Columbia Generating Station
2Q/2010 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: FIN Finding
Digital Electro-Hydraulic Leak Results in Reactor Scram
Green. The inspectors reviewed a self-revealing finding for the failure of the licensee to provide an adequate procedure for the installation of an o-ring in the digital electro-hydraulic system. Specifically, failure to provide the methods and details for the preparation, review, approval, and implementation of procedures contributed to the improper installation of an o-ring in the digital electro-hydraulic system. This improper installation resulted in a failure of the o-ring seal, a leak in the digital electro-hydraulic system, and a subsequent manual reactor scram. The licensee entered the issue into the corrective action program and conducted a root cause evaluation.

This finding was more than minor because it is an equipment performance issue that affected the Initiating Events Cornerstone objectives to limit the likelihood of those events that upset plant stability. Specifically, use of a less than adequate procedure during the installation of an o-ring in an accumulator lower block in the digital electro-hydraulic system resulted in a failure of the o-ring seal, a subsequent leak in the digital electro-hydraulic system, and a manual reactor scram due to a decreasing digital electro-hydraulic fluid inventory as indicated by a low low-level alarm for the digital electro-hydraulic tank (initiating event). The finding was of very low risk significance because the finding did not result in the loss of a safety function of a single train for greater than its technical specification allowed outage time. The cause of the finding is related to the crosscutting aspect of human performance with a resources component, because the licensee failed to provide adequate procedural requirements for o-ring installation work [H.2(c)](Section 4OA3.1).

Inspection Report# : 2009005 *(pdf)*

Significance: G Sep 30, 2009
Identified By: NRC
Item Type: FIN Finding
Failure to Perform Inspections Resulted in Bus Failure and Reactor Scram
Green. The inspectors reviewed a self-revealing finding for the failure to follow Procedure PPM 1.5.13, “Preventive Maintenance Optimization Living Program,” Revision 16, for not evaluating the scope changes for the preventive maintenance inspections on the non segregated high voltage buses. The preventive maintenance work orders included visual inspection, cleaning, torque verification of the rigid and flexible bus connections, and high potential testing of the bus to ground. The inspectors reviewed completed work orders and determined that for all the work orders performed from 2001 through 2005 that the steps to check the torque verification of the bus connections and the high potential testing were inappropriately marked as not applicable. For the 2009 work orders, the inspectors found that the steps for the torque verification and the high potential testing were deleted. In doing so, the licensee was no longer using industry operating experience that was determined to be applicable to the station and had changed the scope of the work orders by not performing these steps; performance of these steps could have prevented the August 5, 2009, 6900 Vac bus failure.

The inspectors determined that the finding was more than minor because it impacted the human performance attribute of the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Using the Significance Determination Process Phase 1 worksheets from Inspection Manual Chapter 0609, the inspectors determined that the finding was of very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. This finding also had a human performance crosscutting aspect associated with the decision making component in that personnel performing the preventive maintenance work orders

failed to use conservative assumptions and in doing so changed the scope of the work inappropriately [H.1(b)] (Section 2.3).

Inspection Report# : 2009010 *(pdf)*

Significance: G Sep 26, 2009
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Perform Back-up Monitoring
Green. The inspectors reviewed a self-revealing finding for the failure of Energy Northwest to implement the standards and guidance provided in Operations Instruction OI-09, "Operations Standards and Expectations," Revision 24. As a result, an operator failed to ensure that the turbine lube oil exhauster system was adjusted to within its normal operating band after valve manipulations to clear an alarm in the control room. This resulted in a loss of an air-to-oil seal within the main turbine, which ultimately led to a manual plant scram.

This finding is more than minor because it affected the human performance attribute of the initiating events cornerstone's objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. This finding was determined to be of very low safety significance (Green) due to not contributing to both the likelihood of a reactor trip and the likelihood of mitigation equipment or functions not being available. A cross cutting aspect in human performance was identified with a work control component because Energy Northwest failed to incorporate actions to address plant conditions that may affect work activities [H.3(b)](Section 40A3).

