U.S. NUCLEAR REGULATORY COMMISSION REGION I

Report No. 50-247/87-06

Docket No. 50-247

License No. DPR-26

Licensee: Consolidated Edison Company Broadway and Bleakley Avenue Buchanan, New York 10511

Indian Point Nuclear Generating Station Unit 2 Facility Name: and Consolidated Edison Warehouse

Inspection At: Buchanan and Cortlandt, New York

Inspection Conducted: February 23-27, 1987

Inspector: <u>M. J. Blumberg</u>, Lead Reactor Engineer, DRS

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Approved by: Jon R. Johnson, Acting Chief

Operations Branch, DRS

4/4/87 date

Inspection Summary: Inspection on February 23-27, 1987 (Inspection Report No. 50-247/87-06)

Areas Inspected: Routine announced inspection of licensee actions on previous inspection findings from probabilistic risk analysis (PRA) team inspection (50-247/86-19) and operational assessment team inspection (OAT) (50-247/84-03). The inspection was conducted onsite and at the Cortlandt warehouse by one region-based inspector.

<u>Results</u>: One violation was identified (failure to take proper corrective action for a previously identified housekeeping violation, paragraph 2.1).

DETAILS

1.0 Persons Contacted

| W. A.J.D.J.F.**B.J.B.H.**M.W.R.F. R. | Borek Cook Corvese Curry Gaynor Goebel Inzerillo Lee Marguglio Quirk Raskovic Sager Schmeiser Selman Smith Spring Urbin | Manager, Financial and Material Controls Generation Support Technical Engineer Senior Quality Assurance Engineer Chief, Plant Engineer Manager of Risk and Radiological Analysis Test Engineer Assistant Watch Supervisor General Manager, Technical Support Manager, Nuclear Power Quality Assurance Test and Performance Engineer Regulatory Affairs Engineer Manager, Nuclear Power Quality Assurance Engineering Generation Support Manager Vice President, Nuclear Power Manager, Operations Manager, Regulatory Affairs Quality Assurance Examiners Cortlandt Warehouse Receipt Inspection Training Administrator Radiation Protection |
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| R. | Vogel | Training Administrator Radiation Protection and Chemistry |

U.S. Nuclear Regulatory Commission

*L. Rossbach Senior Resident Inspector *P. Kelley Resident Inspector

* Denotes those present at the exit interview.

2.0 Licensee Action On Previous Inspection Findings

This inspection was conducted to evaluate licensee corrective actions on violations and other deficiencies identified during three previous NRC inspections. Also evaluated were actions concerning unresolved items and other open findings which were determined to need correction. In some cases, deficiencies had been identified in the reports as requiring corrective action but were not specifically identified for formal NRC followup. This followup reviewed the status of licensee actions resulting from the following inspections:

-- 50-247/84-03 - Special Operations Assessment Team (OAT) inspection in the Areas of Maintenance, Procurement, and Materials Storage (Paragraph 2.2).

50-247/86-19 - Special Probabilistic Risk Assessment (PRA) Team Inspection (Paragraph 2.1).

- 50-247/86-31 Special Followup Inspection Concerning Loose Electrical Connections In the Control Room (Paragraph 2.3).
- 2.1 Followup on Inspection Report 50-247/86-19 Open Items and Other Identified Deficiencies

(Open) Inspector Follow Item (50-247/86-19-02):

Modifications had been made to Motor Control Centers (MCC's) 24, 27 and 29. Although the as-built drawings had reflected the modifications, the associated drawings in the FSAR and system descriptions were not updated for the changes. The inspector observed that Revision 2 has been issued to System Description No. 27.3, "Emergency Diesels" which describes the changes to the MCC's. The licensee stated that the FSAR drawings would be changed during the next scheduled revision to the FSAR. This item remains open.

(Open) Unresolved Item (50-247/86-19-04):

A local/remote switch on each Emergency Diesel Generator control board is used for voltage regulation and speed control. Since there is no "remote" control for these functions in the Control Room, placing this switch in the remote position will disable the applicable EDG. To reduce the potential for disabling an EDG, a caution tag has been placed on each switch to ensure they remain in the local position. A precaution (2.4) has been added to SOP 2.7.3.1 that states "LOCAL/REMOTE switch on diesel generator control panel shall be in LOCAL at all times. REMOTE provides no function." In addition, the manual starting procedure and standby automatic operation both have check off steps to ensure the LOCAL/REMOTE switch is in LOCAL.

