U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-461/89007(DRSS)

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

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

Facility Name: Clinton Power Station, Unit 1

Inspection At: Clinton Site, Clinton, Illinois

Inspection Conducted: January 31-February 3 and February 13-15, 1989

Inspectors: W. B. Grant — 3/21/89 Date

R. A. Paul — 3/22/89 Date

Approved By: M. Schumacher, Chief
Radiological Controls and
Chemistry Section — 3/23/89 Date

Inspection Summary

Inspection on January 31-Februry 3 and February 13-15, 1989 (Report No. 50-461/89007(DRSS))
Areas Inspected: Routine, unannounced inspection of the radiological protection program during a refueling and maintenance outage, including: changes; audits and appraisals; planning and preparation; training and qualification of new personnel; external exposure control; internal exposure control; control of radioactive material and contamination surveys and monitoring and ALARA (IP 83750). Specific and general allegations concerning the radiation protection program were reviewed (IP 92701); also reviewed were previous open items (IP 92701).
Results: The licensee's radiation protection program appears to be adequately developed and generally effective in protecting the health and safety of occupational workers.

DETAILS

1. Persons Contacted

*D. Brown, Supervisor, Radiological Controls
*J. Brownell, Project Specialist Licensing
*R. Campbell, Manager, Quality Assurance
*J. Cook, Manager, Nuclear Planning and Support
*R. Delong, Supervisor, Radiological Engineering
M. Dodds, Radiological Project Engineer/ALARA Coordinator
*R. Freeman, Manager, NSED
*J. Greenwood, Manger, Power Supply
*M. Hollon, Acting Director, NPAG
*D. Holtzscher, Acting Manager, Licensing and Safety
*J. Howland, Supervisor, Radiological Operations
*G. Kephart, Supervisor, Radiological Support
*W. Manganaro, Supervisor, Chemistry/Radiation Protection Support
*D. Miller, Director, Plant Radiation Protection
*J. Miller, Manager, Scheduling and Outage Management
J. Niswander, Health Physics Supervisor
*J. Perry, Assistant Vice President
*J. Wilson, Plant Manager
*R. Wyatt, Manager, Nuclear Training

*S. Ray, NRC, Resident Inspector

The inspectors also contacted other licensee and contractor personnel.

*Denotes those present at the exit meeting on February 15, 1989.

2. General

This inspection, was conducted to review aspects of the licensee's radiation protection program during an refueling/maintenance outage, including: changes since the last inspection, audits, exposure controls, control of radioactive materials and contamination and ALARA program. Specific and general allegations were reviewed as were several past open items.

During plant tours, no significant access control, posting, or procedure adherence problems were identified; housekeeping was generally good.

3. License Action on Previous Inspection Findings (IP 94701)

(Closed) Unresolved Item (461/87028-05): Review fuel handling procedures, projected drywell radiation levels through penetrations in the biological shield, and drywell radiological controls during spent fuel movement. Clinton Power Station (CPS) Procedure No. 1705.12 describes the controls in place to conduct appropriate radiological surveys to determine personnel access. CPS No. 7105.12 outlines the access requirements into the drywell and the areas surrounding the fuel transfer tube shield. Shielding verification surveys were performed in

conjunction with initial removal of spent fuel from the reactor. A spent fuel assembly was oriented in different positions within the vessel while a series of radiation surveys were performed. Plant areas adjacent to the reactor vessel and the inclined fuel transfer system (IFTS) were thoroughly surveyed. Based on these initial assessments, drywell access for outage work was revised to ensure access and dosimetry controls commensurate with the potential for transient high radiation areas during spent fuel movement. Additional shielding was installed over access manways into the biological shield where needed and special RP approval was required for access to upper elevation of the drywell and portions of 755' of containment. This matter is considered closed.

(Closed) Open Item (461/87028-06): Review development and implementation of training concerning radiological hazards associated with working in the drywell and accessible areas of the inclined fuel transfer system during spent fuel movement. Radiation worker training lesson plans were revised to include a discussion of the radiological hazards in these areas. In addition, control point access personnel are required to discuss the specific hazards such as radiation/contamination level, location of hot spots and other conditions within the controlled area with each individual or group prior to entry into a high radiation area or controlled area. This matter is considered closed.

