Use ACEMAN during U1R28 – a message from Gary VanMiddlesworth

The foundation of Point Beach Excellence is Individual Excellence. Our path to Excellence is based on every individual/employee understanding *our* Picture of Excellence and how their actions and behaviors integrate into the picture.

Part of demonstrating the picture requires employees to exemplify the six basic individual results. These six basic individual results outline what each one of us, individually, can do to support Point Beach.

Accident Free
Control Dose
Event Free
Meet Schedule
Attend Training
No Rework

I'd like to review some of the events we've had during this outage that demonstrate the importance of individual performance and the impact it has on our overall results.

Letdown gas stripper secured early (CAP055326)
The Unit 1 Letdown Gas Stripper was inadvertently removed from service too early. The Reactor Coolant System hydrogen gas concentration was well above its limit.

Why did it happen? There was a lack of knowledge in the outage schedule, in addition to a lack of communication verifying/validating that the system should be secured.

The gas concentration in the RCS was specifically discussed at the 0600 OCC meeting the day before this event. The gas concentration was high and site management was assured that the letdown gas stripper system would resolve the issue. Later that night the system was secured with gas concentration still high.

Individual results not met: Event free, Meet schedule and Rework

Steam generator nozzle dams (CAP055538)
The potential was there to not have a hot leg vent path during the installation of Unit 1 steam generator nozzle dams.

Management communicated at the 0600 OCC turnover meeting the importance of ensuring the hot leg vent path was maintained. In addition, regulatory commitments clearly state in Generic Letter 88-17 and NUREG-1449 the requirement for a hot leg vent path. A hot leg vent path is and was sequenced correctly in the U1R28 outage schedule as follows:

* Remove hot leg S/G man ways
* Remove cold leg S/G man ways
* Install cold leg nozzle dams

* Remove pressurizer man way (hot leg vent path)
* Install hot leg nozzle dams

We encountered some difficulties in removing the pressurizer man way, which would have established the hot leg vent path. At this point individuals decided to deviate from the schedule and proceed with the installation of the hot leg nozzle dams – while developing a plan to remove the pressuizer man way.

Why did it happen? Employees were performing in the knowledge base area and proceeded in the face of uncertainty. We should have stopped, got the right people together to adhere to the schedule.

Individual results not met: Control dose, Event free, Meet schedule and Rework

Bolted fault work; opened wrong breaker during lineup
During preparations for the Bolted Fault modification, the incorrect breaker was opened, which resulted in the loss of the 'A' Spent Fuel Pool cooling pump.

An employee was performing the lineup needed for the modification work to begin. The correct breaker was identified, the control room was notified, and **then** the worker opened the breaker next to the correct one.

Why did it happen? Inattention to detail, failure to self-check, and the lack of obtaining a peer check were a few of the major contributors.

As a result, the work was stopped and the modification was removed from the outage. We later placed the modification back into the outage schedule. As a result of removing the work and reinserting it – additional time was added to the outage.

Individual results not met: Event free, Meet schedule and Rework

Polar crane failures
A growling noise was identified on the auxiliary and main hook of the polar crane. This noise was noticed during previous outages; however, with the heightened emphasis on "doing things right" the organization decided to investigate and fix the issue. **THIS IS THE RIGHT BEHAVIOR!**

However, troubleshooting and repair communications (between days and nights) resulted in rework.

Why did it happen? We did not implement the Issue Manager process to establish a single point of ownership. This resulted in plans being changed depending on who was on shift, poor communications also contributed to rework.

Individual results not met: Meet schedule and Rework

Reactor head lift; bullet nose inadvertently lifted (CAP055951)
During the Unit 1 reactor head lift, one incore thermocouple guide (bullet nose) was inadvertently lifted along with the head. This prevented cavity flood up.

A white rag used as a temporary FME barrier while preparing the thermocouple penetration for the head lift was inadvertently left. The rag had jammed in the annulus between the T/C bullet nose guide and the head penetration; this caused the guide to be lifted with the head instead of slipping through it and remaining on the upper internals.

Why did it happen? Past practices used the rag as an FME barrier. There wasn't a formal (such as a procedure requirement) barrier in place to ensure it was removed.

Individual results not met: Control dose, Event free, Meet Schedule and Rework

These examples illustrate the importance of individual performances in regards to the Point Beach Picture of Excellence.

It is important to remember: **EVERY TASK, EVERY JOB, EVERY DAY, EVENT FREE.**

By using the Picture of Excellence we *will* do the job right the first time! Remember to use the individual results associated with ACEMAN.

Gary Van Middlesworth