U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-461/88021(DRP)

Docket No. 50-461 License No. NPF-62

Licensee: Illinois Power Company
500 South 27th Street
Decatur, IL 62525

Facility Name: Clinton Power Station

Inspection At: Clinton Site, Clinton, Illinois

Inspection Conducted: August 10 through September 6, 1988

Inspectors: P. Hiland

S. Ray

Approved By: R. W. Cooper, Chief
Reactor Projects Section 3B

9/16/88
Date

Inspection Summary

Inspection on August 10 through September 6, 1988 (Report No. 50-461/88021(DRP))
Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of licensee action on previous inspection findings; onsite followup of written reports of nonroutine events at power reactor facilities; operational safety verification; monthly maintenance observation; monthly surveillance observation; training effectiveness; onsite followup of events at operating reactors; and licensee plans for coping with strikes.
Results: Of the eight area. inspected, one violation was identified in the area of licensee action on previous inspection findings concerning the failure to take prompt corrective action for an identified condition adverse to quality (Paragraph 2.a). A second violation was identified in the area of onsite followup of events at operating reactors concerning the failure to promptly report an event to the NRC (Paragraph 8.b.(4)). The violations were receiving management attention.

DETAILS

1. Personnel Contacted

Illinois Power Company (IP)

W. Kelley, President
*W. Gerstner, Executive Vice President
*D. Hall, Vice President, Nuclear
K. Baker, Supervisor, I&E Interface
*J. Brownell, Project Engineer/Specialist
*R. Campbell, Manager, Quality Assurance
*J. Cook, Manager, Nuclear Planning and Support
E. Corrigan, Director, Quality Engineering and Verification
*R. Freeman, Manager, Nuclear Station Engineering Department
D. Holesinger, Assistant Manager, Clinton Power Station
*D. Holtzcher, Acting Manager, Licensing & Safety
K. Jones, Principal Assistant
*A. MacDonald, Director, Nuclear Program Assessment
*J. Miller, Manager, Scheduling & Outage Management
*J. Perry, Manager, Nuclear Program Coordination
*R. Schaller, Assistant Manager, Plant Operations
*R. Schultz, Director, Planning & Programming
F. Spangenberg, Manager, Licensing & Safety
*T. Weaver, Director, Licensing
*J. Wilson, Manager, Clinton Power Station
*R. Wyatt, Manager, Nuclear Training

Soyland/WIPCO

*J. Greenwood, Manager, Power Supply

Nuclear Regulatory Commission

*P. Hiland, Senior Resident Inspector, Clinton
*S. Ray, Resident Inspector, Clinton

*Denotes those attending the monthly exit meeting on September 6, 1988.

The inspectors also contacted and interviewed other licensee and contractor personnel.

2. Previously Identified Items (92701)(92702)

a. (Closed) Unresolved Item (461/87030-03): Failure to Implement Procedure to Evaluate Revisions to Valve and Electrical Lineup Checklists.

This item was discussed in Inspection Report No. 50-461/87030, Paragraph 9.b.(1). It concerned the licensee's failure to effectively implement Temporary Procedure CPS No. 1005.11 which required that the Shift Supervisor evaluate the impact of all revisions to valve and electrical lineup checklists to determine which valves and breakers needed to be realigned as a result of the revisions. In September 1987, the inspectors found that the requirements of CPS No. 1005.11 were generally not being adhered to but that the licensee was aware of the problem and was in the process of revising CPS No. 1005.01, "Preparation, Review, Approval, and Implementation of and Adherence to Station Procedures and Documents", to improve the evaluation of valve and electrical lineup revisions.

The licensee issued Revision 22 to CPS No. 1005.01 on September 18, 1987. That revision incorporated a new title page to be attached to all revised lineup procedures. The title page included boxes to check whether lineup performance was required upon issuance and a section for evaluating the extent of lineup performance required (i.e., full or partial).

Revision 22 to CPS No. 1005.01 was written as part of the corrective action for LER 87-033-00 (461/87033-LL) in which turbine first stage pressure instruments were found to be isolated during reactor operation on June 7, 1987. The isolation of these instruments defeated the Turbine Stop Valve Closure and Turbine Control Valve Fast Closure Scram functions which were required above 40% power. This event was discussed in Inspection Report No. 50-461/87020, Paragraph 10.b.(3). The event was partially attributed to valves which were added in a revision to a valve lineup checklist, but the checklist was not subsequently performed. Corrective actions were to include procedural controls to ensure valve lineups were verified to the latest revision of the valve lineup procedures.

