique process failure, the White finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program."

Report Details

Baseline Inspection

1. REACTOR SAFETY
Cornerstone: Emergency Preparedness

1EP2 Alert and Notification System Testing (71114.02)

a. Inspection Scope

The inspector performed the following actions to evaluate the licensee's offsite siren and tone alert radio systems for alerting the public in the event of a nuclear emergency for compliance with NRC requirements in 10 CFR 50.47(b) and Appendix E to Part 50:

- Reviewed licensee commitments for the siren and tone alert radio systems contained in the initial and updated system design reports, the emergency plan, and station procedures
- Reviewed changes to the systems and effects on commitments
- Evaluated the adequacy of siren test and maintenance procedures
- Reviewed siren test records from the third and fourth calendar quarters of 2000 and the first calendar quarter of 2001
- Interviewed licensee personnel responsible for siren maintenance and testing
- Observed a siren test performed by the licensee

b. Findings

No findings of significance were identified.

1EP3 Emergency Response Organization Augmentation Testing (71114.03)

a. Inspection Scope

The inspector performed the following actions to evaluate the licensee's system for notification of emergency response organization members and activation of onsite emergency response facilities for compliance with NRC requirements in 10 CFR 50.47(b) and Appendix E to Part 50:

- Reviewed emergency response organization notification and facility activation goals and commitments in the emergency plan and station procedures
- Reviewed the adequacy of design, operation, and testing of the primary and backup notification systems

- Observed simulated operation of the primary notification system during a site-wide emergency preparedness drill
- Reviewed augmentation drill results, problem identification reports documenting augmentation system problems, and the adequacy of corrective actions
- Reviewed the qualification status for a sample of 11 emergency response organization members
- Interviewed five shift communicator-qualified personnel responsible for performing emergency response organization augmentation notifications to evaluate the adequacy of training for this task

b. Findings

No findings of significance were identified.

1EP4 Emergency Action Level and Emergency Plan Changes (71114.04)

a. Inspection Scope

The inspector reviewed Revisions 34 and 35 to the Cooper Nuclear Station Emergency Plan and Revision 27 to Procedure EPIP 5.7.1, "Emergency Classification," for compliance with NRC requirements to determine if these revisions/changes decreased the effectiveness of the plan.

b. Findings

No findings of significance were identified.

1EP5 Correction of Emergency Preparedness Weaknesses and Deficiencies (71114.05)

a. Inspection Scope

The inspector performed the following actions to evaluate the licensee's emergency preparedness related efforts to correct weaknesses and deficiencies for compliance with NRC requirements in 10 CFR 50.47(b) and Appendix E to Part 50:

- Reviewed corrective actions taken for emergency preparedness problems identified in the 2000 biennial exercise
- Observed a site-wide emergency preparedness drill conducted on April 11, 2001, to evaluate the adequacy of corrective actions taken for problems identified in the 2000 biennial exercise
- Reviewed quality assurance audit and surveillance reports for years 2000 and 2001

- Interviewed the lead auditor for the last quality assurance audit
- Reviewed emergency preparedness problem identification reports and action items for the adequacy and timeliness of corrective actions
- Reviewed two root cause determination evaluations for problems identified in the 2000 biennial exercise
- Reviewed emergency planning department self-assessments for the years 1999-2001 to determine the quality of self-initiated corrective actions

b. Findings

An apparent violation of 10 CFR Part 50, Appendix E, Paragraph IV.F.2.g was identified. The apparent violation was preliminarily determined to have low to moderate safety significance (White). Final significance determination of the apparent violation is still under NRC review.

Corrective actions implemented to prevent recurrence of a dose assessment performance weakness identified during the August 29, 2000, biennial exercise were not fully effective in that they were narrowly focused. In that exercise, the dose assessment team failed to recognize a degraded core condition and to revise its dose projections for the degraded condition. Corrective actions for the performance weakness concentrated on procedural inconsistencies that contributed to the failure and did not sufficiently recognize the need for additional personnel training. As a result, the performance weakness was repeated during an April 11, 2001, drill.

