

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-315/94013(DRP); 50-316/94013(DRP)
Docket Nos. 50-315; 50-316

License Nos. DPR-58; DPR-74

Licensee: Indiana Michigan Power Company
1 Riverside Plaza
Columbus, OH 43216

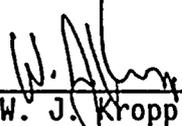
Facility Name: Donald C. Cook Nuclear Power Plant, Units 1 and 2

Inspection At: Donald C. Cook Site, Bridgman, MI

Inspection Conducted: June 4 through July 1, 1994

Inspectors: J. A. Isom
D. J. Hartland
D. L. Shepard

Approved By:


W. J. Kropp, Chief
Reactor Projects Section 2A


Date

Inspection Summary:

Inspection from June 4, 1994, through July 1, 1994
(Report Nos. 50-315/94013(DRP); 50-316/94013(DRP))

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of action on previous inspection findings; operational safety verifications; onsite event follow-up; current material conditions; housekeeping and plant cleanliness; safety assessment/quality verification; maintenance activities; and surveillance activities.

Results: In the eight areas inspected, one violation was identified that pertained to repeated packing failures with a test selector valve associated with the main steam stop valve (paragraph 5.a). Four non-cited violations were identified during the inspectors' LER review.

The following is a summary of the licensee's performance during this inspection period:

Plant Operations:

The licensee's performance in this area was good. The modification performed on the Unit 1 control room that included installing computer consoles at operators' desks, was useful for trending parameters and for entering action requests. Also, the new digital controllers allowed increased precision in control of equipment in service. The inspectors also observed one of the five

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operating crews during the annual dynamic simulator requalification sessions and noted that the crew performed very well using the Emergency Operating Procedures (EOP). The operators displayed excellent command and control and communications. Also, the inspectors noted that the licensee's line management was involved in the evaluation sessions.

Maintenance and Surveillance:

The licensee's performance in this area was adequate. The electricians' performed a thorough investigation and repaired a safety-related motor-operated valve in the safety injection system. However, a violation was identified concerning the repetitive packing failure of a Unit 2 main steam test selector valve over a period of two years that resulted in several entries into four hour Limiting Condition of Operations (paragraph 5.a). The inspectors were concerned because neither the licensee's staff nor program identified this repetitive packing failure as a candidate for the forced outage maintenance list. An unresolved item was identified concerning the failure to identify this rework in a Condition Report.

The inspectors determined that the repair to the Unit 1 ATWS Mitigation System Actuation Circuitry (AMSAC) was performed satisfactorily. The inspectors also noted that the licensee took additional action to ensure that the system outage time would be minimized in the future.

DETAILS

1. Persons Contacted

- *A. A. Blind, Plant Manager
- K. R. Baker, Assistant Plant Manager-Production
- *L. S. Gibson, Assistant Plant Manager-Technical
- J. E. Rutkowski, Assistant Plant Manager, Support
- R. K. Gillespie, Executive Staff Assistant
- D. C. Loope, Executive Staff Assistant
- *T. P. Beilman, Maintenance Superintendent
- P. F. Cardeaux, Training Superintendent
- *D. L. Noble, Radiation Protection Superintendent
- T. K. Postlewait, Design Changes Superintendent
- *P. G. Schoepf, Project Engineering Superintendent
- *J. S. Wiebe, Quality Assurance and Controls Superintendent
- L. H. Vanginhoven, Site Design Superintendent
- *G. A. Weber, Plant Engineering Superintendent

*Denotes those attending the exit interview conducted on July 5, 1994.

The inspectors also had discussions with other licensee employees, including members of the technical and engineering staffs, reactor and auxiliary operators, shift engineers and foremen, and electrical, mechanical and instrument maintenance personnel, and contract security personnel.

2. Action on Previous Inspection Findings (92701)

- a. (Closed) Unresolved Item 50-316/94009-02(DRP): Repack of Test Selector Valve, 2-MMO-240:

Main Steam Stop Dump Valve Test Selector, 2-MMO-240, was repacked several times between 1992 and 1994. The inspectors reviewed this matter and closed it based on a violation described in paragraph 5.a. of this report.

