

ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.: 50-382
License No.: NPF-38
Report No.: 50-382/99-21
Licensee: Entergy Operations, Inc.
Facility: Waterford Steam Electric Station, Unit 3
Location: Highway 18
Killona, Louisiana
Dates: October 12-15, 1999
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Division of Reactor Safety
Attachment: Supplemental Information

EXECUTIVE SUMMARY

Waterford Steam Electric Station, Unit 3
NRC Inspection Report No.50- 382/99-21

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

Plant Support

- Overall performance was good. The control room, technical support center, operational support center, and emergency operations facility successfully implemented key emergency plan functions including emergency classifications, protective action recommendations, notifications, and dose assessment. Coordination between the licensee and the offsite agencies was excellent.
- The performance of the control room staff was good. Command and control of the facility was effective, and appropriate corrective actions were taken for degraded plant conditions. With one minor exception, caused by scenario control problems, classification was generally accurate and timely. Offsite notifications were accurate and timely, but the activation of the onsite response organization was slow due to the time requirements for making offsite notifications for the fast-breaking scenario. Individual errors affecting the emergency response were quickly identified and corrected by other staff members (Section P4.2).
- The performance of the technical support center staff was very good. The emergency coordinator demonstrated good management and control of facility operations. Plant conditions were analyzed and evaluated effectively. The staff developed appropriate priorities and strategies to mitigate the emergency. The technical support center staff functioned well as a team and maintained good communications with the control room, operational support center, and emergency operations facility. Personnel accountability and site evacuation were appropriately implemented. The technical support center effectively coordinated and dispatched onsite monitoring teams (Section P4.3).
- The performance of the operational support center staff was satisfactory. Operational support center staffing and activation were organized and timely. Facility management was organized and effective. Facility briefings were timely and complete, although radiological information was not fully discussed in every briefing. Radiation protection practices were inconsistent. An operational support center radiation survey was not performed until 25 minutes after the start of the release, even though the facility was close to the projected plume centerline. Some emergency repair teams were not formed, briefed, and dispatched in a timely manner. Only 3 of 11 teams were dispatched within 30 minutes of being briefed. Facility documentation lacked sufficient detail to fully reconstruct repair team activities (Section P4.4).

- The performance of the emergency operations facility staff was very good. Staffing was rapid, although activation was delayed because one key responder position was not filled. Command and control was very strong. Classifications, notifications, protective action recommendations, and dose projections were all accurate and timely. Coordination between the licensee and the offsite agencies was excellent (Section P4.5).
- The scenario was sufficient to test onsite response capabilities and to drive the interaction between the licensee and offsite officials; however, some aspects of scenario conduct detracted from the realism and training value of the exercise. The scenario timeline allowed an inadequate amount of time to classify the unusual event before the occurrence of the alert event. The simulated onsite radiation levels near the plume were unrealistically low. Controller activities were properly conducted (Section P4.6).
- The post-exercise critiques were generally detailed, self-critical, and included wide participation. Participation in the operational support center critique was limited. The formal management critique was also self-critical, captured most of the items identified by the NRC team, and referenced a corrective action system entry for the most significant items (Section P4.7).

IV. Plant Support

P4 Staff Knowledge and Performance in Emergency Preparedness

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

The licensee conducted its full-scale, biennial emergency preparedness exercise on October 13, 1999. The exercise was conducted to test major portions of the onsite (licensee) and offsite emergency response plans. The licensee activated its emergency response organization and all emergency response facilities. The Federal Emergency Management Agency evaluated the offsite response capabilities of the State of Louisiana and Saint Charles and Saint John the Baptist parishes. The Federal Emergency Management Agency will issue a separate report.

The exercise scenario was conducted using the plant control room simulator. The exercise began at 7:55 a.m. with a chemistry report of high reactor coolant activity, designed to prompt a notification of an unusual event declaration based on a degraded core condition. At 8:15 a.m., a leak of radioactive gas from a gas decay tank occurred to prompt an alert declaration based on a release of radioactive material at a level ten times the Technical Specification limit.

