

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-456/88013(DRP); 50-457/88014(DRP)

Docket Nos. 50-456; 50-457

License Nos. NPF-72; NPF-75; NPF-77

Licensee: Commonwealth Edison Company
Post Office Box 767
Chicago, IL 60690

Facility Name: Braidwood Station, Units 1 and 2

Inspection At: Braidwood Site, Braidwood, Illinois

Inspection Conducted: April 10 through May 28, 1988

Inspectors: T. M. Tongue
T. E. Taylor
R. M. Lerch
G. A. VanSickle
J. A. Gavula
F. A. Maura

Approved By: *J. M. Hinds, Jr.*
for J. M. Hinds, Jr., Chief
Reactor Projects Section 1A

June 15, 1988
Date

Inspection Summary

Inspection from April 10 through May 28, 1988 (Report Nos. 50-456/88013(DRP); 50-457/88014(DRP))

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors and region-based inspectors of licensee action on previously identified items; licensee event report review; startup test observation; operational safety verification; radiological protection; engineered safety feature systems; physical security; monthly maintenance observation; monthly surveillance observation; inoperability of OB control room chiller; confirmatory action letters; issuance of Unit 2 full power license; increased control room and plant observations; training effectiveness; initial synchronization to the grid of Unit 2; and report review.

Results: Of the sixteen areas inspected, no violations were identified in fourteen. In the remaining areas two violations were identified, one regarding a missed surveillance requiring the use of moveable incore detectors (MIDs) (Paragraph 10) and the other concerning the inoperability of the OB control room chiller (Paragraph 11).

DETAILS

1. Persons Contacted

Commonwealth Edison Company (CECo)

T. J. Maiman, Vice President
M. J. Wallace, Manager of Projects
D. L. Shamblin, Project Manager
*R. E. Querio, Station Manager
W. E. Vahle, Construction Superintendent
*D. E. O'Brien, Station Services Superintendent
*K. Kofron, Production Superintendent
L. E. Davis, Assistant Superintendent - Technical Services
B. Byers, Assistant Construction Superintendent
M. Lohman, Project Startup Superintendent
P. Cretens, Station Startup Assistant Superintendent
S. C. Hunsader, Nuclear Licensing Administrator
F. Willaford, Security Administrator
D. E. Paquette, Maintenance Assistant Superintendent
*G. R. Masters, Operations Assistant Superintendent
E. L. Martin, Quality Assurance Superintendent
R. Benn, Assistant Security Administrator
*P. L. Barnes, Regulatory Assurance Supervisor
M. Takaki, Regulatory Assurance
J. Gosnell, Quality Control Supervisor
R. E. Aker, Radiation/Chemistry Supervisor
J. Jasnoz, Technical Staff AR/PR Coordinator
R. Lemke, Technical Staff Supervisor
F. G. Lentine, Licensing Supervisor
G. M. Orlov, Staff Assistant to Project Manager
P. G. Holland, Regulatory Assurance
T. W. Simpkin, Regulatory Assurance Operating Experience Group
R. C. Bedford, Regulatory Assurance
R. D. Kyroutac, Quality Assurance Supervisor
L. Kline, Regulatory Assurance Industry Group
*L. W. Raney, Nuclear Safety
R. J. Ungeran, Operating Engineer Unit 1
R. Yungk, Operating Engineer
R. J. Legner, Lead Operating Engineer
T. O'Brien, Tech Staff
S. Hedden, Master, Instrument Maintenance
R. Hoffman, Master, Mechanical Maintenance
J. Smith, Master, Electrical Maintenance
W. McGee, Training Supervisor
B. Tanouye, Project Construction Department
A. J. D'Antonio, Quality Control
D. H. Schavey, Training
*E. W. Carroll, Regulatory Assurance
*P. F. Hart, Quality Assurance Engineer

- *D. Pierce, Assistant Technical Staff Supervisor
- *L. Bush, Regulatory Assurance
- *R. A. Fessner, Operations Staff

*Denotes those attending the exit interview conducted on May 26, 1988 and at other times throughout the inspection period.

