U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-263/88006(DRP)

Docket No. 50-263 License No. DPR-22

Licensee: Northern States Power Company
414 Nicollet Mall
Minneapolis, MN 55401

Facility Name: Monticello Nuclear Generating Station

Inspection At: Monticello Site, Monticello, MN

Inspection Conducted: April 9 through May 27, 1988

Inspectors: P. L. Hartmann

C. L. Vanderniet

Approved By: I. N. Jackiw, Chief
Reactor Projects Section 2B

6-16-88
Date

Inspection Summary

Inspection on April 9 - May 27, 1988 (Report No. 50-263/88006(DRP))
Areas Inspected: A routine, unannounced inspection by the resident inspectors of previous inspection findings; operational safety verification; maintenance; surveillance; Reactor Core Isolation Cooling (RCIC) system turbine trips; condenser tubing investigation; small valve issue; fire doors; informational notices; and generic letters.
Results: During this inspection period the unit continued 100% power operations and in general the plant continues to operate well. Concern still exits, however with the operation of the RCIC turbine. This concern is discussed at length in paragraph 6 of this report. An updated status report of the "small valve" issue is also discussed within paragraph B. Of the 10 areas inspected, one violation was identified in the area of control and maintenance of fire doors and no new unresolved items were identified.

DETAILS

1. Persons Contacted

W. A. Shamla, Plant Manager
*M. H. Clarity, Assistant to the Plant Manager
D. E. Nevinski, General Superintendent, Engineering & Radiation Prot.
H. M. Kendall, Plant Office Manager
D. D. Antony, General Superintendent, Operations
R. L. Scheinost, Superintendent, Quality Engineering
J. R. Pasch, Superintendent, Security and Services
J. H. Swailes, Superintendent, Radiation Protection
W. J. Hill, Superintendent, Technical Engineering
W. W. Albold, General Superintendent, Maintenance
B. D. Day, Superintendent, Operating Engineering
L. L. Nolan, Superintendent, Nuclear Technical Services
D. A. Scott, Lead Quality Engineer, Quality Engineering
S. A. Engelke, Lead Production Engineer, Operating Engineering

The inspector also contacted other licensee employees including members of the technical and engineering staffs, and reactor and auxiliary operators.

*Denotes the licensee representatives attending the management exit interviews.

2. Licensee Action on Previous Inspection Findings

a. (Closed) Open Item 50-263/88004-01 Valve Out of Position

This item has been closed and the corrective action incorporated into Open Item 50-263/88006-01

b. (Closed) Unresolved Item 50-263/87021-01 Material Condition of Valves

This item has been closed and the corrective action incorporated into Open Item 50-263/88006-01

c. (Closed) Unresolved Item 50-263/87012-02 Discrepancies Involving Locked Valves.

This item was initiated after a walkdown of the Standby Liquid Control system identified valves in locked conditions that did not correspond with the system drawings and valve lineup sheets.

The licensee has reviewed its locked valve criteria and redefined that criteria to formulate a clearer position. This review has prompted the licensee to review all locked valves in the facility and thereby reassess and reassign locked valve status. This is a positive response by the licensee to regain control of the facility's use of locked valves. As a result of the licensee's efforts, the inspectors feel adequate attention has been applied to the identified problem and therefore, this item is considered closed.

d. (Closed) Open Item (263/85007-01(DRS)): Licensee had no written requirements/procedures for calibrating LPRMs. A region-based inspector reviewed a copy of a LPRM calibration procedure from the licensee's Operations Manual, Section B.5.1.2, dated December 26, 1985. The written instructions for calibrating the LPRMs and the stated frequency of calibrations were considered to be adequate. Discussions with the licensee indicated that the Nuclear Engineers perform the activities, documenting their results on data sheets/logs which are filed in the Engineering Department. Based on the inspector's review of the procedure and the discussions with the licensee, this item is considered to be closed.

e. (Closed) Open Items (263/85999-04, 263/86999-01, and 263/87999-01. These open items are closed in accordance with DRSS memo dated December 15, 1987. These emergency plan activities are reviewed by routine inspection.

