Browns Ferry 2
4Q/2009 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Operating Procedures Cause Partial Loss of Reactor Feedwater Which Results In Unit 2 Manual Reactor Scram
A Green self-revealing noncited violation of Technical Specifications 5.4.1.a was identified for failure to adequately maintain the accuracy of critical operating procedures for Power Maneuvering, and Reactor Feedwater (RFW) and Condensate System operation, which subsequently resulted in a partial loss of RFW and a Unit 2 manual reactor scram. These procedures were subsequently revised to more accurately reflect integrated plant response and establish appropriate operating limitations for the RFW and Condensate systems. This event was entered into the licensee's corrective action program as PER 203538.

This finding was determined to be of greater than minor significance because it was associated with the Initiating Events cornerstone attribute of Procedure Quality, and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during at-power operations. Specifically, the licensee's inappropriate revision of critical operating procedures directly contributed to an unintended partial loss of RFW flow resulting in a manual reactor scram. RFW was available throughout the event. The finding was evaluated using Phase 1 of the At-Power Significance Determination Process, and was determined to be of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment or functions were not available. The cause of this finding was directly related to the cross-cutting aspect of complete, accurate and up-to-date procedures in the area of Human Performance because the licensee improperly revised several critical operating procedures [H.2(c)].

Inspection Report# : 2009005 *(pdf)*

Mitigating Systems

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Unit 2 RCIC System Inoperable Beyond the Technical Specification Allowed Outage Time
A Green self-revealing non-cited violation of Unit 2 Technical Specifications (TS) Limiting Condition for Operation 3.5.3, Reactor Core Isolation Cooling (RCIC) System, was identified for the licensee's failure to comply with the TS required actions for an inoperable RCIC system. The RCIC system was inoperable for approximately 33 days due to an internal failure of the electric governor - magnetic (EG-M) controller, which exceeded the TS allowed outage time (AOT) of 14 days. This issue was entered into the corrective action program as Problem Evaluation Report 203537. The EG-M was replaced and the RCIC system was restored to an operable condition.

This finding was determined to be of greater than minor significance because it was associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, the unresolved failure of the RCIC EG-M resulted in the RCIC system being unable to perform its intended function for an extended period of time (i.e., 33 days). In accordance with IMC 0609, Significance Determination Process (SDP), Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," this finding required a Phase 2 analysis

since it represented an actual loss of a single train for greater than its TS AOT. The Phase 2 SDP analysis determined that the finding was potentially greater than Green (i.e., greater than very low safety significance). A regional Senior Reactor Analyst then performed a Phase 3 SDP analysis which subsequently concluded the finding was of very low safety significance or Green. The cause of this finding was directly related to the cross-cutting aspect of Prompt Identification of Issues in the Corrective Action Program in the Problem Identification and Resolution area, because the licensee failed to enter the identified problem regarding abnormal EG-M voltage into their corrective action program in order to evaluate and resolve the adverse impact of the abnormal EG-M voltage on RCIC system operability [P.1(a)].

Inspection Report# : 2009005 *(pdf)*

Significance: G Oct 09, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Deficiencies with Emergency Lighting Units
The team identified a Green non-cited violation of Browns Ferry Units 1, 2, and 3 Operating License Conditions 2.C (13), 2.C(14), and 2.C(7), respectively, for the licensee's failure to maintain in effect all provisions of the NRC-approved fire protection program, as described in the Final Safety Analysis Report. The Fire Protection Report (referenced in the Final Safety Analysis Report) requires that measures be established to ensure that conditions adverse to fire protection, such as failures and deficiencies, are promptly identified and corrected. The licensee had not established measures to identify and correct an excessive number of Appendix R emergency lighting unit failures. Specifically, emergency lighting unit failures were not being entered in the corrective action program as problem evaluation reports in order to evaluate and resolve why many of the emergency lighting failures occurred prior to reaching their 6-year replacement date. Additionally, the Fire Protection Report surveillance requirement to replace the Appendix R emergency lighting unit batteries and lamp heads every six years was not being adequately implemented, in that licensee data revealed that several installed emergency lighting units were beyond their 6-year replacement date. The licensee entered this finding into their corrective action program and initiated corrective actions to address these issues.