The electrical loss of a charging pump at 9:15 a.m. was designed to exercise engineering and maintenance restoration actions and to limit inventory make-up capability to the reactor for following exercise events. At 10:15 a.m., a reactor coolant system cold leg line rupture occurred, causing a loss of coolant accident. This event was designed to prompt a site area emergency declaration, which in turn directed a partially simulated site evacuation.

A containment spray pump failure to reduce containment pressure, followed by the failure of a containment penetration, was designed to prompt a general emergency declaration based on the loss of the barriers between the radioactive material in the core and the environment. A specific protective action recommendation for the offsite areas was expected for the provided meteorological conditions. A change in the simulated wind direction was designed to prompt a modification of this initial protective action recommendation to include additional areas. The exercise concluded at 1:40 p.m. following demonstration of the licensee's objectives to the NRC.

P4.2 Control Room

a. Inspection Scope (82301-03.02)

The inspectors observed and evaluated the control room simulator staff as they performed emergency response tasks. These tasks included event detection and classification, analysis of plant conditions, coordination of control room response, offsite agency notification, and adherence to the emergency plan and procedures. The inspectors reviewed applicable emergency plan sections, emergency plan implementing procedures, notification forms, Technical Specifications, and plant procedures.

b. Observations and Findings

The shift manager exercised good command of the control room team and control of the emergency activities performed. The shift manager held control room briefs when appropriate and conveyed priorities to the staff. The shift manager prioritized crew actions to ensure the notifications were accurate and timely.

The assessment of plant indications and event diagnoses were rapid and accurate. Analysis of plant conditions was aggressive. The shift manager and control room supervisor proactively sought trend information on coolant activity to anticipate the time it would exceed the unusual event threshold. Corrective actions taken for degraded plant conditions were appropriate and in accordance with applicable procedures and instructions.

Detection and classification of emergency events were generally accurate and timely. One declaration of an unusual event based on reactor coolant activity level was not made because scenario control problems allowed insufficient time for the shift manager to properly classify the event (See Section P4.6). The declarations of unusual event and alert for following events were accurate and timely.

Notifications to the offsite authorities were accurate and timely. The shift manager's reviews of the notification forms identified some minor errors which were corrected prior to transmission.

The pager activation of the licensee's emergency response organization was not timely; however, the plant public address system was used to notify almost all response personnel. Pagers were not activated until 30 minutes after the alert declaration. This was partially due to the time required for the control room staff to notify the offsite agencies of the unusual event and alert declarations. Due to the rapidly occurring scenario events, the alert notification was made 18 minutes after the unusual event notification. The untimely pager notification did not cause late activations of the emergency response facilities; however, the activation of the emergency operations facility was delayed pending the arrival of one responder who had not heard the plant public address announcement. The licensee identified the untimely emergency response organization notification as a significant improvement item to be investigated further.

Dose assessment was performed in the control room by use of a computer-based system. Protective actions, based on dose assessments, were developed for inclusion in the offsite notification forms. The initial dose assessment developed was excessively high because a reading from the wrong radiation monitor channel was used. This error was quickly identified and corrected by the staff, and the correct dose assessment was transmitted to the offsite agencies.

c. Conclusions

The performance of the control room staff was good. Command and control of the facility was effective, and appropriate corrective actions were taken for degraded plant

conditions. With one minor exception, caused by scenario control problems, classification was generally accurate and timely. Offsite notifications were accurate and timely, but the activation of the onsite response organization was slow due to the time requirements for making offsite notifications for the fast-breaking scenario. Individual errors affecting the emergency response were quickly identified and corrected by other staff members.

P4.3 Technical Support Center

a. Inspection Scope (82301-03.03)

The inspectors observed and evaluated the technical support center staff as they performed emergency response tasks. These tasks included staffing and activation, facility management and control, accident assessment and classification, dose assessment, protective action decision making, implementation of protective actions, assistance and support to the control room, and coordination of environmental monitoring teams. The inspectors reviewed applicable emergency plan sections, procedures, and logs.

b. Observations and Findings

The technical support center was activated 40 minutes after the alert declaration, consistent with the licensee's emergency plan commitments. The facility was adequately staffed when activated. The emergency coordinator appropriately announced the facility activation to all plant personnel.