3. Operational Safety Verification (71707)

Routine Inspection

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the inspection period. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of the torus, radwaste building, reactor building, intake structure, and turbine building were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance.

A system walkdown was performed on portions of the Residual Heat Removal Service Water (RHRSW) system and the Emergency Service Water (ESW) system located in the Intake Structure. During the walkdown the following discrepancies were noted:

a. Local pressure gages on the discharges of ESW pumps 111-C and 111-D are not shown on the system piping diagram.

b. Valve RHRSW-23-2, Pressure Indicator 7361-B isolation was missing a nut from one of the packing gland studs.

These discrepancies were identified to the licensee. Item 2 is a valve that is on the prestartup valve lineup checksheet for the RHRSW system. The inspectors reviewed the requirements of the checksheets and found that the material condition of the valves is not required to be checked, only their position. The licensee evaluated the condition of RHRSW-23-2 and determined that it posed no safety problem; however, they also stated that its condition was unsatisfactory. The licensee replaced the missing nut shortly after it was brought to their attention. Further discussion of this issue will be covered in paragraph 8 of this report. No open item will be issued for this walkdown due to the work in progress described in paragraph 8.

The inspector, by observation and direct interview verified that portions of the physical security plan were being implemented in accordance with the station security plan.

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. The inspector also witnessed portions of the radioactive waste system controls associated with radwaste shipments and barreling.

These reviews and observations were conducted to verify that facility operations were in conformance with the requirements established under technical specifications, 10 CFR, and administrative procedures.

On May 10, 1988 at 2:30 AM the #12 Residual Heat Removal Service Water (RHRSW) pump was declared inoperable when an air vent top flange gasket failed. The # 11 RHRSW pump had previously been declared inoperable due to another unrelated problem. This condition resulted in two RHRSW pumps being inoperable at the same time. The two pumps, however, are installed in different RHRSW trains and each train still maintained 100% flow capacity due to installed standby pumps. The #12 RHRSW pump was returned to service approximately three hours after it was declared inoperable. The Technical Specifications do not specifically address the above situation and the licensee's current interpretation of the Technical Specification is being reviewed. This event will be reviewed as part of Unresolved Item 50-263/88003-04, RHRSW Operability.

4. Monthly Maintenance Observation (62703)

Station maintenance activities of safety-related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with technical specifications.

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and fire prevention controls were implemented. Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety-related equipment maintenance which may affect system performance.

Portions of the following maintenance activities were observed/reviewed:

- Repair of HPCI-3 Steam Leak.

  During this inspection period a 3/4" drain valve on the High Pressure Core Injection System, HPCI-3, developed a steam leak. The licensee, following appropriate maintenance practices, repaired the valve leak. At no time did the leakage from this valve effect the operability of the HPCI system.

- Replacement of Residual Heat Removal Service Water (RHRSW) Pump.

  As a result of the 11 RHRSW pump to fully meet the acceptance criteria of Test Procedure #0255-05-IA, Part 1, RHR Service Water Pump and Valve Test, Revision 16, the licensee initiated the replacement of the pump. This replacement was accomplished in a smooth and professional manner.

5. Monthly Surveillance Observation (61726)

The inspector observed surveillance testing and verified that testing was performed in accordance with adequate procedures, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspector observed/reviewed the following test activities:

- Test #0255-08-IA, Part 1, RCIC System Test, Revision 17

  No discrepancies were identified during the observance of this test procedure.

- Test #1136, RHR Heat Exchanger Efficiency Test, Revision 9

  No discrepancies were identified during the observance of this test procedure.

- Procedure #0255-04-IA, Part 1, RHR Pump and Valve Test, Revision 22

  No discrepancies were identified during the observance of this test procedure.

- Procedure #0255-05-IA, Part 1, RHR Service Water Pump and Valve Test, Revision 16

  During the performance of this test the 11 RHRSW pump was found to be operating with a pump differential pressure of 222 psig. This placed the pump in the alert range according to acceptance criteria for this procedure. The inspector reviewed the past three performances of this test and observed that the pump had also previously been in the alert range. The inspector discussed this with the licensee and was informed that a Work Request Authorization (WRA) had been initiated to remove the pump from service and rebuild it.