On August 25, 1988, the inspectors selected 12 revised valve and electrical lineup checklists, including several safety related lineups. All of the lineups indicated the need for full or partial lineup performance upon issuance, according to their title pages. The inspectors examined valve and electrical lineup checklists on file for those systems and determined that none of the 12 had the lineup performed upon issuance as required. One of the 12 had been done about five weeks after issuance, three had been done six to seven months after issuance, and eight had never had the revised portions of the lineups performed.

The Supervisor - Plant Operations Support indicated that he had also become aware about two weeks earlier that Revision 22 to CPS No. 1005.01 had never been properly implemented. He said he was planning to audit valve and electrical lineups the next week to determine which ones had not been performed after being revised. He had not written a Condition Report or brought the problem to the attention of his supervisors.

After the condition was brought to the attention of plant management, the licensee examined all revisions to valve and electrical lineup checklists that had been issued since Revision 22 to CPS No. 1005.01. Of about 400 revisions issued, they identified about 20 systems that needed to have their lineups verified. The licensee checked the lineups of those systems and did not find any valves or breakers out of the specified positions. The licensee was continuing to take other corrective actions for this finding.

10 CFR 50, Appendix B, Criterion XVI and the Illinois Power Company Operational Quality Assurance Manual, Chapter 16, required that measures be established to assure that conditions adverse to quality were promptly identified and corrected. Failure to promptly correct an identified condition in the control of revised valve and electrical lineup checklists which resulted in the condition of a number of safety related systems becoming indeterminate was a violation. Unresolved Item 461/87030-03 is closed and upgraded to a violation (50-461/88021-01(DRP)).

One violation was identified.

3. Onsite Followup of Written Reports (92700)

a. (Closed) LER 87-006-00 (461/87006-LL): Partial Group I Containment Isolation Due to Blown Fuse on Circuit Card in Containment Isolation Logic.

This event was previously documented in Inspection Report No. 50-461/87007, Paragraph 8.b.(8), and Inspection Report No. 50-461/87015, Paragraph 7.a.(2). The event was also discussed in Inspection Report No. 50-461/88003, Paragraph 5.a. at which time the LER remained open pending the issuance and review of a letter from the Nuclear Station Engineering Department on the consequence of not modifying 514 circuit cards in the Nuclear Systems Protection System.

After a similar event occurred on April 30, 1988, as documented in Inspection Report No. 50-461/88009, Paragraph 10.b.(8), and reported by the licensee as LER 88-013-00 dated May 18, 1988, the licensee reevaluated the need to modify the circuit cards and the Modification Review Committee approved a gradual spare card replacement of the 514 circuit cards to be implemented in 1989 as Modification SP-17. This item is closed.

b. (Closed) LER 88-010-00 (461/88010-LL): Oversight by Utility Licensed Operators Results in Failure to Perform Shift Control Room Operator Surveillance Log.

This event was previously discussed in Inspection Report No. 50-461/88009, Paragraph 5.a. The event was considered a

violation (50-461/88009-01) which was closed at the issuance of the inspection report based on the inspectors' verification that all corrective actions had been completed. The inspectors reviewed the LER for completeness, accuracy and timeliness, and noted no deficiencies. This item is closed.

No violations or deviations were identified.

4. Operational Safety Verification (71707)

The inspectors observed control room operations, attended selected pre-shift briefings, reviewed applicable logs, and conducted discussions with control room operators during the inspection period. The inspectors verified the operability of selected emergency systems and verified tracking of LCOs. Routine tours of the auxiliary, fuel, containment, control, diesel generator, turbine buildings and the screenhouse were conducted to observe plant equipment conditions including potential for fire hazards, fluid leaks, and operating conditions (i.e., vibration, process parameters, operating temperatures, etc). The inspectors verified that maintenance requests had been initiated for discrepant conditions observed. The inspectors verified by direct observation and discussion with plant personnel that security procedures and radiation protection (RP) controls were being properly implemented.