(Closed) Open Item (461/87037-01): Revise the task qualification and sign-off procedure to clarify the program intent and to describe acceptable method of task qualification and sign-off. CPS No. 1902.10 (Radiation Protection Qualifications) has been revised to define who can observe a qualification demonstration and the experience and knowledge level required for the person signing and/or observing the practical factor qualification. This matter is considered closed.

(Closed) Open Item (461/88005-02): Revise procedure CPS 1960.01, "Radwaste Organization Responsibilities and Minimum Qualifications," to be compatible with technical specifications and to reflect the current radwaste organization. The licensee has revised CPS 1960.01 to reflect the current radwaste organization. This matter is considered closed.

(Closed) Open Item (461/88022-01): Review two corrective actions taken by the licensee in response to allegations transmitted by the NRC to the licensee for review. The licensee revised RWP Procedure 1905.10, "Radiation Work Permit," to address the administrative action required to be completed when changing RWP protection requirements. The licensee also revised Procedure CPS No. 7003.01, "Personnel Decontamination," to include decontamination of localized high level skin contamination. This matter is considered closed.

4. Changes (IP 83750)

The inspectors reviewed changes in organization, personnel, facilities, equipment program and procedures that could affect the occupational radiation protection program. The following organizational changes were noted.

The Corporate Health Physicist was transferred to the Plant Radiation Protection Department as Supervisor, Radiological Operations; the Supervisor, Radiological Operations was transferred to Supervisor, Chemistry and Radiation Protection Support; the Acting Supervisor, Radiological Support (a contractor) terminated; and the Supervisor, Radiological Environmental transferred to Supervisor, Radiological Support. These four positions report to the Director of Plant Radiation Protection. The Supervisor, Radiological Environmental position remains vacant as of February 15, 1989. Candidates for the Environmental Supervisor position are being screened.

A full time Radiological/ALARA Engineer was added to the ALARA staff and a full time HP Planning Engineer was added in maintenance work planning. In addition, four contractor ALARA engineers have been added to the ALARA staff for the outage.

All supervisors meet or exceed the qualification requirements listed in ANSI N18.1-1978 for the positions they occupy.

No violations or deviations were identified.

5. Audits and Surveillances (IP 83750)

The inspectors selectively reviewed the results of Quality Assurance (QA) audits and surveillances conducted by the licensee since the last inspection. Also reviewed were the extent of the audits and surveillances, their thoroughness, and the qualifications of the auditors.

Two QA surveillances, one of portable survey instrument daily response checks and one of the radiological control agreement between Clinton Power Station (CPS) and General Electric (GE) were conducted during this period. Corrective action on the three minor findings appeared timely and adequate.

During the inspection, a review of selected RWPs and associated Personnel Time Records (PTRs) by a licensee health physics consultant revealed that some workers were not initialling the PTRs as required by licensee procedure and in one case identified a contract RP technician working on an RWP without having properly signed the PTR. These problems occurred early in the outage; the licensee strengthened its enforcement of the RWP procedure and a followup review of the PTRs indicated the problem had been corrected. The extent of the audits/surveillances and the qualifications of the auditors appeared adequate.

No violations or deviations were identified.

6. Planning and Preparation (IP 83750)

The inspectors reviewed the outage planning and preparation performed by the licensee, including: additional staffing, special training, increased equipment supplies, and job related health physics considerations.

The licensee contracted about 40 RP technicians to support work being performed during the current outage. The licensee originally intended to have 27 contract RP technicians to cover the main control points. However, due to man power supply and processing problems only 14 RP technicians were available and the licensee did not have the full crew until about two weeks into the outage. During that period, house Radiation Protection Technicians (RPTs) helped the contract technicians provide health physics coverage at the main control points on each shift. When this coverage proved inadequate, all the RP technicians were placed on 12 hour shifts. This situation lasted for about one week until the full complement of contract technicians were available. Although inadequate staffing cost some work delays, the inspectors found no indications that radiological controls were compromised for work activities during this period.

The licensee resolved its concerns about the possibility of inadvertent isolation of the Breathing Air (RA) System in containment. Preoutage testing by NSED and RP determined that the system was reliable and the RA system was used to supply air to CRD removal crews in bubble hoods which helped keep person-rem doses within estimates and probably minimized contamination events. No problems were noted.

