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

October 4, 2001

EA-01-231

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

SUBJECT: COOPER NUCLEAR STATION - NRC INSPECTION REPORT 50-298/01-09; PRELIMINARY WHITE FINDINGS

Dear Mr. Swailes:

This refers to the inspection conducted from June 25 through September 6, 2001, at the Cooper Nuclear Station. The purpose of the inspection was to follow up on the June 25, 2001, event in which an Alert declaration was made following a fire affecting the station startup transformer. The enclosed report presents the results of the inspection which were discussed on September 6, 2001, with Mr. Wetherell and other members of your staff.

This inspection was an examination of 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. Within these areas, the inspection covered selected examination of procedures and representative records, observations of activities, and interviews with personnel.

This report discusses three issues that appear to have low to moderate safety significance. As described in Section 4OA3 of this report, these issues involved: (1) the failure to implement planning standard 10 CFR 50.47(b)(5), resulting in an untimely notification to state and local response organizations following declaration of an Alert on June 25, 2001; (2) the failure to meet emergency planning standard 10 CFR 50.47(b)(2), resulting in untimely activation of the emergency response facilities on June 25, 2001; and (3) the failure to meet emergency planning standard 10 CFR 50.47(b)(8), resulting in your having not maintained an adequate emergency operations facility to support emergency response since September 14, 1991. These issues were assessed, using the applicable significance determination process, as potentially being safety significant and, therefore, have been preliminarily determined to be White. White issues represent an increased importance to safety, which may require additional NRC inspection and potentially other NRC action.

These issues also appear to be apparent violations of NRC requirements 10 CFR 50.54(q), 10 CFR 50.47(b)(2), and 10 CFR 50.47(b)(8). Title 10 of CFR 50.54(q) requires that a licensee authorized to possess and operate a nuclear power reactor shall follow and maintain in effect emergency plans which meet the standards in 10 CFR 50.47(b). Planning Standard 50.47(b)(2) requires that the onsite emergency response plan provide for timely augmentation of response capabilities, and 10 CFR 50.47(b)(8) requires that the onsite emergency response plan provide

for the maintenance of adequate emergency facilities and equipment to support the emergency response. These issues are being considered for escalated enforcement action 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 findings, the bases for your position, and whether you agree with the apparent violations. 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 Regulatory Conference is held, it will be open for public observation. The NRC will also issue a press release to announce the Regulatory Conference.

Please contact Kriss Kennedy at (817) 860-8144 within 7 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 these inspection findings 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 enclosures 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/

Ken E. Brockman, Director
Division of Reactor Projects

Docket: 50-298
License: DPR-46

Enclosure:
NRC Inspection Report
50-298/01-09

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket:	50-298
License:	DPR 46
Report:	50-298/01-09
Licensee:	Nebraska Public Power District
Facility:	Cooper Nuclear Station
Location:	P.O. Box 98 Brownville, Nebraska
Dates:	June 25 through September 6, 2001
Inspector:	M. Hay, Senior Resident Inspector
Approved By:	Kriss M. Kennedy, Chief, Project Branch C Division of Reactor Projects
ATTACHMENT:	Supplemental Information

SUMMARY OF FINDINGS

Cooper Nuclear Station
NRC Inspection Report 50-298/01-09

IR 050/298-01-09; on 06/25-09/06/2001; Nebraska Public Power District; Cooper Nuclear Station. Resident Inspector Report; Event Followup.

The inspection was conducted by the resident inspector. The inspection identified three apparent violations of low to moderate safety significance. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609 "Significance Determination Process." Findings for which the significance determination process 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

- **TBD.** The licensee failed to notify state and local governmental agencies within 15 minutes of declaring an Alert on June 25, 2001. This was an apparent violation of 10 CFR 50.54(q) and the licensee's emergency plan.