During the biennial emergency preparedness exercise on August 29, 2000, the dose assessment staff failed to recognize that the reactor core was degraded and consequently underestimated offsite doses and issued an incorrect (non-conservative) protective action recommendation for offsite populations. The licensee implemented immediate corrective actions and actions to prevent recurrence of this problem. These actions included revision to the dose assessment procedure, briefing dose assessment teams and decision makers on the identified weakness, promulgation of a white paper containing guidance for decision makers, and administration of dose assessment workshops to emergency response teams to improve command and control and dose assessment technical skills. These actions were completed by March 4, 2001.

The licensee's corrective actions were primarily directed toward the procedural inconsistencies between its emergency classification and dose assessment procedures. The root cause evaluation report for the performance weakness described differences between these two procedures as the root cause and corrective actions were listed to address this root cause. The root cause evaluation did not identify additional training needs beyond training on the procedural differences and subsequent procedural revisions. Training and workshops given to the emergency response teams after the exercise did not sufficiently cover the concepts of recognizing the radiological symptoms of a degraded core and resolving inconsistencies between conflicting indications. In addition, the command and control workshops administered to the emergency response and dose assessment teams did not sufficiently emphasize the need for support staffs

to aggressively inform decision makers of their technical assessments. Finally, the workshops did not train senior emergency management personnel of the need to ensure prompt evaluation of core conditions when conflicting indications are reported.

During a site emergency preparedness drill on April 11, 2001, a different dose assessment team also failed to recognize a degraded core condition. In this drill, the radiological control manager failed to recognize a degraded core condition (during a release of radioactive material) for 32 minutes after radiation monitor channel indications and field team sample results supported this determination. The radiological control manager's failure to recognize a degraded core condition when indications were available was not corrected by other members of the response team who correctly recognized the condition. The other members of the dose assessment team and the Technical Support Center staff had recognized and communicated that degraded core conditions existed. Moreover, the emergency director failed to direct a qualitative evaluation of the core condition, using best available indications, when the radiological control manager reported conflicting indications of core condition with a release in progress. As a result, the protective action recommendation for offsite populations was not upgraded to include evacuation out to 10 miles for the three downwind sectors of the emergency planning zone.

This finding was preliminarily determined to have low to moderate safety significance (White) using the Emergency Preparedness Significance Determination Process because it represented a failure to correct a performance weakness associated with a risk-significant emergency preparedness planning standard. The failure to use a degraded core in dose calculations had a credible impact on safety because it resulted in incorrect protective action recommendations which could have caused offsite populations to receive unnecessary radiation dose.

Paragraph IV.F.2.g of Appendix E to 10 CFR Part 50 requires that weaknesses or deficiencies identified from exercises shall be corrected. The failure to take effective corrective actions to prevent the recurrence of a risk-significant performance weakness is a violation of Appendix E, Paragraph IV.F.2.g. This issue was entered into the licensee's corrective action program as RCR 2001-0331 (AV 298/01004-01).

4 OTHER ACTIVITIES

4OA1 Performance Indicator Verification (71151)

.1 Drill and Exercise Performance

a. Inspection Scope

The inspector reviewed classification, notification, and protective action recommendation results from the 2000 biennial exercise and selected emergency preparedness drills, simulator scenarios, and shift communicator drills from the third and fourth calendar quarters of 2000 and the first calendar quarter of 2001 to verify the accuracy of the reported performance indicator data for that period. The inspector evaluated licensee

performance indicator collection and reporting practices against the standards of NEI 99-02, "Regulatory Assessment Performance Indicator Guideline."

b. Findings

No findings of significance were identified.

.2 Emergency Response Organization Drill Participation

a. Inspection Scope

The inspector reviewed drill participation data for the third and fourth calendar quarters of 2000 and the first calendar quarter of 2001 for a sample of 34 key emergency response organization members to verify the accuracy of data reported for the performance indicator for that period. The inspector evaluated licensee performance indicator collection and reporting practices against the standards of NEI 99-02, "Regulatory Assessment Performance Indicator Guideline."

b. Findings

No findings of significance were identified.

.3 Alert and Notification System Reliability

a. Inspection Scope

The inspector reviewed siren test results from the third and fourth calendar quarters of 2000 and the first calendar quarter of 2001 to verify the accuracy of data reported for the performance indicator for that period. The inspector evaluated licensee performance indicator collection and reporting practices against the standards of NEI 99-02, "Regulatory Assessment Performance Indicator Guideline."

b. Findings

No findings of significance were identified.

