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ACCESSION NBR:9403230032 DOC.DATE: 94/03/15 NOTARIZED: NO DOCKET #
 FACIL:50-244 Robert Emmet Ginna Nuclear Plant, Unit 1, Rochester G 05000244
 AUTH.NAME AUTHOR AFFILIATION
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 MCCREEDY,R.C. Rochester Gas & Electric Corp.
 RECIP.NAME RECIPIENT AFFILIATION
 JOHNSON,A.J. Project Directorate I-2

SUBJECT: LER 94-004-00:on 940214,Four surveillance test missed due to lack of Clearly defined interperations of TS.
 Intermediate Range bistable circuits reviewed to verify trip signal would deenergize reactor trip relay.W/940315 ltr.

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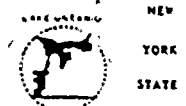
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March 16, 1994

U.S. Nuclear Regulatory Commission
Document Control Desk
Attn: Allen R. Johnson
Project Directorate I-3
Washington, D.C. 20555

Subject: LER 94-004, Missed Surveillances, Due to Lack of Clearly Defined Interpretations of Technical Specifications Requirements, Resulted in Violations of Technical Specifications
R.E. Ginna Nuclear Power Plant
Docket No. 50-244

In accordance with 10 CFR 50.73, Licensee Event Report System, item (a) (2) (i) (B) which requires a report of, "Any operation or condition prohibited by the plant's Technical Specifications", the attached Licensee Event Report LER 94-004 is hereby submitted.

This event has in no way affected the public's health and safety.

Very truly yours,

Robert C. Mecredy
for
Robert C. Mecredy

xc: U.S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406

Ginna Senior Resident Inspector

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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) R.E. Ginna Nuclear Power Plant

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TITLE (4) Missed Surveillances, Due to Lack of Clearly Defined Interpretations of Technical Specifications Requirements, Resulted in Violations of Technical Specifications

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
02	14	94	94	--004--	00	03	16	94	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
POWER LEVEL (10)	098	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME John T. St. Martin - Director, Operating Experience

TELEPHONE NUMBER (Include Area Code)
(315) 524-4446

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES

(If yes, complete EXPECTED SUBMISSION DATE).

X

NO

EXPECTED
SUBMISSION
DATE (15)

MONTH

DAY

YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On February 14, 1994, at approximately 1000 EST, with the reactor at approximately 98% steady state power, the Plant Operations Review Committee determined that four surveillance tests had not fully complied with the requirements of Technical Specifications (TS).

Immediate corrective action was to confirm that four missed surveillances had been completed (or other methods used) to ensure that all TS requirements were fully complied with. Except for a test of a pushbutton for manual Containment Isolation actuation, necessary tests and/or verifications had been completed.

The underlying cause of the four missed surveillances was a lack of clearly defined interpretations of the TS wording for the four missed surveillances. (This event is NRC Performance Indicator Program cause code 5.8.1.)

Corrective action to preclude repetition is outlined in Section V (B).

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

I. PRE-EVENT PLANT CONDITIONS

Rochester Gas and Electric (RG&E) formed a Technical Specifications Review Team in October, 1993, as a result of LER 93-005. (Refer to Ginna Docket No. 50-244, LER 93-005. See Section VI.C. of this report for details concerning the Review Team.) This Review Team reported their initial findings to the Ginna Station Plant Operations Review Committee (PORC) on February 14, 1994.. There were four issues discussed at the PORC meeting related to testing of the Nuclear Instrumentation System (NIS) Intermediate Range trip bistables, 480V Bus Undervoltage System, Reactor Trip Breaker Logic Channels, and the Containment Isolation system.

The plant was at approximately 98% steady state reactor power at the time of the PORC meeting, and there were no activities in progress related to the review of these four issues.

II. DESCRIPTION OF EVENT

A. DATES AND APPROXIMATE TIMES OF MAJOR OCCURRENCES:

1. May 11, 1992, 0405 EDST: Initial startup from the 1992 refueling outage. Testing performed during the outage did not fully comply with the requirements of Technical Specifications (TS) for the 480V Bus Undervoltage System. Event date and time.
2. April 25, 1993, 0600 EDST: Initial startup from the 1993 refueling outage. Testing performed during the outage did not fully comply with the requirements of TS for the Reactor Trip Breaker Logic Channels and manual Containment Isolation actuation. Event date and time.
3. November 22, 1993, 0542 EST: Initiated reactor startup after a brief maintenance outage. Surveillance testing related to NIS Intermediate Range trip bistables did not fully comply with the requirements of TS. Event date and time.

