

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-346  
License No: NPF-3

Report No: 50-346/98015(DRS)

Licensee: Centerior Service Company

Facility: Davis-Besse Nuclear Power Station

Location: 5503 N. State Route 2  
Oak Harbor, OH 42449

Dates: September 14 - 18, 1998

Inspectors: Robert Jickling, Emergency Preparedness Analyst  
James Foster, Senior Emergency Preparedness Analyst

Approved By: James R. Creed, Chief, Plant Support Branch 1  
Division of Reactor Safety

## EXECUTIVE SUMMARY

Davis-Besse Nuclear Power station  
NRC Inspection Report 50-346/98015

This inspection reviewed the Emergency Preparedness (EP) program, an aspect of Plant Support. The inspectors selectively evaluated the quality of EP program-related audits and reviews, reviewed the effectiveness of management controls, verified the adequacy of emergency response facilities and equipment, reviewed a number of EP training and qualification activities, and performed follow-up review of previous inspection findings. This was an announced inspection conducted by two regional inspectors.

### Plant Support

- Overall, the EP program had been maintained in an effective state of operational readiness. Management support to the program was apparent and interviewed key emergency response personnel demonstrated a good working knowledge of responsibilities and emergency procedures. (General)
- The emergency plan was effectively implemented during the June 24, 1998, tornado event, which was properly classified as an Alert. Delays in completion of initial offsite notifications and facility staffing were attributed to the severe weather conditions. Station personnel responded well to this event. (Section P1.1)
- The inspected emergency response facilities were found in an excellent state of operational readiness. Equipment, supplies, and prompt alert and notification system sirens were well-maintained. The weekly pager testing and semi-annual augmentation testing was effective. Very good procedures provided for semiannual augmentation drills and included criteria for their evaluation. (Section P2.1)
- The EP training program appeared effective. Selected key Emergency Response Organization (ERO) personnel demonstrated good working knowledge of emergency responsibilities and procedures. The licensee was proactive in identifying and immediately correcting four ERO personnel's training needs. Emergency response organization personnel self-contained breathing apparatus qualifications included sufficient numbers of personnel from each department and were appropriately tracked. (Section P5)
- The EP program reporting structure continued to be effective. Management support for the emergency preparedness program was evident, as indicated by the demonstrated capabilities during the recent tornado event and continued improvement in the program, training, and equipment. (Section P6)
- The annual audits of the EP program were very detailed, comprehensive, and met the requirements of 10 CFR 50.54(t). Surveillance reports reviewed were comprehensive and well detailed. The overall audit program was excellent. (Section P7)

## Report Details

### IV. Plant Support

#### **P1 Conduct of Emergency Preparedness (EP) Activities**

##### **P.1.1 Actual Emergency Plan Activations**

###### **a. Inspection Scope (82701)**

The inspectors reviewed documents, reports, and logs related to the June 24, 1998, declaration of an Alert due to a tornado onsite.

###### **b. Findings and Observations**

On June 24, 1998, at 9:18 p.m., the Shift Supervisor declared an Alert due to a report of a tornado onsite. The tornado, high winds, heavy rains, and lightning damaged the station switchyard, turbine building roof, several buildings in the owner controlled area, and disrupted electrical service to the station. Approximately 90% of the telephone service, which was supplied by fiber-optics, was destroyed by the storm. The emergency diesel generators powered the vital systems after the loss of offsite power which was caused by a lightning strike to the switchyard. Roadways within five miles of the station were severely impacted by the downed power lines, downed trees, and overturned vehicles.

The Ottawa County emergency response staff was notified within six minutes of the Alert declaration and the NRC was notified within 18 minutes by backup telephone line. The dedicated phone lines to State and County officials and the Federal Telephone System (FTS) were not inservice. Only two phone lines were available due to the storm. Lucas County officials and State of Ohio officials were contacted by the Emergency Director (ED) approximately ten minutes after the Alert declaration; however, they were not notified of the emergency declaration.

The ED was successful in contacting Lucas County official's with the third phone number used; however, he was put on hold and terminated the call after a period of time, thinking he had been disconnected. The ED then attempted to notify the State of Ohio, but the line was busy on three different attempts. Next, the ED attempted to notify the NRC on the Emergency Notification System (ENS), but found it out of service. He was successful in calling the NRC using the only operable phone line available in the control room. After the required information was communicated to the NRC, the NRC requested the ED to stay on the phone for open communication, which tied up the only control room phone line. The ED advised the NRC that he had not completed his required notifications; however, he was requested to stay on the line until a number of NRC personnel had been briefed on the event. The ED properly used all means at his disposal to perform required notifications.