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

2. Licensee Action on Previously Identified Items (92701)

(Closed) Open Item 457/87028-01: Completion of local leak rate testing required to calculate the containment integrated leak rate test (CILRT) valve lineup penalty. The inspector reviewed the local leak rate results of 2BwPT-PC-50 for the steam generator blowdown and fuel transfer tube penetrations, and the local leak rate results of 2BwPT-PC-50, Retest #24, for the CILRT test instrumentation and H₂ monitoring penetrations. Using the minimum pathway leakage methodology, the overall penalty leakage calculation, including instrument error, was 683 sccm, which is equivalent to 0.0003 wt %/day. As a result, the NRC calculated Lam (total measured containment leakage rate at the calculated peak containment internal pressure) at the 95% upper confidence limit remained 0.049 wt %/day, which is below the Appendix J acceptance criteria of <0.075 wt %/day. This item is considered closed.

(Closed) Open Item 457/88004-01: Inconsistent thermal movements between high temperature and ambient conditions necessitated additional testing and verification of piping thermal expansion.

Due to the previously identified inconsistencies, Preoperational Test Procedure BwPT-EM-50, "Thermal Expansion-Primary Side," Retest No. 038, was conducted during February 1988. Subsystems 2CV09, 2CV15, 2CV25, 2RC13 and 2MS01 were included in this retest procedure. Based on the previous test results, approximately six supports were modified in order to reduce the frictional forces inherent in the original support designs. System temperatures were extensively monitored and used in thermal expansion calculations in order to obtain additional accuracy for predicted piping movements.

The NRC inspector reviewed relevant portions of the above test results to confirm the correlation between the as-analyzed and as-observed thermal displacements. This review showed that all the observed thermal displacements were within the stated tolerances of the predicted displacements. Based on this review, this item is considered closed.

No violations or deviations were identified.

3. Licensee Event Report (LER) Review (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, immediate corrective action was accomplished, and corrective action to prevent recurrence had been or would be accomplished in accordance with technical specifications:

(Closed) 456/87031-L1 and L2: Control Room Ventilation Shift to Emergency Makeup Mode as Result of Spurious Actuation of Rad Monitor Due to a Design Deficiency. Supplemental reports issued to include an additional occurrence of December 28, 1987, and to update the corrective action taken. Overall, three actuations (June 23, October 16, and December 28, 1987) occurred. The root cause of all three events has been attributed to the pressure switches of monitors OPR 31J and OPR 32J, which have repeatedly generated noise spikes when the monitor vacuum level has fluctuated around a high vacuum (approximately 10 inches of mercury below atmospheric). As part of the licensee's corrective actions, noise suppressing electro cubes were installed into the monitors' pressure switch assemblies. There have been no further occurrences of this type. This item is considered closed.

(Closed) 456/87058-LL: Both Trains of Control Room Ventilation Inoperable Due to Incorrect Design Incorporation. This LER was reviewed and is specifically addressed in Inspection Report 50-456/88007(DRSS). Enforcement actions are addressed in associated correspondence and tracked under that inspection report number. This LER is considered closed.

(Closed) 456/87063-LL and 456/88006-LL: Two Inoperable Non-Accessible VA Filter Plenums Due to Misalignment. This event is addressed in Inspection Reports 456/88011(DRP); 457/88013(DRP). A Notice of Violation was issued for these events. This LER is considered closed.

(Closed) 457/88001-LL: Safety Injection Pump Discharge Valve Found Locked Closed. This issue is addressed in Inspection Report 457/88012(DRP). A Notice of Violation was issued for this event. This LER is considered closed.

(Closed) 456/88004-LL: Rod Withdrawal as Indicated by Digital Rod Position Indication (DRPI). At 6:55 a.m. on March 11, 1988, Unit 1 was in hot shutdown with the control rods fully inserted and the reactor trip breakers closed, when an annunciator indicated a control rod deviation. The DRPI display for rod D-4, Control Bank D, was at 18 steps. An attempt to manually insert control rod D-4 failed to change the indication and as a result, at 6:57 a.m. the reactor trip breakers were manually opened with no change in rod D-4 indication. Boration was then initiated to increase the boron concentration by 100 ppm per procedure for shutdown margin considerations.