  The pump was removed from service and is currently being rebuilt by the licensee. The inspectors feel the licensee is demonstrating adequate corrective actions regarding this issue and will monitor the rebuilding of the 11 RHRSW pump.

- Test #0255-08-IA, Part 1, RCIC System Test, Revision 17

  This is was the second observance of this test procedure during this report period, due to the concerns over the operability of RCIC the inspectors felt the second observance was warranted. During this test a steam leak developed on an instrument fitting. This problem was immediately corrected and the rest of the test proceeded without incident.

- Test #0255-06-IA, Part 1, HPCI System Test, Revision 25

  This test was performed several times due to maintenance and the inoperability of the RCIC system; however, the inspector only observed the full test once. No discrepancies were identified during the observance of this test procedure.

6. Reactor Core Isolation Cooling (RCIC) System Turbine Trips

The licensee has continued to have problems with the operability of the RCIC turbine. In order to follow and update the current status of the RCIC system problems the following chronology will be useful.

From inspection report 87021

The inspector observed Test #0255-08-IA, Part 1, RCIC System Test, Revision 17 as it was conducted on 01-04-88. During the performance of this test the RCIC turbine is started, stopped, and restarted. The restarting of the turbine is conducted under step 19 of the procedure and when this step was performed the turbine tripped for no identifiable reason. The turbine trip was reset and a visual walkdown of the turbine was performed. The operator repeated step 19 and the turbine started normally allowing the test to be completed.

From inspection report 88004

Test #0255-08-IA, Part 1, RCIC System Test, Revision 17, was performed on 4-4-88. The electrical breaker on MO-2076, RCIC Outboard Steam Isolation Valve, would not close resulting in the declaration of the valve and the RCIC System inoperable. A Work Request Authorization was written to troubleshoot the breaker and repair the problem.

During the repeat of the RCIC System Test the RCIC turbine tripped for an unknown reason. A strip chart recorder had been attached to monitor the following parameters in an effort to identify the cause of the trips:

a. Trip coil on MO-2080 (RCIC Trip Throttle Valve)

b. RCIC Pump Suction Pressure (15" Hg)

c. Instantaneous High Turbine Exhaust Pressure (40 psig)

d. High Turbine Exhaust Pressure (25 psig)

e. Turbine Mechanical Overspeed Trip (5652 RPM)

The strip chart revealed that the Instantaneous High Turbine Exhaust Pressure indicated a pressure spike of 34 psig. The setpoint of this pressure switch was checked and was found to be within tolerance but set at 38 psig instead of 40 psig. The pressure switch was reset to the appropriate setting of 40 psig.

The RCIC System Test was repeated on 4-5-88 and operated without a trip; however, the licensee left the system inoperable wanting to perform a second repeat test to ensure no trip occurred. On the second repeat test on 4-6-88 personnel were in the RCIC room to observe the operation of the RCIC turbine. During the test, which was performed without a trip, the

personnel in the RCIC room noticed an abnormal amount of vibration on the mechanical trip connecting rod. Closer inspection of the connecting rod appeared to show that the required clearance between the rod and the trip lever was missing. The licensee suspected that the lack of this clearance could have caused the unexplained trips due to increased vibrations. A WRA was written to inspect and repair the clearance which was found to be none existent.

The RCIC System Test was repeated again on 4-6-88, no trip occurred, and the licensee declared the RCIC system operable. The frequency of the RCIC System Test; however, remained at two weeks and the strip chart recorder remained attached until the licensee was satisfied the unexplained trips had been corrected.

Current status

On April 18, 1988, the RCIC system test was performed again resulting in a trip of the RCIC turbine. The strip chart was reviewed and it was determined that the turbine had tripped on a high instantaneous exhaust pressure. The RCIC turbine was declared inoperable and the licensee began to reevaluate the probable cause of the trip.