Inspection Report# : 2009004 *(pdf)*

Mitigating Systems

Significance: G Mar 27, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain Reactor Core Isolation Cooling Turbine Bearing Oil Level in Accordance with the Applicable Operating Procedure Requirements
Green. The inspectors identified a noncited violation of Technical Specification 5.4.1.a for a failure to maintain reactor core isolation cooling turbine bearing oil level in the proper band in accordance with procedural requirements. Not documenting oil additions to the reactor core isolation cooling turbine per paragraph 8.0 of PPM 10.2.13, Approved Lubricants, caused a high oil level on the inboard and outboard bearing housings resulting in the reactor core isolation cooling system becoming inoperable on December 20, 2009. Corrective actions for this issue included restoring oil level in the green band and initiating interim actions at the prompting of the resident inspectors to maintain proper oil level.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and because it affects the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609, Phase 1 Initial Screening and Characterization of Findings," the inspectors determined that the finding was of very low risk significance (Green) because failure to maintain the reactor core isolation cooling system oil level in the proper band did not result in the loss of a safety function of a single train for greater than its technical specification allowed outage time. In addition, the finding would not have likely affected other mitigating systems resulting in a total loss of their safety function. This finding has a cross-cutting aspect in the area of human performance with a work practices component [H.4.b] (Section 1R12).
Inspection Report# : 2010002 *(pdf)*

Significance: G Nov 21, 2009

Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Promptly Correct an Adverse Trend in Keep Fill Pump Performance
Green. The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," which occurred when the licensee failed to promptly correct an identified condition adverse to quality. Specifically, in 1998, the licensee identified an inadequate design of the in keep fill pumps for the reactor core isolation cooling system and emergency core cooling system that resulted in repetitive unexpected failures of the pumps. Corrective actions for this condition adverse to quality had been repeatedly deferred since the condition was originally identified; no effective corrective actions had been taken as of September 2009. The licensee entered this issue into their corrective action program as Action Request/Condition Report 204768.

This performance deficiency was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that this performance deficiency was of very low safety significance because it did not represent a loss of system safety function, did not represent the actual loss of safety function of a single train for greater than its technical specification allowed outage time, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The team determined that this finding had a crosscutting aspect in the resources component of the human performance area because the licensee failed to ensure that resources were available to minimize long-standing equipment issues [H.2 (a)].

Inspection Report# : 2009008 *(pdf)*

Significance:  Nov 21, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Ensure Suitability of Class 1E Electrical Components
Green. A noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was revealed on April 7, 2007, when overheating of a Class 1E power conditioning transformer resulted in a fire. The licensee determined that the failed transformer, which had been installed as part of a July 2000 design change, was of an inappropriate design for its application. The licensee replaced the transformer and entered this issue into their corrective action program as Action Request/Condition Report 204769.

This performance deficiency was more than minor because it was associated with the design control attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that this performance deficiency was of very low safety significance (Green) because it did not represent a loss of system safety function, did not represent the actual loss of safety function of a single train for greater than its technical specification allowed outage time, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The team determined that this performance deficiency did not have a crosscutting aspect because it was not indicative of current licensee performance.

Inspection Report# : 2009008 *(pdf)*

Significance:  Nov 21, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Housekeeping Program Requirements
Green. The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to properly implement housekeeping procedures to control transient equipment and materials. Specifically, the inspectors identified loose maintenance carts in both the control room and emergency diesel generator rooms, a large metal ramp in the emergency diesel generator room and improperly stored ladders the emergency core cooling system pump rooms. The licensee either secured or removed the equipment and

entered this issue into their corrective action program as Action Request/Condition Report 204514.

The finding was more than minor because if left uncorrected, the programmatic deficiency could lead to a more significant safety concern. Using Inspection Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the finding was determined to have very low safety significance (Green) because it did not result in an actual loss of a system safety function, did not result in a loss of a single train of safety equipment for greater than its technical specification allowed outage time, did not involve the loss or degradation of equipment specifically designed to mitigate a seismic, flooding, or severe weather initiating event, and did not involve the total loss of any safety function that contributes to an external event initiated core damage accident sequence. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program area component because the licensee failed to have a low threshold for identifying deficient housekeeping issues [P.1(a)].