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TEXT CONTINUATION

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4. February 14, 1994, 1000 EST: The PORC determined that testing of the NIS Intermediate Range trip bistables, 480V Bus Undervoltage System, Reactor Trip Breaker Logic Channels, and the Containment Isolation system had not fully complied with the requirements of TS. Discovery date and time.
5. February 14, 1994, 1000 EST: The PORC determined that testing and/or verification of functionality of the NIS Intermediate Range trip bistables, 480V Bus Undervoltage System, and Reactor Trip Breaker Logic Channels, to fully comply with the requirements of TS, had been successfully completed since the identified event dates.
6. February 14, 1994, 1000 EST: One pushbutton for manual Containment Isolation actuation was declared inoperable and the Action Statement for TS Table 3.5-2, No. 4.1.a was entered.
7. February 14, 1994, 1400 EST: RG&E verbally requested NRC Enforcement Discretion related to the failure to test one pushbutton for manual Containment Isolation actuation.
8. February 14, 1994, 1520 EST: RG&E received verbal notification of NRC Enforcement Discretion, provided RG&E also submit a written request.
9. February 15, 1994, 1200 EST: RG&E submitted written request for NRC Enforcement Discretion.
10. February 16, 1994, 1256 EST: RG&E received a facsimile notification, which documented that the NRC would exercise Enforcement Discretion, not to enforce compliance with the requirements of TS Table 4.1-2, No. 9, until 2400 EST on March 6, 1994.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

B. EVENT:

RG&E formed a Technical Specifications Review Team in October, 1993. This team was directed to perform a review of the surveillance requirements contained in TS Section 4 to ensure that there are implementing procedures for every surveillance required by TS. The Review Team completed this review. RG&E expanded the scope of the team to review the identified implementing procedures related to TS Section 4, to ensure that these procedures do, in fact, implement the TS requirements.

On February 14, 1994, at approximately 1000 EST, the Review Team presented their initial findings to the PORC. The PORC reviewed the initial findings of the Review Team, and determined that four violations of the TS had occurred. The PORC confirmed that surveillance test procedures had not fully complied with the requirements of TS Section 4 and notified the NRC Senior Resident Inspector. Since all four TS violations were identified at the same time and by the same method and are the result of the same root cause, the four issues are documented in this Licensee Event Report. The four violations are described below:

1. TS Table 4.1-1, No. 2 (Nuclear Intermediate Range) - The TS requires a test of the NIS Intermediate Range trip bistables prior to startup. Procedure PT-6.2, "NIS Intermediate Range Channels", performs this test by independently testing various sections of the channels, but does not verify that the trip signal will deenergize the reactor trip relay when the trip bistable setpoint is reached. Therefore, the PORC determined that the requirements of TS Table 4.1-1, No. 2, were not fully complied with prior to reactor startups.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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2. TS Table 4.1-1, No. 30 (Loss of Voltage/Degraded Voltage on 480 Volt Safeguards Bus) - The TS requires a monthly Channel Functional Test (CFT) of the Undervoltage (UV) system. A CFT is defined in TS Section 1.7.3 as verifying the "operability including alarm and/or trip functions." The UV system contains logic cards located between the UV relays and associated auxiliary relays which are used to shed the loads from each safeguards bus. Due to their location in the circuit, failure of the logic cards could prevent actuation of the auxiliary relays and prevent operation of the UV system. Monthly surveillance test procedures have been performed, but testing of the logic cards has not been regularly performed as a part of these procedures. Therefore, the PORC determined that the requirements of TS Table 4.1-1, No. 30, were not fully complied with on a monthly basis.
3. TS Table 4.1-1, No. 38A and No. 38B (Trip Breaker Logic Channel Testing) - Procedures PT-32A-SD, "Reactor Trip Logic Test "A" Train" and PT-32B-SD, "Reactor Trip Logic Test "B" Train", are performed during each refueling shutdown, to comply with the requirements of TS Table 4.1-1, No. 38B. Procedures PT-32A, "Reactor Trip Breaker Testing - "A" Train", and PT-32B, "Reactor Trip Breaker Testing - "B" Train", are performed for each train, on an alternate monthly basis, to comply with the requirements of TS Table 4.1-1, No. 38A. These four procedures fully implement the requirements of TS Table 4.1-1, No. 38A and No. 38B, with one exception.

The Review Team identified that PT-32A and PT-32B verify Main Control Board annunciation for the trip logics, and PT-32A-SD and PT-32B-SD do not. PT-32A and PT-32B are performed for each train, on an alternate monthly basis, during power operation. This verification also complies with the refueling outage frequency for testing as specified in TS Table 4.1-1, No. 38B.