No violations or deviations were identified.

7. Training and Qualifications of New Personnel (IP 83750)

The inspectors reviewed the education and experience qualifications of new plant and contractor radiation protection and chemistry personnel, and training provided to them. Also reviewed was radiation protection training provided to other contractor personnel.

Initial selection of contracted radiation protection technicians includes contractor recommendation and a review of technician resumes'. Senior technicians must meet or exceed ANSI/ANS 3.1-1978 selection criteria to be accepted. In addition, the Supervisor, Radiological Controls, telephoned the last plant listed in the technicians resume' and then another plant or two listed earlier in the work resume' to verify work times and activities. The success of this industry accepted practice depends largely on the previous employer's knowledge of the persons work and how much they will divulge. The licensee's contract with Bartlett Nuclear, Inc. also requires each technician upon arrival to read and verify the accuracy of his or her resume. Each incoming technician is required to get a passing grade (80% for a Senior Technician and 60% for a Junior Technician) on a 50 question challenge exam prior to acceptance. The exam consisted of moderate to fairly difficult questions in radiation protection/health physics theory and problem solving; those who fail to pass are not normally accepted. Successful candidates then receive site orientation consisting of General Employee Training, Respiratory Protection and Radiation Worker Training and a description of the Refueling activities.

No violations or deviations were identified.

8. External Exposure Control (IP 83750)

The inspectors reviewed the licensee's external exposure control and personal dosimetry programs, including: changes in program to meet outage needs; use of dosimetry to determine whether requirements are met; planning and preparation for maintenance and refueling tasks including ALARA considerations; and required records, reports, and notifications.

The licensee's personal dosimetry program remains essentially as previously described (Inspection Report No. 461/87028). Exposure records of plant and contractor personnel were selectively reviewed for 1988 and 1989 through January. No exposures greater than regulatory limits (10 CFR 20.101) or the station's quarterly whole body administrative limit of 1.0 rem were noted. For 1988, the station's total exposure was 130 person-rem. The estimated radiation exposure thus far in 1989 (based on self reading pocket dosimeter estimates) is about 125 person-rem.

As of the end of January 1989, 1683 individuals were issued TLDs. This represents an increase from the previous month due mostly to increased manning for the refueling outage. The inspectors selectively reviewed termination reports pursuant to 10 CFR 20.408/20.409 for personnel who terminated in 1988. No problems were noted.

No violations or deviations were identified.

9. Internal Exposure Control and Assessment (IP 83750)

The inspectors reviewed selected aspects of the licensee's internal exposure control and assessment programs, including: determination whether engineering controls, respiratory equipment, and assessment of intakes meet regulatory requirements; and planning and preparation for maintenance tasks including ALARA considerations.

The licensee's program for controlling internal exposures during this outage includes the use of protective clothing, respirators, and portable ventilation equipment as well as control of surface and airborne radioactivity. The inspectors selectively reviewed the licensee's air sample and survey program for drywell activities; it appears that sufficient air samples are collected and analyzed, and that sufficient direct and smear surveys are performed.

The licensee used its commercial whole-body counter (WBC) during this outage for base-line counting of incoming contractor personnel. The inspectors observed the counting of several workers and selectively reviewed whole-body count results. No one exceeded the 40-hour control measure, and no significant internal disposition was identified. Contractor and nonstation personnel are counted when they complete their work at the station.

The inspector reviewed the licensee's method of relating WBC data to regulatory requirements (MPC-hours) by asking the radiation protection staff to convert WBC data to MPC-hours for an example given by the inspector. The results indicated that the licensee's procedure can be used adequately to estimate MPC-hours from WBC results.

Selective Review of air sample data indicated they were taken, counted, and evaluated in accordance with procedural requirements. The procedures appeared adequate. Special air samples are collected to establish RWP requirements and job conditions, and it appears the licensee properly uses the results to establish respirator and protective clothing requirements. No problems were noted.

Workers' General Employee Training cards list respirator protection qualifications, including medical evaluation, documentation of training, and the types of respirators approved. To obtain a respirator, a worker presents the card to an RPT at the mask issue area. The RPT reviews it to confirm qualification for the respirator requested, and logs the workers name and respirator serial number. Upon completion of the work, the worker is expected to return the respirator to the mask issue areas where it is logged and inspected. The licensee's tracking system appears to function well. A spot check of respirators by the inspector indicated or respirators available for issue indicated that respirator inspection, storage, and maintenance were adequate. No problems were noted.

