

Point Beach Nuclear Plant  
U1R28  
OCC Interactive Turnover

Meeting Agenda  
Friday, April 9, 2004

Start Time: 0600 1800

NSB 217

<b>Attendees:</b>	Shift Outage Directors (SOD)	Rad Protection Manager (RPM)
	Shift Outage Managers (SOM)	Chemistry Manager
	Operations Coordinators (SOC)	IC General Supervisor
	Maintenance Coordinators (MOC)	Electrical General Supervisor
	Engineer Coordinators (EOM)	Mechanical General Supervisor
	Major Project Coordinators (MPC)	Supply Chain Manager
		Installation Services General

Expected Duration: 30 Minutes

- Agenda:**
1. Safety Issue Discussion (SOD)
  2. RP Status (RPM)
  3. Plant Status / Operations Coordinator Turnover (SOC)
  4. Shutdown Safety Assessment (SOC)
  5. Maintenance Coordinator Turnover (MOC)
  6. Engineering Coordinator Turnover (EOC)
  7. Major Projects Coordinator Turnover (MPC)
  8. Rapid Trending Assessment (NOS)
  9. Action Item Review (SOM)
  10. Critical Path (SOM)
  11. Shift Goals (SOM)
  12. ACEMAN Assessment (SOM)
  13. Final Comments (SOD)

**Items Included in Daily Package:**

- Safety Snippet
- Outage Alara Report
- Daily Outage Status Report
- Shutdown Safety Assessment
- Workdown Curves
- Contractor Mobilization/Demobilization
- Medium/High Risk Activities
- Defined Critical Path Review
- Daily Outage OE

Information in this record was deleted  
in accordance with the Freedom of Information  
Act, exemptions 4  
FOIA # A-2004-0282

## Point Beach Nuclear Plant U1R28 Refueling Outage

Safety Topics for week of April 4-10, 2011
Theme for the week
This week's theme is <b>Close Calls</b> or more specifically, what we call near misses. Learning from close calls should be looked on as golden opportunities to prevent actual accidents. Let's not miss out on this opportunity.
Work Daily Safety Shippets
Sunday
<b>"Fix the danger-save a stranger"</b> OE from U1R27 – A compressed gas cylinder in containment stored in a walkway, was not secured. The cylinder was bumped by a worker and fell over. Fortunately a co-worker noticed the situation and caught the cylinder before any damage could be done. Are all of our compressed gas cylinders secured?
Monday
<b>"When you fail to report a hazardous condition, you may contribute to employee attrition"</b> <u>Near-miss failure story:</u> A co-worker is using a ladder. It seems fine, but as he comes down, one of the rungs sags as he steps on it. He notices a crack. He puts the ladder back without tagging it as needing repairs. The next day you grab the same ladder. As you start to climb you put your foot through the rung, lose your balance and fall, spraining your ankle. Do you check your ladder before you climb?
Tuesday
<b>"Report and repair or someone may despair"</b> 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.
Wednesday
<b>"Sidestepping a hazardous condition leaves others at risk of hospital admission"</b> A worker was attempting to remove a water tank from a piece of heavy equipment. He was removing some bolts not realizing that they were the only support for the heavy tank itself. When the last bolt came out, the 1,200-pound tank fell on the victim, crushing his chest. He never regained consciousness, and died of the injuries. Investigation showed two years before, a similar incident had occurred involving another worker. The worker involved had escaped with only a bad scare but the condition was not corrected.
Thursday
<b>"Your neglect could result in his broken neck"</b> OE17264 Comanche Peak – Truck entering the parking lot struck a pedestrian, knocking him to the ground. Luckily the person was not injured. The pedestrian was walking in an open area and thought the driver had given him the right of way. However the driver of the truck did not see him. Has a near miss like this happened at PBNP?
Friday
<b>"Ignoring safety in any way may cause someone else to pay"</b> OE17626 TMI – During the disassembly of a RCP snubber a technician suffered the loss of the fingertip. A coworker shifted the position of the snubber cylinder and did not realize the technician's finger was in the assembly.
Saturday
<b>"Most obituaries would not be recorded if all close calls were reported"</b> <u>It happened at Prairie Island:</u> A year ago, somebody damaged one of the roll-up doors with a hydraulic lift. Unfortunately the employee failed to report this mishap and later the door fell narrowly missing another employee. This time we were lucky however the whole thing could have been avoided if only the damaged door were identified and repaired.