The licensee has also performed an engineering evaluation (ESR IP-60784) concerning modifying the LOCAL/REMOTE switch. The result of this evaluation is that a modification is planned to electrically bypass the switch and allow the EDG's to operate no matter which position the switch is in. No implementation date has been assigned. This item remains open pending licensee completion of the modification.

(Closed) Violation (50-247/86-19-06):

Deficiencies were identified concerning the emergency operating procedures (EOP's) and an abnormal operating procedure concerning operation with degraded power sources. The inspector verified the following corrective actions had been taken concerning each example given in the violation.

-- A contingency procedure in EOP ES-1.3 failed to open RHR pumps discharge valve MOV-744 after it had been shut in an earlier step. ES-1.3 has been revised to open MOV-744.

- EOP's EO and E-1 failed to recognize that two containment isolation valves located on Control Room Panel SM needed to be reset. Procedures E-0, E-1, E-3, ECA-3.1, FR-P.1, ECA-0.1, ECA-2.1, ES-1.1, and ECA-1.2 were revised to add a step to "place personnel hatch solenoids to CONTAINMENT ISOLATION on SM panel."
- The Boron Injection Tank (BIT) has been removed from service; however, operation of BIT valves were still included E-O and other EOP's. Procedures E-O, ES-1.1, ECA-0.0, ECA-0.2, and ECA-2.1 have been revised to delete reference to any BIT operations.
- Loss of offsite power via the 138 KV station auxiliary transformer would cause the station electrical systems to be in a degraded mode. There was no abnormal procedure established for operation in this mode. AOI 17.2.2, "Loss of 138 KV," has been written for electrical operation following loss of this power.

In addition the licensee is establishing a computer program in order to facilitate changes to EOP's when required. The licensee stated that this program should be in effect by June 1987. Based on the corrective actions concerning the EOP's listed above this item is closed.

(Closed) Violation (50-247/86-19-08):

Recirculation sump protective grating was not in place, thereby causing the potential of large objects to possibly enter the sump and clog the recirculation pumps. One apparent cause of this problem was incomplete checkout of the containment just prior to closeout for power operation. In order to assure that this problem will not recur, the licensee has issued a new procedure, SOP 10.6.1, "Containment Closeout Housekeeping." This procedure assures proper cleanup of the containment including verification that the containment and recirculation sump gratings are in place; and must be used in addition to 10.6.2 which is the normal containment closeout procedure. 10.6.1 is intended to be performed after outages and is to be performed at the discretion of the Operations Manager.

The inspector observed that there was no mechanism to assure that 10.6.1 would be performed. As a result of the inspector's concerns, the licensee issued a temporary procedure change to PCO-3, "Precriticality and Reactor Startup" to recognize that 10.6.1 may have to be performed in addition to 10.6.2 after containment closeout.

Based on the above actions, the inspector considers this item closed.

(Closed) Unresolved Item (50-247/86-19-09):

The licensee was unable to blackstart Gas Turbine (GT)-2 during the inspection. Blackstart capability (ability to start the GT after loss of all AC power) had been specified in the FSAR. During demonstration blackstart attempts GT-2 failed to start and remain on line. Since that time the licensee has repaired electrical faults which caused the inability to blackstart.

During this inspection, the inspector observed the successful blackstart of GT-2. The unit blackstarted and achieved three megawatts power. While attempting to blackstart the GT, GT-2 did trip off line twice; however, it was ultimately restarted and brought on line. These trips appeared to be those that could normally be expected on a cold start and did not appear to ultimately affect sustained blackstart capability.

Since inspection 86-19, SOP 31.22, "Gas Turbine No. 2 Operating Procedure - LOCAL," was issued for operation GT-2. A portion of this procedure provides a blackstart procedure for GT-2. Subsequent to the blackstarting of GT-2 during this inspection and because of the two trips, the licensee decided that another revision to SOP 31.2.2was needed. At the conclusion of the inspection, the inspector reviewed a draft revision to clarify to the operator what to do if the unit trips.

The inspector considered the blackstart test successful and this item is closed.