As part of the troubleshooting the following items were completed:

a. RCIC turbine exhaust check valve RCIC-10 was verified to be operating properly by performing a manual cycling of the valve through use of an external connection.

b. RCIC vacuum breaker solenoid valve was tested and found to be operating properly and the vacuum breaker line was verified to be clear of obstructions.

c. A pressure test was conducted to determine the integrity of the the RCIC turbine exhaust check valves RCIC-9 and RCIC-10. The test was completed satisfactorily.

d. RCIC turbine exhaust vacuum breaker check valve was verified to open freely by performing an air test.

e. The setpoint of the high instantaneous exhaust pressure trip was verified to be set at 40 psig.

The RCIC turbine was again tested on April 20, 1988, under controlled conditions and tripped due to high instantaneous exhaust pressure.

The setpoint of the high instantaneous exhaust pressure was raised from 40 psig to 50 psig on April 22, 1988. The increase in the setpoint was completed after the licensee completed a safety evaluation of the change which was reviewed by licensee management. The RCIC turbine was retested on April 22, 1988, and again tripped, this time as a result of the mechanical overspeed.

An inspection of the RCIC turbine produced no observable mechanical problems, the turbine was retested, and operated satisfactorily. Since that test, the turbine has been tested two more times and the RCIC system was declared operable. The RCIC turbine remains on an accelerated testing schedule of two week intervals. The licensee will continue the accelerated testing until they feel confident that the turbine is fully reliable. The licensee has also left a recorder attached to the turbine to ensure any future trips are adequately documented. The resident inspectors will also continue to monitor the progress of the RCIC testing.

7. Condenser Tubing Investigation

The resident inspectors received a call for assistance from the International Programs Section of the NRC regarding the sale of contaminated copper tubing from Monticello to Taiwan. The inspectors questioned licensee management and determined that condenser tubing was replaced in 1984 and transferred to an off-site contractor for processing and disposal.

The removal of the condenser tubing was part of a normal condenser retubing evolution that was performed during the 1984 refueling outage. The condenser tubes were cut into lengths of approximately 34-36 feet long and 4 feet long and were removed from the condenser. There were approximately 40,000 tubes of each length that were removed for a total of approximately 80,000 pieces. The tubing was made of Admiralty Brass with a composition of 70% copper, 28.5% zinc, and 1.5% of tin.

The longer pieces were placed in specially designed and sealed shipping containers. These containers were 24" ID spiral-weld piping that was sealed at both ends by a bolted flange connection and Isocryl tape #5601. 108 of these containers were used, 54 were 37 feet long and 54 were 34' 4" long. Each container held approximately 375 tubing sections. The shorter pieces were shipped in standard LSA shipping containers. The tubing was surveyed prior to loading into the containers and the containers were surveyed prior to their leaving the site. The licensee provided the inspectors with requested random copies of the survey and no abnormalities were discovered. Approximately 30 shipments were made by truck from the licensee in early 1985 to the Quadrex facility in Oak Ridge, TN.

The licensee and the resident inspectors contacted Quadrex management and were informed that the facility had chemically cleaned the tubing to remove any fixed contamination, surveyed it as clean, and sold as it as scrap to a scrap metal dealer in the southern part of the United States. The scrap dealer apparently sold the tubing to a party in Taiwan.

8. Small Valve Issue

The licensee has experienced problems with the control and material condition of small 3/4" valves over the past several years. These problems still exist; however, the licensee has taken additional new steps in an effort to control and correct the problems. To fully understand the issue, the following is a chronology of the previous findings and an update of the current status of this issue.

Inspection Report 87012

SYSTEM: Core Spray (CS) (Drawing M-122)

Valve: High Point Vent Valve on instrument line to PT-14-38B

Valve was missing both packing gland nuts and one packing gland stud. The inspectors believed this to be a one time occurrence. The licensee replaced the missing parts immediately.

Inspectors identified the following weaknesses in the use of Form #2161, Plant Pre-Startup Checklist:

- Instruments were listed but the respective valves for those instruments were not individually identified.
- Root Valve for PT-14-38A was not lockwired as required by Form 2161.
- Root Valve for PS-14-44B was not lockwired as required by Form 2161.