No violations or deviations were identified.

10. Hot Particle and Personal Contamination Events (IP 83750)

The licensee's hot particle program is described in Inspection Report No. 50-461/88029. It requires an investigation of each hot particle event, that include interviews with individuals involved, review of related work activities and a skin dose assessment. The licensee has identified one hot particle to date. From its location on an individuals shoe, there was no potential for personal exposure.

The licensee reporting criterion for personal contamination events is 100 cpm above background on the skin or clothing. In January, 1989, the first month of the outage, 23 personal contamination events were identified, 14 clothing and nine skin. No problems were noted.

No violations or deviations were identified.

11. Maintaining Occupational Exposures ALARA (IP 83750)

According to the ALARA Coordinator, operational health physics radiological engineering personnel participated in preplanning meetings and were involved in planning for the radiation work in advance of the refueling outage. The ALARA Coordinator was sufficiently involved in outage planning. Some of the major outage jobs included remove/replace SRV's, RT valve rework, MSIV work, replacement of a recirculating pump seal, ISI activity, and snubber testing. An inspector attended an impromptu

meeting of the ALARA committee and members of the plants radiation protection, engineering, maintenance, technical and operations staff which was held to discuss a valve repair/ALARA problem. The discussion appeared to be intense, cooperation was evident, and the solution appeared to be properly ALARA.

Before this outage, the plant ALARA staff was increased by an additional permanent ALARA engineer and four contract ALARA engineers. The ALARA staff appears to be qualified and dedicated to its assignments. Inspector reviews, including walkdowns in containment, indicated sufficient incorporation of ALARA principles in pre-job planning of station work requests and station generated modifications. The licensee achieved dose saving by extensive use of lead shielding, use of mockups during pre-job training, and expanded use of video equipment and its photo-library.

The 1988 radiation dose was approximately 130 person-rem. The 1989 radiation dose through February 11, 1989, was about 125 person-rem. This included the refueling/maintenance outage which began January 3, 1989. The licensee's goal for the outage is 250 person-rem which appears achievable based on work to date.

No violations or deviations were identified.

12. Surveillance, Independent Surveys; Plant Tours (IP 83750)

The inspectors observed the following during several plant tours. Posting, labeling, and radiological controls for radiation and high radiation areas were in accordance with regulatory requirements. However, some rope barriers used for radiological controls were found on the ground because they were either taped to a wall or loosely attached to a piece of equipment rather than attached to a stanchion. The inspectors informed the licensee that use of poorly secured radiological control rope barriers is a poor health physics practice. The licensee acknowledged the problem and stated that not enough stanchions were available for the outage, but stated that more had been ordered.

One of the major RCA exits during this outage was in the radwaste building machine shop. It was equipped with three whole-body friskers but full time health physics coverage was not provided. The inspectors noted that significant numbers of workers exit there during both peak and non-peak hours. Although many of them survey themselves at upstream work locations, many do not, and the lack of full time health physics coverage at this exit during a major outage is a poor practice. This matter was discussed with the licensee who then assigned full time health physics coverage for the remainder of the outage. This matter was also discussed at the exit meeting.

13. Allegation Followups (AMS No. RIII-89-A-0003)

Discussed below are several specific allegations relating to the radiation protection program at the Clinton Power Station which were evaluated during this inspection. The evaluation consisted of record and

procedure review and interviews with licensee and contractor personnel. In addition other nonspecific allegations about the Radiological Control Program were received. These general issues (e.g., outage staffing, radiological postings, whole body counting) were reviewed during the course of the NRC's routine inspection. The results of those reviewed can be found in the programmatic sections of this report.

Allegation: Portable survey instruments are not source response checked correctly, a low range button source (18 mr) is used to check the high and low ranges (5 mr/hr and 5 R/hr). The intervals between instrument calibrations are excessive. There is no instrument issuance documentation.