# Point Beach Nuclear Plant Outage 1R28

DAY 4

## Supporting Operational Excellence

## Outage Radiation Performance

Path



Picture

Meets



Doesn't Meet Exceeds

### Definition/Goal

This indicator measures cumulative dose radiation exposure and total number of personnel-contamination events (PCE's > 5000 cpm) during refueling outages. The dose indicator is measured in Rem and individual PCE events.

### Analysis and Actions

Day 4 - April 7  
Actual = 2.110  
Cumulative = 14.256  
Cumulative Forecast = 14.483

Received more dose than expected for a valve packing job in the regen Hx area.

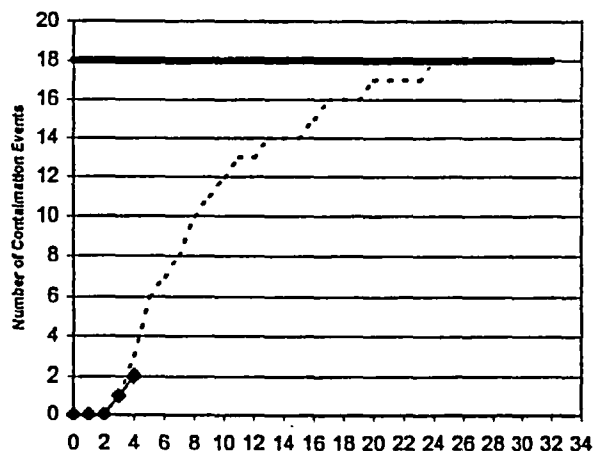
PCE #2 recorded 4/7/04 - Individual was removing scaffolding in Unit 1 Containment Keyway. Found to have 8,000 cpm contamination on his hand plus lower doses on his arm, modesty top and bottom. Actions were taken to remove the contamination. CAP written.

Meets: <=75 Rem Actual Cum.  
Exceeds: <=71 Rem Dose: 14.256 Rem  
Meets: <= 18 Exceeds: <= 12 Actual PCE's: 2

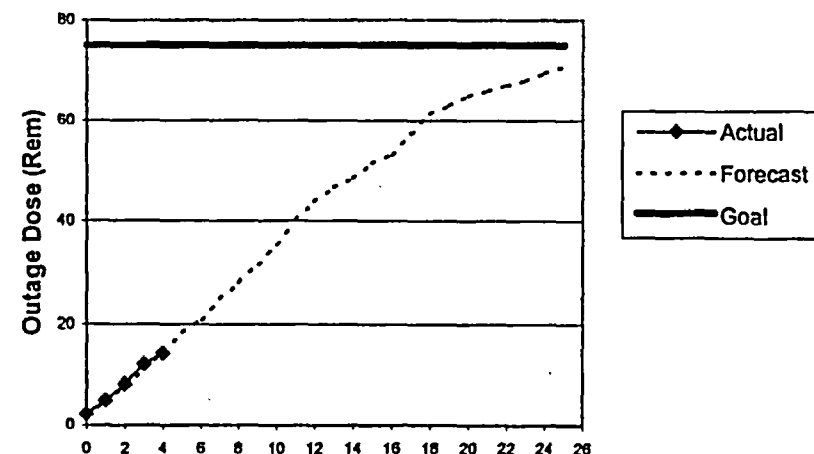
### Responsible Manager/Owner

Stu Thomas

Personnel Contamination Events



Cummulative Dose Exposure



# Outage Status Report

142B 005

Plant: Point Beach Unit 1 Day: Friday Today's Date / Time: 4/09/04 / 0400

Outage Duration: Day 6 of 28

## Safety Status

### Industrial

OSHA Recordables in last 12 hours 0 First Aid cases in last 12 hours 0 Significant near misses 0  
Total for this outage 0

