UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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February 23, 2000

Gregg R. Overbeck, Senior Vice
President, Nuclear
Arizona Public Service Company
P.O. Box 52034
Phoenix, Arizona 85072-2034

SUBJECT: NRC INSPECTION REPORT NO. 50-528/00-02; 50-529/00-02; 50-530/00-02

Dear Mr. Overbeck:

This refers to the inspection conducted on January 24-28, 2000, at the Palo Verde Nuclear Generating Station, Units 1, 2, and 3 facilities. The purpose of this inspection was to review the emergency preparedness program at the Palo Verde Nuclear Generating Station. The enclosed report presents the results of this inspection.

Overall, the emergency preparedness program was effectively implemented; however, one exercise weakness was identified during the simulator walkthrough scenarios. The exercise weakness involved the failure to accurately classify an emergency condition.

In addition, your two most recent emergency preparedness program audits identified certain instances of either inadequate or ineffective corrective actions. Additional examples of either inadequate or ineffective corrective actions in the same or similar areas of the emergency preparedness program were identified during this inspection. These findings indicate that increased attention to problem resolution is warranted.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room (PDR).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

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

Docket Nos.: 50-528
50-529
50-530
License Nos.: NPF-41
NPF-51
NPF-74

Enclosure:
NRC Inspection Report No.
50-528/00-02; 50-529/00-02; 50-530/00-02

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E-Mail report to D. Lange (DJL)
E-Mail report to NRR Event Tracking System (IPAS)
E-Mail report to Document Control Desk (DOCDESK)

E-Mail notification of report issuance to the PV SRI and Site Secretary (JHM2, TLB4).

E-Mail notification of issuance of all documents to Nancy Holbrook (NBH).

bcc to DCD (IE35)

bcc distrib. by RIV:

Regional Administrator	PV Resident Inspector
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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.:	50-528 50-529 50-530
License Nos.:	NPF-41 NPF-51 NPF-74
Report No.:	50-528/00-02 50-529/00-02 50-530/00-02
Licensee:	Arizona Public Service Company
Facility:	Palo Verde Nuclear Generating Station, Units 1, 2, and 3
Location:	5951 S. Wintersburg Road Tonopah, Arizona
Dates:	January 24-28, 2000
Inspector(s):	William A. Maier, Senior Emergency Preparedness Inspector
Approved By:	Gail M. Good, Chief, Plant Support Branch Division of Reactor Safety

Attachment: Supplemental Information

EXECUTIVE SUMMARY

Palo Verde Nuclear Generating Station, Units 1, 2, and 3
NRC Inspection Report No. 50-528/00-02; 50-529/00-02; 50-530/00-02

A routine, announced inspection of the operational status of the licensee's emergency preparedness program was conducted. The inspection included the following areas: emergency response facilities, emergency plan and implementing procedures, training, emergency planning organization, audits, and effectiveness of licensee controls.

Plant Support

- The onsite and nearsite emergency response facilities were operationally maintained. Supplies were adequate, instruments were calibrated and operable, communication circuits were operable, and ventilation systems were appropriately maintained (Section P2).

- Communication circuit testing was being performed in accordance with requirements. However, the inspector identified a vulnerability in the offsite notification circuit testing, in that telephones in the technical support center were not regularly tested and circuit testing in the emergency operations facility was not specifically documented. The licensee planned to investigate the need to incorporate these telephones into its testing schedule (Section P2).

- Emergency plan changes made since the last NRC inspection were appropriate and in accordance with NRC regulations (Section P3).

- The licensee's process for controlling procedures in the emergency response facilities and vehicles was not effective, in that complete and accurate procedure copies for all response positions were not maintained. None of the discrepancies would have significantly affected response capabilities. For example, (1) two field monitoring vehicles did not have all required procedures, (2) procedure indexes used for maintaining procedure binders were not correct for all binders, and (3) two binders were inappropriately located in the technical support center. The licensee initiated a condition report to investigate the discrepancies identified by the inspector and took appropriate immediate corrective action to update the copies (Section P3).

- Performance of the two crews in the simulator walkthroughs was generally good. All risk-significant activities were completed in a timely manner. With one exception, emergency classifications were accurate. Emergency management was appropriately pro-active in anticipating the need to update classifications and protective action recommendations. Offsite dose assessment was performed properly and projections were consistent with predicted values for the scenario. Critiques were effective in identifying deficiencies needing correction (Section P4).