Inspections were routinely performed to ensure that the licensee conducted activities at the facility safely and in conformance with regulatory requirements. The inspections focused on the implementation and overall effectiveness of licensee's control of operating activities, and the performance of licensed and nonlicensed operators and shift technical advisors. The following items were considered during these inspections:

- Adequacy of plant staffing and supervision.
- Control room professionalism including procedure adherence, operator attentiveness and response to alarms, events, and off normal conditions.
- Operability of selected safety related systems including attendant alarms, instrumentation, and controls.
- Maintenance of quality records and reports.

a. On July 29, 1988, while performing a monthly surveillance test of the Division I Diesel Generator (DG) the licensee noted that the DG took 12.8 seconds to reach rated speed. Technical Specification 4.8.1.1.2.a.4 required that the DG reach rated speed in less than or equal to 12 seconds. The licensee attributed the slow start to clogged fuel filters. The filters were cleaned and the test rerun successfully. The licensee discovered that no

preventative maintenance (PM) task existed for periodic changing of the fuel filters. As a corrective action, an annual PM to change the fuel filter was created. The licensee increased the frequency of DG testing in accordance with their technical specifications and made a special report to the NRC dated August 29, 1988.

On August 25, 1988, the Division I DG experienced another slow start which the licensee believed was caused by an air leak in the supply line to the servobooster in the fuel system. The investigation was continuing and a second special report was to be submitted by September 26, 1988.

b. On August 26, 1988, the licensee's Quality Assurance (QA) Department identified a concern with the implementation of administrative procedure CPS No. 1050.02, "Foreign Material Exclusion in the Containment and Drywell". The procedure limited the cumulative amount of flexible material that could be placed in the lower two elevations of containment to 16 square feet. The purpose of the limit was to prevent excessive fouling of the suction strainers for the Emergency Core Cooling System pumps in the suppression pool in the case of a loss of coolant accident. QA found that that limit may have been exceeded. An investigation by plant staff determined that the limit was not exceeded but several other discrepancies with the implementation of CPS No. 1050.02 were noted.

Among the problems noted were that there was no accounting system to add up the total number of square feet of flexible material brought into the containment, individuals were not always logging material into and out of the containment, material was not being promptly removed from the containment when work was complete, and material near the suppression pool was not being properly secured. The licensee was taking actions to improve compliance with CPS No. 1050.02.

Control of foreign material in the containment has been a continuing concern of the inspectors and has been discussed in several inspection reports. Poor control of material by the licensee resulted in a violation (461/88004-03) discussed in Inspection Report No. 50-461/88004, Paragraph 5.c. The inspectors will closely monitor the licensee's implementation of corrective actions to improve performance in this area.

c. On August 29, 1988, while performing maintenance which required that the lower fuel transfer pool be pumped down, the upper containment fuel pool was inadvertently overflowed into the containment equipment drain and containment ventilation systems. During a critique of the event attended by the inspector, it was determined that the Fuel Pool Cooling and Cleanup (FC) System valve lineup had been improperly restored following a local leak rate test on August 23, 1988. A restoration lineup had been provided to the Line Assistant Shift Supervisor (LASS) who noted that the proposed

positions for valves 1FC012A and 1FC012B were not correct. He crossed out and changed the desired restoration positions and initialed and dated the changes. His initials and dates were in the same spaces as the operators normally put their initials and dates indicating that the valves are lined up properly. Later the operators lining up the system apparently believed that the initials and dates of the LASS indicated that those valves had already been checked resulting in them leaving 1FC012 A and B in the wrong positions. The result was that there was no drain path for the upper containment fuel pool and it overflowed during a water transfer evolution. The licensee was pursuing corrective actions to prevent the situation from reoccurring.

d. The inspectors continued to monitor the number of discrepant conditions in the main control room. Some progress was made in each of the areas monitored. Listed below is the status of the main control room noted on September 6, 1988, with the plant at about 100% power. These were compared to the status under similar conditions in the last report. The licensee continued to focus a significant amount of management attention to these problems.

	THIS REPORT PERIOD	LAST REPORT PERIOD
Total Lighted Annunciators	24	27
Total OOS/Disabled Annunciators	10	14
Total Instr/Recorder Problems	14	18
Total Yellow Caution Stickers	43	56

Of the 24 lighted annunciators, 10 were reported to be lighted per design and were not considered discrepancies.