- b. (Closed) Unresolved Item 50-315/93018-01: Low AFW Bearing Oil Condition

The inspectors were concerned that the low oil condition found on the Unit 2 turbine-driven auxiliary feedwater pump during a plant tour on September 2, 1993, would result in inadequate bearing lubrication to the pump. The inspectors observed the testing performed by the system engineer on the spare auxiliary feedwater pump to determine the minimum oil quantity needed to ensure sufficient bearing lubrication. This test verified that there was adequate oil in the reservoir to provide lubrication to the bearings. The inspectors discussed the results of this testing in more detail in paragraph 4.a. of NRC inspection report 50-315/93019(DRP);50-316/93019(DRP). This item is closed.



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No violations or deviations were identified.

3. Plant Operations:

The licensee operated both units up to full power during the inspection period, with no significant operational problems noted. The licensee reduced power on Unit 2 to 55 percent on June 10, 1994, to repair a weld leak on an "East" main feed pump suction instrument line. The licensee returned Unit 2 to full power on June 12, 1994.

a. Operational Safety Verification: (71707)

The inspectors verified that the facility was being operated in conformance with the licenses and regulatory requirements, and that the licensee's management control system was effective in ensuring safe operation of the plant.

On a sampling basis the inspectors verified proper control room staffing and coordination of plant activities; verified operator adherence with procedures and technical specifications; monitored control room indications for abnormalities; verified that electrical power was available; and observed the frequency of plant and control room visits by station management. The inspectors reviewed applicable logs and conducted discussions with control room operators throughout the inspection period. The inspectors observed a number of control room shift turnovers. The turnovers were conducted in a professional manner and included log reviews, panel walkdowns, discussions of maintenance and surveillance activities in progress or planned, and associated LCO time restraints, as applicable. The inspectors had the following observations:

- The reactor operators found the new Unit 1 control room modification, with the computer consoles at operators' desks, was useful for trending parameters and for entering action requests. Also, the new digital controllers allowed increased precision in control of equipment in service.
- The inspectors observed one of the five operating crews during the annual dynamic simulator requalification sessions and noted that the crew performed very well using the Emergency Operating Procedures (EOP). The operators displayed excellent command and control and communications. Also, the inspectors noted that the licensee's line management was involved in the evaluation sessions.

b. Onsite Event Follow-up: (93702)

During the inspection period, the licensee experienced an event, which required prompt notification of the NRC pursuant to 10 CFR 50.72. The inspectors pursued the event onsite with licensee

and/or other NRC officials. The inspectors verified that any required notification was correct and timely. The inspectors also verified that the licensee initiated prompt and appropriate actions. The specific event was as follows:

On June 23, 1994, the licensee made a 1 hour report in accordance with 10 CFR 73.71 and Generic Letter 91-03 after they determined that unescorted access would have been denied to a contractor individual based on developed information. The individual was temporarily employed during the recent Unit 1 refueling outage. The inspectors will review the licensee's LER to verify that adequate root cause for the event is determined and that effective corrective actions are taken to minimize recurrence.

c. Current Material Condition: (71707)

The inspectors performed general plant as well as selected system and component walkdowns to assess the general and specific material condition of the plant, to verify that work requests had been initiated for identified equipment problems, and to evaluate housekeeping. Walkdowns included an assessment of the buildings, components, and systems for proper identification and tagging, accessibility, fire and security door integrity, scaffolding, radiological controls, and any unusual conditions. Unusual conditions included but were not limited to water, oil, or other liquids on the floor or equipment; indications of leakage through ceiling, walls or floors; loose insulation; corrosion; excessive noise; unusual temperatures; and abnormal ventilation and lighting. The inspectors noted no unusual conditions during this inspection period.

d. Housekeeping and Plant Cleanliness:

The inspectors also monitored the status of housekeeping and plant cleanliness for fire protection and protection of safety-related equipment from intrusion of foreign matter, and identified no problems in this area. Housekeeping was considered very good during this inspection period.

No violations or deviations were identified.

4. Safety Assessment/Quality Verification: (40500 and 92700)

Licensee Event Report (LER) Follow-up: (92700)

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, that immediate corrective action was accomplished, and that corrective action to prevent recurrence had been or would be accomplished in accordance with Technical Specifications (TS):



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(Closed) LER 315/93001: Fuel handling exhaust fan charcoal filter bed alarm inoperable due to moving alarm to new annunciator location.