Summary:

### Radiological

Dose outage to date 14.256 Projected to date 14.483 Outage Goal <75 R  
Difference -227 Number of PCEs 4

Summary: On Forecast

### Nuclear

Significant human performance errors and events in last 24 hours 0

Summary:

- None

## Plant Status

Mode: ☐ Hot Standby (Mode 3) ☐ Hot Shutdown (Mode 4) ☐ Cold Shutdown (Mode 5) ☒ Refueling Shutdown (Mode 6)  
RCS: Temperature: 104 Pressure: Vented to Atmosphere RV Level: 25%  
Time to Boil: 28 Minutes

## Shutdown Safety Assessment

Reactivity: Green Core Cooling: Orange Power Availability: Green  
Containment: Green Inventory: Orange Spent Fuel Pool Cooling: N/A

## Protected Equipment:

## Major Activities Completed in Last 24 Hours Critical Path and Near Critical Path Activities (Next 24 Hours)

Removed Conoseals	Schedule: 26 Hrs Behind - Based Rx Head Lift @ 1100 4/10/04
Drained Steam Generator Channel Heads	Exit Reduced Inventory
Steam Generator Primary Manway Removal	Refill RCS to 70% RX Vessel Level
Replace ISI-845A	Remove Rx Head Studs
Rx Head Detension - Mode 6	Move 1PIB RCP Motor to Stand
Nozzle Dam Installation in progress	Install Cavity Seal Ring
Manipulator Repairs	Rx Vessel Head Left Head Lift

## Significant Outstanding Issues

Date	Issue	Due Date	Responsibility
4/03/04	Repair Blowdown Tank Leakage	4/15/04	Scott Manthei
4/04/04	IP2A Charging Pump Troubleshooting (After Orange Path)	4/10/04	Mike Schug
4/08/04	Z-16 Reactor Cavity Fuel Manipulator	4/09/04	Bill Herrman
4/08/04	Incorporate Lessons Learned from 1 <sup>ST</sup> Reduced Inventory Orange Path	4/18/04	Dave Dyzak

## Upcoming Major Milestones

	Scheduled		Actual			Scheduled		Actual	
	Date	Time	Date	Time		Date	Time	Date	Time
Cooldown <200°	4/03/04	2100	4/03/04	2230	Heatup >200°	4/25/04	0900		
Head Lift	4/09/04	0900			Initial	4/28/04	1100		
Refueled	4/14/04	0300			On-Line	4/30/04	0100		

Point Beach Nuclear Plant  
PBNP SHUTDOWN SAFETY ASSESSMENT AND FIRE CONDITION CHECKLIST

OUTAGE SAFETY ASSESSMENT

UNIT: 1

DATE: April 9, 2004

TIME: 0100

KEY SAFETY FUNCTIONS:

REACTIVITY: GREEN

POWER AVAILABLE: GREEN

CONTAINMENT: GREEN

CORE COOLING: ORANGE

INVENTORY: ORANGE

SFP COOLING: NA

PROTECTED EQUIPMENT:

COMMENTS:

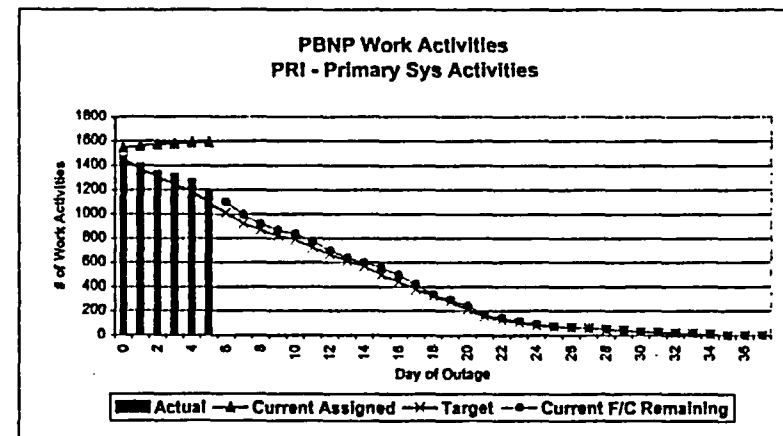
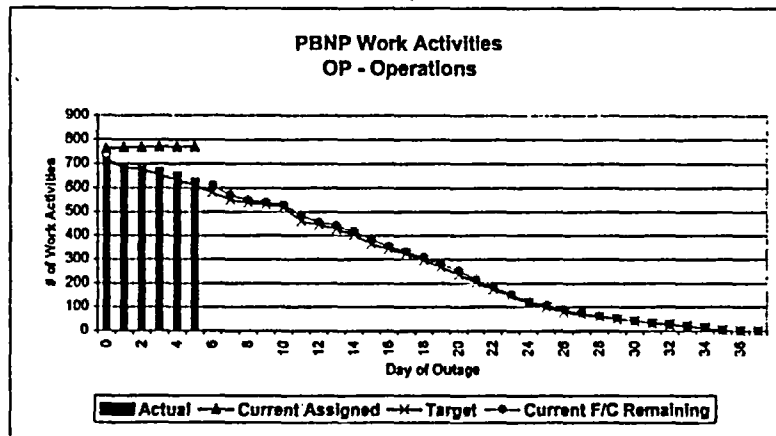
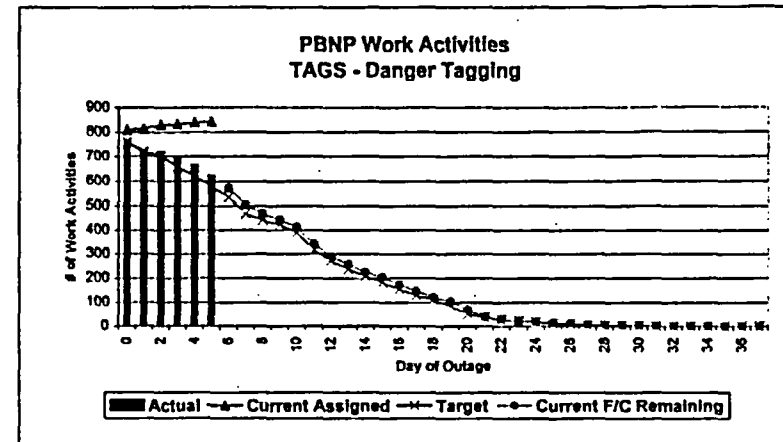
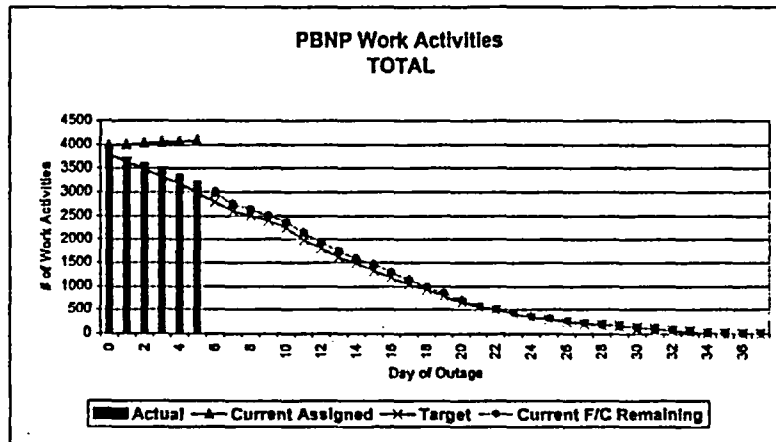
Fire Protection Condition III: Credit taken for fire rounds  
RCS Time to Boil is 28 minutes  
RCS is in Reduced Inventory