- During the simulator walkthroughs, an exercise weakness was identified for failure of one crew to make an accurate declaration of an alert condition based on fission product

barrier conditions. The licensee recognized the improper performance, documented it in the corrective action system, and initiated appropriate corrective actions (Section P4).

- The management expectation to independently verify emergency classifications was not consistently followed. The management expectation to include previously affected sectors in protective action recommendation updates was not clearly conveyed to the crews. As a result, these activities did not consistently occur between the two crews. The licensee entered the issues into the corrective action system and took appropriate immediate corrective action (Section P4).

- Emergency response organization members were being appropriately trained in accordance with emergency plan and implementing procedure requirements (Section P5).

- The licensee's recently implemented site-wide management system for tracking emergency responder qualifications was not effective as a management tool to determine actual qualification status. Software problems resulted in an erroneously high number of unqualified responders on generated reports, although the actual number of qualified responders was satisfactory. The licensee identified this problem during a self-assessment and documented it in the corrective action system (Section P5).

- The emergency planning department was sufficiently staffed with personnel who had the appropriate diverse backgrounds (Section P6).

- The two Nuclear Assurance Division emergency preparedness audits performed since the last NRC inspection were conducted by personnel with the necessary technical expertise. The audits were thorough and highly critical. The audits identified a number of significant issues including inadequate problem identification, ineffective corrective actions, and inadequate self-assessments. Both audits met the requirements of NRC regulations, and the appropriate sections were made available to the offsite governmental authorities (Section P7.1).

- The emergency planning department's corrective action program effectively captured problem areas. Root cause determinations were appropriately performed for the most significant problems (Section P7.2).

- There were instances where corrective actions were incomplete or ineffective. The inspector identified some corrective actions for problems associated with emergency classification and emergency response facility ventilation systems that were not complete, resulting in follow-up condition reports. Incomplete or ineffective corrective actions associated with these areas were previously identified in licensee audits (Section P7.2).

Report Details

IV. Plant Support

P2 Status of Emergency Preparedness Facilities, Equipment, and Resources

a. Inspection Scope (82701-03.02)

The inspector toured the Unit 1 control room, Unit 1 satellite technical support center, technical support center, Unit 1 operations support center, emergency operations facility, and backup emergency operations facility to determine their operational readiness. The inspector spot-checked these facilities for adequate supplies, operable and calibrated radiation monitoring equipment, and operable communication circuits. The inspector also reviewed a sample of completed communication circuit tests performed in the last two calendar years. The inspector walked down the ventilation systems of the technical support center and the emergency operations facility to determine their material condition.

b. Observations and Findings

The facilities observed were maintained with adequate supplies and equipment. Communication circuits checked were operational. Calibrations of radiation monitoring equipment were current. Source checks of selected radiation monitors showed measurable instrument responses. The backup emergency operations facility located at a licensee facility, 18 miles from the site, contained required emergency supplies. Communication circuits tested at the backup emergency operations facility were operable.

Notification circuits to the NRC and offsite agencies were appropriately tested monthly. The notification alert network circuit, a ringdown telephone circuit used to notify offsite agencies of emergencies at the site, was tested from the three control rooms. However, this circuit was not regularly tested from the emergency operations facility or the technical support center, where telephones on this circuit existed. The telephones in the emergency operations facility were regularly tested during drills and exercises, when offsite notifications were made from that facility. However, the circuits' performance was not specifically documented. The telephones in the technical support center were not tested as regularly, since offsite notifications from that facility would be made only if the emergency operations facility was determined to be uninhabitable and evacuated of personnel.

As a result, the inspector expressed a concern about the licensee's ability to ensure operability of the offsite notification function from the technical support center. The emergency planning department leader acknowledged the concern and stated that the need to incorporate the notification alert network telephones in the emergency operations facility and technical support center into the overall circuit testing program would be evaluated.

The ventilation systems for the technical support center and the emergency operations facility were operationally capable of performing their designed functions. These systems were continuously operating such that developing problems would be quickly identified. The emergency operations facility ventilation system maintained that facility at a positive pressure with respect to adjacent areas (see Section P7).

c. Conclusions

The onsite and nearsite emergency response facilities were operationally maintained. Supplies were adequate, instruments were calibrated and operable, communication circuits were operable, and ventilation systems were appropriately maintained.