The Operations Support Center (OSC), Technical Support Center (TSC), Emergency Control Center (ECC), Radiological Testing Laboratory (RTL), Dose Assessment

Center, and Joint Public Information Center (JPIC) were activated, per the emergency plan.

Personnel responding to the station were delayed by severe weather and debris obstructing plant access roads and by the failures of the automated callout system telephones. Additionally, some responders were detoured by local law enforcement personnel. These factors led to unavoidable and unforeseen delays in staffing of the emergency response facilities. The licensee properly used all reasonable means to perform a timely staffing of emergency facilities.

The Alert was appropriately downgraded to an Unusual Event on June 26, 1998, at 2:00 a.m. as conditions improved and one of the offsite transmission lines was restored. The Unusual Event was correctly terminated on June 26, 1998, at 2:02 p.m. when the second offsite transmission line became available. The station emergency organization transferred into a recovery/outage organization which was able to facilitate the return to power operations.

The draft report prepared by the Emergency Preparedness (EP) Unit was comprehensive and self-critical. The EP staff reviewed the event according to procedure RA-EP-02720, "Recovery Organization," Revision 1, which identified responsibilities related to collection of records, evaluation of an event, resolution of identified problems, and preparation of an evaluation report. Opportunities for improvement were identified, including having only one operational telephone line initially in the control room, the delayed State and Lucas County initial notifications, delayed Emergency Response Facility (ERF) staffing due to road and telephone failures, the impact of the reduced telephone service for ERF operations, ERF manual log-keeping, and control room weather monitoring capabilities. In addition to the identified opportunities for improvement, 57 comments were also captured for evaluation. Review of any corrective actions developed will be tracked as an Inspection Followup Item (50-346/98015-01).

c. Conclusions

The inspectors concluded that the emergency plan was effectively implemented and the 1998 tornado event was properly classified as an Alert. The event was reviewed according to the appropriate procedure and issues were properly captured. The draft event report was excellent in scope and detail and provided good assessments of the event, licensee's response, and specific improvement items. Completion of offsite notifications were delayed due to damaged communication lines and staffing times of ERFs were affected by the severe weather and hazardous road conditions near the station. The inspectors concluded that the delays were due to the severe weather conditions and that the station personnel responded well to this event.

**P2 Status of EP Facilities, Equipment, and Resources**

**P2.1 Material Condition of Emergency Response Facilities**

**a. Inspection Scope (82701)**

The inspectors evaluated the material condition of emergency response equipment in the control room, TSC, OSC, Radiation Monitoring Team (RMT) vehicles, RTL, Alternate Emergency Operations Center (AEOF), and ECC. The licensee demonstrated the performance of numerous pieces of emergency response equipment, including radiological survey instruments, dose assessment and plant data computers, radiation monitoring team vehicles, and communications equipment. Additionally, the inspectors reviewed procedures and records relative to semi-annual augmentation drills.

**b. Observations and Findings**

Each facility was well maintained and in an excellent state of operational readiness. Copies of the implementing procedures and appropriate forms were available and current in each facility, as required. Dose assessment equipment and software was demonstrated operable in the ECC and TSC by the EP staff. The inspectors observed that rubber items, including air sampler "O" rings, rubber boots, and rubber gloves, were in excellent condition. Emergency lights were verified operable and observed to be in very good material condition.

The control room was well maintained and had current EP procedures available. The emergency notification system phone was verified operable. The OSC, TSC, ECC, RTL, and RMT vehicles were well maintained.

Telephones, computer terminals, and other equipment were tested and found operable. The licensee provided demonstrations of dose assessment computers, and plant data computers.

By letter of June 29, 1998, the NRC staff provided a safety evaluation reviewing the propose AEOF for the Davis-Besse site, and found that the proposal met Commission guidance. The inspectors toured the AEOF located at the Bay Shore Station in Oregon, Ohio, and inspected supplies intended for alternate EOF usage. The facility appeared to have a seating capacity for approximately 30 personnel in a central room. Additional office space was available adjacent to the central room. Discussion indicated that sufficient telephones were available, and both copy and facsimile equipment was available. Current copies of the Emergency Plan and Emergency Plan Implementing Procedures, as well as a map of the ten-mile emergency planning zone, were available.