The technical support center emergency coordinator demonstrated good management and control practices that included:

- Comprehensive and concise plant-wide briefings
- Use and enforcement of three-way communication practices
- Routine staff briefings to communicate changes in plant conditions
- Statements of priorities and goals for the emergency organization
- Emphasis on status board and log accuracy and completeness

Plant conditions were effectively analyzed and evaluated. The technical support center staff discussed and appropriately responded to emerging issues. The staff also discussed the responses with the control room, operational support center, and emergency operations facility, as appropriate. The emergency coordinator appropriately reviewed the emergency action levels to verify proper event classification.

Upon activation, the technical support center dose assessment personnel were briefed by the control room and accepted the responsibility for the dose assessment function. Calculations were timely, and the protective action recommendations were appropriate. Dose assessment personnel properly briefed the emergency operations facility staff before transferring dose assessment responsibility to that facility.

Onsite radiological protective actions were appropriate. The health physics coordinator and the emergency coordinator discussed radiological conditions and how to minimize radiation exposure to onsite personnel. Onsite protective actions were properly formulated using plant status, current dose assessment results and projections, release type and duration, and current/projected meteorological conditions. These discussions were documented in the technical support center logs.

Initial personnel accountability was implemented and completed in the technical support center within 30 minutes. This was consistent with the licensee's emergency plan commitments. Final accountability was completed, and all missing persons accounted for 38 minutes after the site area emergency announcement. A simulated site evacuation was properly initiated following the site area emergency declaration.

The technical support center effectively coordinated and dispatched the onsite environmental monitoring teams. Teams were directed to predetermined monitoring locations to characterize the plume. The data was documented in the technical support center on log forms and status boards.

c. Conclusions

The performance of the technical support center staff was very good. The emergency coordinator demonstrated good management and control of facility operations. Plant conditions were analyzed and evaluated effectively. The staff developed appropriate priorities and strategies to mitigate the emergency. The technical support center staff functioned well as a team and maintained good communications with the control room, operational support center, and emergency operations facility. Personnel accountability and site evacuation were appropriately implemented. The technical support center effectively coordinated and dispatched onsite monitoring teams.

P4.4 Operational Support Center

a. Inspection Scope (82301-03.05, 03.08)

The inspectors observed and evaluated the operational support center staff as they performed emergency tasks. These tasks included staffing and activation, dispatch and coordination of emergency repair teams, and the support of control room and technical support center requests. The inspectors reviewed applicable emergency plan sections, procedures, logs, checklists, and forms.

b. Observations and Findings

The operational support center was staffed promptly. Initial responders arrived within 2 minutes of the plant announcement to staff emergency facilities. Access control was immediately established. The facility was activated 30 minutes after the plant announcement to staff emergency facilities, consistent with the licensee's emergency plan commitments.

Operational support center management was organized and effective. The operational support center supervisor demonstrated capable command of the facility and a good knowledge of responsibilities. The supervisor took prompt action to expedite the staffing of important facility positions. The command room remained focused on station priorities as established by the technical support center, and activities were prioritized accordingly. The operational support center supervisor made occasional rounds through the facility to review facility operations.

The operational support center supervisor regularly conducted facility briefings which included current emergency classification, plant conditions, teams that had been dispatched, and station priorities. In-plant and onsite radiological information were not discussed in most briefings. Additional briefings were conducted in the command room for the facility leads. The public address system was clearly audible throughout the facility, and personnel were consistently attentive to announced information.

Radiation protection practices at the operational support center were inconsistent. Entrance frisking was well-performed while the facility was being activated. Self-reading dosimetry was issued to all personnel during facility activation. Continuous air radiation monitors were operational during the exercise. Facility habitability surveys were infrequent with only two performed after the start of the release. A radiation survey was not conducted in the operations support center until 25 minutes after the start of the major release even though the facility was close to the projected plume centerline. Minor radiation levels were noted inside portions of the building during the second release, but facility staff were not informed of this information.

In-plant support to the operational support center from the remote -4 checkpoint was good. Five teams were directed to the -4 location for initial radiological briefings and health physics support. Health physics personnel were aware of radiological conditions inside the plant and under the radioactive plume. Surveys were not performed in the south part of the protected area even though there was a clear line-of-sight to the unshielded plant stack. The use of thyroid blocking agent was discussed, authorized, and properly issued to affected individuals.