ex4

# PBNP U1R28 Workdown Curves

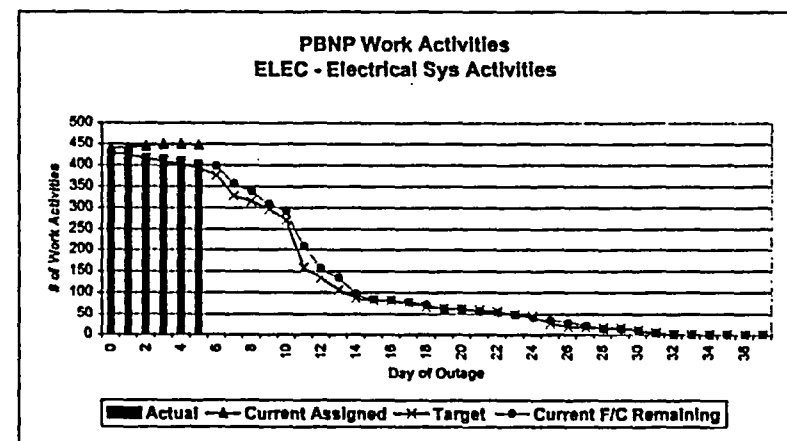
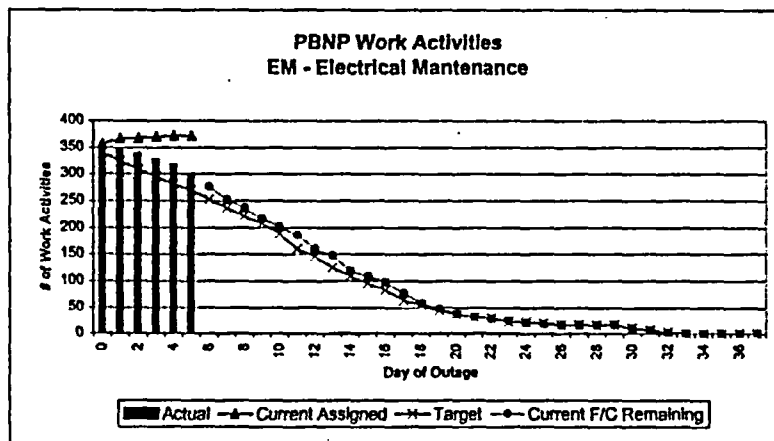
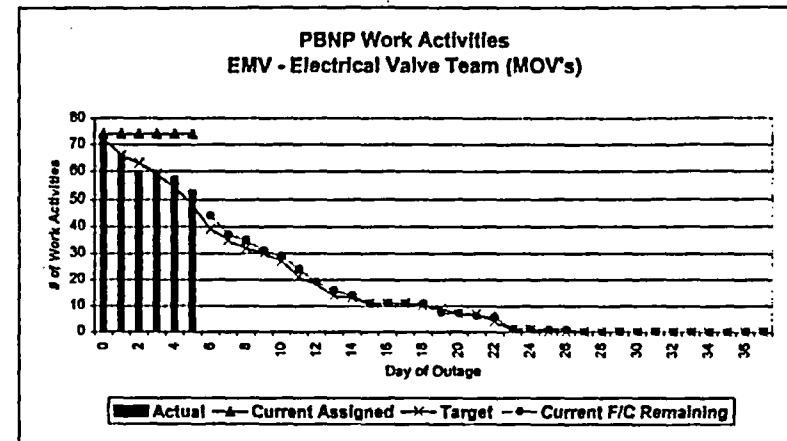
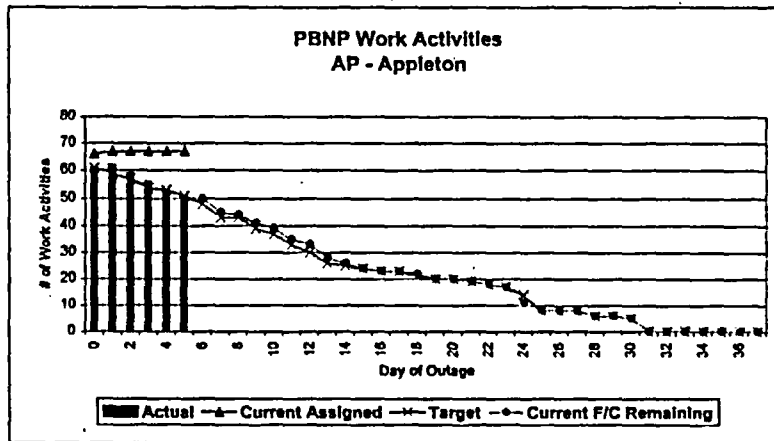