The inspectors requested and observed an actual real time test of the Prompt Notification System. Of the 57 offsite sirens for public warning, 54 sirens responded properly to the test signal. Two of the sirens not responding were previously known to have circuit board problems which would prevent them from responding to a test, but not preclude operation.

Siren system statistics for 1997 indicated a monthly average of 94.44 percent monthly and 97.52 percent annual average availability. Siren statistics for the first and second quarters of 1998 were 88.89 percent monthly availability and 95.64 percent annual average availability. Annual siren availability exceeded both the Federal Emergency Management Agency acceptability limits of greater than or equal to 90 percent for annual availability and the monthly availability limit of 70 percent.

Emergency Plan Administrative Procedure RA-EP-00200, Revision 0, was reviewed for applicability to augmentation drills. Attachment 2, "Annual drill Program Plan," provided for staff augmentation drills. Table 2, "Drill Requirements," provided for semi-annual augmentation drills.

Procedure RA-EP-0550, "Computerized Automated Notification System (CANS)," Revision 0, was reviewed by the inspectors. This procedure provided for the daily checking, weekly testing, and semiannual drills associated with the CANS system. Attachment 2 of the procedure, "Semiannual Augmentation Drill Checklist", was required to be completed using the estimated time of arrivals from notified responders. The number of individuals and expected response times were provided on the checklist. The procedure provided that drill data be entered on the checklist and deficiencies resolved.

The inspectors also reviewed documentation for the following augmentation drills:

- February 12, 1998, passed procedural criteria.
- August 20, 1997, did not pass procedural criteria.
- February 6, 1997, did not pass procedural criteria.

Records for the most recent augmentation drill, conducted August 19, 1998 at 6:29 p.m., indicated the drill did not meet the success criteria of procedure RA-EP-00550.

For each case where procedural requirements were not met, "Augmentation Drill Comments" provided information as to the identified discrepancies, whether the position(s) not filled within the prescribed time frame was a required position, and corrective actions where appropriate.

Discussion with licensee EP staff indicated that replacement of the CANS system by new equipment was in process. The new equipment, a callout system by DialLogic, had been procured and was expected to be installed prior to the end of the 1998. Changes to procedures and ERO training were being discussed for support of the new equipment.

The inspectors reviewed the results of weekly pager testing for the months of April through August of 1998. These tests were conducted in accordance with EP Administrative Procedure RA-EP-04003, "Computerized Automated Notification System Weekly Test." Pager test documentation included time of page initiation, time of individual response, and estimated time of arrival for individuals paged.

c. Conclusions

The emergency response facilities, equipment, and supplies were in an excellent state of operational readiness. The Prompt Notification System sirens were appropriately maintained. Augmentation drills had been conducted and evaluated as required. The weekly pager testing and semi-annual augmentation testing was effective. Very good procedures provided for semiannual augmentation drills, including criteria for their evaluation.

**P5 Staff Training and Qualification in EP**

a. Inspection Scope (82701)

The inspectors reviewed various aspects of the licensee's EP training program. This included interviews with selected key emergency response organization (ERO) personnel, including two Shift Supervisor/Emergency Directors (EDs), one ECC/ED, and one TSC/Emergency Plant Manager. Current attendance records and the Davis-Besse Emergency Plan Telephone Directory were reviewed to determine whether ERO personnel were currently qualified. Additionally, Self-Contained Breathing Apparatus (SCBA) qualifications of plant personnel were reviewed.

b. Observations and Findings

Interviews with four key emergency response personnel indicated a good working knowledge of procedures and emergency responsibilities. Personnel described their response process and used the Emergency Plan Implementing Procedures (EPIPs) and forms. During the interviews, personnel commented that the EP program and training were appropriate and showed general improvement.