Operational support center logs contained partial information about every team assembled and dispatched but did not fully describe the activities of any team. For example, Team 8 was formed and then canceled prior to dispatch. The logs did not show that Team 8 was canceled or when this occurred. Other documentation omissions included:

- Time that a team was requested by the technical support center
- Time that a team began to be assembled
- Time that a team was briefed
- Time that a team exited the operational support center

- Time that a team re-entered the operational support center after completing its mission
- Radiation dose received by a team

The operational support center was not timely in dispatching emergency repair teams. The command room closely tracked plant events and anticipated technical support center requests for work. The plant priorities and team tracking status boards were updated frequently as the situation and technical support center priorities changed. However, teams were not briefed and dispatched promptly after being formed, especially when formed in anticipation of work request from the technical support center. Only 3 of 11 teams were dispatched within 30 minutes of being briefed. Thirty-seven minutes elapsed between a team being briefed and the decision to cancel the team.

Communications between the operational support center and emergency repair teams were very timely. All emergency repair teams were given call-back times and reported frequently. There were consistently good interactions between teams in the field and the maintenance leads in the operational support center with consistent use of three-way communications.

c. Conclusions

The performance of the operational support center staff was satisfactory. Operational support center staffing and activation were organized and timely. Facility management was organized and effective. Facility briefings were timely and complete, although radiological information was not fully discussed in every briefing. Radiation protection practices were inconsistent. An operational support center radiation survey was not performed until 25 minutes after the start of the release, even though the facility was close to the projected plume centerline. Some emergency repair teams were not formed, briefed, and dispatched in a timely manner. Only 3 of 11 teams were dispatched within 30 minutes of being briefed. Facility documentation lacked sufficient detail to fully reconstruct repair team activities.

P4.5 Emergency Operations Facility

a. Inspection Scope (82301-03.04)

The inspectors observed the emergency operation facility staff as they performed emergency tasks. These tasks included facility activation, command and control, emergency classification, notification of state and local response agencies, development and issuance of protective action recommendations, development and interpretation of dose projections, field team control, and direct interactions with offsite agency response personnel. The inspectors reviewed applicable emergency plan sections and procedures, forms, dose projections, and logs.

b. Observations and Findings

Emergency operations facility staffing was timely, but activation was delayed because one key responder position was not filled. The facility was staffed with all but one key positions within 40 minutes of the alert declaration. This one responder's (field team communicator) absence delayed the facility's activation until 90 minutes after the alert declaration. This decision was consistent with the licensee's procedures. The time to activate was still within the licensee's emergency plan requirements. The licensee recognized this delay as excessive and stated that it would investigate corrective actions to prevent recurrence.

The emergency operations facility director's command and control of the facility was very strong. Expectations were frequently conveyed via the public address system. Facility noise level was generally good, but when it degraded, the director or the assistant director forcefully restored order. Briefings were regularly held and contained all the information necessary for the facility staff.

The site area emergency and general emergency classifications were correct and timely. The director and the assistant director reviewed the emergency action levels independently to verify that the correct classifications were made. The director also consulted with the emergency coordinator to ensure that classifications were consistent with the technical support center's assessment of plant conditions. The emergency operations facility director also looked ahead to anticipate possible future classifications based on plant conditions.

Protective action recommendations were accurate and timely. The emergency operations facility director noted wind direction trends and preemptively updated the protective action recommendation to include additional areas prior to the actual wind shift. This update was made after considering the size of the affected population and the ease of evacuation of the affected area. The decision was discussed with the state representatives, who concurred with the action.

Dose projections developed at the emergency operations facility were accurate and timely. Generated values tracked closely with the scenario's predicted values. The dose assessment team quickly recognized the wind shift when it occurred and promptly made a correct dose projection update.

Field team control was effective. Teams were quickly deployed to the downwind areas. The teams were sent in and out of the plume as necessary to characterize the plume boundaries while minimizing their exposures. When state field teams arrived in the plume exposure area, the licensee and state field team controllers coordinated closely to utilize the combined teams most effectively.