Licensee stated that Form 2161 was under review and was to be revised to provide clearer direction to I&C Technicians performing the checklist. The above root valves were immediately lockwired.

Inspectors opened Open Item 50-263/87012-01 to track the revision of Form 2161.

Inspection Report 87015

SYSTEM: High Pressure Core Injection (HPCI) (Drawing M-124)

VALVE: Upstream Isolation Valve on FE-23-80

Valve was missing one packing gland nut and stud.

SYSTEM: Reactor Core Isolation Cooling (RCIC) (Drawing M-126)

VALVE: Isolation Valve on FT-13-58

Valve was missing one packing gland nut

Both of the above valves were immediately repaired by the licensee. The inspectors closed Open Item 50-263/87012-01 and opened Unresolved Item 50-263/87015-05 to track the corrections of all the aforementioned problems with the control of instrument isolation, vent, and drain valves.

Inspection Report 87021

SYSTEM: Control Rod Drive Hydraulic (Drawing M-118)

VALVE: Isolation Valve on PT-3-205

Valve was missing one packing gland nut and stud. Valve was immediately repaired by the licensee.

As a result of the findings from Inspection Reports 87012 and 87015 the licensee had performed a walkdown of the instruments listed on form #2161. Valves for each instrument had been identified and tags had been hung on the valves with their respective instrument numbers on them. The above valve was found after this walkdown had been completed and was one of the valves identified and tagged as a result of the licensee's walkdown.

During the exit the licensee verbally committed to the following:

- Establish a completion date for the final revision of Form 2161.
- Provide training to I&C Technicians on proper material condition of instrument isolation, vent, and drain valves.
- Convey the above verbal commitments to the inspectors in writing.

The licensee's written response, dated March 28, 1988, stated the following:

- Review of all plant process instrumentation to identify those instruments that should be included on Form #2161. Completion Date: 1 June, 1988.
- Uniquely identify all valves associated with the instruments identified in the above step. Completion Date: 1 December, 1988.

- Modify Form #2161 to include all instrument valves identified in the above steps and list all uniquely identified valves. Completion Date: 1 December, 1988.
- Training all I&C Technicians on proper material condition of instrumentation valves. Completion Date: 1 May, 1988.

Inspection Report 88003

SYSTEM: Reactor Core Isolation Cooling (RCIC) (Drawing M-125)

VALVE: Isolation Valve on LS-13-74

This valve was found in the closed position while the licensee was troubleshooting the failure of the above level transmitter. The position of this valve was not controlled under either Form #2161 or the Pre-Startup Valve Lineup. The valve was placed in the open position by the licensee.

No new open item was issued because the inspectors felt the valve was covered under Unresolved Item 50-263/87015-05 and, would subsequently be corrected under the written commitments to Inspection Report 87021.

Inspection Report 88004

SYSTEM: Residual Heat Removal (RHR) (Drawing M-120)

VALVE: #12 RHR Pump Suction Drain Valve RHR-44-2

Valve was missing both packing gland nuts. The valve was listed on the Pre-Startup Valve Lineup for the RHR system which is completed by operations prior to plant startup. The licensee's procedure requires the operators to only sight verify the position of the valve and not the material condition of the valve. The valve was immediately repaired by the licensee.

Inspectors issued Open Item 50-263/88004-01 to track this item because it concerned operations personnel and not I&C personnel.

In response to the above additionally identified problem, the licensee established a new inspection program for all safety-related systems. This new program requires a complete walkdown of all accessible portions of the systems. The walkdowns are intended to provide a detailed assessment of the systems material condition and list any discrepancies that are identified.

Current Status

SYSTEM: RHR Service Water (RHRSW) (Drawing M-811)

VALVE: RHRSW-23-2, Isolation Valve for PI-7361-B

Valve was missing one packing gland nut.

This valves is listed on the RHRSW Pre-Startup Valve Checklist. The nut was immediately replaced on the valve by the licensee.

SYSTEM: Fuel Pool Filter/Demin System (FP) (Drawing M-136)

VALVE: Isolation Valve for PI-2831.
VALVE: Root Isolation Valve for PI-2831.
VALVE: Isolation Valve for PI-2832.