(Closed) Violation (50-247/86-19-10):

Various deficiencies were identified concerning station housekeeping as follows:

- -- Plastic bags, rags, tools and debris were observed inside the Fuel Handling Building and outside the Fan House.
- -- Oil spills were observed on floors of the cable spreading room and emergency diesel generator room.
- -- Plastic bags and tubing were left on the floor of the containment in the vicinity of the recirculation sump.
- -- Two ton gantry cranes and instrument tables with wheels were observed in the cable spreading room unsecured; and four instrument tables with wheels were also observed unsecured in the 480 Volt Switchgear room.

Other housekeeping deficiencies were also identified which not considered as part of the violation. The inspector toured the plant to review corrective action on each deficiency previously observed except for the recirculation sump which was in containment. Except as noted below, the inspector observed that the licensee had corrected most of the previously identified deficiencies.

During the plant tour, the inspector observed that housekeeping was in general acceptable. There were a few isolated examples of tools left out of place but there was no trash or debris observed. However, the licensee appeared not to have taken adequate corrective action concerning control of compressed gas bottles in the plant. In spite of previous corrective actions including upgrading of housekeeping instructions. The inspector observed several examples of unsecured or poorly secured bottles in the Primary Auxiliary Building (PAB).

- -- A welders argon bottle was tied off by a large rope that would not have prevented the bottle from falling.
- -- Two acetylene bottles were loosely secured at the top in an ineffective manner.

-- An oxygen bottle was secured only with a thin plastic tie strap.

Procedure SAO-218 requires gas cylinders to be capped if not in use and left unattended. The inspector observed one uncapped gas bottle in the fuel handling building and two uncapped nitrogen bottles at the steam generator blowdown station. Each of the above bottles were not in use and were unattended. Other housekeeping deficiencies were also observed. SAO-218 states that cable trays shall not contain trash and that electrical leads are properly insulated. The following trash was observed in the electrical penetration room cable trays in the PAB - one telephone, a light bulb cage, a coil of rope, wire and some miscellaneous material. Temporary cable in the Fan House had uninsulated leads and (apparently unused) cable in the Maintenance Outage Building also had uninsulated leads.

Although overall housekeeping has improved, the inspector considered (by the number of existing deficiencies) that previous corrective actions had not been completely effective. Properly used, the housekeeping checklist in SAO-218, "Housekeeping Policy" should have prevented each of the deficiencies observed by the inspector.

Because, the housekeeping problems observed in violation 86-19-10 have been substantially corrected this item is considered closed. However, the deficiencies observed concerning uncapped and improperly secured gas cylinders, the trash in the cable trays, and uninsulated 7

cable ends are examples of inadequate corrective action and are considered a violation of 10 CFR 50, Appendix B, Criterion XVI (50-247/87-06-01).

Subsequent to the inspector pointing out the above deficiencies, the licensee removed the unsecured gas cylinders from the PAB, removed some of the trash from the cable tray, and removed the temporary cable from the Fan House in the PAB. The licensee stated that part of the problem was difficulty in controlling gas cylinders brought by contractors doing work in the PAB.

As part of additional planned corrective actions, the licensee presented a draft of a new attachment to SAO-218 which includes specific control of gas cylinders. In addition, in October 1986, the licensee had performed a gas cylinder inventory. As followup to this inventory, a December 8, 1986 memorandum was prepared by the Financial and Material Control Section for recommendations to establish better controls of gas cylinders. The effectiveness of these proposed actions will be reviewed in a future inspection.

(Closed) Inspector Follow Item (50-247/86-19-12):

The voltage restraint relays (SIV) and the loss of field relays for the emergency diesel generators and gas turbines are subject to tripping upon a blown fuse. Also there is no blocking of the voltage regulator if its associated fuse is blown. The licensee planned an engineering evaluation of the acceptability of the design.

An engineering evaluation (ESR-IP-60783) was completed on September 15, 1986. Two resolutions were considered by the licensee but neither was recommended as each would cause other problems. It was noted in the recommendations for the ESR that, during an emergency condition, a safety injection signal would block any EDG trip due to the operation of the over current or reverse power relays. Hence, the licensee had determined that the identified condition is acceptable as is. This item is closed.

