

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-295/90030(DRP); 50-304/90030(DRP)

Docket Nos. 50-295; 50-304

Licenses No. DPR-39; DPR-48

Licensee: Commonwealth Edison Company
Opus West III
1400 Opus Place
Downers Grove, IL 60515

Facility Name: Zion Nuclear Power Station, Units 1 and 2

Inspection At: Zion, Illinois

Inspection Conducted: October 23 through December 17, 1990

Inspectors: W. G. Rogers
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M. J. Farber, Chief
Reactor Projects Section 1A

1-3-91
Date

Inspection Summary

Inspection from October 23 through December 17, 1990 (Reports No. 50-295/90030 (DRP); 50-304/90030(DRP))

Areas Inspected: Special unannounced safety inspection to review and categorize the licensee's response to the diagnostic evaluation team report to help ascertain whether the proposed plans for improvement address the reported weaknesses and their root causes in accordance with the September 4, 1990 direction from the Executive Director for Operations.

Results: No violations were identified. Twelve unresolved items were identified and eighteen open items were identified. The adequacy of the licensee's response to the diagnostic team report will require additional review since a significant number of the implementation plans are being developed by the licensee.

DETAILS

1. Persons Contacted

T. Joyce, Station Manager
T. Rieck, Superintendent, Services
W. Kurth, Superintendent, Production
P. LeBlond, Assistant Station Superintendent, Operations
P. Johnson, Assistant Station Superintendent, Maintenance
J. LaFontaine, Assistant Station Superintendent, Planning
R. Budowle, Assistant Station Superintendent, Technical Services
D. Karjala, Director of Performance Improvement
W. Stone, Regulatory Assurance Supervisor
W. TiNiemi, Technical Staff Supervisor
T. Saksefski, Regulatory Assurance

* Indicates persons present at the exit interview.

The inspectors also contacted other licensee personnel including members of the operating, maintenance and engineering staff.

2. Introduction

During the inspection period the oversight team evaluated the diagnostic evaluation team (DET) report and identified twenty six areas of concern. The team reviewed the licensee's response to the DET report and identified what actions if any were being taken by the licensee to address those areas. The twenty six areas were categorized in terms of potential violations, unresolved items and open items. Some of the areas of concern were partially evaluated by region based inspectors prior to issuance of the licensee's DET response. Where appropriate these previous inspection results were discussed under the applicable area of concern.

3. Management Weaknesses with the Control of Licensed Operators

There were fourteen line item observations from the DET report; thirteen of which could be summarized as weaknesses in shift crew teamwork and supervisory effectiveness. The last line item dealt with failures of shift personnel to adhere to established administrative controls.

- a. In the area of teamwork and supervisory effectiveness the licensee completed a realignment of responsibilities among the on-shift supervisors establishing clearer lines of authority/communication and a more team oriented approach to operating the two units. Certain administrative duties were redistributed to allow supervision more time for direct observation of crew activities. Recurring shift supervisory meetings were enacted to improve supervisory confidence. Two consultant companies were hired to help develop management skills and perform a cultural assessment leading to training targeted at the areas of weakness. To increase licensed control room operator (NSO)

awareness of plant conditions administrative controls were revised to allow qualified NSOs to perform independent verifications. It should be noted that some of the NSOs are not qualified for independent verifications activities. Other field activities in which NSOs would become involved are being discussed with bargaining unit personnel. The licensee is working on a split grade level for the unit supervisor position to enhance the attractiveness of the position. Completion of these management initiatives and NRC evaluation of their effectiveness is considered an open item (295/90030-01(DRP); 304/90030-01(DRP)).

- b. The licensee response to the administrative controls adherence observation was to give seminars on log keeping, have the assistant superintendent of operations review the shift engineer and unit logs daily and provide feedback to on-shift personnel. A memorandum was issued to all operating personnel generally concluding that log keeping quality was adequate. Also, the conduct of operations administrative procedure would be reviewed to assure senior management expectations were delineated. This matter is considered unresolved (295/90030-02(DRP); 304/90030-02(DRP)) pending review of the on-shift personnel adherence to the established administrative controls especially as they relate to log quality.

4. Inadequate Management Control of Overtime

The DET noted excessive use of overtime for on-shift operating authority personnel and weaknesses in management's oversight of overtime. This item was previously identified by the NRC resident staff as an unresolved item (295/90017-01(DRP); 304/90019-01(DRP)).