Supplemental Inspection

01 Inspection Scope (95001)

This supplemental inspection was performed by the NRC to assess the licensee's evaluation associated with the failure of the formal critique process to identify a dose assessment performance weakness during the 2000 biennial emergency preparedness exercise. This weakness resulted in issuance of incorrect protective action recommendations for offsite populations. This performance issue was previously characterized as White in NRC Inspection Report 50-298/2000-16 and is related to the emergency preparedness cornerstone in the reactor safety strategic performance area.

02 Evaluation of Inspection Requirements

02.01 Problem Identification

a. Determination of whom (i.e., licensee, self-revealing, or NRC) identified the issue and under what conditions.

The NRC identified the failure of the licensee's formal critique process to identify the dose assessment performance weakness during observation of the licensee's critique of the 2000 biennial exercise. The issue is documented in NRC Inspection Report 50-298/2000-16. The licensee's root cause evaluation did not specify that the problem was identified by the NRC; although, it accurately described the sequence of events leading up to the discovery of the problem. NRC identification of the problem is intrinsic to the issue and failure of the licensee to state that fact in its evaluation did not affect the evaluation's quality.

b. Determination of how long the issue existed, and prior opportunities for identification

The licensee's evaluation contained a section to document the licensee and industry's experience with similar issues to the White inspection finding. However, this section of the report only described the licensee's actions to contact various utilities to determine if the issue had been identified in NRC inspections at those utilities. The evaluation did not describe any actions by the licensee to determine how long the issue existed at its own site; however, the evaluation recognized that performance standards for emergency preparedness drills had historically been developed concurrently with the drill report (i.e., after the fact). Therefore, the condition had existed for an indeterminate period. No previously identified problems were noted from this practice. The licensee's emergency preparedness management and staff performed a keyword search of the licensee's problem identification report data base for related occurrences, but none were found.

c. Determination of the plant-specific risk consequences (as applicable) and compliance concerns associated with the issue

The licensee's evaluation did not assess the risk consequences of the issue. It did quote the NRC's preliminary significance determination of the issue, which was a qualitative assessment of the issue's significance relative to the risk-significant emergency planning standards. The licensee's procedures for condition report development do not require significance determination as part of the root cause evaluation, but rather as part of the condition report screening process. This requirement is not specified for the level of condition report at which the licensee classified this issue. The inspector concluded that the licensee's lack of qualitative assessment of the risk consequence of the issue beyond that already described by the NRC was in compliance with the licensee's procedures and did not detract from the quality of the evaluation.

02.02 Root Cause and Extent of Condition Evaluation

a. Evaluation of methods used to identify root causes and contributing causes.

The licensee used a combination of structured root cause analysis techniques to evaluate this issue, including event and causal factors, change, and TapRoot® analyses. The inspector determined that the licensee followed its procedural guidance for performing root cause analysis for the category of condition assigned to the critique failure finding. The procedure provides guidelines for conduct of interviews, and the licensee reviewer interviewed six individuals to gather data. The licensee also conducted a human performance review board, which concluded that the issue was programmatic, rather than a human performance error.

b. Level of detail of the root cause evaluation.

The licensee's root cause evaluation was thorough and identified the primary root cause of the critique failure to be the lack of a performance standard for exercise evaluators to use in evaluating dose assessment performance. The evaluation also identified some contributing causes for the event. These included the time pressure to prepare exercise results for presentation to the NRC inspection team and the failure of the dose assessment evaluator to attend the evaluator training briefing given prior to the exercise.

c. Consideration of prior occurrences of the problem and knowledge of prior operating experience.

The licensee's evaluation included a review of industry operating experience to determine if the issue had been identified in any other power reactor facilities. The licensee had determined that no identification of the issue had occurred at any of the facilities surveyed. The licensee had not documented the performance of any historical investigation of the problem at its own facility; however, a key word search of problem identification reports did not reveal any previously identified problems. The inspector determined that this level of operating experience investigation was in accordance with the licensee's procedures.

d. Consideration of potential common cause(s) and extent of condition of the problem

The licensee's evaluation considered the extent of condition associated with the lack of performance standards for evaluation of exercise performance. The licensee determined that a lack of performance standards occurred for other risk-significant planning standards evaluated during the exercise. The licensee's investigation determined that the exercise manual also did not include objective performance standards for evaluating offsite notification activities.