(Complete) EOP Procedural Corrections on pages 20 and 21 of 50-247/86-19:

Inspection report 50-247/86-19 identified several procedural errors and weaknesses in procedure ES-1.3 which appeared to need correction but were considered minor in nature. The inspector observed that the following corrective actions:

-- Valve numbers for diesel generator service water flow control valves, MOV-1176 and 1176A were not given. These valves have been deleted from the procedure as no longer being required.

- ES-1.3 requires resetting of MCC's 26A and 26B which could cause MCC's for the BIT to be inadvertently operated. The inspector verified that breakers for the BIT have now been labeled "BIT RETIRED - DO NOT ENERGIZE."
- -- ES-1.3 identifies valve 1813 as an MOV while it is actually an air operated valve. The MOV designator in the procedure for 1813 has been removed.
- -- ES 1.3 does not identify that valves MOV-743 and MOV-1870 cannot be operated from the control room. In this case the licensee chose not to change to procedure to include this clarification.

The inspector considers the above actions acceptable and has no further questions concerning this item.

(Complete) PT-R13A Procedural Changes on pages 25 and 26 of 50-247/86-19:

Minor deficiencies were noted test procedure PT-R13A, "Test of Recirculation System." The inspector reviewed a draft of procedure changes for this procedure and observed the following:

- -- The words "cycle complete light illuminated" has been added to the test of Switch No. 5.
- -- The switch position for stopping pumps SWP's No. 26 and No. 25 is now "Auto Off."
- -- Valve lineup changes have been made to assure that there will be no inadvertent backflow from the RHR system to the RWST in case valves 842 and 843 do not automatically shut when Switch No. 6 is operated.
- The procedure has been changed to check the automatic arming of safety injection pump low pressure alarm PT-947.

-- Valve 1813 is no longer erroneously identified as an MOV.

Although changes to PT-R13A were in draft, the inspector considered the licensee's actions as acceptable and had no further questions.

(Completed) Revision to A-27.1.9, Page 41 of 50-247/86-19:

A-27.1.9, "Control Room Inaccessibility," specifies operation from the safe shutdown panel should the control room become unavailable. This procedure assumes that some 480 volt power would be available. The inspector observed that the loss of all AC power after the control room is evacuated should be considered a valid contingency to be included in A-27.1.9. Procedure A-27.1.9 has now been revised to provide for plant operations if no station AC power is available and the control room is inaccessible. This item was considered to be complete and the inspector had no further questions.

(Completed) Reflector Tapes for Breaker, page 60 of 50-247/86-19:

To ensure that 480 volt switch gear room motor control center breakers are properly reset during an emergency, reflector tape was to be installed on the MCC 211 feeder breaker. The inspector observed that reflector tape installed was too small to be adequately visible. During this inspection, the licensee installed a larger, more visible tape - on MCC 211. This item is completed.

(Open) Component Identification, page 61 of 50-247/86-19:

This item identified several deficiencies concerning component labeling. The inspector verified the following items had been corrected:

- -- RHR valves MOV-744 and 882 are now identified with permanent labels.
- -- Mechanical position indicator for valve 1813 is now visible.
- -- City water valve FCV-1205A was now labeled.

Large labels have not been installed for MOV breakers at MCC's 26A and 26B. The licensee stated that their component labeling program should be completed by August 30, 1987 and that these and other deficiencies should be corrected.

The satisfactory completion of the valve labeling program will be reviewed during a future inspection.

(Completed) Backup MCC Breaker Operator, Page 62 of 50-247/86-19:

The inspector observed that the 480 V switchgear room breaker operator backup tool was still being maintained in the watch supervisors safe. However, some personnel were not aware of its reason for being in the safe and it could be inadvertently removed. During the inspection the tool was painted with caution not to remove from the safe. This item is completed.

2.2 Followup on Inspection Report 50-247/84-03 Open Items and Other Identified Deficiencies

(Closed) Open Item (50-247/84-03-05):

Several weaknesses were identified in maintenance program controls.

There were no administrative controls for PGM maintenance, nuclear related maintenance at Van Nest Shops, and Maintenance Departments interfaces with the modification process. The inspector observed that that maintenance program procedures have been significantly upgraded; Van Nest Shop procedures have been reissued and SAO 405, "Modifications To Indian Point Facilities" has been revised to recognize interface with Plant Maintenance Department. Based on the above this is closed.