Discussion: Licensee Procedure CPS No. 1911.10 "Radiological Control Instrumentation Calibration and Control," dated September 1988 requires calibration to be performed prior to first use, after maintenance, adjustment or modification that may affect instrument response, and at least semiannually. It also requires a daily source response check to be performed on instruments in use and documented in the Daily Response Check Log. The daily checks are usually done on the back shift, by Radiation Protection Instrument Calibration Facility (RPICF) personnel. The instruments are source checked on all ranges using a shielded calibrator located in the RPICF. The calibrator, a Shepard Model 89, uses two Cs-137 sources to provide a calibration range of 0.1 mr/hr to 1200 R/hr. Calibration labels and a daily source response check sheet are attached to each instrument to inform the user when it was last calibrated and if it was source response checked that day. Instruments not in use are stored in the RPICF and are response checked prior to issuance. Portable radiation protection instruments are issued from the RPICF to qualified individuals and during outages, several instruments may be issued to control points. This is an acceptable practice.

A review of instrument calibration records for 1988 and 1989 to date indicated instruments are calibrated at least semiannually, at two points on each range and on all ranges. A review of the Daily Response Check Log and the daily response check sheet attached to each radiation protection instrument indicated that instrument in use had been source response checked the same day and that none were out of calibration. Selective examination of issuance records RPIC indicated the instruments were being returned at the end of the shift.

Finding: This allegation was not substantiated. The licensee does not use a low range (18 mr) source for high range source checks. The licensee's practices and procedures for calibration and source checks are acceptable and considered adequate by the appropriate ANSI Standards. Instruments are issued in accordance with procedures and the documentation of issuance is adequate. Records reviewed by the inspectors indicated the procedures were being followed.

Allegation: Iodine adsorber cartridges for respirators were unavailable when the drywell was initially opened; particulate cartridges were used instead.

Discussion: This allegation was reviewed by examination of air sample results, RWP's, iodine cartridge inventory records, and discussions with licensee personnel. The Radiation Work Permit for initial removal of the drywell head required use of iodine cartridges and the licensee had about 150 cartridges available when removal occurred. However, the cartridges were not used because air samples collected by radiation protection technicians before head removal indicated that no iodine radioactivity was present in the drywell. The RWP was subsequently amended to delete the requirements for charcoal adsorber cartridges.

Finding: This allegation was not substantiated. Licensee radiological controls during head removal and entry into the drywell appeared adequate and charcoal adsorber (iodine) cartridges apparently were available if needed. During tours of the facilities, charcoal adsorber cartridges were observed by the inspectors and the licensee stated that supplied air respirators were also available for use if needed.

Allegation: Radiation Protection coverage of the dryer removal was inadequate; the dryer was not kept wet during the extended time it took to move the dryer because of the crane radiation monitor interlock problem.

Discussion: The inspectors interviewed several individuals who had been present during the operation, reviewed licensee sampling and monitoring records, and reviewed the licensee's Condition Report of the incident. They also reviewed a training video tape that was being made at the time of this unexpected occurrence. The licensee's accounts indicated that on January 7, 1989, the Area Radiation Monitor (ARM) on the polar crane alarmed during removal of the steam dryer from the reactor vessel. This caused electrical power to the crane to be interrupted at a point where approximately two-thirds of the dryer had emerged from the reactor vessel. This situation lasted approximately ten minutes until the crane operator got assistance to override the ARM interlock while he concurrently operated the crane. This allowed removal of the dryer to proceed.

Three radiation protection technicians and their foreman were present throughout the dryer removal and personnel access onto the refuel floor was limited. Area radiation levels on the refuel floor did not exceed 700 mrem/hr during dryer movement and radiation levels in the polar crane cab did not exceed 100 mrem/hr. A continuous air monitor was operating on the floor and portable high volume air samplers were available and were used to sample the air at specific locations.

The video tape showed the lifting rig spray system functioning to keep the dryer wet, and in addition, showed that a hose was being used throughout to wet the dryer. Air samples taken during dryer movement did not show any airborne radioactivity problems and the workers who were present wore respirators.

The inspectors perceived no inadequacy in radiation protection coverage from their examination of records or from discussions with persons interviewed.

Finding: This allegation was not substantiated.

Allegation: There was a discrepancy between the initial results of an air sample calculated by a contract RPT to be 3.7 MPC and later results from the licensee's laboratory that indicated 0.25 MPC.