  This apparent violation was evaluated under the risk significance determination process as having low to moderate safety significance based on the following: (1) the failure to notify state and local governmental agencies in a timely manner, following declaration of an Alert, during an actual event on June 25, 2001; and (2) this finding represents a failure to implement the risk significant planning standard 10 CFR 50.47(b)(5) (Section 4OA3.1).

- **TBD.** The licensee failed to activate the emergency response facilities within approximately one hour following declaration of an Alert on June 25, 2001. This was an apparent violation of 10 CFR 50.54(q) and 10 CFR 50.47(b)(2).

  This apparent violation was evaluated under the risk significance determination process as having low to moderate safety significance based on the following: (1) the finding is an apparent violation of 10 CFR 50.54(q); and (2) this finding was a failure to meet nonrisk significant planning standard 10 CFR 50.47(b)(2) (Section 4OA3.2).

- **TBD.** The licensee failed to maintain an adequate emergency operations facility to support emergency response since September 14, 1991. This is an apparent violation of 10 CFR 50.54(q) and 10 CFR 50.47(b)(8).

  This apparent violation was evaluated under the risk significance determination process as having low to moderate safety significance based on the following: (1) the finding is an apparent violation of 10 CFR 50.54(q); and (2) this finding was a failure to meet nonrisk significant planning standard 10 CFR 50.47(b)(8) (Section 40A3.3).

Report Details

On June 25, 2001, the licensee declared an Alert due to a fire that affected the station startup transformer. During an inspection following the event, several issues were identified in the emergency preparedness cornerstone. This report describes the results of the NRC inspection related to these issues.

4. OTHER ACTIVITIES

4OA3 EVENT FOLLOWUP

a. Inspection Scope

The inspector observed and evaluated the licensee's performance during and after an event that occurred on June 25, 2001. These inspection activities focused on evaluating the licensee's ability to implement and/or meet the emergency planning standards contained in 10 CFR 50.47(b), required by 10 CFR 50.54(q). Specifically, the following emergency planning standards were evaluated:

- 10 CFR 50.47(b)(5), pertaining to the capability to provide early notification to state and local response organizations
- 10 CFR 50.47(b)(2), pertaining to timely augmentation of response capabilities
- 10 CFR 50.47(b)(8), pertaining to maintenance of adequate emergency facilities and equipment to support emergency response

b. Findings

.1 The licensee failed to provide a timely notification to state and local governmental agencies following an Alert declaration on June 25, 2001. The inspector determined this was an apparent violation of 10 CFR 50.54(q) and the licensee's emergency plan.

On June 25, 2001, at 4:55 a.m., the licensee declared an Alert due to a fire with the potential to cause degradation of plant safety systems required to be operable. At 5:20 a.m., 25 minutes following the Alert declaration, the licensee made the notifications to state and local governmental agencies containing information about the class of emergency. Section 6.2.4 of the Cooper Nuclear Station Emergency Plan, Revision 35, states, "Initial notifications to responsible state and local governmental agencies will be completed within 15 minutes of the declaration of an emergency."

The licensee determined that the following causes contributed to the untimely notifications:

- The shift supervisor/emergency director, who was responsible for ensuring that timely notifications were performed, did not effectively prioritize this activity to the shift communicator.

- The shift communicator was performing multiple activities in the control room. These additional activities distracted the communicator, resulting in untimely notifications being made to state and local governmental agencies.

Using the Emergency Preparedness Significance Determination Process, this finding was determined to be an apparent violation of low to moderate safety significance based on the following: (1) the failure to notify the state and local governmental agencies in a timely manner following declaration of an Alert occurring during an actual event on June 25, 2001; and (2) this finding represents a failure to implement the risk significant planning standard, 10 CFR 50.47(b)(5).