(Closed) Open Item (50-247/84-03-06):

Various materials were being stored at Buchanan Service Center, the Tensolite Building, Bleakley Avenue satellite storage area, and the plant maintenance storage facility. Numerous deficiencies were noted at these storage locations including:

- -- Lack of temperature control
- -- Inadequate fire protection
- -- Poor housekeeping
- -- Class "A" materials not segregated
- -- Improper storage of combustibles
- -- Improper preservation of equipment

The storage locations mentioned above are no longer in use. All storage has been consolidated at the Consolidated Edison Warehouse at Cortlandt, New York, approximately ten miles from the site. The inspector toured this facility and observed that all deficiencies listed in 84-03-06 appeared to have been corrected. The warehouse and storage was in excellent condition. Only one deficiency was observed - some small diameter class diameter class piping was uncapped. In some cases the covering tape had fallen off; and in others, the tape appeared not to have been installed. The licensee stated that this would be corrected immediately. Based on the above, this item is closed.

(Closed) Open Item (50-247/84-03-08):

This was no formal procedure detailing receipt inspection. The licensee utilized an unapproved check list "Directory of Quality Assurance Documentation Requirements" for determining receipt inspection requirements. The inspector observed that procedure QA-745-1, "Use of Receipt Inspection Checklists" has been issued and is in use at the Cortlandt Warehouse. This item is closed.

(Closed) Open Item (50-247/84-03-09):

The licensee's material control program did not require a formal method of inspecting stored components with respect to shelflife, preventive maintenance, or general care during storage. Also

procedures had not been developed for the control of Class A components. Since the establishment of the Cortlandt warehouse, the licensee has established the following Central Stores Administrative Directives:

- CSAD-2, "Receiving of Class A Material" CSAD-3, "Storage and Handling of Class A Material" CSAD-4, "Issuing of Class A Material" _ _
- ___
- CSAD-5, "Stores Shelf Life Procedure" ----
- CSAD-6, "Preventative Maintenance of Material in Storage"

The inspector reviewed records indicating that the shelf life and preventative maintenance program were being implemented. In addition, during the tour of the Cortlandt warehouse, the inspector observed that Class A material appeared to be very well controlled and properly segregated. Based on the above this item is closed.

(Closed) Open Item (50-247/84-03-10):

CI-240-1, "Quality Assurance Program for Operating Nuclear Power Plants" and the majority of QA operating procedures did not reflect quality the Quality Assurance and Reliability Departments current organization and/or define the QA responsibilities and interfaces for the New Engineering design/modification process. The inspector observed that the above weaknesses have been a corrected by revision to CI-240-1 and the establishment of the following procedures:

- QA-700-3, Nuclear Power QA Organization and Responsibilities
- QA-701-3, Nuclear Power QA Engineering Organization and Responsibilities
- Power Quality Control Organization QA-702-3, Nuclear and Responsibilities
- AO-405, Modifications To Indian Point Facilities, Revision 1

The licensee stated since CI-240-1 had been revised, the QA organization had been changed and CI-240-1 no longer completely reflected this change. CI-240-1 was to be changed in the near future. Based on the establishment of procedures listed above, this item is considered closed.

(Closed) Open Item (50-247/84-03-14):

QA Engineering used a Directory of Quality Assurance Requirements (DOOAR), a controlled procedure, to identify QA requirements for procurement of Class "A" items. Instructions for use of, and revision to, the DOQAR was by memorandum. The inspector observed that the DOQAR is now controlled by procedure QA-504-1, "Application of Directory of Quality Assurance Requirements (DOQAR) to Class "A" Requisitioning Documents." This item is closed.

2.3 <u>Followup on Licensee Actions Identified in Inspection Report</u> No. 50-247/86-31

(Open) Review of Licensee Actions For Preventive Maintenance Concerning Loose Electrical Leads, Page 8 of 50-247/86-31:

Following identification of loose electrical connections in Control room panels, the licensee performed a check of 20,000 terminal connections finding approximately 2% were not completely tightened. Based on this, the licensee was evaluating the need to check additional terminal connections and whether to establish a preventive maintenance program for periodic checks for loose terminals.