No violations or deviations were identified.

5. Monthly Maintenance Observation (62703)

Selected portions of the plant maintenance activities on safety-related systems and components were observed or reviewed to ascertain that the activities were performed in accordance with approved procedures, regulatory guides, industry codes and standards, and that the performance of the activities conformed to the Technical Specifications. The inspection included activities associated with preventive or corrective maintenance of electrical, instrumentation and control, mechanical equipment, and systems. The following items were considered during these inspections: 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 calibration was performed prior to returning the components or systems to service; parts and materials that were used were properly certified; and maintenance of appropriate fire prevention, radiological, and housekeeping conditions.

The inspectors observed/reviewed the following work activities:

Maintenance Work Procedure No.	Activity
C-52191	Chlorination Modification M-53
C-48382	Polar Crane Inspections
C-52685	Traversing Incore Probe Computer Troubleshooting
C-58012	"A" Average Power Range Monitor Troubleshooting
C-53389	Reactor Core Isolation Cooling (RCIC) Low Flow Annunciator Troubleshooting

For C-53389, on August 19, 1988, the technicians were unable to find a problem with the annunciator. The Maintenance Work Request stated that the annunciator failed to annunciate during the performance of Maintenance Procedure CPS No. 8673.02, RCIC Pump Discharge Flow E51-N051 Channel Calibration. Step 8.1.1.b. of that procedure required that the RCIC Pump Discharge Flow Low annunciator be verified alarming at the start of the procedure. The inspector informed the technicians that he believed the annunciator would not normally be lit with the RCIC system shutdown. After further review of the schematics, the technicians determined that the annunciator would not be enabled unless the RCIC system had been operating for at least 15 seconds. Thus the procedure was in error and there was nothing wrong with the annunciator. The inspectors verified that a Comment Control Form was written to request a change to CPS No. 8673.02.

No violations or deviations were identified.

6. Monthly Surveillance Observation (61726)

An inspection of inservice and testing activities was performed to ascertain that the activities were accomplished in accordance with applicable regulatory guides, industry codes and standards, and in conformance with regulatory requirements.

Items which were considered during the inspection included whether adequate procedures were used to perform the testing, test instrumentation was calibrated, test results conformed with technical specifications and procedural requirements, and that tests were performed within the required time limits. The inspector determined that the test results were reviewed by someone other than the personnel involved with the performance of the test, and that any deficiencies identified during the testing were reviewed and resolved by appropriate management personnel.

The inspectors observed/reviewed the following activities.

Surveillance/Test Procedure No.	Activity
CPS No. 9080.02	DG 1C Operability
CPS No. 9064.02	Drywell Post-LOCA Vacuum Breaker Verification Test
CPS No. 9052.01	LPCS Pump Operability
CPS No. 9052.02	LPCS Valve Operability Checks
CPS No. 9069.01	Shutdown Service Water Operability Test

During the performance of CPS No. 9069.01 the inspectors noted that Step 9.2.1.3 was incorrect. If Inservice Test (IST) data was in the required action range, the procedure allowed three options; recalibrate the instruments and rerun the test, further analyze the data and complete corrective actions within 96 hours, or declare the pump inoperable. During discussions with the Shift Supervisor, the inspectors determined that he was not aware of any other interpretation of these requirements. On September 22, 1987, the Region III Regional Administrator sent a memorandum to all Region III plants which stated NRR's position that whenever IST data fell within the required action range, the component must immediately be considered inoperable and the appropriate Limiting Condition for Operation ACTION statements implemented. The inspectors confirmed by spot checking that other IST procedures had been revised to reflect the NRR interpretation and that CPS No. 9069.01 was in the process of being revised.

No violations or deviations were identified.

7. Training and Qualification Effectiveness (41400) (41701)

The effectiveness of training programs for licensed and nonlicensed personnel were reviewed by the inspector during the witnessing of the licensee's performance of routine surveillance, maintenance, and operational activities and during the review of the licensee's response to events which occurred during the months of August/September 1988. Personnel appeared to be knowledgeable of the tasks being performed.

No violations or deviations were identified.