Communication circuit testing was being performed in accordance with requirements. However, the inspector identified a vulnerability in the offsite notification circuit testing, in that telephones in the technical support center were not regularly tested and circuit testing in the emergency operations facility was not specifically documented. The licensee planned to investigate the need to incorporate these telephones into its testing schedule.

P3 Emergency Preparedness Procedures and Documentation

a. Inspection Scope (82701-03.01)

The inspector reviewed the licensee's effectiveness screenings and reviews of emergency plan revisions and implementing procedures to determine if the changes were made in accordance with NRC regulations. The inspector also spot-checked procedures in place at the onsite emergency response facilities to determine if current, approved procedures were present.

b. Observations and Findings

The licensee had completed four revisions to the emergency plan since the last NRC inspection. One revision involved a reduction of on-shift staffing and was appropriately made with prior NRC approval. The other revisions were minor in scope and appropriately made in accordance with NRC regulations. Effectiveness reviews were completed for most of the changes the inspector reviewed.

A spot check of emergency response facilities revealed the following discrepancies with respect to controlled copies of the emergency plan implementing procedures:

- The emergency operations director's binder at the emergency operations facility was missing the procedure for relocation to the backup emergency operations facility. However, copies of this procedure were available in other position binders at the same facility.

- Two of the three radiological field assessment team vehicles were missing two procedures required for relocation to the backup emergency operations facility and for establishment of reassembly areas.

- A procedure binder in the technical support center contained copies of superseded emergency planning instructional guides, which were replaced by the current emergency plan implementing procedures

- A noncontrolled copy of a position binder in the technical support center was labeled “Government Liaison” and did not contain the appropriate procedure for that position.

- Several position binders in the Unit 1 operations support center were missing indexes that were needed to verify the binder contents.

The inspector discussed these discrepancies with the emergency planning department leader. The procedure discrepancies were not considered significant since there were other copies of the affected procedures available for use. The lack of proper procedures in the radiological field assessment team vehicles was more significant, because the teams using those vehicles would not have ready access to backup copies of those procedures after deployment. However, the missing procedures would not have prevented the field teams from accomplishing their assigned function.

The discrepancies were immediately corrected and the emergency planning department leader initiated Condition Report 115588 to address the problem. A procedure audit of the emergency operations facility position binders revealed one other missing procedure, which was also replaced.

Initial licensee investigation of the procedure discrepancies revealed that the indexes used by the licensee’s Nuclear Information Records Management group to maintain the procedure binders in the emergency response facilities did not coincide with those specified by the Emergency Services Division’s procedure group for inclusion in the binders. This created the possibility for incorrect procedures being maintained in the binders. Investigation of this condition was ongoing at the end of the inspection.

The use of incorrect procedure indexes by the Nuclear Information Records Management organization did not impact the readiness of the emergency response facilities. Except for the discrepancies noted above, procedure binders contained the appropriate procedures. Additional copies of procedures were always available in the emergency response facilities for use by responders. However, the inspector concluded that the licensee’s process for controlling procedures at the emergency response facilities and vehicles was not effective in maintaining complete and accurate procedure copies for all response positions.

c. Conclusions

Emergency plan changes made since the last NRC inspection were appropriate and in accordance with NRC regulations.

The licensee's process for controlling procedures in the emergency response facilities and vehicles was not effective, in that complete and accurate procedure copies for all response positions were not maintained. None of the discrepancies would have significantly affected response capabilities. For example, (1) two field monitoring vehicles did not have all required procedures, (2) procedure indexes used for maintaining procedure binders were not correct for all binders, and (3) two binders were inappropriately located in the technical support center. The licensee initiated a condition report to investigate the discrepancies identified by the inspector and took appropriate immediate corrective action to update the copies.

P4 Staff Knowledge and Performance in Emergency Preparedness

a. Inspection Scope (82701)

The inspector observed the performance of two control room crews as each responded to a dynamic walkthrough scenario on the control room simulator. The inspector evaluated the crews' abilities to classify events accurately, perform offsite notifications in a timely manner, assess the dose consequences of radiological releases, and make accurate and timely offsite protective action recommendations. The inspector also assessed the crews' and licensee evaluators' abilities to accurately critique performance.