On March 30, 1993, the technicians disabled the "Fuel Handling Exhaust Fan Charcoal Filter Fire or Abnormal" alarm during a modification to the plant fire protection system. When the operators recognized the fact that the problem with the alarm circuitry placed the plant in Technical Specification action statement 3.3.7.b., required compensatory action to station a fire watch was taken. As corrective actions, the licensee revised several Plant Manager Procedures that dealt with modifications to require a review of the modification activities to determine the impact on Technical Specifications required systems. In the past, the responsibility for this review was not clearly delineated between the maintenance planner or the project engineer. Additionally, as a lessons learned, the engineering department gave training on this LER to other project engineers. The failure to properly implement the fire protection modification resulted in a TS violation of fire watch requirements. However, this violation was not cited because the licensee identified the problem and initiated appropriate corrective actions. Therefore, pursuant to the criteria specified in 10 CFR Part 2, Appendix C, Section VII.B(2), no notice of violation will be issued. This item is closed.

(Closed) LER 315/93003-LL: Fire watch patrols not established per TS due to personnel error.

On July 2, 1993, a reactor operator placed the Unit 1 fire detection monitor alarm switch in the "off" position to reset a standing annunciator. The switch was inadvertently left in that position for over 7 hours. In the "off" position, visual and audible alarms associated with the pyrotronics fire detection system would not alarm in the control room. The operators were unaware of the mispositioned switch and did not take compensatory actions required by TS. Upon discovery, the operators returned the switch to the "on" position, and toured the affected alarmed areas. No fires were discovered. The licensee determined that the root cause was operator error. As corrective action, the licensee took the appropriate administrative actions with the personnel involved.

This event involved a violation of TS 3.3.3.7; however, the event had minimal safety significance because a fire system actuation or CO2 header pressurized alarm would still annunciate in the control room for the areas provided with fire suppression capabilities. In addition, routine security guard patrols and operator tours were conducted in the areas that are monitored by the fire detection system but do not have fire suppression capabilities. The licensee properly reported the event and took appropriate corrective action. Therefore, pursuant to the criteria specified in 10 CFR Part 2, Appendix C, Section VII.B(2), no notice of violation will be issued. This item is closed.



(Closed) LER 315/93002-LL: Assumptions for high energy line break (HELB) not met due to use of low temperature thermal links to maintain required vent area.

On July 9, 1993, during a review of assumptions used in environmental qualification related analysis, the licensee discovered that doors to the turbine-driven auxiliary feedwater (TDAFW) pump rooms and the adjacent hallway might close following a HELB. The licensee purposely maintained the doors open to prevent pressurization of the rooms following a postulated break of the four-inch steam supply lines to the TDAFW pumps.

The licensee determined that the original HELB analysis for the TDAFW pump rooms only considered a four-second blowdown interval. However, a subsequent analysis concluded that, since a small line break would not cause any auto safety system actuation, the accident could progress for several minutes. This could result in the melting of thermal links used for fire protection and the closing of the doors. With the doors shut, the TDAFW pump rooms, and possibly the adjoining East (E) motor-driven auxiliary feedwater (MDAFW) pump rooms as well, would become pressurized. This is contrary to the assumptions in the HELB analysis as stated in the FSAR.

As immediate corrective action, the licensee blocked the doors open and established compensatory TS-required fire watches. As long-term action, the licensee installed fusible links with higher temperature ratings.

This event involved a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control"; however, the event had minimal safety significance because an automatic actuation of the auxiliary feedwater (AFW) system would not occur during a rupture of the TDAFW pump steam supply line. In addition, the licensee determined that, except for a very small break, the differential pressure across the doors would prevent complete closure. Operators would then be able to isolate the break by closing valves from the control room. The licensee also properly reported the event and took appropriate corrective action. Therefore, pursuant to the criteria specified in 10 CFR Part 2, Appendix C, Section VII.B(2), no notice of violation will be issued. This item is closed.

(Closed) LER 316/93006-LL: Exceeded TS LCO action time limit due to time required for repair of charging pump.