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Due to plant conditions, procedures PT-32A-SD and PT-32B-SD (and not PT-32A and PT-32B) are performed prior to startup. Note 2 for TS Table 4.1-1, No. 38A, specifies that the reactor trip breaker logic channel testing "shall be performed prior to startup if testing has not been performed with the last 30 days." Therefore, the PORC determined that performance of PT-32A-SD and PT-32B-SD prior to startup does not fully comply with the requirements of TS Table 4.1-1, No. 38A, when PT-32A and PT-32B have not been performed within the last 30 days.

4. TS Table 4.1-2, No. 9 (Containment Isolation Trip) - The TS requires a test each refueling shutdown to ensure that the Containment Isolation Trip is "functioning". The automatic Containment Isolation trip function is tested every refueling outage by procedure RSSP 2.1, "Safety Injection Functional Test". TS Table 3.5-2, No. 4.1 defines the Containment Isolation function as:

- 4.1.a Manual
- 4.1.b Safety Injection
(Auto Actuation)

The Review Team could not identify a periodic test procedure that tested the individual pushbuttons for manual Containment Isolation actuation. One pushbutton for manual Containment Isolation actuation was utilized to actuate Containment Isolation during the 1993 Containment Integrated Leak Rate Test (ILRT). The PORC determined that failure to perform the surveillance on the other pushbutton within the specified time interval constituted a non-compliance with the Operability Requirements of the Limiting Conditions for Operation (LCO). The PORC notified the Control Room operators, and the Action Statement for TS Table 3.5-2, No. 4.1.a, was entered at approximately 1000 EST on February 14, 1994. The Action Statement required restoration of the inoperable channel to operable status within 48 hours or be in Hot Shutdown within an additional 6 hours, and at Cold Shutdown within the following 30 hours.

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Following a review of electrical drawings, it was concluded that the necessary test has the potential for challenging both trains of engineered safety features. RG&E requested NRC Enforcement Discretion to delay testing of the manual pushbutton until the refueling outage. RG&E received a facsimile of documented notification that the NRC would exercise Enforcement Discretion on February 16, 1994, at approximately 1256 EST.

C. INOPERABLE STRUCTURES, COMPONENTS, OR SYSTEMS THAT CONTRIBUTED TO THE EVENT:

None

D. OTHER SYSTEMS OR SECONDARY FUNCTIONS AFFECTED:

None

E. METHOD OF DISCOVERY:

RG&E formed a TS Review Team in October, 1993, to review TS Section 4 to ensure that there are implementing procedures for every surveillance required by TS, and to review the identified implementing procedures to ensure that these procedures do, in fact, implement the TS requirements. The Review Team reported their initial findings to the PORC on February 14, 1994. The PORC determined that four violations of the TS had occurred.

F. OPERATOR ACTION:

The PORC notified the Control Room operators of the failure to test one pushbutton for manual Containment Isolation actuation. The Control Room operators declared one pushbutton for manual Containment Isolation actuation inoperable at approximately 1000 EST on February 14, 1994, in accordance with TS Table 3.5-2, No. 4.1.a. The 48 hour Limiting Condition For Operation was subsequently extended to 2400 EST on March 6, 1994, by the exercise of NRC Enforcement Discretion.

LICENSEE EVENT REPORT (LER)
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G. SAFETY SYSTEM RESPONSES:

None

III. CAUSE OF EVENT

A. IMMEDIATE CAUSE:

The immediate cause of the four missed surveillances was failure to perform testing to fully comply with the requirements of TS. The PORC concluded that the four identified tests are required by TS Section 4, and tests previously conducted did not fully comply with the requirements of TS.

B. ROOT CAUSE:

The underlying cause of the failure to fully comply with TS requirements was a lack of clearly defined interpretations of the TS wording for the four issues identified by the Review Team. The wording of the TS requirements and bases for these four issues are ambiguous, such that there is interpretation required to ensure full compliance with the TS requirements.

This event is NRC Performance Indicator Program cause code 5.8.1, Administrative Control Problem. There is no NUREG-1022 cause code that accurately classifies this root cause. The closest would be NUREG-1022 (X) cause code, "Other", because the proximate cause has been identified, and this cause (lack of clearly defined interpretation of TS wording) cannot be assigned to one of the five classifications listed in NUREG-1022, Appendix B.