02.03 Corrective Actions

a. Appropriateness of corrective action(s)

The licensee took specific corrective actions to address the root cause of the lack of objective performance standards. The licensee revised its drill and exercise manual to require a risk-significant planning standard answer key to be included in each drill/exercise package. Corrective actions to address contributing causes were also implemented, including establishing an independent technical review of exercise results, enforcing controller and evaluator attendance at pre-exercise briefs, and implementing an evaluator training module. The inspector determined that the proposed corrective actions to address the root and contributing causes were appropriate.

b. Prioritization of corrective actions

The licensee's actions to address the root cause and contributing causes were completed within four months and were completed in sufficient time to ensure that risk-significant performance problems in drills and exercises did not go undetected by the critique process.

c. Establishment of schedule for implementing and completing the corrective actions

The licensee's plan for correcting the critique failure was implemented according to the risk significance of the issue. The schedule for accomplishing the corrective actions was detailed in a December 4, 2000, letter from the licensee to the NRC.

d. Establishment of quantitative or qualitative measures of success for determining the effectiveness of the corrective actions to prevent recurrence.

The licensee implemented new performance evaluation and critique checklists to evaluate the success of measuring the risk-significant activities occurring in drills and exercises. The licensee's quality assurance organization has increased its surveillance of the drill and critique process to determine if corrective actions taken are effective. This was evidenced by quality assurance presence in the critique of an April 11, 2001, drill that the inspector observed. The inspector observed the licensee's critique of that drill. The critique was effective and successfully identified a repeat of the same performance weakness that had occurred during the August 29, 2000, biennial exercise.

03. Management Meetings

Exit Meeting Summary

The inspector presented the inspection results to Mr. J. McDonald, Plant Manager, and other licensee personnel at the conclusion of the inspection on April 17, 2001. Additional meetings occurred via telephone on April 26; May 7, 24, 29, and 30, 2001. A

final exit interview was conducted via telephone on June 27, 2001, in which the characterization of one finding was revised. The licensee acknowledged the findings presented.

The inspector asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT

Supplemental Information

PARTIAL LIST OF PERSONS CONTACTED

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K. Kirkland, Manager, Information Services
D. Kunzmiller, Manager, Licensing
W. Macecevic, Manager, Operations
J. MacKinnon, Chairman, Industry Advisory Group
J. McDonald, Plant Manager
D. Meyers, Senior Manager, Emergency Preparedness
J. Ranalli, Senior Manager, Engineering
L. Schilling, Manager, Administrative Services
J. Sumpter, Project Manager, Licensing
J. Swailes, Vice President of Nuclear Energy
R. Zipfel, Manager, Emergency Preparedness

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-298/01004-01 AV Failure to correct a risk-significant EP performance weakness

DOCUMENTS REVIEWED

Emergency Plan and Implementing Procedures:

Procedure No.	Title	Revision No(s).
N/A	Cooper Nuclear Station Emergency Plan	34, 35
EPIP 5.7.1	Emergency Classification	27
EPIP 5.7.6	Notification	31
EPIP 5.7.17	Dose Assessment	24
EPIP 5.7.22	Communication	1

Other Licensee Procedures:

Procedure No.	Title	Revision No(s).
0.5	Conduct of the Problem Identification and Resolution Process	23
0.5.PIR	Initiation of Problem Identification Reports (PIRs)	1
0.5.CLSS	Classification of Problem Identification Reports (PIRs)	3
0.5.RCR	Preparation of Resolve Condition Reports	1
0.5.SCR	Preparation of Significant Condition Reports	2
EPDG2 Att. H	Cooper Nuclear Station Drill and Exercise Manual	3

Miscellaneous Documents:

Nebraska Public Power District Letter NLS2000111, dated December 4, 2000, “Information Related to Apparent Finding NRC Inspection Report No. 50-298/00-16"

Root Cause Evaluation 2000-0912, “Inadequate Emergency Preparedness Critique,” dated November 27, 2000

Root Cause Evaluation 2000-0909, "Dose Assessment Process Failure to Identify a Degraded Core Condition," dated November 2, 2000

Prompt Alert and Notification System Design Report for Cooper Nuclear Station, Revision 10, dated October 2000

Cooper Nuclear Station Quality Assurance Audit Reports 00-02 and 01-01, "Emergency Preparedness"

Drill Reports for July 19, August 29, and November 29, 2000, emergency preparedness drills