Title 10 of CFR 50.54(q) requires that a licensee authorized to possess and operate a nuclear power reactor shall follow and maintain in effect emergency plans which meet the standards in 10 CFR 50.47(b). Cooper Nuclear Station Emergency Plan, Section 6.2.4, “Offsite Authorities and Support Agencies,” states, in part, that initial notifications to responsible state and local governmental agencies will be completed within 15 minutes of the declaration of an emergency. The failure to notify the state and local governmental agencies within 15 minutes after declaring the Alert on June 25, 2001, is an apparent violation of 10 CFR 50.54(q) and the licensee's emergency plan (50-298/0109-01). This finding has been entered into the licensee’s corrective action process in Significant Condition Report 2001-0577.

.2 The inspector determined that the inability of control room operators to activate the emergency response organization automated notification system, together with delays in activating the backup notification system, resulted in the licensee failing to meet the emergency planning standard, 10 CFR 50.47(b)(2). The inspector determined this was an apparent violation of 10 CFR 50.54(q) and 10 CFR 50.47(b)(2).

Following the declaration of an Alert on June 25, 2001, at 4:55 a.m., the licensee failed to perform timely augmentation of the emergency response facilities. To illustrate, the emergency operations facility was declared activated at 6:32 a.m., 97 minutes following the Alert declaration. The operations support center was declared activated at 6:06 a.m., 71 minutes following the Alert declaration, and the technical support center was declared activated at 6:08 a.m., 73 minutes following the Alert declaration. Cooper Nuclear Station Emergency Plan, Section 5.2, “Onsite Emergency Organization,” states, in part, that the emergency response facilities will be activated within approximately one hour following the declaration of an Alert or higher classification.

The inspector determined that the following factors resulted in the untimely augmentation of the emergency response organization:

- The automated notification system used to notify licensee personnel of the need to augment the emergency response organization failed to operate. The automated notification system is activated by control room personnel and automatically notifies designated plant personnel, via pagers, of the need to respond to the site to staff the emergency response facilities. The failure of the automated notification system was attributed to a design change that the licensee performed in February 2001. The design change connected the site

local area network computers to the automated notification system computer. During the June 25, 2001, event, the site local area network became inoperable due to a loss of power. The loss of the local area network resulted in the failure of the automated notification system. The inspector determined that the design change was not adequately evaluated to determine the potential impacts on the automated notification system.

- There was a significant delay in activating the backup notification system. The control room shift communicator, responsible for activating the primary automated notification system, attempted to activate the system approximately 7 times, starting at 4:53 a.m. The communicator then contacted an emergency preparedness person, who was at home, for assistance. The emergency preparedness person attempted to activate the automated notification system several times with no success. The emergency preparedness person then called the control room stating that the system would not work. The emergency preparedness person then contacted the emergency preparedness manager, who was at home, to discuss the difficulties. A decision was made to activate the backup notification system. The emergency preparedness person then activated the backup notification system from his home at 5:19 a.m.

Emergency Plan Implementing Procedure 5.7.6, “Notification,” Section 5.4.5, Revision 31, states, “If the Cooper Nuclear Station automated notification system is discovered to be inoperable, then use the backup method of pager activation.” The inspector concluded that, since multiple personnel attempted to activate the automated system several times with no success, the procedural guidance and/or training for determining when to declare the system inoperable and use the backup system was not adequate. The licensee’s evaluation, documented in Significant Condition Report 2001-0577, determined that procedural changes were needed. Specifically, the licensee identified that, although the notification procedure stated to use the backup method when the automated notification system is determined to be inoperable, this statement was contained in the body of the procedure. The section of the procedure actually used by the shift communicator to activate the automated notification system (Attachment 4) did not state to use the backup method if the automated method is inoperable. The licensee determined that this procedural guidance was inadequate and revised Attachment 4 to direct the communicator to use the backup method when the automated notification system fails following two unsuccessful attempts.