Inspection Report# : 2009008 *(pdf)*

Significance: G Sep 30, 2009
Identified By: Self-Revealing
Item Type: FIN Finding
Inadquate Technical Review of Design Change Packages
Green. The inspectors reviewed two examples of a self-revealing finding for the failure to follow Procedure SWP-DES-01, “Plant Modification & Configuration Control,” Revision 11, for the modifications to the digital electrohydraulic control system and the reactor feedwater pumps. The first example occurred when the licensee installed a new digital electrohydraulic control system with an incorrect pressure setpoint due to an erroneous calculation in the plant design change. The licensee determined that this pressure setpoint was too low for expected pressures under all potential conditions, including transients. This resulted in the turbine bypass valves remaining open and causing the reactor pressure vessel to exceed the cooldown safety limit of 100°F per hour. The second example occurred when the licensee installed a new reactor feedwater level control system which raised and staggered the suction pressure setpoints between the pumps, and the time delay between the pumps was not staggered. The licensee’s investigation into the reactor feedwater trips determined that the speed setpoint that the level control system allowed the reactor feedwater pumps to achieve was too high.

The inspectors determined that the finding was more than minor because it affected the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Significance Determination Process from Inspection Manual Chapter 0609, the inspectors determined that a Phase 3 analysis was required. Based on the senior reactor analyst’s significance determination process Phase 3 analysis, this finding was determined to have very low safety significance. This finding had a human performance crosscutting aspect associated with the work practices component in that the personnel associated with the technical review did not use human error prevention techniques commensurate with the assigned task [H.4(a)] (Section 2.1).

Inspection Report# : 2009010 *(pdf)*

Significance: G Sep 26, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Adequately Implement the Requirements of Procedure SOP-ENTRY-DW
Green. The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for Energy Northwest’s failure to effectively implement procedure SOP-ENTRY-DW, “Personnel Entry into Drywell.” Energy Northwest’s corrective actions for this issue included removing the NRC identified debris from the drywell, informing personnel of the ineffective drywell cleaning, and conducting an assessment to determine more effective methods for cleaning the drywell during future outages.

The finding was greater than minor because, if left uncorrected, it could result in the continued accumulation of foreign material in the drywell. The accumulation of foreign material could result in blocking the emergency core cooling system suction strainers during normal operation or accident conditions. The finding was determined to be of

very low risk significance (Green) since the debris did not result in an actual loss of safety function for any system and because the debris was removed by the licensee. A crosscutting aspect in problem identification and resolution, with a corrective action program component was identified in that the licensee failed to ensure that corrective actions were taken to address a previously identified adverse trend [P.1(d)](Section 1R20).

Inspection Report# : 2009004 *(pdf)*

Significance: G Jul 13, 2006
Identified By: NRC
Item Type: AV Apparent Violation
Lack of an Evaluation of the Effect of Fire on the Reactor Protection System / Scram Capability
The team identified an apparent violation (AV) of License Condition 2.C.(14) concerning failure to evaluate the potential effect of fire damage on the Reactor Protection System circuits relied upon for reactor scram capability in the approved fire protection program. Although the reactor protection and control rod drive systems are identified as part of the minimum safe shutdown systems necessary to accomplish the reactivity control shutdown function, and are credited in the post-fire safe shutdown procedures developed by the licensee, the potential for fire to cause a loss of this required shutdown function had not been evaluated. The licensee's post-fire safe shutdown analysis included the assumption that the operator would initiate and confirm shutdown before control circuits were damaged, therefore, evaluation of the effects of fire damage to the reactor protection (RPS) and control rod drive (CRD) systems was not necessary. Review of the RPS circuits identified the potential for a fire in the control room to prevent the scram of one rod group.

The finding is greater than minor in that it affected the ability to achieve and maintain hot shutdown following a control room fire. This finding is associated with the Mitigating Systems cornerstone and the respective attribute of protection against external factors (e.g., fire). This finding impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to external events (such as fire) to prevent undesirable consequences. It is the NRC's understanding that the licensee does not consider these circuit vulnerabilities to be violations of NRC requirements. The licensee considers multiple hot shorts due to fire in the control room to be outside of the plant licensing basis for the Fire Protection Program. Specifically, in this case, two hot shorts due to fire induced circuit damage would be required to prevent the scram of one rod group. The NRC staff and the industry are currently working on developing a resolution methodology to address these types of potential fire induced circuit failures. The team concluded that this violation meets the criteria of the NRC Enforcement Manual Section 8.1.7.1 for deferring enforcement actions for postulated fire induced circuit failures.