Two crews responded to a scenario involving a reactor coolant system leak with core damage that developed to a loss of coolant accident. Failure of both containment spray trains and a breach of the containment barrier resulted in an offsite release of radioactive material. A wind shift required an update of protective action recommendations.

The inspector interviewed two shift managers to determine their knowledge of duties and awareness of recent changes to the licensee's onsite emergency preparedness program.

b. Observations and Findings

Both crews accurately assessed plant conditions and entered the appropriate emergency operating procedures to respond to emergency events. All emergency classifications were timely, and most were accurate. All offsite notifications were both accurate and timely. Protective action recommendations were accurate and timely for all meteorological conditions presented in the two scenarios. Emergency management was appropriately proactive in anticipating the need to update classifications and protective action recommendations. Offsite dose assessment was performed properly, and projections were consistent with predicted values for the scenario.

Critiques were comprehensive and the emergency preparedness aspects of each crew's performance were appropriately discussed. The licensee's evaluation of each crew's performance was consistent with the inspector's evaluation.

However, the shift manager for the first crew, while functioning as the on-shift emergency coordinator, made one inaccurate emergency classification. A site area emergency was declared for plant conditions that only supported an alert classification. The shift manager incorrectly interpreted the fission product barrier reference table, believing the containment barrier was lost when, in fact, it was only potentially lost. This classification was concurrently checked by the shift technical advisor, who neither noted nor challenged the erroneous classification. The erroneous classification was carried forward when a relieving emergency coordinator initially announced a general emergency to the control room for plant conditions that only supported a site area emergency classification. A relieving shift technical advisor, properly performing a concurrent classification, noted the error and corrected the emergency coordinator.

The erroneous classification represented an improperly performed instance of a risk-significant emergency preparedness function and was classified as an exercise weakness (IFI 50-528;-529;-530/0002-01).

Both crews experienced a simulated shift in wind direction during their scenarios which necessitated an update of the protective action recommendation made to offsite agencies. When transmitting the updated protective action recommendation, the first crew included only the map sectors downstream of the new wind direction, while the second crew retained the sectors that were downstream of the previous wind direction. In an actual event, this lack of consistency could create confusion for offsite agencies if the licensee did not include previously identified sectors in protective action recommendation updates. This would be particularly true if protective actions in the previous sectors had not yet been completed.

The inspector discussed the above performance issues with licensee management, who acknowledged that an erroneous classification had occurred and that inconsistency in revised protective action recommendations could adversely affect the accomplishment of offsite protective actions. The licensee management representatives further stated that the failure of the shift technical advisor to independently verify all emergency classifications did not meet management expectations. Finally, the licensee stated that the expectations were for emergency coordinators to include previously affected sectors in all protective action recommendation updates.

As a result of the walkthroughs, the licensee initiated Condition Report 115711, which documented the performance issues for investigation and corrective action. The licensee promptly conducted remedial training for the involved individuals. The licensee also stated that it intended to take the following actions:

- Revision of the protective action recommendation procedure to ensure that previously affected sectors were carried over on protective action recommendation updates

- Lessons learned training for all emergency coordinators covering the performance issues observed

- Reaffirmation of management expectations for shift technical advisors to provide independent and timely verification of all emergency declarations

The inspector considered the licensee's documentation of the above issues and the proposed corrective actions to be appropriate.

The two shift managers interviewed were knowledgeable of their general duties. They were aware of recent changes made to the onsite emergency preparedness program. They were also knowledgeable of their responsibilities for maintaining qualification in the emergency response organization.

c. Conclusions

Performance of the two crews in the simulator walkthroughs was generally good. All risk-significant activities were completed in a timely manner. With one exception, emergency classifications were accurate. Emergency management was appropriately pro-active in anticipating the need to update classifications and protective action recommendations. Offsite dose assessment was performed properly and projections were consistent with predicted values for the scenario. Critiques were effective in identifying deficiencies needing correction.

During the simulator walkthroughs, an exercise weakness was identified for failure of one crew to make an accurate declaration of an alert condition based on fission product barrier conditions. The licensee recognized the improper performance, documented it in the corrective action system, and initiated appropriate corrective actions.