The cause of this event was a failure of the detector/encoder card in the DRPI Data A cabinet. The detector/encoder card was replaced and the system was declared operable. The failure affected rod position indication only; there was no physical control rod movement. The licensee is continuing to monitor DRPI system performance for any generic or recurring failures. This item is considered closed.

(Closed) 456/88009-LL: Loss of OB Control Room Chiller Due to Determination of Temperature Controller. During routine maintenance on the OB Control Room Chiller OW001CB, instrument technicians found leads for the chilled water sensor lifted and taped off. This issue is the subject of a Notice of Violation and is discussed in detail in paragraph 11 of this report. This LER is considered closed.

(Closed) 456/88010-LL: Control Room Ventilation to Makeup Mode of Operation From a High Radiation Alarm Due to Incorrect Setpoint. At 1:03 a.m. on April 10, 1988, the control room ventilation system automatically shifted to the emergency makeup mode of operation. This was in response to a high radiation setpoint being exceeded on control room outside air intake particulate channel ORE-PR033A. Samples by the Radiation/Chemistry Department verified that there were no abnormal levels of radioactivity present. It was discovered that an incorrect setpoint had been entered for the monitor. This was due to a management deficiency in that permanent changes to the instrument data sheets were not properly implemented in accordance with the procedure when the setpoint was modified by a change to the Final Safety Analysis Report. The proper setpoint was entered, operation of the monitor was returned to normal, and the control room ventilation system lineup was returned to normal. Radiation setpoints have been reviewed and verified to be correct on all control room ventilation monitors, and the setpoint data sheet documentation has been reviewed and corrected. Dual verification is now required on the data sheets, and the instrument procedure will be revised to require technical staff notification when a discrepancy between the as-found condition and the data sheet is identified. This item is considered closed.

In addition to the foregoing, the inspector reviewed the licensee's Deviation Reports (DVRs) generated during the inspection period. This was done in an effort to monitor the conditions related to plant or personnel performance, potential trends, etc. DVRs were also reviewed for assurance that they were generated appropriately and dispositioned in a manner consistent with the applicable procedures and the quality assurance (QA) manual.

No violations or deviations were identified.

4. Startup Test Observation (72302)

The inspectors witnessed performance of portions of the following Unit 2 startup test procedures in order to verify that testing was conducted in accordance with the operating license and procedural requirements, that test data was properly recorded, and that performance of licensee

personnel conducting the tests demonstrated an understanding of assigned duties and responsibilities:

AP-70 - Loss of Offsite Power

RC-75 - Shutdown From Outside the Control Room

No violations or deviations were identified.

5. Operational Safety Verification (71707)

The inspectors conducted routine plant tours during the inspection period to make an independent assessment of equipment conditions, plant conditions, construction activities, security, fire protection, general personnel safety, housekeeping, and adherence to applicable regulatory requirements. During the tours, the inspectors reviewed various logs and daily orders, interviewed personnel, attended shift briefings and plan of the day meetings, witnessed various construction work activities, and independently determined equipment status. During the shift changes, the inspectors observed operator, shift control room engineer, and shift engineer turnovers and panel walkdowns.

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

No violations or deviations were identified.

6. Radiological Protection (71709)

The inspectors selected portions of the licensee's radiological program to verify conformance with facility policies, procedures, and regulatory requirements. Observed aspects included the health physics managers' awareness of any unusual conditions or challenges, the implementation of the ALARA program, the use of Radiological Work Permits (RWPs), the control and monitoring of radiation exposures, including work in high radiation areas if applicable, and the control of radioactive material.

No violations or deviations were identified.