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IV. ANALYSIS OF EVENT

This event is reportable in accordance with 10 CFR 50.73, Licensee Event Report System, item (a) (2) (i) (B), which requires a report of, "Any operation or condition prohibited by the plant's Technical Specifications". The four issues identified by the Review Team were determined by the PORC to be failures to fully comply with the surveillance requirements of TS Table 4.1-1, No. 2, No. 30, and No. 38A, and TS Table 4.1-2, No. 9. This constitutes a condition prohibited by the Ginna TS.

An assessment was performed considering both the safety consequences and implications of not fully complying with the requirements of TS for the four identified issues, with the following results and conclusions:

- A. The failure to fully comply with the surveillance requirements for the NIS Intermediate Range trip bistables did not affect the public's health and safety because:
- The NIS Intermediate Range trip signal will deenergize the reactor trip relay when the trip bistable setpoint is reached. Verification that a trip signal would deenergize the reactor trip relay when the trip bistable setpoint is reached can be accomplished by confirming that Main Control Board status lights are appropriately illuminated, when the NIS Intermediate Range is tripped at power.
 - Operators verify these status lights every shift, per procedure O-6.13, "Daily Surveillance Log". This verification was performed immediately following the startup from the brief maintenance outage in November, 1993, and continues to be performed every shift. No failure of the status lights (and the continuity from the trip bistable to the reactor trip relay) has been observed.
 - There are no active components located between the trip bistable and the reactor trip relay. There is a high degree of reliability that continuity exists.

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B. The failure to fully comply with the surveillance requirements for the 480V Bus Undervoltage System did not affect the public's health and safety because:

- Prior to January 13, 1994, the UV logic cards were tested on an annual basis as part of the diesel generator autostart UV logic tests.
- The UV logic cards had been tested by upgraded procedures on January 13, 1994. Consequently, the logic cards were tested within the required one month surveillance interval at the time of discovery.
- The logic cards are replaced and/or refurbished every four years as part of the Reliability Centered Maintenance (RCM) Program. Four years is less than the Mean Time Between Failure (MTBF) for these components. Therefore, the logic cards could be expected to perform their function if needed.

C. The failure to fully comply with the surveillance requirements for the Reactor Trip Breaker Logic Channels did not affect the public's health and safety because:

- Sufficient procedural guidance exists in the Emergency Operating Procedures which provide instructions for operators in the event that expected annunciator windows do not acknowledge a reactor trip.
- One train of the Reactor Trip Breaker Logic Channels is tested each month during power operation, on an alternate monthly basis, such that each train is tested every two months. Consequently, there was at most one month in which the annunciators for both trains of reactor trip breakers were not tested and two months in which the annunciator for one train was not tested.
- Verification of the Main Control Board annunciation was accomplished by the performance of procedures PT-32A and PT-32B in the first two months after the 1993 refueling outage.

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

- D. The failure to fully comply with the surveillance requirements for manual Containment Isolation actuation did not affect the public's health and safety because:
- Manual Containment Isolation is a backup that would be needed if two independent automatic Containment Isolation actuation channels (from Safety Injection) failed.
 - One of the two manual Containment Isolation pushbuttons had been verified to be operable during the 1993 refueling outage. This pushbutton actuates both trains of Containment Isolation.
 - All automatic Containment Isolation valves had been verified to be operable by stroke testing, and therefore there was high confidence that the operators could remotely close all affected Containment Isolation valves from the Control Room, if required.
 - Based on the simple mechanical design of the pushbutton, there is a reasonable degree of confidence that the pushbutton will operate if required.
 - The NRC concurred with RG&E's assessment, and exercised Enforcement Discretion for this issue on February 16, 1994.

Based on the above, it can be concluded that the public's health and safety was assured at all times.

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V. CORRECTIVE ACTION

A. ACTION TAKEN TO RETURN AFFECTED SYSTEMS TO PRE-EVENT NORMAL STATUS:

1. The NIS Intermediate Range bistable circuits were reviewed to verify that the trip signal would deenergize the reactor trip relay when the trip bistable setpoint is reached. The PORC concluded that, since the plant was currently at power and the NIS Intermediate Range channels were both tripped, proper illumination of the Main Control Board status lights provided sufficient verification that continuity existed between the trip bistable and the reactor trip relay. Therefore, the PORC declared that adequate verification had occurred, and that actions taken assured compliance with TS requirements.
2. The testing of the UV logic cards had been under consideration since 1993, due to ongoing concerns for the reliability of the logic cards and reevaluation of the long-term commitments related to LER 91-008. (Refer to Ginna Docket No. 50-244, LER 91-008.) Based on this reevaluation, the UV system monthly surveillance test procedures were upgraded on January 12, 1994, and the UV logic cards were tested by these upgraded procedures on January 13, 1994. Consequently, the logic cards were tested within the required one month surveillance interval at the time of discovery. Therefore, the PORC declared that adequate testing had occurred, and that actions taken assured compliance with TS requirements.
3. PORC concluded that the verification of the Main Control Board annunciation for the Reactor Trip Breaker Logic Channels was accomplished by performance of procedures PT-32A and PT-32B in the first two months after the 1993 refueling outage. PT-32A was performed on May 3, 1993, and PT-32B was performed on May 24, 1993. These procedures continued to be performed, on an alternate monthly basis. Therefore, the PORC declared that adequate testing had occurred, and that actions taken assured compliance with TS requirements.