Each valve was missing two of the four body to bonnet nuts and bolts.

These valves were discovered while the inspector was conducting a tour of the reactor building and are located in the plant sample area. These valves have been brought to the attention of the licensee.

Thus far the inspectors have identified 10 3/4" valves that have some material condition or configuration control deficiency. The licensee has committed to the following corrective items:

- Identification of all plant process instrumentation that should be included on Form #2161. Completion Date: 1 June, 1988.
- Uniquely identify all instrument valves. Completion Date: 1 December, 1988.
- Revision of Form #2161. Completion Date: 1 December, 1988.
- Training all I&C Technicians. Completion Date: 1 May, 1988.

In addition to the above items the licensee has instituted a program to walkdown all safety-related systems to determine the material condition of the systems. The inspectors feel that the completion of the above licensee commitments will adequately correct any existing problems; however, to eliminate the possible reoccurrence of similar problems training is needed for maintenance and operations personnel in addition to the training for I&C technicians. Also, the responsibility for maintaining the material condition for the various systems needs to be established and given to specific individuals or organizations. The completion of the above listed licensee corrective items, the correction for the lack of material condition responsibility, and training for maintenance and operations personnel shall be tracked as an inspector open item (Open Item 50-263/88006-01).

9. Fire Door Found Open

During a routine plant tour by the resident inspector at 5:30 AM on March 14, 1988, fire door 105 (access to the Turbine Building) was found to be ajar and had its automatic door closure disconnected. The licensee was informed of the condition by the inspector and immediately repaired the fire door. Further investigation determined that the fire door had its automatic closure device disconnected since March 12, 1988; thereby, rendering the fire door inoperable.

The period while the fire doors were inoperable had minimal effect on safety. The fire loading in the area is minimal. And fire detection equipment is installed in the room and was available to provide early notification.

When a fire door is inoperable the licensee is required to post a continuous fire watch until the door is returned to it's operable condition. The posting of the fire watch was not done and no provisions were made to ensure that personnel entering or exiting the Turbine Building through fire door 105 checked the closure of the door. This is considered a violation of the licensee's Technical Specification 3.13.G.2 (Violation 50-263/88006-02).

10. Information Notices

a. (Closed) Information Notice 87-08: Degraded Motor Leads in Limitorque DC Motor-Operated Valves. The inspector reviewed the licensee assessment of the information notice and found the licensee: performed a search and determined none of the subject motor operators were found to be on site; determined Monticello was not on the list of plants that received the affected operators; inspected a large number of installed motor operators and determined the type motor lead wire used was not nomex-kapton; and no further action was required for this concern.

b. (Closed) Information Notice 87-42: Diesel Generator Fuse Contacts. The inspector reviewed the licensee assessment of the information notice and found the licensee promptly conducted visual inspections of the spring finger contacts as described in the information notice for both emergency diesel generators during the 1987 refueling outage. The inspection showed no evidence of any indication of the spring finger contacts. The plant has determined that visual inspection of these contacts every other fuel cycle is appropriate and has scheduled a change to the EDG preventive maintenance procedures to accomplish this action.

11. Generic Letters

a. (Closed) Generic Letter 84-23: Improvements to Reactor Vessel Water Level Instrumentation. The inspector reviewed the licensee letter to NRR dated December 5, 1984, which described the proposed response to the generic letter. The improvements discussed were made and the new instrumentation is currently in use.

b. (Closed) Generic Letter 85-07: Implementation of Living Schedule. The inspector reviewed the letter which was sent to the NRC dated July 17, 1985, which responded to the generic letter request. The licensee decided to implement an informal integrated living schedule which is termed the five-year plan. This plan has been implemented and is currently in use.

12. Exit Interview

The inspectors met with the licensee representatives denoted in Section 1 at the conclusion of the inspection on May 31, 1988. The inspectors discussed the purpose of the inspection and the findings.

The inspectors also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspectors during the inspection. The licensee did not identify any documents/processes as proprietary.