8. Onsite Followup of Events at Operating Reactors (93702)

a. General

The inspectors performed onsite followup activities for events which occurred during the inspection period. Followup inspection included

one or more of the following: reviews of operating logs, procedures, condition reports; direct observation of licensee actions; and interviews of licensee personnel. For each event, the inspectors reviewed one or more of the following: the sequence of actions; the functioning of safety systems required by plant conditions; licensee actions to verify consistency with plant procedures and license conditions; and attempted to verify the nature of the event. Additionally, in some cases, the inspectors verified that licensee investigation had identified root causes of equipment malfunctions and/or personnel errors and were taking or had taken appropriate corrective actions.

Details of the events and licensee corrective actions noted during the inspectors' followup are provided in Paragraph b. below.

b. Details

(1) Reactor Water Cleanup (RWCU) System Isolation During Surveillance Due to Equipment Deficiency [ENS No. 13168]

On August 11, 1988, the licensee experienced an unexpected isolation of the RWCU System while performing a functional test surveillance of the RWCU Leak Detection System. The plant was operating at about 85% power throughout the event. As a prerequisite to the surveillance, the isolation circuit had been placed in bypass and the bypass light was verified lit. The licensee's investigation determined that the cause of the event was due to high resistance on the bypass switch contacts due to oxidation. The high resistance prevented the isolation feature from actually being bypassed even though the indicating light showed that it was. The indicating light contacts were in a 120 volt circuit while the bypass contacts were in a 24 volt circuit. The licensee reported this event to the NRC Operations Center via the ENS on August 11, 1988.

The cause of this event was similar to the reactor scram discussed in Inspection Report No. 50-461/88014, Paragraph 12.b.(3) and reported as LER 88-017-00 dated July 26, 1988. The licensee was still investigating the generic problem of high contact resistance in low voltage circuits.

(2) Possible Tampering Identified Causing Increased Input of Water Into the Liquid Radwaste System [ENS No. 13171]

On August 12, 1988, the licensee identified possible tampering with several valves in the Cycle Condensate System which resulted in a significant increase in the amount of water being routed to the Liquid Radwaste System. Seven normally closed manual valves in the Radwaste Building were discovered

to be open. Most of the valves were used to provide water to form loop seals in floor drain traps. The licensee had started to notice increased water inventories in the Radwaste System on about August 8, 1988, and had been trying to determine the source since that time. The misaligned valves were difficult to locate because they directed water into tanks that had no input flow indication. Because of the nature and location of the valves, the licensee believed that the mispositioning was an act of deliberate tampering by an unknown individual. The licensee informed the NRC Operations Center via the ENS and Federal Bureau of Investigation.

(3) Possible Walkout By 13 Employees [ENS No. 13207]

On August 15, 1988, the licensee informed the NRC Operations Center via the ENS that 13 bargaining unit employees had gone home sick at the same time. The employees all worked outside of the protected area and the action had no affect on plant operations. Because the utility was under the threat of a strike by the union representing the employees, the licensee believed the action might have been the precursor to a strike and reported the situation to the NRC. No strike actually occurred. The possible strike is discussed below in Paragraph 9.

(4) Four Hour Report to NRC Required by 10 CFR 72 Not Made For 14 Days After Notification of Other Government Agencies [ENS No. 13234]

On August 18, 1988, the licensee informed the NRC Operations Center via the ENS of an event that had occurred on August 3, and had been reported to other government agencies on August 4, 1988. The event was a spill of approximately 79 gallons of sulfuric acid from the Waste Water Treatment System onto the floor of the Sediment Pond Filter House. It was discovered on August 4 but was believed to have occurred on August 3. The Supervisor - Radwaste notified Illinois Power Company's Environmental Affairs Department who in turn notified the National Response Center, Illinois Emergency Services and Disaster Agency, and the Illinois Environmental Protection Agency. The Shift Supervisor was not notified.

On August 18, 1988, the licensee discovered that they had failed to inform the NRC of the event and they then made the required notification. 10 CFR 50.72 (b)(2)(vi) required that a report to the NRC be made within four hours of any event related to the health and safety of the public or onsite personnel or the protection of the environment for which notification to other government agencies has been or will be made. Failure to notify the NRC until August 18, 1988, of the acid spill event which was discovered and reported to other government agencies on August 4, 1988, is a violation. (50-461/88021-02(DRP)).