In response to this concern the licensee bypassed previous bargaining unit agreements to drastically reduce instances of personnel exceeding overtime requirements. Two implementing procedures associated with overtime are to be revised to assure site guidance consistency with corporate guidance. Finally, a corporate review of overtime practices is to be completed by January 1, 1991, to determine if different corporate guidance is needed.

Following this first corrective action only three instances of exceeding overtime requirements were noted with the appropriate management approval received prior the individuals exceeding the requirements between September and October. However, during early/mid-November three unanticipated times of overtime excesses were noted by the licensee on their overtime deviation post authorization sheets. A more detailed followup and review of this situation is discussed in inspection report 295/90024(DRP); 304/90026(DRP). Therefore, followup of the overtime concern will be documented under the resolution to unresolved item 295/90017-01(DRP); 304/90019-01(DRP) in inspection report 295/90024(DRP); 304/90026(DRP).

5. Weak Administrative Controls Utilized

There were four line item observations from the DET report associated with this area of concern. Three of the observations could be summarized

as burdensome or weak administrative controls over testing, equipment out-of-service and throttle valve position. The fourth observation dealt with use of a standing order in lieu of a procedure change.

- a. No response was discussed with regard to testing or equipment out-of-service control. The licensee did respond that a valve position control program for service water valves would be established by September 30, 1991. Program implementation is contingent upon creating a flow model for the service water system by July 31, 1991.

Whether any actions would be taken with testing and equipment out-of-service will be pursued in a future inspection report. Initiatives in these two areas and actions associated with throttle valve position will be reviewed as an open item (295/90030-03(DRP)); 304/90030-03(DRP)).

- b. In response to the standing order use the licensee incorporated the standing order guidance into the applicable emergency operating procedure (EOP). Also, a design change will be implemented to replace the present operator EOP action with an automated action. Whether this incorporation of the EOP action into an EOP procedure was untimely and why the action was not already an automated function is considered an unresolved item (295/90030-04(DRP)); 304/90030-04(DRP)).

6. Weaknesses in Training and Management Oversight of Training

There were six line item observations from the DET report associated with this area of concern. These six observations delineated weaknesses in supervisory training, preparation for licensed operation requalification examinations, training instructor workload, some simulator proficiency deficiencies and one instance of training material inaccuracy.

Subsequent to the DET inspection a new services director was selected. Also, the atmospheric relief valve training material was determined valid. The problem dealt with the guidance used for setting the valves' controllers in the plant.

In the licensee response associated with this area a dedicated requalification program group was established and the observed proficiency deficiencies were discussed with the simulator participants. Evolution of and resource allocation to the dedicated requalification program group, especially as it interacts with the simulator upgrade effort and the resources limitations associated with on-shift personnel (paragraph 7), is considered an open item (295/90030-05(DRP)); 304/90030-05(DRP)).

7. Resource Limited for On-Shift Operating Authority Personnel

The DET reported that overtime excesses and the lack of NSOs present in the field were partially contributed to by strained resources in the on-shift operating authority staff.

In response the licensee delineated a long term plan to expand the on-shift personnel and achieve stability through increased entry level training to allow successive training throughout all the on-shift positions. Licensee management expects the implementation of this long term plan to result in full staffing compliment by March, 1992.

The viability of this plan will be evaluated in a future inspection report with the achievement of stability considered an open item (295/90030-06(DRP)); 304/90030-06(DRP)).

8. Motor Operated Valve (MOV) Program Deficiencies

There were ten line item observations from the DET report associated with this area of concern. Three observations dealt with poor torque switch and bypass switch setting control. The remaining observations could be summarized as weak corporate support for MOVs, high failure rates of MOVs, lack of limiter plates on at least 48 valves and incomplete trending records.

- a. In response to the switch setting control observations the licensee indicated that a MOV setpoint control procedure, including provisions to do an operability assessment when outside the setpoints, was issued with corporate engineering to do a followup assessment of the procedure's implementation by January 31, 1991. Also, all the actions necessary for CAL 90-011 terminations were performed, a MOV setpoint data base was provided, operators would be trained on the ramifications on valve stroke times for 2 rotor configurations, a procedure requiring stroke time testing of 2 rotor MOVs from the motor control center would be issued by December 31, 1990, and all valves would be reconfigured to 4 rotors through design changes.