7. Engineered Safety Feature (ESF) Systems (71710)

During the inspection, the inspectors selected accessible portions of several ESF systems to verify their status. Consideration was given to the plant mode, applicable Technical Specifications, Limiting Conditions for Operation Action Requirements (LCOARs), and other applicable requirements.

Various observations, where applicable, were made of hangers and supports; housekeeping; whether freeze protection, if required, was installed and operational; valve positions and conditions; potential ignition sources; major component labeling, lubrication, cooling, etc.; interior conditions of electrical breakers and control panels; whether instrumentation was

properly installed and functioning and significant process parameter values were consistent with expected values; whether instrumentation was calibrated; whether necessary support systems were operational; and whether locally and remotely indicated breaker and valve positions agreed.

During the inspection, the following ESF systems/components were walked down:

Unit 1

1A and 1B Emergency Diesel Generators
4160 ESF Switchgear

Unit 2

2A Emergency Diesel Generator

No violations or deviations were identified.

8. Physical Security (71881)

At various times throughout the inspection period, the inspectors monitored compliance with the Physical Security Plan (PSP). Observations were made of selections of manning levels and collateral duties of assigned personnel; access control equipment and processes, such as x-ray machines, metal detectors, explosive detectors, and other search mechanisms; whether protected area (PA) and vital area (VA) barriers were properly maintained; whether procedures were properly followed; whether compensatory measures were appropriately used when required; whether persons in the PA and VA were properly badged and escorted if required; whether various detection/assessment aids such as fences and illumination of the PA, were operable, and whether TV monitors had sufficient clarity and resolution.

No violations or deviations were identified.

9. Monthly Maintenance Observation (62703)

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

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from and restored to service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were

accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and fire prevention controls were implemented. Work requests were reviewed to determine the status of outstanding jobs and to assure that priority is assigned to safety-related equipment maintenance which may affect system performance.

Maintenance activities on the following equipment were observed and reviewed:

Unit 1

1D, C, FW00a Feedwater Isolation Valves Hydraulic System
1B Emergency Diesel Generator
Moveable Incore Detector System Troubleshooting

Unit 2

2A RHR Pump Shaft Seal Replacement
2B Diesel Generator Water Jacket Inspection on 10L Cylinder

Unit 1 and Unit 2

Environmentally Qualified (EQ) Motor Operated Valves (MOV) Grease Sampling and Replacement

EQ Pressure Switch Replacement

No violations or deviations were identified.

10. Monthly Surveillance Observation (61725)

The inspectors observed surveillance testing required by technical specifications for Units 1 and 2 during the inspection period and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspectors also witnessed portions of the following test activities:

Unit 1

1B Diesel Generator Monthly Operability Surveillance

BwOP IC-3, Incore Moveable Detectors Flux Mapping Procedure

BwOP 3.4.2.a-1, Turbine Throttle Governor, Reheat and Intercept Valve Monthly Surveillance

Unit 2

2BwOS 3.2.1-870, Unit 1 ESFAS (Engineered Safety Feature Actuation System) Instrumentation Slave Relay Surveillance

2B Auxiliary Feedwater AFW ASME Pump Run

Surveillance Requiring Use of the Moveable Incore Detectors (MIDs)

During the inspection, the inspectors became aware that the licensee was experiencing problems with Unit 1 Moveable Incore Detectors (MIDs). Only 43 of the pathways were available for flux mapping. This number is less than the 75% (44 of 58) required by Technical Specification 3.3.3.2 for the performance of surveillances involving the MIDs. The blocked thimbles (passages), which were initially found on May 10, 1988, apparently resulted from the settling of the lubricant (neolube) used to lubricate the thimble tubes. An additional 2 clogged thimbles were later identified. This phenomenon had been experienced at other similar facilities in the past. The licensee made several unsuccessful attempts to clear the thimble tubes by running the normal neutron detector or a blank cable with the normal drives through the affected thimbles.

This issue also received attention from Region III and NRC Headquarters due to previous thimble failures during attempts to clear blockages and unusual radiation exposures to hands during removal of irradiated cables and detectors at other facilities. These occurrences were discussed in IE Information Notice 84-55.