On July 6, 1993, the licensee secured the West (W) centrifugal charging pump (CCP) due to degraded performance. After some troubleshooting, the licensee determined that the pump was inoperable and the rotor assembly needed to be replaced. In anticipation that the repairs would exceed the TS LCO time limit, the NRC granted a notice of enforcement discretion (NOED) on July 9, 1993. The licensee returned the pump to service on July 10, 1993.



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Upon disassembly of the rotor assembly, the licensee discovered that the pump shaft was cracked. Although the cracks were attributed to high cycle low amplitude fatigue failure, the licensee was unable to determine the root cause of the failure. As corrective action, the licensee initiated a design change to install some vibration monitoring equipment on the CCPs. In addition, the licensee was evaluating adjustments to the surveillance schedule to minimize pump starts. This item is closed.

(Closed) Licensee Event Report No. S01: This LER, dated September 20, 1991, was submitted to advise the NRC that a contractor employee with past positive fitness-for-duty (FFD) test results was granted unescorted access to the D. C. Cook Nuclear Plant.

10 CFR 26.27(a) requires a management and medical determination of fitness for duty to be performed if an individual granted unescorted access has had previous positive FFD test results. 10 CFR 26.27(a) also requires such an evaluation to be completed prior to granting of unescorted access.

Contrary to this requirement, the management and medical determination of fitness for duty was not completed prior to the granting of unescorted access for the individual because the individual and employer did not advise the licensee of the past positive FFD test results. The licensee identified the violation and initiated aggressive corrective actions and an investigation into the incident. We have determined that the violation meets the criteria of 10 CFR Part 2, Appendix C, Section VII,B(2) for a non-cited violation. (Refer to Inspection Report No. 50-315/91020(DRSS); 50-316/91020(DRSS), dated July 23, 1992, for related information). This item is closed.

Four non-cited violations were identified. No deviations were identified.

5. Maintenance/Surveillance: (62703 & 61726)

a. Maintenance Activities: (62703)

Routinely, station maintenance activities were observed and/or 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 also considered during this review: limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; and activities were accomplished by qualified personnel.



The inspectors observed portions of the following activities and did not identify any deficiencies:

JO# R0018201, Preventive Maintenance on Plant Air Compressor 1-OME-41

JO# R0018176, Preventive Maintenance on the Unit 2 North Control Rod Drive Mechanism Motor Generator

JO# C0021351, Repair valve leakby on containment spray additive tank sample valve, 1-CTS-115

The inspectors identified concerns with the following maintenance activities:

1) Repack of Test Selector Valve, 2-MMO-240

On May 25, 1994, the licensee entered a four hour Limiting Condition for Operation (LCO), as required by Technical Specification (TS) 4.7.1.5.1, to repack main steam stop valve (MSSV) dump valve test selector, 2-MMO-240. TS 4.7.1.5.1 was entered because repacking of the valve results in isolation of one of the two dump valves associated with an MSSV. The inspectors reviewed the maintenance history of valve 2-MMO-240 and determined that the valve was repacked six times since the last refueling outage in 1992. The repetitive packing failure on valve 2-MMO-240 was caused by a pitted valve stem.

The inspectors' review of the maintenance history determined the following:

- On July 8, 1992, an operator identified that 2-MMO-240 had a packing leak. Because the stem was badly pitted, the mechanics determined that Chesterton packing, which has good sealing characteristics, could not be installed and conventional packing was used. The licensee initiated Action Request (AR) #25594 to replace the pitted valve stem. The AR was scheduled for the 1994 refueling outage because valve 2-MMO-240 could not be isolated from the main steam header.
- From December 1992 to May 1994, the mechanics repacked valve 2-MMO-240 five times with varying degrees of success. Although repacking the valve initially stopped the leak, the leak would recur due to the repositioning of 2-MMO-240 during monthly surveillance testing on the MSSV dump valves.