SCBA qualification documentation indicated that the following personnel had been SCBA qualified:

- 79 Operators
- 31 Radiation Protection
- 30 Maintenance Services
- 21 Mechanical
- 15 Electrical
- 17 Instrument and Control
- 18 Chemistry
- 22 Miscellaneous

NRC Information Notice 98-20, "Problems With Emergency Preparedness Respiratory Protection Programs," was issued June 3, 1998. This information notice alerted licensees to multiple generic weaknesses in respiratory protection programs supporting emergency preparedness. The information outlined above indicated that the licensee personnel were aware of this Information Notice, and had taken measures to provide an adequate number of emergency personnel who were qualified.

Training records were compared with the Emergency Plan Telephone Directory to verify that ERO personnel listed on the call list were qualified. The licensee self-identified that four emergency response personnel had not completed their training requirements and initiated immediate corrective actions by training two of the four persons by the next day and the other two by the next week. All other ERO personnel reviewed were currently qualified for their emergency response positions as indicated by their training records.

c. Conclusions

The EP training program appeared effective. Selected key ERO personnel demonstrated good working knowledge of emergency responsibilities and procedures. The licensee was proactive in identifying and immediately correcting four ERO personnel's training needs. Emergency response organization personnel SCBA qualifications included sufficient numbers of personnel from each department and were appropriately tracked.

**P6 EP Organization and Administration**

The EP program reporting structure had the Senior EP Specialist reporting to the EP Supervisor, who reported to the Regulatory Affairs Manager, who next reported to the Engineering Services Director, who then reported to the Vice President - Nuclear. Management support for the emergency preparedness program continued to be strong, as indicated by the station personnel's response to the recent tornado event and continued improvement in the EP program, training, and equipment.

**P7 Quality Assurance in EP Activities**

a. Inspection Scope (82701)

The inspectors reviewed Toledo Edison Quality Assessment Audit AR-97-EMPRP-01, addressing Emergency Preparedness, the Emergency Response Organization, Plant Engineering, Plant Maintenance and Chemistry, dated March 3, 1997. Also reviewed was QA Audit report AR-97-EMPRP-02, Dated January 14, 1998. The 1998 audit was scheduled to be performed during November 1998.

The following surveillances were reviewed: SR-97-EMPRP-01, Dry Run Exercise, dated June 5, 1997, and SR-97-EMPRP-02, Severe Accident Management, dated December 19, 1997.

b. Observations and Findings

Audit AR-97-EMPRP-01 was performed by three individuals during January 13-24, 1997. The audit team concluded the EP program was adequate, but "performance observed by the audit team [was] less than the standards previously demonstrated by the EP organization." The audit resulted in the issuance of seven audit findings, one Potential Condition Adverse to Quality, and four observations. In addition, Quality Assessment personnel recommended that the EP group perform self-assessments on a routine basis, to aid in identifying strengths and weaknesses.



The auditors visited and interviewed offsite authorities to assess the effectiveness of the offsite interface, as required by 10 CFR 50.54(t), and determined that the positive offsite relationship was a strength. However, it was noted that improvement was needed in the communication needed between Toledo Edison management and Ottawa County EMA personnel regarding their needs for portal monitoring equipment. Later documentation indicated the licensee had purchased portal monitors for the county.

Audit AR-97-EMPRP-02 was conducted by three individuals during November 24 through December 12, 1997. This audit evaluated Emergency Preparedness, Radiation Protection, Chemistry, and Plant Engineering. The audit team concluded that "there is reasonable assurance that adequate protection can and will be taken in the event of a radiological emergency. Areas in need of improvement include coordination and conduct of the Post Accident Sampling System (PASS) drill, update of training lesson plans, and effectiveness of previous corrective actions related to Emergency Response Facility preventative maintenance activities." The audit also identified strengths related to offsite interfaces, ERF state of readiness and self-assessment activities. The audit resulted in six findings and five observations. One finding self-critically noted that Quality Assurance had erroneously found that a proposed corrective action was acceptable.

Meetings were again held with offsite officials, and it was determined that communications with Ottawa County had improved since the last audit. Auditors reviewed the six-year exercise objective plan and verified that objective completion was being tracked.

Both audits were very detailed, and Audit AR-97-EMPRP-01 identified a potentially significant problem related to the emergency response facility heating, ventilating and air conditioning (HVAC) equipment. It was found through review of the maintenance procedure that the chillers were set to lockout at 40 degrees Fahrenheit to preclude introduction of liquid coolant into the system compressors.