The licensee's failure to meet the Fire Protection Report requirements to establish measures to identify and correct a condition adverse to fire protection (excessive Appendix R emergency lighting unit failures); and, to implement the Appendix R emergency lighting system replacement program, is a performance deficiency. The finding is more than minor because it is associated with the reactor safety, mitigating systems cornerstone attribute of protection against external factors (i.e., fire). The excessive emergency lighting unit failures affected the objective of ensuring the reliability and capability of operator manual actions during response to initiating events, The team determined that this finding was of very low safety significance (Green) because the operators had a high likelihood of completing the tasks using flashlights. The cause of this finding has a cross-cutting aspect in the Work Control component of the Human Performance area, in that it was directly related to the licensee not planning and coordinating work activities to support long-term equipment reliability, and their maintenance scheduling was more reactive than preventive (H.3 (b))
Inspection Report# : 2009009 *(pdf)*

Significance: G Oct 09, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish Adequate Compensatory measures for an Out-of-Service Hose Station
The team identified a Green non-cited violation of Browns Ferry Units 1, 2, and 3 Operating License Conditions 2.C (13), 2.C(14), and 2.C(7), respectively, for the licensee's failure to maintain in effect all provisions of the NRC-approved fire protection program as described in the Final Safety Analysis Report. The Fire Protection Report (referenced in the Final Safety Analysis Report) requires the licensee to establish adequate compensatory measures for degraded or inoperable fire protection equipment. The licensee failed to establish adequate compensatory measures for an out-of-service hose station, in that the staged additional lengths of hose connected to the closest in-service hose station, established as a compensatory measure, did not provide equal or better protection than the out-of-service hose station that it was replacing. The licensee entered this finding into their corrective action program and took immediate action to review all existing fire protection impairment permits for similar problems. The licensee removed the

compensatory measure and restored the out-of-service hose station to service.

The licensee's failure to provide compensatory measures of equal or better protection for an out-of-service hose station is a performance deficiency because it did not meet the requirements of the approved fire protection program. The finding was more than minor because it affected the protection against external factors attribute of the mitigating systems cornerstone, in that it impacted manual fire suppression (i.e., fire brigade) capability; and, affected the cornerstone objective of ensuring the availability of systems that respond to initiating events. Since Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," does not provide guidance for assigning a degradation rating to manual fire suppression, this determination was made using qualitative methods which received NRC management review as provided for in Inspection Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." This finding was determined to be of very low safety significance (Green) because it represented a low degradation of the manual fire suppression function. Although the fire protection impairment permit had been implemented for an out-of-service hose station, the hose station was still functional at the time this issue was identified, because the water supply to the hose station had not been physically isolated. However, the team concluded the fire brigade would have experienced delays in initiating manual fire suppression for a fire in a fire area covered by the impairment. The cause of this finding has a cross-cutting aspect in the Work Control component of the Human Performance area, in that it was directly related to the licensee not planning and coordinating work activities, consistent with nuclear safety, to ensure that adequate compensatory actions were established for an out-of-service hose station (H.3 (a)).
Inspection Report# : 2009009 *(pdf)*

Significance: TBD Oct 09, 2009
Identified By: NRC
Item Type: AV Apparent Violation
Failure to Protect Cables of Systems Necessary to Achieve and/or Maintain Post-Fire Safe Shutdown Conditions for Fire Areas Subject to the Requirements of 10 CFR Part 50, Appendix R, Section 111.G.2.
The team identified an apparent violation of Title 10 of the Code of Federal Regulations (10 CFR), Part 50, Appendix R, Section lll.G.2, for the licensee's failure to ensure one of the redundant trains of cables and equipment required for safe shutdown and located in the same fire area was free of fire damage. Specifically, cables associated with equipment required for safe shutdown had not been protected by one of the methods specified in 10 CFR Part 50, Appendix R, Section Ill.G.2 (i.e., use of spatial separation, passive barriers, and fire detection and an automatic fire suppression system). This apparent violation applies to Browns Ferry Units 1, 2, and 3, and resulted from review and closure of two unresolved items which were opened in previous inspections. The licensee entered this apparent violation into their corrective action program and posted additional compensatory measures while long term corrective actions are being implemented.