The licensee interaction with offsite officials at the emergency operations facility was excellent. Arriving offsite officials were quickly processed into the facility and introduced to their counterparts. Close working relationships were observed at all levels of response. The licensee discussed the protective action recommendation update with

the state officials prior to issuance. Field team control was well coordinated between the two organizations.

c. Conclusions

The performance of the emergency operations facility staff was very good. Staffing was rapid, although activation was delayed because one key responder position was not filled. Command and control was very strong. Classifications, notifications, protective action recommendations, and dose projections were all accurate and timely. Coordination between the licensee and the offsite agencies was excellent.

P4.6 Scenario and Exercise Control

a. Inspection Scope (82301, 82302)

The inspectors made observations during the exercise to assess the challenge and realism of the scenario and to evaluate exercise control.

b. Observations and Findings

The licensee submitted the exercise objectives and scenario for NRC review on July 13, and August 12, 1999, respectively. The inspectors discussed minor questions related to the exercise objectives and scenario with licensee staff on August 24 and September 15, 1999. The licensee resolved the inspectors' questions satisfactorily. The exercise objectives and scenario were reviewed and considered adequate to meet emergency plan requirements (reference NRC letter dated October 5, 1999).

The following aspects of exercise control detracted from the realism and training value of the exercise:

- The scenario timeline allowed an inadequate amount of time between the high coolant activity report that prompted the declaration of the unusual event and the radioactive gas release that prompted the alert. The control room staff had insufficient time to properly perform the unusual event classification and response. This resulted in a lost opportunity to evaluate the timeliness and accuracy of the classification of this particular event.
- The simulated onsite radiation levels near the plume were unrealistically low (14 mR/hr directly below the plume centerline for a 180 Ci/sec release rate). This precluded demonstration of adequate protective actions to limit radiation exposure for repair teams in transit from the operational support center to the plant. Adequate protective actions were demonstrated for teams inside the plant.
- The simulated containment radiation levels were excessively high for the plant conditions toward the end of the scenario and did not track properly as plant conditions changed. This created confusion as the technical support center staff analyzed core damage and effectiveness of mitigation actions.

c. Conclusions

The scenario was sufficient to test onsite response capabilities and to drive the interaction between the licensee and offsite officials; however, some aspects of scenario conduct detracted from the realism and training value of the exercise. The scenario timeline allowed an inadequate amount of time to classify the unusual event before the occurrence of the alert event. The simulated onsite radiation levels near the plume were unrealistically low. Controller activities were properly conducted.

P4.7 Licensee Self Critique

a. Inspection Scope (82301-03.13)

The inspectors observed and evaluated the licensee's post-exercise facility critiques and the formal management critique conducted on October 15, 1999, to determine whether the licensee's critique process identified and characterized weak or deficient areas in need of corrective action.

b. Observations and Findings

The post-exercise facility critiques were open and thorough at the emergency operations facility and the technical support center. The emergency operations facility critique included input from a controller representing the state. Field teams also attended the critique and provided input. The technical support center critique allowed each participant the opportunity to provide positive and negative comments. Detailed comments were solicited, and all comments from the participants were well received.

Participation in the operational support center critique was limited. The operational support center supervisor and lead facility controller did not actively encourage participation. Though all operational support center staff were given an opportunity to provide feedback and observations, only a small number did so. Participants did discuss performance issues but generally emphasized positive observations rather than areas for improvement.

The formal management critique was very detailed and self-critical, and it contained an appropriate level of management involvement. It captured almost all of the NRC inspection team's observations. The licensee identified several training needs from the exercise. The most significant deficiencies were promptly entered into the corrective action system for evaluation and resolution.

c. Conclusions

The post-exercise critiques were generally detailed, self-critical, and included wide participation. Participation in the operational support center critique was limited. The formal management critique was also self-critical, captured most of the items identified by the NRC team, and referenced a corrective action system entry for the most significant items.

P8 Miscellaneous Emergency Preparedness Issues (82301)

- P8.1 (Closed) Inspection Followup Item (50-382/97018-03): Exercise weakness-failure to issue a timely protective action recommendation upgrade - The scenario included a wind direction change following issuance of the original protective action recommendation. This was designed to prompt a modification of the recommendation. The emergency operations facility director pre-emptively updated the protective action recommendation and communicated this updated recommendation to the offsite agencies within 15 minutes of the upgrade decision.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on October 15, 1999. The licensee acknowledged the facts presented. The licensee identified a proprietary draft exercise evaluation report that had been provided to the inspectors. The inspectors reviewed the report and returned it to the licensee.