Discussion: The air sample in question was taken in the containment building during the removal of the steam dryer. A field analysis by a contract RPT using a portable GM counting system, performed about 15 minutes after collection showed airborne concentrations of 3.54E-9 uCi/cc. This concentration is slightly above one MPC for unidentified beta not 3.7 MPC as alleged. Nevertheless, the sample was then sent to the laboratory for a gamma isotopic analysis as required by procedure. The results of this analysis, performed about 1.5 hours after the sample was collected, was reported as less than 25% of MPC. The actual value measured by the laboratory was 0.16 MPC but was reported as less than 25% MPC which is the decision point for requiring airborne area posting. The inspector's review of the air sample data indicated that the RPT had correctly calculated the initial airborne concentration (3.5E-9 uCi/cc), but erred regarding the MPC fraction. The inspectors verified that the laboratory computation of 0.16 MPC, based on a gamma isotopic analysis, was correct. The difference between the initial and final air sample results (1 MPC and 16% MPC) is attributable to decay of short-lived naturally occurring radioactivity collected on the sample and to the less restrictive MPC for the sample determined from the gamma isotopic analysis.

Finding: The allegation was not substantiated.

Allegation: The licensee takes too long to determine the results of air samples. The licensee does a poor job of documenting air sample results; they just record them as less than 25% of MPC instead of the actual numerical values.

Discussion: The inspectors reviewed licensee procedures and practices for air sample analyses and reviewed the results of air samples collected between January 3-7, 1989.

Air samples are analyzed to determine airborne radioactivity concentration levels, and thereby, the need for radiological controls such as airborne area postings and respirator use. The samples are first counted in the field soon after collection.

If the first count indicates above 25% of the unidentified beta MPC value, the sample is recounted in the laboratory using a gamma ray spectrometer. The inspector's review indicated the field counts are usually completed with 30 minutes of sampling and the final counts within two hours. These delays are not excessive if, as was indicated by the records reviewed, no work was initiated without adequate knowledge of airborne conditions.

The records examined also indicated that when the first count was below 25% of MPC, that fact was recorded on the data sheets rather than the actual air concentrations as a means of highlighting the fact the airborne

radioactivity controls were not needed. This practice is generally acceptable and consistent with regulatory requirements; however, logging of the actual field count results, in addition to the "less than 25%" notation, would provide more meaningful information.

Finding: While this allegation was partly substantiated in that "less than 25% MPC" is logged on air sample data sheets for the first field count, when appropriate, rather than the actual concentration values, this practice is consistent with regulatory requirements. No problems were identified concerning timeliness of air sample analyses.

Allegation: Because of high airborne levels found on an air sample taken during the removal of the steam dryer, a contract RPT attempted to stop persons from removing their respirators at a step-off-pad (SOP) when they were leaving the containment building; the RPT was overruled by a station radiation protection shift supervisor (RPSS).

Discussion: As noted above, on January 7, 1989, the licensee removed the steam dryer assembly from the reactor vessel. Personnel on the refuel floor at this time wore a full set of protective clothing and full face respirators. Based on interviews held between inspectors and persons working on the floor that day, it was verified that a contract RPT did direct the workers leaving the floor to remove their full protective clothing, at the SOP but to continue wearing their respirators until they reached the containment building exit hatch which was about 20 feet away. The workers interviewed, including the RPSS, stated that all protective clothing except respirators were removed at the SOP as directed by the RPT and that the respirators were removed at the exit hatch. No attempt to overrule the RPT was made, however, several of the individuals interviewed asserted that the SOP was poorly located if there was a potential for airborne contamination and noted that the location was changed shortly after this episode. As noted above, subsequent analyses of the airborne sample showed that respirators were not needed during the steam dryer removal.

Finding: The inspectors were unable to substantiate the allegation that the RPT's directions were overruled by an RPSS. Given the information known to the contract RPT at the time concerning the level of airborne activity, the RPT did not act unreasonably. However, a better choice of SOP location was evidently available which should have been noted by the station HP staff in the course of maintaining oversight or contractor activities.

14. Exit Meeting (30703)

The inspectors met with licensee representatives (denoted in Section 1) at the conclusion of the inspection on February 15, 1989, to discuss the scope and finding of the inspection. 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/processes as proprietary. One matter was discussed specifically by the inspectors concerning the timely manning of the machine shop egress point by an HP technician.