Failure to protect one train of cables and equipment necessary to achieve post-fire safe shutdown from fire damage, as required by 10 CFR Part 50, Appendix R, Section lll.G.2, is a performance deficiency. This finding is more than minor because it is associated with the reactor safety mitigating system cornerstone attribute of protection against external events (i.e., fire). Failure to protect safe shutdown cables and equipment from fire damage affects the reactor safety mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team performed a significance determination process Phase 1 screening. Given the likely impact of the risk contribution arising from the assessment of multiple fire areas, Region II senior reactor analysts performed a Phase 3 significance determination, which resulted in a preliminary risk of Greater Than Green. The team determined that this apparent violation did not present an immediate safety concern because the licensee implemented compensatory measures while long-term corrective actions are being implemented. The compensatory measures included operator manual actions to mitigate or prevent damage to equipment necessary for safe shutdown in the event of a fire. The licensee also implemented fire watches as additional compensatory measures to mitigate the safety hazard. Subsequent to the onsite inspection, the licensee evaluated the most critical operator manual actions, and revised selected safe shutdown instructions to include steps for independent confirmation of operator manual actions in order to improve the likelihood of success of these steps, and thus reduce the risk associated with this apparent violation. The cause of this finding has a cross-cutting aspect in the Corrective Action Program component of the Problem identification and Resolution area, in that the licensee did not take appropriate corrective actions to address the issue in a timely manner, commensurate with the safety significance (P.1.(d)).
Inspection Report# : 2009009 *(pdf)*

Significance: TBD Oct 09, 2009
Identified By: NRC
Item Type: AV Apparent Violation
Failure to Meet the Requirements of 10 CFR Part 50, Appendix R, Section 111.G.1 for 20 Fire Areas
The team identified an apparent violation of Title 10 of the Code of Federal Regulat/ons(10 CFR), Part 50, Appendix R, Section lll.G.1, for the licensee's failure to ensure that one train of cables and equipment necessary to achieve and maintain hot shutdown conditions was free of fire damage in 20 fire areas. In addition, these cables had not been protected by one of the methods specified in Appendix R, Section lll.G.2 (i.e., use of spatial separation, passive barriers, and fire detection and an automatic suppression system). This apparent violation applies to Browns Ferry Units 1, 2, and 3, and resulted from review and closure of two unresolved items which were opened in previous inspections. The licensee entered this finding into their corrective action program and posted additional compensatory measures while long term corrective actions are being completed.

Failure to meet the requirements of 10 CFR Part 50, Appendix R, Section lll.G.1 is a performance deficiency. It is more than minor because it is associated with the reactor safety mitigating system cornerstone attribute of protection against external events (i.e., fire). Failure to ensure that one train of safe shutdown cables and equipment was free of fire damage affects the reactor safety mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. This finding was evaluated in accordance with NRC Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process." The team performed a significance determination process Phase 1 screening. Given the likely impact of the risk contribution arising from the assessment of multiple fire areas, Region II senior reactor analysts performed a Phase 3 significance determination, which resulted in a preliminary risk of Greater Than Green. The team determined that this apparent violation did not present an immediate safety concern because the licensee implemented compensatory measures while long-term corrective actions are being implemented. The compensatory measures included operator manual actions to mitigate or prevent damage to equipment necessary for safe shutdown in the event of a fire. The licensee also implemented fire watches as additional compensatory measures to mitigate the safety hazard. Subsequent to the onsite inspection, the licensee evaluated the most critical operator manual actions, and revised selected safe shutdown instructions to include steps for independent confirmation of operator manual actions in order to improve the likelihood of success of these steps, and thus reduce the risk associated with this apparent violation. The cause of this finding has a cross-cutting aspect in the Corrective Action Program component of the Problem Identification and Resolution area, in that the licensee did not identify and thoroughly evaluate the problem, and the resolution did not address causes and extent of condition (P.1 (c)).
Inspection Report# : 2009009 *(pdf)*

Significance: TBD Oct 09, 2009
Identified By: NRC
Item Type: AV Apparent Violation
Inadequate Safe Shutdown Instruction Entry Conditions for Appendix R Fire Events
The team identified an apparent violation of Technical Specification 5.4.1.a., in that, the licensee's revision to the safe shutdown instruction entry conditions in December 2008 resulted in inadequate procedural guidance. Specifically, the revision to Procedure 0-SSI-001, "Safe Shutdown Instructions," added an entry condition based on the operator's ability to restore and maintain reactor water level above +2 inches on the narrow range scale, utilizing available equipment. This revision could have delayed or prevented entry into the safe shutdown instructions if reactor water level stayed at or above +2 inches on the narrow range scale. Furthermore, this entry condition was not consistent with the initial plant conditions assumed in the fire protection program safe shutdown analysis. The licensee entered this finding into the corrective action program and revised the entry conditions for the safe shutdown instructions on February 27, 2009, to eliminate the +2-inch reactor vessel water level entry condition.