Inspection Report# : 2006008 *(pdf)*

Barrier Integrity

Significance: G Jun 26, 2010
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Translate Appropriate Acceptance Critereia
• Green. The inspectors reviewed a Green self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings" for Energy Northwest's failure to include acceptance criteria appropriate to the circumstances in surveillance testing Procedure TSP-CREF-Z801, "Control Room Envelope Unfiltered In-leakage Tracer Gas Test," Revision 2. Specifically, Energy Northwest personnel incorrectly documented a design bases unfiltered air in-leakage value as an administrative limit in the surveillance testing procedure. This led to a delay in declaring the control room emergency filtration system inoperable and a delay in the implementation of mitigating actions to protect control room occupants in the event of an accident. The violation has been placed in the licensee's corrective action program and corrective actions are being implemented.

The performance deficiency is more than minor because it affects the procedure quality attribute of the Barrier Integrity Cornerstone for maintaining the radiological barrier functionality of the control room. This performance

deficiency was of very low safety significance (Green) because the finding represented a degradation of only the radiological barrier function provided for the control room. Also, if left uncorrected, incorrectly documenting design bases acceptance criteria could lead to a more significant safety concern. Specifically, incorrectly documenting design bases acceptance criteria could lead personnel to rely on equipment to perform a specified safety function when it is incapable of doing so. This finding has a crosscutting aspect in the area of problem identification and resolution, self and independent assessments, in that the licensee failed to conduct self assessments that are of sufficient depth. Specifically, Energy Northwest focused too narrowly on the affect of licensing changes, in a 2007 self assessment, on the licensing organization instead of the impact of licensing changes to the organization as a whole [P.3.a] (Section 1R15).

Inspection Report# : 2010003 *(pdf)*

Significance: G Mar 27, 2010
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Provide Adequate Acceptance Criteria
Green. The inspectors reviewed a self revealing non-cited violation of Technical Specification 5.4.1a for a failure to provide procedures appropriate to the circumstance for rebuilding hydraulic control unit directional control valves. The failure to provide adequate instructions resulted in multiple control rod mis-positions at Columbia Generating Station.

This finding is greater than minor because it is associated with the configuration control attribute of the Barrier Integrity cornerstone because it affects the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, failing to establish appropriate acceptance criteria for systems that control rod movement could lead to exceeding thermal safety limits. Using Inspection Manual Chapter 0609, “Phase 1 Initial Screening and Characterization of Findings,” this finding was determined to be of very low safety significance (Green) because it only affected the fuel barrier. The inspectors determined that since the inadequate procedure for evaluating the directional control valves had been in place more than 2 years in the past, the finding did not represent current plant performance. Therefore no cross cutting aspect was identified (Section 1R12).
Inspection Report# : 2010002 *(pdf)*

Emergency Preparedness

Significance: G Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Classify a Notification of Unusual Event During a Toxic Gas Event
Green. The inspectors identified a noncited violation of 10 CFR 50.47(b)(4) for the failure to classify an emergency condition during a toxic gas event. The licensee’s failure to classify a Notification of Unusual Event on May 20, 2009, after being informed of toxic gas levels in the 422 foot elevation reactor core isolation cooling system room was identified as a performance deficiency.

This finding is more than minor because the failure to declare an emergency classification when conditions meet an emergency action level threshold may prevent adequate measures from being taken to protect the health and safety of licensee employees and the public. The finding is of very low safety significance because it was a performance deficiency occurring during an event which would have properly been classified as a Notification of Unusual Event. The licensee has entered this issue into their corrective action system as Action Request/Condition Report 00203804. This finding has been evaluated as having a crosscutting aspect of human performance, decision making, because the licensee did not make a safety-significant decision using a systematic process when faced with uncertain or unexpected plant conditions [H.1(a)] (Section 1EP5).

Inspection Report# : 2009005 *(pdf)*

Significance: G Aug 28, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Adequate Respiratory Protection Equipment for Emergency Response
Green. The inspectors identified a non-cited violation of 10 CFR 50.47(b)(10) for the failure to provide adequate respiratory protection equipment for emergency response, compromising the protective actions developed for the plume exposure pathway for emergency workers. Adequate quantities of small sized self-contained breathing apparatus respirator masks were not available in the control room for licensed plant operators that were fit-tested for small sizes. This issue was entered into the licensee's corrective action program as Action Request 00201679.