The Federal Emergency Management Agency and the NRC scheduled a public meeting in LaPlace, Louisiana, on October 14, 1999, to discuss the preliminary exercise results. Since there was no media or public attendance, the meeting was convened and immediately adjourned.

ATTACHMENT

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

A. Bergeron, Chemistry Superintendent
M. Brandon, Supervisor, Licensing
R. Burski, Director, Site Support
C. Dugger, Vice President, Operations
E. Ewing, Director, Nuclear Safety Assurance
J. Fields, Senior Emergency Planner
C. Fugate, Superintendent, Operations
R. Fuller, Emergency Planning Manager, ANO
R. Gresham, Emergency Plan Training, ANO
M. Guynn, Emergency Planning Manager, Grand Gulf
J. Hoffpauir, Manager, Operations
M. Huskey, Emergency Planner
R. Killian, Supervisor, Quality Engineering
R. Lailheugue, Manager, Materials Purchasing and Contracts
M. Langan, Work Week Manager
T. Leonard, General Manager, Plant Operations
T. Lett, Superintendent, Radiation Protection
J. Lewis, Emergency Planning Manager
S. Lubinski, Emergency Planner
D. Madere, Superintendent, Project Management
J. Morgan, Quality Assurance
J. O'Hern, Manager, Training and Emergency Planning
E. Perkins, Manager, Licensing
R. Perry, Emergency Planner
R. Peters, Manager, Corrective Action and Assessments
J. Ridgil, Mechanical Maintenance Superintendent
G. Scott, Licensing Engineer
R. Williams, Licensing Engineer
A. Wrape III, Director, Engineering

NRC

J. Keeton, Resident Inspector

LIST OF INSPECTION PROCEDURES USED

IP 82301	Evaluation of Exercises at Power Reactors
IP 82302	Review of Exercise Objectives and Scenarios for Power Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Closed

50-382/97018-03 IFI Exercise weakness - Failure to issue a timely protective action recommendation upgrade (Section P8.1)

Discussed

None

LIST OF DOCUMENTS REVIEWED

Emergency Plan and Procedures

Waterford 3 Steam Electric Station Emergency Plan, Revision 24
Waterford 3 Emergency Action Level Basis Document, Revision 3

EP-001-001 "Recognition and Classification of Emergency Conditions," Revision 18
EP-001-010 "Unusual Event," Revision 22
EP-001-020 "Alert," Revision 25
EP-001-030 "Site Area Emergency," Revision 24
EP-001-040 "General Emergency," Revision 25
EP-002-010 "Notifications and Communications," Revision 27
EP 002-030 "Emergency Radiation Exposure and Controls." Revision 8
EP 002-031 "In Plant Radiological Controls and Surveys During Emergencies," Revision 6
EP 002-032 "Monitoring and Decontamination." Revision 0
EP-002-033 "Administration of Iodine Blocking Agents," Revision 8
EP-002-034 "Onsite Surveys During Emergencies," Revision 0
EP-002-050 Offsite Dose Assessment (Manual), Revision 15
EP-002-051 Offsite Dose Assessment (Computerized), Revision 8
EP-002-052 "Protective Action Guidelines," Revision 17
EP-002-060 "Radiological Field Monitoring," Revision 9
EP 002-071 "Site Protective Measures," Revision 15
EP-002-090 "Core Damage Assessment," Revision 6
EP-002-091 "Emergency Chemistry," Revision 7
EP-002-100 "Technical Support Center Activation, Operation and Deactivation," Revision 30
EP 002-101 "Operational Support Center Activation, Operation and Deactivation,"
Revision 23
EP-002-102 "Emergency Operations Facility Activation, Operation, and Deactivation,"
Revision 26
EP 002-130 "Emergency Team Assignments," Revision
17EP-002-190 "Personnel Accountability," Revision 16

Other Documents

Waterford - Unit 3 Technical Specifications