Two unresolved items [(295/90014-02(DRS); 304/90016-02(DRS)) & (295/90014-03(DRS); 304/90016-03(DRS))] encompassing the DET switch control observations were identified in an inspection of motor operated valves subsequent to the DET inspection period. Therefore, these corrective actions will be reviewed as part of the two unresolved items.

- b. In response to the other aspects of the MOV program deficiencies the licensee:

- will be installing limiter plates as conditions permit
- has assigned a full time MOV coordinator with a backup being trained
- is reviewing the best method of issuing timely guidance for generic issues at the corporate engineering level
- assigned specific electrical and mechanical maintenance workers to MOV maintenance with commensurate training

- provided corporate troubleshooting guidelines for incorporation into the appropriate site instruction
- reaffirmed that diagnostic testing would be in accordance with their Generic Letter 89-10 response
- provided additional torque switch training to maintenance personnel
- is considering main steam isolation valve drain valve (spring pack failure potential) reorientation.

Presently, NRR is performing an evaluation of the valve failure rate on previous probabilistic risk assessments. Followup on these corrective actions and their ability to improve the MOV reliability effort is considered an open item (295/90030-07(DRS)); 304/90030-07(DRS)).

9. Section XI Valve Testing Program Deficiencies

There were five line item observations from the DET report associated with this area of concern. These observations dealt with apparent omissions from the valve testing program, failures to establish baseline flow curves following service water pump impeller modifications, lack of comprehensive service water pump testing and accuracy of service water system flow measurement.

- a. One of the observations, accuracy of service water system flow measurement, was identified as an unresolved item (295/90018-05(DRS); 304/90020-05(DRS)) in an inspection report subsequent to the DET inspection period.
- b. In response to the other observations the licensee stated that the applicable baseline flow curves were developed, procedures were to be changed to envelope the omitted valves by November 30, 1990, and engineering was evaluating alternate hydraulic service water pump testing methods.

The lack of testing in these areas is considered an unresolved item (295/90030-08(DRS); 304/90030-08(DRS)). Presently, NRR is reviewing all outstanding Section XI testing relief requests targeted for completion by March, 1991. Further followup of these potential testing inadequacies/licensee corrective actions is partially contingent upon the NRR review.

10. Material Condition of Service Water System

There were six line item observations from the DET report associated with this area of concern. These observations dealt with the timeliness associated with service water corrective maintenance, condition of the service water heat exchangers, present flow adjustment of the system, ramifications of silting on system performance and whether a section of the system was properly seismically supported.

- a. In response to the observations excluding the seismic support issue the licensee discussed prioritization of all service water work requests, continued development of the station system engineer program with inclusion of corporate expectations into a nuclear operations directive by June 30, 1990, reconfirmation of implementation of their Generic Letter 89-13 response, and the establishment of the optimum valve position for the heat exchanger valves by December 31, 1990. Also, along more generic lines the licensee discussed overall changes in site maintenance planning/scheduling and the projected walkdown of the top fifteen systems (based on PRA) by the end of the next applicable refueling outage. Followup on the licensee implementation of these actions is considered an open item (295/90030-09(DRS); 304/90030-09(DRS)).
- b. In response to the observations on the seismic support issue the licensee stated that a IEB 79-14 scope re-review was to be completed by November 30, 1990, an unapproved piping support was removed, engineering analysis of suspect piping sections were performed with all piping considered operable, bent axial supports will be straightened and a new support on the strainer 2B line installed by February 1, 1991 to place the line back in conformance with original FSAR stress safety factors, and support location/presence will be added to the system engineer walkdown checklist. The ramifications of the missing support on the strainer 2B line, the IEB 79-14 effort and the associated corrective actions shall be pursued as an unresolved item (295/90030-10(DRS); 304/90030-10(DRS)).

11. Preventive Maintenance Program Deficiencies

These observations could be summarized as a lack of a comprehensive preventive maintenance program and the lack of an equipment performance trending program (examples: inverters and battery chargers).

In response the licensee stated that a preventive maintenance improvement program would be implemented, the preventive maintenance to corrective maintenance ratio would be tracked for systems and components and a reliability centered maintenance program would be established. Implementation of these corrective actions will be followed as an open item (295/90030-11(DRS); 304/90030-11(DRS)).