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4. The NRC exercised Enforcement Discretion, not to enforce compliance with the requirements to test one Containment Isolation pushbutton. Operations management also provided additional guidance to the Control Room operators, by the Operations Plan, that if manual Containment Isolation were required, and if one pushbutton did not actuate Containment Isolation, to use the other pushbutton.

B. ACTION TAKEN OR PLANNED TO PREVENT RECURRENCE:

- For the wording of the requirements of TS Section 4 that were not clearly defined, documented interpretations have been prepared. These interpretations will be submitted to the PORC for approval.
- RG&E has committed to implement Improved Technical Specifications (NUREG-1431). The Technical Specification Improvement Program (TSIP) will consist of upgrading the current Ginna Station TS consistent with industry standards for format and bases content.
- Procedure RSSP-2.1, "Safety Injection Functional Test", has been upgraded to formally document the testing of both manual Containment Isolation pushbuttons.
- Procedure PT-6.2, "N.I.S. Intermediate Range Channels", has been upgraded to include documented verification that the channel circuit continuity from the trip bistable to the reactor trip relay is tested.
- Procedures PT-32A-SD and PT-32B-SD have been upgraded to include documented verification of Main Control Board annunciators during testing of the Reactor Trip Breaker Logic Channels.

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VI. ADDITIONAL INFORMATION

A. FAILED COMPONENTS:

None

B. PREVIOUS LERs ON SIMILAR EVENTS:

A similar LER event historical search was conducted, with the following results:

- LER 83-018, Failure to Perform Surveillance Testing on the Residual Heat Removal Pumps, due to failure to properly incorporate new TS requirements into the existing test program.
- LER 90-014, Pressurizer Relief Valve Inoperability During Defeat of Pressurizer Channel, due to failure to apply a rigorous interpretation of the TS definition of operability.
- LER 91-008, One Train of UV Inoperable, due to circuit design.
- LER 93-005, Failure to Perform Surveillance, due to misinterpretation of TS.

LER 83-018 was a similar event, but with a different root cause. LER 90-014 was a different event, but with a similar root cause as this report. The corrective action was limited to maintenance and calibration procedures. LER 91-008 was a different event with a different root cause, but involved failure of the UV system logic card, which has not been tested monthly, as identified in this report. LER 93-005 was a similar event with a similar root cause, and resulted in formation of the Review Team, which directly resulted in the identification of the missed surveillances documented in this report.

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C. SPECIAL COMMENTS:

RG&E formed the TS Review Team, with representation from Ginna Station (Technical Engineering, Results and Test, Maintenance Support Services) and corporate engineering (Nuclear Safety and Licensing). Where necessary, specific discipline knowledge was solicited. The members included two individuals who held NRC Senior Reactor Operator (SRO) certification, and a third who held a Reactor Operator (RO) license. The Review Team collectively spent over five hundred (500) man-hours in this self-assessment program, identifying and reviewing procedures which implement TS surveillance requirements.

RG&E began considering a Technical Specification Improvement Program (TSIP) in the summer of 1993, following requests from the plant (Operations and Technical Engineering). Discussions were initiated between RG&E and the NRC in October, 1993, to refine the scope and goals of the TSIP. Following further discussions with the NRC in early February, 1994, RG&E committed to the upgrade effort. (Refer to a letter from RG&E (R.C. Mecredy) to NRC (A.R. Johnson), dated February 28, 1994.) The TSIP for Ginna Station began on March 1, 1994, with the objective of implementing TS which are standardized to current industry criteria and which provide a significant human factors improvement over the current Ginna TS. This includes an upgrade of the TS bases to support all specifications and testing requirements. RG&E recognizes the importance of this program, and has committed significant resources from the plant (Operations and Technical Engineering), Training, and Nuclear Safety and Licensing. Ginna Station is one of the first nuclear plants to commit to the Improved TS and believes that the TSIP will resolve many of the issues identified by the Review Team.