After discussions between the licensee and regional personnel, the licensee chose not to attempt to clean the thimbles while the reactor was at normal operating temperature and pressure. In addition, after the failed attempts to clear the blockage, the licensee pursued relief from Technical Specification 3.3.3.2 in order to perform the required surveillances with fewer thimbles. This had been done in the past at other similar facilities; however, the submittal for Braidwood Unit 1 was disapproved by NRR due to a lack of core information for high power levels at that unit.

Subsequent to the inspection period, on June 3, 1988, an emergency Technical Specification relief was granted for a period of ten days for continued operation, during which preparations could be made for shutdown, cooldown, and cleaning of the blockages.

One surveillance for which 75% of the detector thimbles must be available is the incore-ecore calibration of the power range high neutron flux trip setpoint. Table 4.3-1 of the Technical Specifications requires this surveillance to be performed quarterly, above 75% of rated thermal power. This surveillance was last performed in January 1988, and the latest allowable date for completion of the subsequent surveillance was March 23, 1988, in accordance with Technical Specification 4.0.2. Since the MIDs were unavailable and a current calibration was not in effect, the appropriate action would have been to reduce power to less than 75%, where the calibration requirement does not apply.

Contrary to the foregoing, on May 23, 1988, during sustained observation of control room and plant activities, an inspector noted that reactor power was between 75% and 76%. This condition had existed for 13 days. In discussions with the inspectors, plant management personnel stated that they chose to stay at greater than 75% power as an incentive to operating personnel to correct the MID problem, thereby enabling performance of the required surveillance. However, no corrective action to restore MID operability was available for the immediately foreseeable future. When the Senior Resident Inspector pointed out this state of affairs to the plant manager and indicated that reducing power to less than 75% would be appropriate, the licensee reduced power to 74%.

The licensee contended that it was within the Technical Specifications as long as it was actively pursuing the calibration. The licensee also stated that the basis for Technical Specification 4.0.4 allowed this operation. After further review, the inspectors contended that the basis for 4.0.4 does not apply in this instance, and that as long as the equipment to perform the calibration was inoperable (less than 75% of the MIDs available), the surveillance could not be performed.

Subsequent to the inspection period, the inspectors consulted with NRR on June 6, 1988, and found that NRR concurred with the inspectors' evaluation. In addition, guidance provided in Generic Letter 87-09 provides a period of 24 hours for a surveillance to be performed following an outage; however, this guideline has not been made part of the Braidwood/Byron Technical Specifications.

The failure to take appropriate corrective action when it was found that the excore neutron detectors could not be calibrated is considered a violation of Technical Specification 4.3-1, item 2 (50-456/88013-01(DRP)).

11. Inoperability of OB Control Room Chiller

On March 2, 1988, the Project Construction Department (PCD) requested the electrical contractor to determinate temperature element 1TE-0082 on containment chiller 1W001CB. On March 16, 1988, using erroneous information referenced on the construction work traveler, an electrical contractor construction worker determinated temperature controller OTC-W0082 for control room chiller OW001CB, and not temperature element 1TE-0082 on containment chiller 1W001CB. On April 7, 1988, during routine maintenance of control room chiller OW001CB, a contractor instrument technician discovered that leads to temperature controller OTC-W0082 were determinated and taped. Investigation by operations personnel found that all the leads to OTC-W0082 were determinated and that no authorized work other than the routine maintenance by the contract instrument technician was in progress for the OW001CB control room chiller. At 11:23 p.m. on April 7, 1988, control room chiller OW001CB was declared inoperable, and the appropriate Technical Specification Action Statement was entered. On April 8, 1988, the OTC-W0082 temperature controller was reterminated, and chiller OW001CB was functionally tested satisfactorily. With the temperature controller determinated, the chiller would have started, but would not have loaded to maintain the control room temperature below 90°F.