Failure to meet Technical Specification requirements due to inadequate procedural guidance is a performance deficiency. This finding is more than minor because it is associated with the procedure quality attribute of the mitigating systems cornerstone and the inadequate procedure affected the cornerstone objective of protection against external events such as fire to prevent undesirable consequences. Given the number of fire areas involved, a significance determination process Phase 2 analysis was not performed. A regional senior reactor analyst determined that there were significant obstacles to quantifying the risk of this finding because the methods and tools are not adequate to determine the significance of this finding within the established timeliness goal of 90 days. Therefore, the safety significance of this finding was determined using the guidance and qualitative techniques contained in NRC Inspection Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." The

preliminary significance of this finding was determined to be Greater Than Green, which was reviewed and approved by NRC management. The team determined that this finding did not present an immediate safety concern because the immediate safety hazard no longer existed after the licensee revised the safe shutdown instruction in February 2009. The cause of this finding had a cross-cutting aspect in the Decision Making component of the Human Performance area, in that it was related to the licensee not using conservative assumptions in decision making and not conducting reviews to verify the validity of underlying assumptions and identifying possible unintended consequences (H.1(b)).
Inspection Report# : 2009009 *(pdf)*

Significance: G Jun 30, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to assess and manage shutdown risk associated with outage activities
A Green self-revealing noncited violation of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified for failure to adequately assess and manage shutdown risk associated with maintenance activities. Specifically, on May 2, 2009, the licensee performed a scheduled activity to install the 2A Recirculation Line nozzle plug in the reactor vessel. Installation of this plug isolated the common residual heat removal (RHR) system shutdown cooling (SDC) suction path while SDC availability was assumed in the shutdown risk assessment and had been designated as protected equipment as part of the specified risk management actions.
Shortly after the nozzle plug was installed, the licensee recognized that SDC was no longer immediately available and promptly removed the plug to restore SDC availability. This event was entered into the licensee's corrective action program as problem evaluation report 170184.

This finding affected the Mitigating Systems cornerstone and was determined to be greater than minor because the licensee failed to effectively manage the prescribed significant compensatory measures (i.e. protection of Loop I RHR). The significance of this finding was evaluated using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," Table 1, "Losses of Control," and Checklist 7 of Attachment 1, "BWR Refueling Operation with RCS Level > 23'" , the inspectors determined that this finding was of very low safety significance (Green) because the event did not result a loss of control per Table 1 of Appendix G, or an actual loss of decay heat removal, and the SDC alignment was restored well within the time to boil, and as such did not require quantification in a Phase 2 or 3 analysis. The cause of this finding was directly related to the cross cutting aspect of work activity coordination in the area of Human Performance, because the licensee failed to adequately evaluate the impact of the work and to communicate, coordinate, and cooperate with each other during activities in which interdepartmental coordination is necessary to assure plant performance (H.3.b). (Section 1R13).

Inspection Report# : 2009003 *(pdf)*

Barrier Integrity

Significance: G Jul 17, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Standby Gas Treatment Subsystem 'A' Inoperable Beyond the Technical Specification Allowed Outage Time (Section 4OA2.a)
• Green. A Green, self-revealing, non-cited violation (NCV) of Technical Specification (TS) limiting condition for operation (LCO) 3.6.4.3, "Standby Gas Treatment (SGT) System", was identified for the licensee's failure to comply with the LCO required actions for one inoperable SGT subsystem due to an inadequate investigation to ensure the system's operability, on November 30, 2008, following a loss of power to one of the three relative humidity heaters. This issue was entered into the corrective action program as Problem Evaluation Report 174597. The cause of the failure of the heater was a failed relay. The relay was replaced and the system was restored to service on June 20, 2009.

The finding is similar to example 2a in Inspection Manual Chapter (IMC) 0612, Appendix E, “Examples of Minor Issues,” in that the example performance deficiency is not minor if Technical Specification limits were exceeded. In accordance with IMC 0612, Appendix B, “Issue Screening,” the finding is greater than minor significance because it was associated with the Barrier Integrity cornerstone attribute of Human Performance and adversely affected the cornerstone objective of maintaining the radiological barrier functionality of Standby Gas Trains. Although the licensee ultimately was able to demonstrate that the SGT system could perform its safety function without the charcoal beds and associated heaters, compliance with SGT TS was a prerequisite to providing reasonable assurance that the SGT can protect the public from radionuclide releases caused by accidents or events. 10 CFR 50.36 defines TS limiting conditions for operation as the lowest functional capability or performance levels of equipment required for safe operation of the facility. The SGT TS LCO requirement was not met and therefore the cornerstone objective for functionality as described in the TSs, was not maintained.