Discussion with the HVAC System Engineer indicated that the chiller lockout setpoint had been evaluated and discussed with the vendor, Trane Air Conditioning. In addition, a drill had been conducted during outside temperatures of approximately 25-30 degrees Fahrenheit, with a full compliment of TSC personnel, to evaluate the extent of facility heat increase with the HVAC chillers removed from operation. The vendor indicated that changes to the chiller lockout setpoint were easy adjustments down to approximately 15 degrees Fahrenheit, and could be further adjusted down to 0 degrees Fahrenheit with minor system readjustments. These changes were possible because the unit compressors were scroll-type compressors which are more tolerant of liquid coolant. The degree of heat increase during the exercise was slight. Based on these efforts, it had been determined that changes to the chiller lockout setpoint were not justified.

Both audits included excellent evaluations of the offsite interface by face-to face interviews. Documents reviewed indicated that the audit findings had been placed in corrective action systems and properly tracked. Audit finding responses included root cause evaluations. Corrective actions were completed within reasonable times, or

extensions obtained for items which required additional effort (revisions to the training program could not be completed prior to the eleventh refueling outage). A memorandum was provided to Quality Assurance regarding completion of three items related to the training program which had been granted extensions.

Surveillance SR-97-EMPRP-02 was conducted October 1 - December 10, 1997, by two surveillance specialists from Duke Power Company, to evaluate the implementation of Severe Accident Management (SAM) Guidelines in accordance with Nuclear Energy Institute (NEI) 91-04, Severe Accident Issue Closure Guidelines, Revision 1. The surveillance Teams' comprehensive reviews concluded that the implementation of the SAM guidelines met the NEI guidance. Recommendations and concerns were adequately addressed before completion of the surveillance and no observations or findings were associated with the surveillance. Both surveillance reports reviewed were comprehensive and very detailed.

c. Conclusions

The annual audits of the EP program were very detailed, comprehensive, and met the requirements of 10 CFR 50.54(t). Corrective actions resulting from the audits were properly tracked and completed within reasonable times. Both surveillance reports reviewed were comprehensive and well detailed. The overall audit program was excellent.

**P8 Miscellaneous EP Issues**

- P8.1 (Closed) Inspection Followup Item No. 50-346/96011-01(DRS): A deviation was identified for the failure to provide for a backup Emergency Operations Facility (EOF) and modify the Emergency Plan to designate the backup EOF location. The NRC has approved the licensee's alternate EOF which was evaluated by the inspectors to be adequate. The licensee's Emergency Plan was revised and sent to the NRC for review. This item is closed.
- P8.2 (Closed) Inspection Followup Item No. 50-346/96011-02(DRS): Training information related to NRC and Department of Energy incident response was not adequately informative or current. Relevant information was included in ERO training for ECC and TSC key personnel and the training was conducted. A reading package with Federal incident response information was mailed to key ERO personnel. This item is closed.
- P8.3 (Closed) Inspection Followup Item No. 50-346/96011-03(DRS): Emergency response time differences between the Emergency Plan and guidance in NUREG 0654, Table B-1 onshift staff augmentation times were identified for licensee evaluation. NRC Inspection Report 50-346/85002, dated 1/30/85, states "sufficient numbers and types of emergency response personnel have been identified to indicate that the augmentation goals of NUREG 0654, Table B-1, can be met." This demonstrated that the NRC staff had previously reviewed this issue. The licensee does not plan on revising this part of the approved Emergency Plan. This item is closed.

- P8.4 (Closed) Inspection Followup Item No. 50-346/97007-01(DRS): During the 1997 evaluated EP exercise an IFI was identified for maintaining sufficient staffing of respirator and SCBA qualified welders and other personnel for emergency response. The licensee evaluated this item and has effectively tracked and maintained adequate respiratory qualified staff for response to emergencies. This item is closed.
- P8.5 (Open) Inspection Followup Item No. 50-346/97007-02(DRS): During the 1997 evaluated EP exercise an IFI was identified for poor radiological control practices out of the OSC. Lessons learned from this issue have been included in continuing training for appropriate personnel. This item will remain open pending appropriate demonstration in an NRC evaluated exercise.
- P8.6 (Open) Inspection Followup Item No. 50-346/97007-03(DRS): During the 1997 evaluated EP exercise an IFI was identified for poor simulation of radiological data by controllers. This item will remain open pending completion of appropriate corrective actions and NRC evaluated demonstration.

