





April 6, 2004

Nuclear Protected Train or Equipment: 

No Protected Equipment at this time.

Accomplishments & Challenges:

- B Train ESFAS Testing
- B Train ESFAS Testing Restoration
- 2B03/B04 480V Bus Tie Breaker Setup and Installation
- A Train ESFAS Testing Preparations


Personnel safety 

Last 24 Hours	Outage to Date
Recordable - 0 Disabling - 0	Recordable - 0 Disabling - 0

No reported injuries.

Schedule Focus Areas/Priorities

- A Train ESFAS Testing
- S/G Safety Valve Header Machining
- A Train ESFAS Testing Restoration
- Drain S/G Tubes
- Enter Reduced Inventory
- S/G Eddy Current Testing
- Refueling Preparations

ALARA 

Last 24 Hours	Outage to Date
5.041 rem	4.821 rem

Dose as of the end of Day 2.
Dose exceeded projected due to BMI project being ahead of schedule.

Message from Outage Director

Lessons Learned are very important to the success of the outage. We need everyone's help to be successful. They will help us improve our performance this outage and in outages to come. Please submit your improvement suggestions as follows:

- 1) Call the OCC Hotline at x7190 and choose Option 2. Leave a voicemail with the information.
- 2) Fill out a PBF-9802 and email it to the Lessons Learned Coordinator (Cindy Haefke), or print and mail.
- 3) Initiate a CAP or a Non CAP OTH as appropriate to the circumstance using the Team Track corrective action

U1R28 Today
This daily publication is provided during U1R28 for employee information and for use as a supervisor briefing tool.

OUTAGE GOALS

NUCLEAR SAFETY PERFORMANCE	GOAL	ACTUAL
Unplanned orange/red paths	None	None
Reactor trips (either unit)	None	None
Safeguards actuation (either unit)	None	None
Loss of shutdown cooling	None	None
Loss of Rx vessel level control	None	None
INDUSTRIAL SAFETY PERFORMANCE		
Lost time accidents	None	None
Personnel Injuries (OSHA recordable)	None	None
RADIOLOGICAL PERFORMANCE		
Radiation exposure (Excludes additional dose from any head or BMI repair contingencies)	≤ 75 R	5.041 R
Personnel contaminations	≤ 18 w / >5K CPM	0
Radiological events (defined as unplanned uptake w/assigned dose >10 mrem or dose event based on ED alarms)	≤ 1 event	1
Radmaterial event (defined as any rad material outside RCA ≥ 100 CPM)	≤ 1 event	0

HUMAN PERFORMANCE	GOAL	ACTUAL
Security Violations	≤ 12 loggable events	0
Station human performance clock resets	None	0
Rework	≤ 1%	<1%
SCHEDULE PERFORMANCE		
Outage Duration(excludes extensions due to extended head or BMI inspections)	≤ 30 days	12 Hrs Late
Mod Implementation	100% of Rev 0	On schedule
Schedule Compliance	> 85% schedule compliance with outage milestone	On Goal
Emergent work (during implementation)	≤ 2% late additions ≤ 5% Emergent	On Goal
Scope	Complete ≥ 95% of Rev 0 scope	On Goal
Operator Burdens	100% of Scheduled Operator Burdens complete	On Schedule
Post Outage availability	≥ 150 days of continuous operation	Available at a later date
BUDGET PERFORMANCE	Within -2% to 0% of outage budget	On Budget



JOURNEY OF EXCELLENCE
FOUR BEARS - THREE

Safety Snippet

Report and repair or someone may despair

OE17263 Comanche Peak - A worker leaned back in his chair when the screws holding the back of the chair to the body separated and he fell back to the floor. Examination of the chair found that only a single screw was holding it together. By someone not reporting this situation, a lost time accident occurred.

Human Performance

Names and numbers can be similar; make sure that you are really familiar.

CAP 32226 documents a situation where SW-534 opened instead of WT-534. The valves have the same number but different system ID and are within inches of each other. **Prior to Act - Physically touch the equipment without actuating it. While still touching the equipment, confirm that it is the correct equipment, per reference to the component label.**

Operating Experience

Loss of Incore Thermocouples at Prairie Island

Maintenance personnel were disassembling instrument port conoseals on the Reactor Vessel Head when the Control Board Operator detected the loss of Rx Head Temperature Indication. The loss of indication occurred because the wrong connector was made up without checking the indication prior to the next set of T/C's being disconnected. The cause of the event was a less than adequate prejob briefing and an inadequate procedure. The procedure was revised to ensure temperatures were verified as working properly prior to proceeding disassembling the next conoseal.



Contact Information

Control Room Emergency - x2911
EMT Pager 6442
Work Control Center - x6703
OCC - x 7190 - Option 1
Lessons Learned - x7190 - Option 2
Plant Status - x7190 - Option 3