The inspector noted the licensee’s quality assurance program had previously identified control room operator performance problems associated with activating the automated notification system. Quality Assurance Audit Report 01-01, “Emergency Preparedness,” stated that the failure to set off the automated notification system in a timely and appropriate manner had been a recurring drill comment or weakness. This audit noted that of 25 observations performed over the past year, the operating crews failed to adequately set off the automated notification system 14 times. This was a failure rate of 56 percent. Quality assurance personnel noted that no corrective actions had been taken to address this performance problem.

Quality assurance personnel performed an additional assessment from April 10-12, 2001, to review the adequacy of the corrective actions taken in response to the issues identified in Quality Assurance Audit Report 01-01. Quality Assurance Report S403-0101, "Emergency Preparedness," stated that the failure to set off the automated notification system in a timely and appropriate manner had not been resolved due, in part, to staffing issues in the emergency preparedness department. Based on this finding, and others, the quality assurance department utilized a formal escalation process to increase senior management attention on emergency preparedness problems not being appropriately resolved.

The inspector determined that the failure of the control room operators to appropriately activate the emergency response organization automated notification system on June 25, 2001, together with the programmatic problems identified in the licensee's quality assurance audits associated with activating the automated notification system, resulted in the licensee failing to meet the emergency planning standard, 10 CFR 50.47(b)(2).

Using the Emergency Preparedness Significance Determination Process, this finding was determined to be an apparent violation of low to moderate safety significance based on the following: (1) the finding is an apparent violation of 10 CFR 50.54(q); and (2) this finding was a failure to meet the planning standard, 10 CFR 50.47(b)(2), a nonrisk significant planning standard.

Title 10 of CFR 50.54(q) requires that a licensee authorized to possess and operate a nuclear power reactor shall follow and maintain in effect emergency plans which meet the standards in 10 CFR 50.47(b). Title 10 of CFR 50.47(b)(2) requires that the onsite emergency response plan provide for timely augmentation of response capabilities. Cooper Nuclear Station Emergency Plan, Section 5.2, "Onsite Emergency Organization," states, in part, that the emergency response facilities will be activated within approximately one hour following the declaration of an Alert or higher classification. The failure to meet emergency planning standard 10 CFR 50.47(b)(2), resulting in untimely activation of the emergency response facilities, is an apparent violation of 10 CFR 50.54(q) and 10 CFR 50.47(b)(2) (50-298/0109-02). This finding has been entered into the licensee's corrective action process in Significant Condition Report 2001-0577.

.3 The inspector determined that the procedural changes to System Operating Procedure 2.2.90, "12.5 kV System," performed on September 14, 1991, coupled with inadequate procedural guidance for emergency response facilities and equipment, resulted in the emergency operations facility failing to meet emergency planning standard 10 CFR 50.47(b)(8). Emergency planning standard 10 CFR 50.47(b)(8) requires that the onsite emergency response plan provide for the maintenance of adequate emergency facilities and equipment to support emergency response.

During the event on June 25, 2001, the inspector noted that the emergency operations facility had no ac power. The emergency operations facility normally receives power from the 12.5 kV subsystem. The 12.5 kV subsystem receives power from the T2 transformer which is supplied from the 345 kV offsite power ring bus. The 12.5 kV

subsystem was lost when the startup transformer isolated following an electrical component failure. As a result, the emergency operations facility had limited communication abilities and emergency battery powered lighting.

Although a backup power supply existed for the emergency operations facility, it was only allowed to supply power to necessary equipment when the plant was operating in Mode 4, Cold Shutdown, or Mode 5, Refueling. In operating Modes 1, 2, and 3, the backup power supply was allowed to power only communication equipment due to electrical loading restrictions on the switchgear.