## **V. Management Meetings**

### **XI Exit Meeting Summary**

The inspectors presented the inspection results to licensee management at the conclusion of the onsite inspection on September 18, 1998. The licensee acknowledged the findings presented.

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

## PARTIAL LIST OF PERSONS CONTACTED

### Licensee

T. Chambers, Supervisor, Nuclear Assurance  
R. Coad, Superintendent, Radiation Protection  
B. Cope, Sr. Emergency Preparedness Specialist  
L. Dohrmann, Manager, Quality Services  
B. Donnellon, Director, Engineering and Services  
D. Eschelman, Manager, Operations  
S. Fox, Supervisor, Business Services  
D. Gordon, Specialist, Emergency Preparedness  
R. Greer, Supervisor, Procurement  
J. Johnson, Supervisor, Independent Safety Engineering  
J. Lash, Plant Manager  
D. Lockwood, Supervisor, Regulatory Affairs  
P. McCloskey, Supervisor, Emergency Preparedness  
J. Michaelis, Manager, Maintenance  
W. Molpus, Manager, Nuclear Training  
L. Myers, Shift Supervisor  
J. Rogers, Manager, Plant Engineering  
F. Swanger, Manager, Design Engineering  
L. Worley, Director, Nuclear Assurance  
G. Wolf, Engineer, Licensing  
J. Wood, Vice President, Nuclear

### NRC

S. Campbell, Senior Resident Inspector  
K. Zellers, Resident Inspector

### Ohio Emergency Management Agency

E. Edwards, Radiological Analyst

## INSPECTION PROCEDURES USED

IP 82701      Operational Status of the Emergency Preparedness Program

## ITEMS OPENED, CLOSED, AND DISCUSSED

### Opened

50-346/98015-01      IFI              Corrective actions developed from review of response to June 1998 alert.

### Closed

50-346/96011-01      DEV              Failure to provide for a backup Emergency Operations Facility as identified in a commitment in a December 6, 1982, correspondence.

50-346/96011-02      IFI              Training information related to NRC and Department of Energy incident response was not adequately informative or current.

50-346/96011-03      IFI              Emergency response time differences between the Emergency Plan and guidance in NUREG 0654, Table B-1, onshift staff augmentation times.

50-346/97007-01      IFI              Maintaining sufficient staffing of respirator and SCBA qualified welders and other personnel for emergency response.

### Discussed

50-346/97007-02      IFI              Poor radiological control practices in the OSC

50-346/97007-02      IFI              Poor simulation of radiological data by controllers.

## LIST OF ACRONYMS USED

AEOF	Alternate Emergency Operations Facility
CANS	Computerized Automated Notification System
CFR	Code of Federal Regulations
DRS	Division of Reactor Safety
ECC	Emergency Control Center
ED	Emergency Director
EMA	Emergency Management Agency
ENS	Emergency Notification System
EP	Emergency Preparedness
ERF	Emergency Response Facility
ERO	Emergency Response Organization
FTS	Federal Telephone System
HVAC	Heating, Ventilation and Air Conditioning
JPIC	Joint Public Information Center
NEI	Nuclear Energy Institute
NPF	Nuclear Power Facility
NRC	Nuclear Regulatory Commission
OSC	Operations Support Center
PAG	Protective Action Guidelines
PASS	Post Accident Sampling System
PDR	Public Document Room
QA	Quality Assessment
RMT	Radiation Monitoring Team
RTL	Radiological Testing Laboratory
SAM	Severe Accident Management
SCBA	Self Contained Breathing Apparatus
TSC	Technical Support Center

## PARTIAL LIST OF DOCUMENTS REVIEWED

### Station Procedure Nos:

RA-EP-02010, "Emergency Management," Revision 1  
RA-EP-02245, "Protective Action Guidelines," Revision 5  
RA-EP-02520, "Assembly And Accountability," Revision 0  
HS-EP-02530, "Evacuation," Revision 3  
RA-EP-00200, Attachment 2, "Annual Drill Program Plan," Revision 0  
RA-EP-0550, "Computerized Automated Notification System," Revision 0

### Emergency Plan

Section 6, "Emergency Measures," Revision 19  
Section 6, "Organizational Control Of Emergencies," Revision 19