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The number of times the valve was repacked, the number of LCO entries, and the Unit 2 forced outage dates were as follows:

7/12/92	Valve repacked
7/15/92 - 7/21/92	Forced Outage-Mode 5
8/01/92 - 8/18/92	Forced outage- Mode 5
9/25/92 - 11/10/92	Forced outage- Mode 5
12/23/92	Valve Repacked- 4hr LCO
5/11/93	Valve Repacked- 4hr LCO
8/04/93 - 8/09/93	Forced outage- Mode 5
11/04/93	Valve Repacked- 4hr LCO
1/23/94 - 1/24/94	Forced outage- Mode 5
4/06/94	Valve repacked
3/24/94 - 4/09/94	Forced outage- Mode 4
5/25/94	Valve Repacked- 4hr LCO

On May 17, 1994, the most recent packing leak was identified on 2-MMO-240. Due to concerns on the possible affect on the associated MSSV closure time, the operators issued Condition Report (CR) 94-1049 on May 24, 1994. The operators were also concerned that a gross failure of the packing could result in an MSSV closure and subsequent reactor trip. Based on these concerns, the operators monitored dump valve pressures, and guidance was provided to the operators in the shift turnover log on actions to be taken in the event that the MSSV started to drift closed. Because of these concerns raised by the operators, the maintenance repack activity, initially scheduled to be worked at about 4:00 PM on May 25, 1994, was completed earlier in the day.

The licensee's current programs would not typically identify rework activities such as the repetitive repacking of 2-MMO-240 that occurred from July 1992 to May 1994. The licensee's process to identify and evaluate adverse trends was a CR as described in procedure, PMI-7030, "Corrective Action," Revision 20. This procedure required that maintenance rework performed within a three month period be documented by a CR. Generally, these types of rework issues can be identified by the maintenance planner during a review of the maintenance history for the component. However, on this occasion, the planner did not identify the two most recent repacks as rework and did not issue a condition report. This matter is an unresolved item pending further NRC review (50-316;94013-01)

Additionally, because most of the valve 2-MMO-240 repack activities were performed at about six month



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intervals, the inspectors concluded that work on 2-MMO-240 would not be identified as rework by the "Corrective Action" program. The system engineer also did not identify the stem replacement as a work activity that was required to be performed to prevent repeated repacking of this valve.

Based on discussions with licensee personnel and review of records, the inspectors concluded that the licensee failed to correct the root cause (pitted stem) for repeated packing problems with valve 2-MMO-240. The licensee's failure to take action to correct the root cause of the repeated packing leaks on valve 2-MMO-240, which resulted in emergent entries into a 4 hour LCO, is considered a violation of Criterion XVI of 10 CFR Part 50, Appendix B (50-316/94013-02(DRP)).

2) IMO-316:

On June 26, 1994, the inspectors observed the electricians' investigation and repairs of valve IMO-361 on Unit 1. This motor-operated valve (MOV) provides the backup cross-connect capability between the residual heat removal and the safety injection systems. The operators initiated job order (JO) C00024672 because the valve would not close unless the handswitch was held in the "close" position during a surveillance. When working properly, once the handswitch is taken to the close position, the seal-in feature of the control circuit will provide power to the MOV until it is fully closed. Once the valve is shut, the torque switch removes power from the MOV.

The inspectors observed that the replacement of the closure contacts in the motor control cubicle by the electricians was performed well and with attention-to-detail. Wiring removal and installation forms were used properly and wires were neatly wrapped with tie-wrap after the repair. After wires were reconnected to the contacts, the electricians also verified that the wires were properly secured. Additionally, the electricians verified electrical interlock checks between the open and closure circuits and measured contact resistances to verify proper operation.

The inspectors also noted good involvement by the first level supervisor in this work activity. The supervisor provided comments and oversight during the repair period.

After the auxiliary contacts were replaced, the operators tested the valve and found that the replacement of the contacts did not correct the problem. The operators still needed to hold the switch in the close position in order to ensure that the valve would fully close. The supervisors



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and the electricians performed further investigation and postulated that the other in-series contact, the torque switch contact, could be intermittently cycling during valve operation. During this portion of troubleshooting, electricians observed blue arc on two of the torque switch contacts while the valve was in motion. This indicated that contacts on the torque switch did not make full contact during the valve movement. Although the initial repair was unsuccessful, the inspectors noted that the electricians successfully identified the cause of the problem.

The licensee replaced the torque switch and the spring pack assemblies. Once these parts were replaced, the valve operated properly.