The inspector determined that the following emergency operations facility equipment would not be energized by backup power in operating Modes 1, 2, and 3:

- filtered ventilation system
- normal ventilation system
- heating and air conditioning systems
- lighting (emergency dc lights would be available until batteries drained)
- plant information contained on the LAN
- facsimile machine
- computer based dose projection capability
- data obtained from the onsite meteorological tower
- safety parameter display system

The inspector determined that this restriction significantly compromised the ability of the emergency operations facility to adequately function following a loss of normal power in Modes 1, 2, and 3. This determination was based on the fact that backup power would be available to supply only the necessary equipment supporting the emergency operations facility when the plant was in cold shutdown or refueling conditions. The inspector noted that the backup power supply was not designed to power the heating and air conditioning system for the emergency operations facility. The inspector determined that this condition would also affect the functionality of the facility during extreme hot or cold weather for any plant condition with the normal power supply unavailable. In addition, the facility would not be habitable during a radiological release, due to the loss of the filtered ventilation system.

The inspector then focused on the licensee's criteria for transferring the command and control function from the primary emergency operations facility to the alternate emergency operations facility, finding that it was inadequate. Following the event on June 25, 2001, the inspector questioned the licensee on why command and control of the event was shifted from the control room to the emergency operations facility when the facility had only emergency powered lighting and limited communications available. The licensee stated that they had no habitability concerns with the emergency operations facility and, therefore, determined that the facility was conditionally functional. The inspector reviewed the emergency operations facility emergency plan implementing procedure and noted that the guidance addressing relocation to the alternate emergency operations facility was solely based on habitability concerns. The inspector determined that basing relocation to the alternate facility solely on habitability concerns could compromise the ability to provide effective command and control from

the emergency operations facility. This determination was based on the significant amount of emergency operations facility equipment that may be unavailable to make important command and control decisions throughout an event. The inspector discussed this concern with the licensee on June 26, 2001. Subsequently, on July 10, 2001, the licensee revised Procedure 5.7.9, "Activation of the Emergency Operations Facility," to require immediate relocation to the alternate emergency operations facility when the normal power supply to the primary emergency response facility is unavailable. Additionally, the licensee modified the alternate emergency operations facility, making it available for immediate use, if needed.

The alternate emergency operations facility was located in a fitness center in Auburn, Nebraska. Prior to June 26, 2001, the space used by the alternate emergency operations facility was also used for gymnastic classes. During an event requiring relocation to the alternate emergency operations facility, the licensee was required to bring equipment from onsite to the alternate facility. The space would then be set up with tables (located in a storage area at the fitness center) and equipment by those personnel activating the facility. Following the event on June 25, 2001, the licensee determined that this arrangement was not adequate and permanently established the alternate facility at the fitness center so that it would be available for immediate use. This was accomplished by bringing the additional equipment needed for activating the alternate facility from onsite and having the space permanently set up to support timely activation. The licensee stated that it planned to maintain this arrangement until the issue of supplying backup power to the emergency operations facility when in operating Modes 1, 2, and 3 is resolved.

Cooper Nuclear Station Emergency Plan Section 7.8, "Habitability Equipment," states, in part, that the emergency operations facility meets the habitability requirements contained in NUREG-0696, "Functional Criteria for Emergency Response Facilities." NUREG-0696, Table 2, "Relation of Emergency Operations Facility Location to Habitability Criteria," states, in part, that for emergency operations facilities located within 10 miles of the technical support center the ventilation system shall function in a manner comparable to the control room ventilation system. Cooper Nuclear Station Updated Final Safety Analysis Report Section 10.4.1, "Safety Objective for the Main Control Room Habitability Controls," states, in part, that the safety objective of the main control room habitability controls is to assure continuous occupancy of the control room during credited plant events. Cooper Nuclear Station Updated Safety Analysis Report, Volume 7, Appendix G, Section 5.3, "Abnormal Operational Transients," Event 25, describes that a loss of offsite power is an evaluated event that could occur in all operating modes. Based on this information, the inspector determined that the ventilation system for the emergency operations facility is required to support continuous occupancy during a loss of offsite power event, comparable to that provided by the control room ventilation system.