The root cause of this event was the erroneous information referenced on the construction work traveler. The errors were introduced during transposition of equipment numbers from the original work request generated on March 2, 1988, to the construction work traveler. The work traveler referenced VC (control room ventilation) Chiller Temperature Controller LTC-0082, instead of Containment Chiller Temperature Element LTE-0082; and Control Room Chiller Equipment Piece Number (EPN) OW001CB, instead of Containment Chiller LW001CB.

Technical Specification 3.7.6 requires that two independent VC systems shall be operable. Additionally, for Modes 5 and 6, Technical Specification 3.7.6 states, "With one Control Room Ventilation System inoperable, restore the inoperable system to operable status within 7 days or initiate and maintain operation of the remaining operable Control Room System in the makeup mode." The B Train of the VC system was inoperable for approximately 22 days. This failure to initiate action to restore operability within 7 days or to maintain Train A of the VC system in the makeup mode with one VC system inoperable is a violation of Technical Specification 3.7.6 (50-456/88013-02(DRP)). Details of this event are documented in LER 456/88009.

As corrective action, licensee management has counseled all individuals onsite involved with this event and revised page 1 of Quality Procedure QP 3-1 to require all maintenance and modification work which is to be done by the Projects and Construction Services Departments or Substation Department to be controlled by the station under the Work Request System. This will eliminate the possibility of transposing incorrect EPNs onto construction travelers. Based on the corrective actions taken by the licensee the inspector has no further concerns regarding this matter and this item is considered closed; consequently, no reply to this violation is required.

12. Confirmatory Action Letters (CALs)

On March 23, 1988, Confirmatory Action Letters (CALs) CAL-RIII-88-05 and CAL-RIII-88-06 were issued for Braidwood Units 1 and 2, respectively (see Inspection Report 456/88008; 457/88009).

The CALs were lifted by Region III letters, dated April 29 and May 16, 1988, for Units 1 and 2, respectively.

During the duration of the CALs, the resident inspectors monitored the progress, status, and results of the corrective action.

No violations or deviations were identified.

13. Unit 2 Full Power License Issued

On May 20, 1988, a Commission briefing was held at NRC headquarters in Rockville, Maryland for determining whether the licensee should receive a full power license to operate Braidwood Unit 2. After presentations

by Commonwealth Edison and members of the NRC Staff, the Commissioners voted 5 to 0 authorizing the granting of the license. NRC Operating License NPF-77 was issued by NRR on that day.

No violations or deviations were identified.

14. Increased Control Room and Plant Observations

In accordance with a commitment to the Commission, the resident inspectors, augmented by Region III inspectors, conducted continuous (24 hours per day) inspections in the control room and in the plant during the first four days when the Unit 2 reactor power was increased above 3% following the issuance of the full power license. In addition, monitoring was increased during other major activities at the plant, such as main turbine rolls and initial synchronization to the grid. This was done to verify that any conflicts were resolved between Unit 1 operation and Unit 2 power ascension. The inspectors found that communications were acceptable.

No violations or deviations were identified.

15. Initial Synchronization to the Grid

On May 25, 1988, the Unit 2 main turbine generator was synchronized to the grid on nuclear steam for the first time. The inspectors monitored the preparation, increase in power, and the execution of the activities. They were carried out in a well planned, cautious manner.

No violations or deviations were identified.

16. Training Effectiveness (41400 - 41701)

The effectiveness of training programs for licensed and non-licensed personnel was reviewed by the inspectors 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 inspection period. Personnel appeared to be knowledgeable of the tasks being performed, and nothing was observed which indicated any ineffectiveness of training.

No violations or deviations were identified.

17. Report Review

During the inspection period, the inspector reviewed the licensee's Monthly Operating Reports for March and April 1988. The inspector confirmed that the information provided met the requirements of Technical Specification 6.9.1.8 and Regulatory Guide 1.16.

The inspector also reviewed the licensee's Monthly Plant Status Reports for March and April 1988.

No violations or deviations were identified.

18. Exit Interview (30703)

The inspectors met with the licensee and contractor representatives denoted in paragraph 1 during the inspection period and at the conclusion of the inspection on May 26, 1988. 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.