12. Corrective Maintenance Program Deficiencies

There were three line item observations from the DET report associated with this area of concern. These observations dealt with control of corrective maintenance work requests, coordination efforts for maintenance and prioritization of the work request backlog.

- a. In response to the coordination/prioritization observations the licensee discussed the planning initiatives mentioned above in paragraph 10.a. and the implementation of a new computerized prioritization system by December 31, 1990. Followup on the implementation of the computerized priority system is considered an open item (295/90030-12(DRP); 304/90030-12(DRP)).

- b. In response to the control of work requests the licensee reviewed for "lost" work requests and identified the need to reinitiate 173 work requests, installed a work request tracking system and revised the applicable administrative procedure. Followup on these actions and the root cause as to how the work requests were "lost" is considered an unresolved item (295/90030-13(DRP); 304/90030-13(DRP)).

13. Accountability for Material Condition

The DET reported that they were unable to ascertain who was accountable for the material condition of the facility.

It did not appear that the licensee specifically addressed this matter in the DET response. The inspectors will followup on this matter as an open item (295/90030-14(DRP); 304/90030-14(DRP)) in a future inspection period.

14. Inadequate Root Cause Analysis of Equipment Failures

The DET reported that repetitive equipment problems were not adequately addressed.

In response the licensee discussed the use of problem analysis data sheets, use of an integrated root cause analysis program, establishment of motor operated valve troubleshooting guidance and the increase of qualified human performance evaluators. This matter was identified as an unresolved item (295/90014-05(DRS); 304/90016-05(DRS)) in an inspection on motor operated valves subsequent to the DET report period. Therefore, all actions associated with resolution of repetitive equipment problems will be dealt with under this unresolved item.

15. Molded Case Circuit Breaker Testing

The DET reported that the licensee did not conduct molded case circuit breaker testing.

- a. The generic ramifications of not performing testing of this nature is presently under AEOD review.
- b. In response to this observation the licensee is developing a testing program for new circuit breakers and establishing a program for periodic testing. Followup on the implementation of these two actions is considered an open item (295/90030-15(DRP); 304/90030-15(DRP)).

16. Staff Awareness of Administrative Controls

There were three line item observations from the DET report associated with this area of concern. These observations dealt with support personnel knowledge of the drawing control system, motor operated valve torque switch setting control and procedure updates to work packages.

In response to these observations the licensee stated that drawing control training would be given, motor operated valve training would be given as

discussed in paragraph 8.b. and training will be provided to personnel accepting a new responsibility position. Followup on the implementation of the drawing control and new position training is considered an open item (295/90030-16(DRP); 304/90030-16(DRP)).

17. Poor Correlation Between Technical Specifications and Surveillance Procedures

The DET reported that the Technical Specification surveillance requirements and the licensee's implementing procedures lacked quantitative acceptance criteria such as flow rates and pressures.

The licensee discussed in general terms their involvement with the methodically engineered restructured and improved Technical Specification program (MERITS). However, this discussion was not specific as to whether flow rate and pressure incorporation was part of that effort. This matter will be pursued with the licensee as an open item (295/90030-17(DRP); 304/90030-17(DRP)). Also, this matter will be pursued with NRR.

18. Emergency Diesel Generator (EDG) Load Sequencer Concerns

The DET reported that loss of offsite power conditions may not be detected by the EDG load sequencer with an EDG loaded to its respective bus. An EDG is routinely loaded to its bus during startups/shutdowns to protect turbine lift oil pumps.

In response the licensee discontinued the practice. Also, the licensee provided an analysis concluding that the EDG was operable during the time loaded to the bus. The ramifications of this previous practice as it relates to EDG operability is considered an unresolved item (295/90030-18(DRS); 304/90030-18(DRS)) and resolution is contingent upon NRC review of the licensee provided analysis.

19. Accuracy of NRC Submittals from Licensee

The DET reported potential inaccuracies associated with the licensee's response to IEB 79-14 on piping supports and IEB 85-03 on torque switch settings.