(5) Initiation of Plant Shutdown Required by Technical Specifications [ENS No. 13?26]

On August 30, 1988, the licensee informed the NRC Operations Center via the ENS that they had initiated a plant shutdown in accordance with Technical Specification 3.8.1.1 ACTION e. At 2:50 P.M. on August 30, 1988, the licensee declared the Division I Diesel Generator inoperable due to seismic concerns caused by a missing bolt on its associated 4160 volt output breaker panel door. Technical Specification 3.8.1.1 ACTION e required that all required systems that depend on the remaining OPERABLE diesel generator as a source of emergency power be verified to be OPERABLE within two hours or the plant must be in at least HOT SHUTDOWN within the next 12 hours. The licensee noted that Main Control Room Ventilation Chlorine Detector VC 118B, a required component powered from Division II, had been declared inoperable at 2:05 P.M. due to a burned out indicating light, thus the ACTION statement applied. The licensee repaired VC 118B by 3:45 P.M. and the shutdown ACTION statement was exited before any actual power reduction.

(6) Unusual Event Declared Due to High Pressure Core Spray (HPCS) Injection [ENS No. 13351]

On September 1, 1988, the licensee notified the NRC Operations Center via the ENS of an unusual event when the HPCS system initiated and injected to the reactor vessel at power. The initiation was caused by a pressure transient in a common sensing line of two "level 2" transmitters in the HPCS circuit. The transient was due to valve manipulations while restoring from a calibration of a wide range reactor vessel level transmitter. The HPCS pump started on the two false low level signals and began injecting into the vessel. Plant operators verified an actual low level did not exist and closed the HPCS injection valve. Total injection time was about 28 seconds during which time actual reactor vessel level increased from 35" to 50". The high level reactor and turbine trip at 52" was not reached. The licensee terminated the unusual event and restored the system to normal after about 10 minutes.

One violation was identified

9. Licensee Plans For Coping With Strikes (92709) (92710)

During this inspection period the inspectors continued to review the licensee's plans for coping with a threatened strike. This was previously discussed in Inspection Report No. 50-461/88016, Paragraph 10. On the evening of August 14, 1988, the licensee called in more than 500 essential management and non-International Brotherhood of Electrical Workers (IBEW) personnel with arrangements so that they could live onsite for an extended

period in case of a strike. The inspectors verified that a sufficient number of properly qualified personnel were available to meet the technical specification requirements for operating shifts and fire brigades, as well as emergency response capabilities, and that arrangements had been made to allow the individuals to be fed and to rest. The inspectors also observed the licensee's actions to try to prevent tampering or other incidents if a strike was called. The inspectors, as well as regional management, were kept abreast by the licensee of developments in the contract negotiations with the union.

On August 16, 1988, a revised contract was offered to the union and they agreed not to strike pending the outcome of a ratification vote. With that agreement, the licensee demobilized its contingency force. On August 29, 1988, the IBEW informed Illinois Power Company that the three year contract had been accepted by its membership.

No violations or deviations were identified.

10. Conclusions

The inspectors noted weakresses in plant operations during this inspection period. Both of the violations discussed in this report were attributed to errors by operating staff personnel. Deficiencies in Operating Department's implementation of the procedure for control of foreign material in containment were also noted. The first violation noted in this inspection report, as well as the problems in containment material control also indicated weaknesses in quality verification in that implementation of corrective actions were not adequately verified. The inspectors noted no significant weaknesses in the areas of radiological protection, maintenance and surveillance, emergency preparedness, security, or engineering and technical support. Management involvement in the planning for and staffing and training of strike contingency personnel was good.

The plant operated at power during the entire inspection period. Power was limited to about 80-85% during the first part of the period due to thermal considerations resulting from one of the three circulating water pumps being removed for repairs. On August 21, 1988, the "A" Circulating Water Pump was returned to service and, with the additional cooling water flow, the plant was able to operate at full power.

11. Exit Meetings (30703)

The inspectors met with licensee representatives (denoted in Paragraph 1) throughout the inspection and at the conclusion of the inspection on September 6, 1988. The inspectors summarized the scope and findings of the inspection activities. The licensee acknowledged the inspection findings.

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