This finding is greater than minor because it is associated with the Emergency Preparedness Cornerstone attribute of response organization performance and adversely affects the cornerstone objective of ensuring the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The finding was evaluated using Inspection Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," Sheet 1, "Failure to Comply." The issue described was a planning standard problem, was not a risk-significant planning standard problem, and did not involve a planning standard function failure. Therefore, the finding is of very low safety significance. This finding has a crosscutting aspect in the area of human performance, associated with resources because the licensee did not have enough small sized self-contained breathing apparatus respirator masks available in the control room for licensed plant operators that were fit-tested for small sizes [H.2(d)](Section 2OS3).

Inspection Report# : 2009009 *(pdf)*

Occupational Radiation Safety

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Follow Radiation Protection Requirements
Green. The inspectors reviewed a self-revealing, noncited violation of Technical Specification 5.4.1.a resulting from a worker's failure to follow radiation protection requirements. The worker failed to ensure he was on the correct radiation work permit, failed to use an electronic dosimeter designed for use in a high noise area, failed to follow instructions related to the travel path to the work area, failed to exit the radiologically controlled area when he received an unanticipated dose rate alarm, and failed to contact radiation protection personnel about the alarm. The licensee documented this occurrence in their corrective action program as Action Request 203711 and coached the worker.

The failure to follow radiation protection requirements is a performance deficiency. This finding is greater than minor because it involved the program attribute of exposure control and affected the cornerstone objective in that the failure of the worker to follow procedural requirements resulted in the worker being unknowledgeable of the dose rates in areas entered. The inspectors used the Occupational Radiation Safety Significance Determination Process and determined the finding had very low safety significance because it was not: (1) an ALARA finding, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an inability to assess dose. The finding had a crosscutting aspect in the area of human performance, work practices component, because the worker failed to use human error prevention techniques such as self and peer checking [H.4(a)]. (Section 2OS1)

Inspection Report# : 2009005 *(pdf)*

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Notify Radiological Planning Personnel of a Work Plan Deviation

Green. The inspectors reviewed a self-revealing, noncited violation of Technical Specification 5.4.1.a resulting from a work group's deviation from an established work plan. The original dose estimate for the refurbishment of the containment recirculation air system and fan motor replacement was 4912 mrem. The actual dose accrued for the work was 7648 mrem. In response, the licensee documented this occurrence in the corrective action program as Action Request 197892 and the radiation protection manager conducted a briefing of the assembled project managers that reinforced the project managers' responsibilities associated with keeping doses ALARA.

This finding is greater than minor because it resulted in the actual collective dose of the work activity exceeding 5 person-rem (5000 person-mrem) and exceeding the planned, intended dose by more than 50 percent (similar to Manual Chapter 0612, Appendix E, Example 6.i). The inspectors used the Occupational Radiation Safety Significance Determination Process and determined the finding had very low safety significance because it was as low as reasonably achievable finding, but the licensee's three-year rolling average collective dose (139 person rem) was less than 240 person-rem/units. The finding had a crosscutting aspect in the area of human performance, work coordination component, because the licensee did not incorporate actions to address the impact of changes to the work scope and work groups did not cooperate with each other during activities in which interdepartmental coordination was necessary to assure plant and human performance [H.3(b)]. (Section 2OS2)

Inspection Report# : 2009005 *(pdf)*

Significance: G Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure To Submit An Outage Job To The Senior Site ALARA Committee For Review
Green. The inspectors identified a noncited violation of Technical Specification 5.4.1.a because the licensee failed to submit an outage job to the Senior Site ALARA Committee for review. The original dose estimate for turbine building general access was 1300 mrem. The actual dose accrued for the work was 5228 mrem. The licensee documented this occurrence in their corrective action program as Action Request 209314, performed an apparent cause evaluation, and plans to clarify its implementing procedure.

This finding is greater than minor because it resulted in the actual collective dose of the work activity exceeding 5 person-rem (5000 person-mrem) and exceeding the planned, intended dose by more than 50 percent (similar to Manual Chapter 0612, Appendix E, Example 6.i). The inspectors used the Occupational Radiation Safety Significance Determination Process and determined the finding had very low safety significance because it was as low as reasonably achievable finding, but the licensee's three-year rolling average collective dose (139 person rem) was less than 240 person-rem/unit. The finding had a crosscutting aspect in the area of human performance, resources component, because the licensee did not implement complete, accurate, and up to-date procedures [H.2(c)]. (Section 2OS2)

Inspection Report# : 2009005 *(pdf)*

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Last modified : September 02, 2010