In accordance with IMC 0609, Attachment 4, “Phase 1 - Initial Screening and Characterization of Findings,” the finding is determined to be of very low risk significance because the finding only represented a degradation of the radiological barrier function provided by the SGT system. Because this finding is of very low safety significance and has been entered in licensee’s corrective action program, the violation is being treated as a non-cited violation. The cause of this finding was directly related to the cross-cutting aspect of thorough evaluation of identified problems in the problem identification and resolution area, because the licensee failed to properly classify, prioritize and evaluate the operability of the SGT system when the heater loss of power annunciator was received [P.1(c)]. (Section 4OA2.a)

Inspection Report# : 2009006 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Jun 30, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to comply with the requirements of an RWP by entering a posted high radiation area
A Green self-revealing non-cited violation (NCV) of TS 5.4.1, Procedures, was identified for a radiation worker who failed to follow the requirements of RWP 09270081 as required by procedure RCI 9.1, Radiation Work Permits, Rev. 57. The licensee has entered this issue into the Corrective Action Program as Problem Evaluation Report 171375. This finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of Program and Process (Exposure Control) and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The finding was evaluated using the Occupational Radiation Safety SDP and determined to be of very low safety significance (Green) because it was not related to ALARA planning, nor did it involve an overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. The cause of this finding was directly related to the cross-cutting aspect of Work Practices in the area of Human Performance, because the radiation worker failed to use self-checking prior to passing through the swing gate into the posted high radiation area (H.4.a). (Section 2OS1)

Inspection Report# : 2009003 *(pdf)*

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Significance: SL-IV Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Report an Automatic RPS Actuation While Shutdown Per 10 CFR 50.73
A Severity Level IV, non-cited violation (NCV) of 10 CFR 50.72(b)(3)(iv)(A) and 10 CFR 50.73(a)(2)(iv)(A) were identified by the inspectors for the licensee's failure to recognize that a valid automatic reactor protection system (RPS) actuation while shutdown was a reportable condition. Consequently, the licensee failed to make an eight hour report as required by 10CFR50.72 and submit a licensee event report (LER) within 60 days as required by 10CFR50.73. This issue was documented in the licensee's corrective action program as Problem Evaluation Reports 172053, 178146, and 206168, and subsequently reported as LER 050-260/2009-006.

This finding was considered as traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. However, because this violation was of very low safety significance, was not repetitive or willful, and was entered into the licensee's corrective action program, the NRC has characterized this violation as a Severity Level IV NCV in accordance with Section IV.A.3 and Supplement I of the NRC Enforcement Policy. The cause of this finding was directly related to the cross-cutting aspect of evaluating and properly prioritizing reportable conditions in the area of Problem Identification and Resolution because the licensee did not adequately prioritize their efforts to meet the LER timeliness requirement of 10CFR50.73 [P.1(c)]. (Section 4OA3.1)

Inspection Report# : 2009005 *(pdf)*

Significance: N/A Jul 17, 2009
Identified By: NRC
Item Type: FIN Finding
Browns Ferry PI&R Summary
The team concluded that, in general, problems were identified, evaluated, prioritized, and corrected. The licensee maintained a reasonable threshold for identifying problems as evidenced by the large number of Problem Evaluation Reports (PERs) entered annually into the CAP, management expectation that all personnel are encouraged to initiate a PER for deficiencies noted, and CAP procedures requiring all personnel initiate PERs to document Significant Conditions Adverse to Quality (SCAQs), Conditions Adverse to Quality (CAQs), and potential items for improvement. However, some deficiencies were identified by the inspection team which were not previously entered into the CAP. Generally, the licensee prioritized and evaluated issues, conducted adequate formal root cause evaluations for significant problems, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective. However, the team identified some examples where corrective actions were not fully effective.

The team determined that overall, audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and generally, appropriate corrective actions were developed to address these issues. However, the team noted that a significant number of deficiencies were identified through self assessments of the CAP, which was indicative of a program that, while improved, has yet to reach the licensee's own desired level of effectiveness. Specifically, a large number of PERs associated with corrective maintenance work orders were not written even though generation of such PERs was explicitly required by corrective action program procedures.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors did not

identify any reluctance by workers to report safety concerns, or utilize the corrective action program.

The team determined that corrective actions implemented, and planned to be implemented, to address the substantive cross-cutting issue in problem identification and resolution identified by the NRC in its annual assessment letter dated March 3, 2008, were appropriate. The team noted that some corrective actions to prevent recurrence associated with the substantive cross-cutting issue problem evaluation report (PER) were improperly implemented and ineffective. Specifically, the corrective action implemented to initiate PERs for all Corrective Maintenance Work Orders (CMWO) was ineffective in that several hundred CMWOs did not have PERs initiated.

Inspection Report# : 2009006 *(pdf)*

Last modified : March 01, 2010