3) AMSAC

The inspectors determined that the repair to the Unit 1 anticipated transient without scram (ATWS) Mitigation System Actuation Circuitry (AMSAC) was performed satisfactorily. The inspectors also noted that the licensee took additional action to ensure that the system outage time would be minimized in the future.

The licensee placed the system in bypass, which rendered AMSAC inoperable, on May 30, 1994, after failure of a controller in the circuitry. The licensee initiated AR# 0072215 to repair the system within 21 days. A few days later, the licensee upgraded the start work date to June 10, but could not replace the controller until June 13 due to a delay in planning the job. The licensee calibrated and returned the system to service on June 17, 1994.

Although AMSAC is not Technical Specification required equipment, the NRC addressed the need for licensees to repair the system in a prompt manner in Information Notice 92-06.

b. Surveillance Activities: (61726)

During the inspection period, the inspectors observed technical specification required surveillance testing and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that results conformed with technical specifications and procedure requirements and were reviewed, and that any deficiencies identified during the testing were properly resolved.

The inspectors witnessed portions of the following surveillances:

**1-IHP-4030.STP.411, "Reactor Trip SSPS Logic and Reactor Trip Breaker Train "B" Surveillance Test," Revision 3



**2-IHP-4030.STP.511, "Reactor Trip SSPS Logic and Reactor Trip Breaker Train "B" Surveillance Test," Revision 2

2-OHP-4030.STP.015, "Full Length Control Rod Operability Test," Revision 4

**1-OHP-4030.STP.018, "Steam Generator Stop Valve Pump Valve Surveillance Test," Revision

One violation and one unresolved item were identified. No deviations were identified.

6. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, violations, or deviations. An unresolved item disclosed during the inspection is discussed in paragraph 5.a.

7. Meetings and Other Activities:

Exit Interview: (30703)

The inspectors met with the licensee representatives denoted in paragraph 1 during the inspection period and at the conclusion of the inspection on July 5, 1994. The inspectors summarized the scope and results of the inspection and discussed the likely content of this inspection report. The licensee acknowledged the information and did not indicate that any of the information disclosed during the inspection could be considered proprietary in nature.



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ENCLOSURE

SYNOPSIS OF OFFICE OF INVESTIGATIONS RESULTS
(BARTLETT NUCLEAR, INC.)

On June 11, 1992, the U.S. Nuclear Regulatory Commission (NRC), Office of Investigation (OI), Region III (RIII), initiated an investigation to determine if Bartlett Nuclear, Inc. (BNI), Plymouth, Massachusetts, deliberately failed to complete required access authorization screening and fitness-for-duty background investigations and deliberately provided false information to NRC licensees regarding those background investigations in an effort to obtain unescorted access for certain BNI technicians.

Initially OI provided investigative assistance to the NRC: RIII Safeguards Section and the Incident Response Section during their evaluation of potential immediate public health and safety considerations related to this allegation (reference OI Case File No. A3-91-020).

This investigation, which included records reviews at BNI, examination of NRC licensee's audits of BNI, and interviews of current and former BNI employees, revealed one instance of a BNI security specialist having falsified a background investigation of a BNI employee. The employee's improprieties were initially discovered by an audit conducted by the Southern Nuclear Operating Company (SNOC). BNI responded to the audit finding and completed a full reexamination of all the background investigations where the employee had performed any functions. The BNI corrective actions, which included allowing the employee to resign, were examined by an NRC:RIII security specialist and no other instances of falsification were discovered. The BNI program as currently designed was noted as adequate by the NRC:RIII physical security specialist. Interviews of current and former BNI employees revealed there had been no training or work orientation in performing background investigations that explained or documented the importance of the background investigation related to the process of granting unescorted access to a nuclear plant. This investigation essentially showed that the allegation that background investigations in one instance had been falsified was true. However, the available evidence was insufficient to conclude that this falsification was done deliberately to allow any BNI technician to gain unescorted access when they otherwise would not have been eligible for such access. Also, the available evidence was insufficient to conclude that any BNI officials knowingly or deliberately falsified any background investigations or requests for unescorted access for BNI technicians at NRC licensed nuclear power plants.