The management expectation to independently verify emergency classifications was not consistently followed. The management expectation to include previously affected sectors in protective action recommendation updates was not clearly conveyed to the crews. As a result, these activities did not consistently occur between the two crews. The licensee entered the issues into the corrective action system and took appropriate immediate corrective action.

P5 Staff Training and Qualification in Emergency Preparedness

a. Inspection Scope (82701)

The inspector reviewed training records for 22 individuals selected from the active emergency response organization to determine if emergency preparedness continuing training was being administered in accordance with emergency plan and implementing procedure requirements.

b. Observations and Findings

Training records for all of the selected individuals showed that they had received the required training specified in the emergency plan and implementing procedures. No expirations of qualifications were observed for the sample of responders selected.

To verify the training records for the selected individuals, the inspector requested information from the licensee's recently implemented site-wide management system for qualification tracking. This system was placed into service for emergency preparedness qualification tracking at the beginning of the calendar year. Obtaining rapid and accurate qualification status using this system was difficult and slow. Software problems caused numerous false reports that individuals were not qualified when they actually were. In order to verify the training adequacy of the selected individuals, training records had to be searched individually, visually looking for required courses and completion dates. The system could not provide reliable reports for a given individual or for groups of individuals.

The licensee identified this problem during a self-assessment of emergency preparedness training conducted the week before the NRC inspection. An initial report showed 82 of the 1200 emergency responders were unqualified. In order to accurately determine the number of responders actually unqualified, the licensee required two people to review individual training records for each of the 1200 responders to verify training completion dates. This effort continued through the inspection week. The licensee initiated Condition Report 115584 to document and investigate problems with the site-wide management system's tracking of emergency responder qualifications.

The inspector expressed concern that, under this system, unqualified responders could unknowingly fill emergency positions. The inspector discussed this concern with the emergency planning department leader. The department leader stated that each individual responder had computer access to their own training records and could verify their qualification status by record review. Individual responders and their supervisors were responsible to verify their qualification status and schedule appropriate training to maintain qualification. Therefore, this verification was still possible with the system in its current condition.

c. Conclusions

Emergency response organization members were being appropriately trained in accordance with emergency plan and implementing procedure requirements.

The licensee's recently implemented site-wide management system for tracking emergency responder qualifications was not effective as a management tool to determine actual qualification status. Software problems resulted in an erroneously high number of unqualified responders on generated reports, although the actual number of qualified responders was satisfactory. The licensee identified this problem during a self-assessment and documented it in the corrective action system.

P6 Emergency Preparedness Organization and Administration

a. Inspection Scope (82701)

The inspector interviewed the emergency preparedness department leader and staff to determine the department's organizational structure and management control systems. Recent staffing changes and the division of responsibilities were discussed.

b. Observations and Findings

The emergency planning department consisted of 12 persons, including the department leader. This staffing level had decreased by one person since the last NRC inspection. The department consisted of personnel with operations, fire protection, and radiation protection backgrounds. The department leader was assigned to the emergency planning department since the last inspection and had appropriately pursued formal training in the emergency planning discipline.

c. Conclusions

The emergency planning department was sufficiently staffed with personnel who had the appropriate diverse backgrounds.

P7 Quality Assurance in Emergency Preparedness Activities

P7.1 Nuclear Assurance Division Audits of Emergency Preparedness Program

a. Inspection Scope (82701-03.05)

The inspector reviewed the two most recent annual audits of the onsite emergency preparedness program to determine compliance with NRC requirements. The inspector verified that audit results were made available to appropriate offsite authorities. The inspector also reviewed condition reports resulting from these audits and other internal reviews to determine the effectiveness of the licensee's corrective action system for emergency preparedness issues.

b. Observations and Findings

Nuclear Assurance Division Audits 98-004 and 99-001 of the emergency preparedness program were each performed over approximately 2 weeks by teams of 6 to 8 auditors. Both teams included emergency preparedness technical specialists from outside organizations.

Both audits were led by the same lead auditor. The lead auditor had no emergency preparedness program responsibilities and was, therefore, sufficiently independent from implementation of the emergency planning program. The lead auditor had background experience in radiation protection and had several years' experience as an auditor.

Both audits were probing and systematic in the areas that were evaluated. Both audits included performance-based observation, including evaluation of drill performance. Conclusions were appropriately critical with condition reports generated for the most significant problems identified. The audits were constructed with an audit plan and a checklist developed from that plan. Reports presented both areas of good performance and areas of management attention, where appropriate.