Pertinent to this matter, in 1986 the licensee performed Design Change 85-45, "Emergency Feed to the Emergency Operations Facility." This modification was performed to increase the reliability of the emergency operations facility and provide a backup source of power during a loss of offsite power event, since this condition would result in a loss of the normal power supply. This design change supplied backup power

to the facility from the Division 2 essential switchgear. This design change originally placed no restrictions on using the backup power supply to the emergency operations facility for any operating mode. On September 14, 1991, System Operating Procedure 2.2.90, “12.5 kV System,” was revised. This revision restricted the backup power source to supply only the emergency operations facility communication system when in operating Modes 1, 2, and 3, due to power limitations on the electrical switchgear. This procedural change resulted in the emergency operations facility ventilation system not operating comparably to the control room ventilation system. Specifically, the emergency operations facility filtered ventilation system would not be available during a loss of offsite power during operating Modes 1, 2, and 3.

The inspector determined that the limitations on the use of the backup power supply to the emergency operations facility during Modes 1, 2, and 3 of plant operation, coupled with inadequate procedural guidance for transferring the command and control function from the primary to the alternate emergency operations facility, resulted in the licensee failing to meet emergency planning Standard 10 CFR 50.47(b)(8).

Using the Emergency Preparedness Significance Determination Process, this finding was determined to be an apparent violation of low to moderate safety significance based on the following: (1) the finding is an apparent violation of 10 CFR 50.54(q); and (2) this finding was a failure to meet nonrisk significant planning standard 10 CFR 50.47(b)(8).

Title 10 of CFR 50.54(q) requires that a licensee authorized to possess and operate a nuclear power reactor shall follow and maintain in effect emergency plans which meet the standards in 10 CFR 50.47(b). Title 10 of CFR 50.47(b)(8) requires that the onsite emergency response plan provide for the maintenance of adequate emergency facilities and equipment to support the emergency response. The failure to maintain an adequate emergency operations facility to support the emergency response since September 14, 1991, is an apparent violation of 10 CFR 50.54(q) and 10 CFR 50.47(b)(8) (50-298/0109-03). This finding has been entered into the licensee’s corrective action process in Significant Condition Report 2001-0576.

4OA6 Meetings, including Exit

On September 6, 2001, the results of the inspection were discussed with Mr. Wetherell and other staff personnel. These personnel acknowledged the inspection results. Plant management informed the inspectors that no proprietary material was examined during the inspection.

ATTACHMENT

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

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D. Meyers, Senior Manager of Site Support
D. Pease, Operations Assistant Manager
S. Rezab, Emergency Preparedness Onsite Coordinator
J. Sumpter, Licensing, Project Manager
L. Wetherell, Assistant to VP-Nuclear
N. Wetherell, Acting Plant Manager

ITEMS OPENED

Opened

50-298/0109-01	AV	Failure to perform timely offsite notification during Alert
50-298/0109-02	AV	Failure to meet Planning Standard 10 CFR 50.47(b)(2)
50-298/0109-03	AV	Failure to meet Planning Standard 10 CFR 50.47(b)(8)

DOCUMENTS REVIEWED

Emergency Plan Implementing Procedure 5.7.9, “Activation of EOF,” Revision 20

Emergency Plan Implementing Procedure 5.7.2, “Shift Supervisor EPIP,” Revision 13

Emergency Plan Implementing Procedure 5.7.6, “Notification,” Revision 31

System Operating Procedure 2.2.90, “12.5 kV System,” Revision 9

System Operating Procedure 2.2.90, “12.5 kV System,” Revision 10
Significant Condition Report 2001-0567

Significant Condition Report 2001-0577

Design Change 85-45, “Emergency Feed to the Emergency Operations Facility”

Quality Assurance Surveillance Report S403-0101, “Emergency Preparedness”

Quality Assurance Audit Report 01-01, “Emergency Preparedness”

Quality Assurance Document 20010014, “Escalation-Failure to resolve emergency preparedness audit findings”

Cooper Nuclear Station Emergency Plan, Revision 35