On February 2, 1987, the licensee completed a tightness check on additional 1318 screws indicated approximately 6% were slightly loosened. On February 17, 1987, the licensee's Electrical Engineering Department determined that since only .7% were greater than 1/2 turn loose there was not a widespread problem and made the following recommendations to the plant's I&C Department:

- 1) Hand tighten all screw connections in the central control room panels and cabinets.
- At the next outage, check a sample population (to be determined by Reliability Engineering and Technical Systems) of terminal connections for proper tightness by gualified technicians.
- 3) If results of the above sample are considered acceptable then no further action is required. This is to be repeated for another sample at the next outage.
- 4) QA Procedure QA-742-1, "Sampling Plan for Inspection," is based on Mil Std 105d and will be used as guidance for sample size and acceptance criteria.

The remaining equipment in the control room to be checked include the Central E, F and G reactor panels, additional supervisory panels, and Foxborough DB blocks. Initially, approximately 1/3 of the remaining screws will be done each refueling outage. The sample will be adjusted up or down depending on problems found. An investigative checklist will be used. Electrical engineering will identify those screws outside of the control room to be checked.

The licensee further determined that the use of torque specification is not required. All screws are to be hand tightened and not forced. The need to establish a continuing P.M. program for checking of terminal block connection screw tightness will be based on the results of the above inspections. The inspector had no further questions at this time.

3.0 QA/QC Interfaces

The inspector held discussions with the Manager Nuclear Power Quality Assurance (NPQA) Engineering concerning any specific QA participation or oversight of verifications of licensee corrective actions to deficiencies identified in NRC PRA inspection 50-247/86-19.

The following is summary of licensee statements that were provided both verbally and in writing to the inspector:

NPQA did not perform any activities expressly for the purpose of verifying or evaluating the corrective action being taken to correct conditions found during the PRA inspection. However, in performing routine NPQA activities, several items related to corrective action for inspection 86-19 were addressed by NPQA as follows:

- -- The Station Administrative Order and some of the other procedures committed to be developed (i.e., Containment Closeout, System Engineer Assignments, etc.) were reviewed by NPQA, and comments were made and resolved to specifically correct PRA inspection findings.
- Frequent (approximately one per week) housekeeping surveillances of plant areas were performed. NPQAE worked with Nuclear Power Generation Maintenance during revision of SA-218, "Housekeeping Policy" to assure that the ability to correct unsatisfactory conditions observed in the past year were factored into the procedure.
- -- The NPQA Surveillance Program periodically samples corrective action implementation in response to NRC Findings or I&E Information Notices or other correspondence. One such surveillance was conducted in October, 1986. In general, three or four are performed annually.
- The NPQA inspection program looks for missing identification tags.
 Missing tags are reported to NPG Operations for replacement.

 NPQA participates on the Station Corrective Action Committee and helps develops action please to identify the root cause of failures and to provide permanent corrective action for recurring plant equipment deficiencies in balance of plant systems. Specifically in the area of housekeeping, the inspector reviewed a sampling of NPQAE audit results. A computer printout status list was provided to the inspector that summarized housekeeping surveillance reports between July 30, 1986 and February 11, 1987. These were 66 reports issued with approximately 20 identifying unsatisfactory conditions. The frequency of those surveillances may be indicative of the inspector reviewed QA-400-6, "Audit Program for Operating Nuclear Plants", and surveillance guideline checklist for "Housekeeping, Safety and Fire Hazard". This checklist is seven pages and quite extensive, and appears to incorporate all the guidelines of the housekeeping checklist of SAO-218. The inspector had no further questions.

4.0 Independent Measurements, Calculations and Observations

The inspector toured the Primary Auxiliary Building (PAB), Turbine Building, Auxiliary Feed Pump Room, 480 V Switchgear Room, Cable Spreading Room, Control Room, PAB piping and electrical penetration areas, Emergency Diesel Generator Room, Outage and Modification Building and the Fuel Handling Building. Overall cleanliness and improvements in housekeeping were observed by the inspector. In addition, the inspector independently verified all corrective actions in component labeling.

5.0 Management Meeting

Licensee management was informed of the scope and purpose of the inspection at an entrance interview conducted on February 23, 1987. The findings of the inspection were periodically discussed with licensee representatives during the course of the inspection. An exit interview was conducted on February 27, 1987 (see paragraph 1 for attendees) at which time the findings of the inspection were presented.

At no time during this inspection was written material concerning inspection findings provided the licensee by the inspector.

A subsequent telephone discussion concerning the inspection findings was conducted between the inspector and Mr. R. Spring of your staff on March 20, 1987.