- a. As discussed in paragraph 10.b, the licensee stated that a re-review of the scope of IEB 79-14 would be completed by November 30, 1990. How these discrepancies affect the accuracy of the IEB 79-14 response is considered an unresolved item (295/90030-19(DRS); 304/90030-19(DRS)).
- b. The accuracy of the IEB 85-03 information was previously identified as an unresolved item (295/90014-01(DRS); 304/90016-01(DRS)) in an inspection of motor operated valves following the DET inspection.

20. Service Water System Design Basis Deficiencies

There were four line item observations from the DET report associated with this area of concern. The observations dealt with lack of understanding

of the service water design basis at the site, inconsistent design documentation on the service water system, estimations as to the service water system capability and discrepancies between the as-built drawings and the actual configuration of the service water system.

- a. In response to the lack of design basis understanding and quality of design basis documentation the licensee discussed programs projected to provide or revise the design basis documentation. Included in this effort were a setpoint control program, updated fuse list, a re-baselined FSAR, a service water system document, involvement in the MERITS effort (previously mentioned in paragraph 17), additional measures to improve site/corporate engineer performance and the generation of system descriptions. Implementation of these licensee actions is considered an open item (295/90030-20(DRS); 304/90030-20(DRS)).

It should be noted that one particular aspect of design document inconsistency associated with the use of service water crosstie valves was identified as an unresolved item (295/90018-01(DRS); 304/90020-01(DRS)) in a previous inspection report on the service water system.

- b. The estimation of the service water capability was identified as an unresolved item (295/90018-02(DRS); 304/90020-02(DRS)) in a previous inspection report on the service water system.
- c. In response to the as-built drawing discrepancies the licensee stated that a service water system walkdown to the P&IDs would occur by February 15, 1991, a drawing assessment program would be implemented, critical drawings would be identified by December 15, 1990, and drawing updates would begin by January 5, 1991. Followup on these drawing discrepancies is considered an unresolved item (295/90030-21(DRP); 304/90030-21(DRP)).

21. Service Water Vulnerability Concerns

There were five line item observations from the DET report associated with this area of concern. These observations dealt with specific scenarios associated with single non-safety related and safety related valve failures, lack of dual isolation at certain portions of safety/non-safety related interfaces in the service water system, a water hammer scenario in the reactor containment fan cooling (RCFC) piping and the service water capability in a particular configuration.

In response the licensee reconfirmed the projected performance of a level II probabilistic risk assessment, is evaluating the need for a modification to RCFC piping, is reviewing numerous procedures associated with the service water system for enhancements and established a minimum number of service water pumps needed in certain plant conditions in a standing order.

Presently, NRR has been tasked to evaluate the licensing basis of the service water system. Contingent upon completion of that licensing basis review each scenario and the licensee's response will be reviewed for its ramifications on the operability of the system. This is considered an unresolved item (295/90030-22(DRS); 304/90030-22(DRS)) pending completion of those reviews.

22. Weakness in the Evaluation and Analysis of the Impact of Past Modifications on Systems

There were six line item observations from the DET report associated with this area of concern. These observations dealt with select modifications to the service water, an EDG water jacket heat exchanger and the reactor containment fan cooling return header.

In response the licensee conceded weaknesses existed in the design change review process as late as January, 1989. Presently only one additional upgrade is scheduled. This is the addition of corporate guidance from NSAC-125 into site procedures by January, 1991.

In light of this situation only two modifications discussed in the DET will be reviewed. Both modifications should have occurred after January, 1989. These modifications dealt with the addition of a maintenance valve in the reactor containment fan cooling isolation return header and the installation of an orifice in the water jacket heat exchanger of EDG 1A. These matters are considered unresolved (295/90030-23(DRP); 304/90030-23(DRP)) pending review of these two modifications.

23. Corporate Engineering Support Weak

There were three line item observations from the DET report associated with this area of concern. The observations dealt with extensive use of contractors with the licensee engineers functioning more as contract managers, of weak in-house design engineering expertise and poor understanding of or access to design basis information.

In response the licensee discussed generic changes for corporate engineering including the establishment of a strategy by January 1, 1991, to reduce the number of engineering contract services, prioritization of work loads, generation of design basis information through re-baselining all the FSARs and creating system descriptions. On a site specific note the project engineering support group was formed.

These initiatives will be followed through an open item (295/90030-24(DRS); 304/90030-24(DRS)) to determine whether any engineering support improvements to the site are observed.