The audits included an evaluation of the interface between the licensee and the offsite governmental authorities as required. The licensee appropriately made those sections of the audit available to the offsite governmental authorities for review.

c. Conclusions

The two Nuclear Assurance Division emergency preparedness audits performed since the last NRC inspection were conducted by personnel with the necessary technical expertise. The audits were thorough and highly critical. The audits identified a number of significant issues including inadequate problem identification, ineffective corrective actions, and inadequate self-assessments. Both audits met the requirements of NRC regulations, and the appropriate sections were made available to the offsite governmental authorities.

P7.2 Effectiveness of Licensee Controls

a. Inspection Scope (82701-03.06)

The inspector reviewed 11 condition reports for the following attributes:

- Complete and accurate problem identification
- Appropriate root cause determination
- Timely and complete corrective actions
- Appropriate implementation of corrective actions to prevent recurrence

The inspector also reviewed the two most recent annual audits of the emergency preparedness program to determine the licensee's recent performance in corrective actions for identified emergency preparedness problems.

b. Observations and Findings

The two most recent emergency preparedness audits determined that there were examples of ineffective corrective actions in emergency preparedness areas. Audit 98-004 identified incomplete corrective actions associated with emergency equipment preventive maintenance and facility habitability. Audit 99-001 identified either incomplete or ineffective corrective actions associated with self-assessment, maintenance of emergency responder qualifications, testing of emergency response organization pagers, and drill comment documentation.

The inspector identified two additional areas where corrective actions were not effective or incomplete. First, an example of ineffective corrective action was identified from

Condition Report 9-7-0729, which was identified from simulator walkthrough performance issues documented in NRC Inspection Report 97-21. One corrective action implemented from this condition report was to require independent shift technical advisor classification of emergency events to prevent inaccurate classification by the emergency coordinator. The shift technical advisors failed to consistently implement this requirement during simulator walkthroughs during this inspection, resulting in an erroneous emergency classification (see Section P4).

Second, incomplete corrective actions were identified from Condition Report 97-0326, which involved emergency response facility habitability issues. One implemented corrective action was to require a multidisciplinary system walkdown of the emergency response facility and technical support center habitability systems to document system condition and configuration. Although this action was documented as completed, the emergency planning department leader initiated a separate condition report to document configuration inaccuracies for the emergency operations facility ventilation system following an independent walkdown.

c. Conclusions

The emergency planning department's corrective action program effectively captured problem areas. Root cause determinations were appropriately performed for the most significant problems.

There were instances where corrective actions were incomplete or ineffective. The inspector identified some corrective actions for problems associated with emergency classification and emergency response facility ventilation systems that were not complete, resulting in follow-up condition reports. Incomplete or ineffective corrective actions associated with these areas were previously identified in licensee audits.

V. Management Meetings

X1 Exit Meeting Summary

The inspector presented the inspection results to members of licensee management at the conclusion of the inspection on January 28, 2000. The licensee acknowledged the findings presented. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

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P. Wiley, Unit Department Leader, Operations

NRC

D. Corporandy, Resident Inspector
J. Moorman, Senior Resident Inspector

INSPECTION PROCEDURES USED

IP 82701: Operational Status of the Emergency Preparedness Program

ITEMS OPENED AND CLOSED

Opened and Closed

50-528;-529;-530/0002-01	IFI	Failure to accurately classify an alert condition during simulator walkthrough evaluation

LIST OF DOCUMENTS REVIEWED

Emergency Plan and Implementing Procedures

Palo Verde Nuclear Generating Station Emergency Plan		Revision 22
EPIP-01	Satellite Technical Support Center Actions	Revision 3
EPIP-05	Backup Emergency Operations Facility Actions	Revision 10
EPIP-06	Reassembly Area Actions	Revision 10
EPIP-08	Emergency Planning Administration	Revision 3

Nuclear Assurance Division Audit Report 98-004

Nuclear Assurance Division Audit Report 99-001

Emergency Planning Condition Report / Determination Resolutions Tracking Matrix

Condition Reports / Determination Resolutions:
97-0326
9-8-Q-074
9-8-Q-075
9-9-Q-016
9-9-Q-017
9-9-Q-026
108307
115584
115588
115666
115711