24. Ineffective Implementation of Corrective Actions

There were eleven line item observations from the DET report associated with this area of concern. These observations could be summarized as ineffective lessons learned mechanisms, ineffective means for resolution

of generic issues, untimely review of the implementation of corporate directives and untimely review of contractor reports/recommendations for motor operated valves and ASME Section XI testing.

- a. In response to all but the contractor reports/recommendations aspect the licensee established an effectiveness review procedure, will go to a three tier priority scheme for corrective action review, will improve corrective status reports, will develop a lessons learned functional area for the quality programs and assessment organization (QP&A), will improve corrective action tracking and use QP&A to coordinate applicable Zion DET findings corrective actions for all other Commonwealth Edison nuclear facilities. Implementation of these initiatives and their ability to improve the effectiveness of corrective actions is considered an open item (295/90030-25(DRP); 304/90030-25(DRP)).
- b. In response to the motor operated valve contractor report the licensee indicated that the problem was a resource constraint. This matter was identified as an unresolved item (295/90014-04(DRS); 304/90016-04(DRS)) in a previous inspection report on motor operated valves.
- c. In response to the ASME Section XI contractor report the licensee indicated that there were problems with the original content of the contractor report and once an acceptable product was received an action plan was generated to deal with the issues. This matter is considered an unresolved item (295/90030-26(DRS); 304/90030-26(DRS)) pending further review into the time frame of the contractor's final report issuance and licensee action plan implementation.

25. Performance Improvement Process (PIP) Program Deficiencies

The DET reported that the PIP lacked administrative controls, lacked resource estimates, and the improvement initiatives were adversely impacted due to limited or strained resources.

In response the licensee stated that an administrative procedure would be developed, a more mature program called the Zion Management Action Plan (ZMAP) would replace PIP and that the top priority ZMAP plans would be determined by December 1, 1990. Implementation of these actions is considered an open item (295/90030-27(DRP); 304/90030-27(DRP)).

26. Air in a Component Cooling Water (CCW) Heat Exchanger

The DET reported the presence of air following the completion of return-to-service activities on a CCW heat exchanger from maintenance.

This concern was not responded to in the licensee's DET response. Further followup of this matter shall be performed under unresolved item (295/90030-28(DRP); 304/90030-28(DRP)) in a future inspection period.

27. Zion Staff Philosophy and Operational Attitude

There were eight line item observations from the DET report associated with this area of concern. These observations centered around a lack of questioning attitudes by staff, little confidence in management to effect

improved performance, the acceptance of weak operations procedures, the acceptance of equipment degradation and minimal proactive resolution to problems.

In response the licensee is forming a committee chaired by the production superintendent dealing with plant/equipment conditions, using quarterly system engineer walkdowns to enhance identification of equipment problems, implementing an action plan for revising operations procedures and has engaged the consultants discussed in paragraph 3. Also, the licensee discussed actions on two specific equipment problems associated with the unit 2 feedwater regulating valves and auxiliary water valves. The ability of these corrective actions to effect a positive modification in staff attitudes is considered an open item (295/90030-29(DRP);304/90030-29(DRP)).

28. Corporate Oversight

The DET reported that corporate support to Zion was not sufficient.

In response the licensee stated that there was an additional allocation of \$18.1 million to Zion. In addition a corporate oversight committee was established and, the performance assessment department will add management/organizational issues as a functional area to its assessments by June 30, 1991. Evaluation of these initiatives to improve corporate oversight is considered an open item (295/90030-30(DRP); 304/90030-30(DRP)).

29. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, violations, or deviations. Unresolved items disclosed during the inspection are discussed in Paragraphs 3, 5, 9, 10, 12, 18, 19, 20, 21, 22 and 26.

30. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed by the inspector and which involve some action on the part of the NRC or licensee or both. Open items disclosed during the inspection are discussed in Paragraphs 3, 5, 6, 7, 8, 10, 11, 12, 13, 15, 16, 17, 20, 23, 24, 25, 27 and 28.

31. Exit

The inspectors met with licensee representatives (denoted in Paragraph 1) throughout the inspection period and at the conclusion of the inspection on December 17, 1990, to summarize the scope and findings of the inspection activities. The licensee acknowledged the inspectors' comments. 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 such documents or processes as proprietary.