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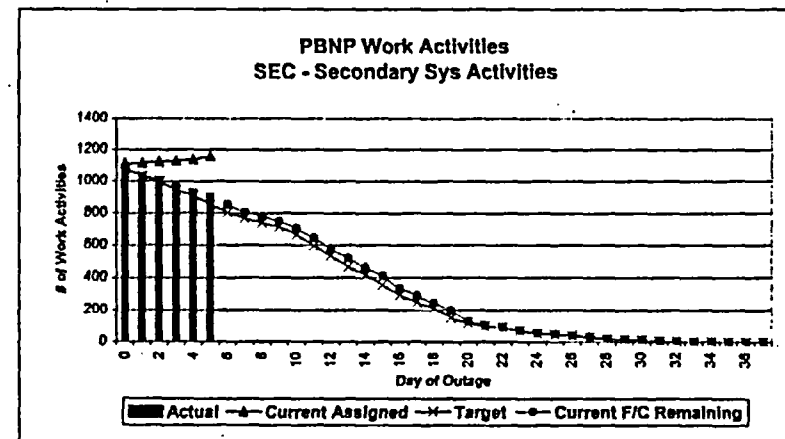
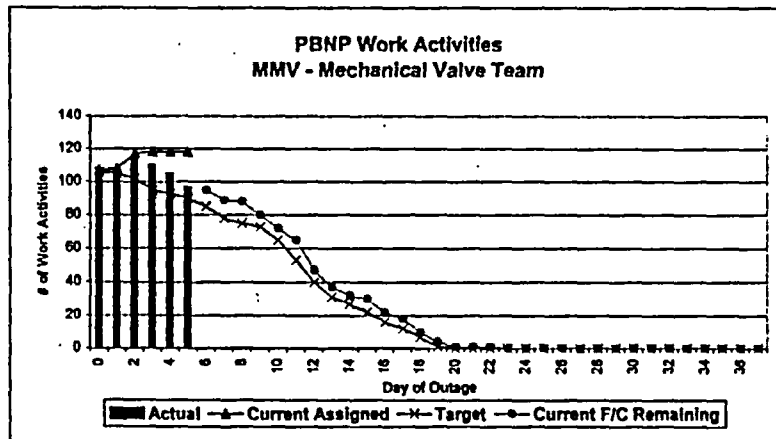
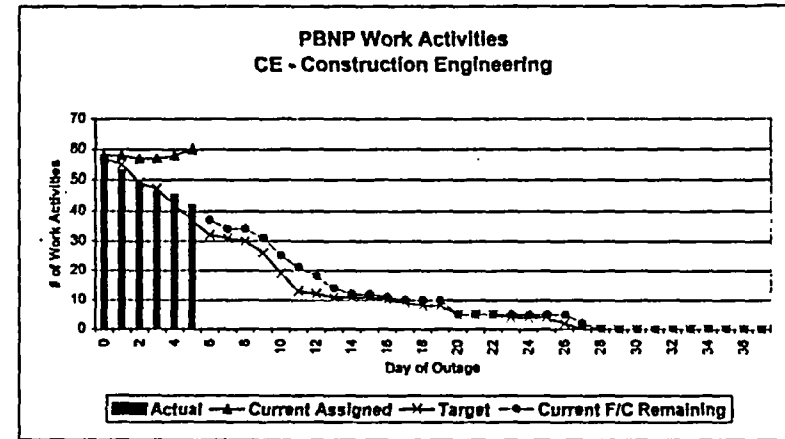
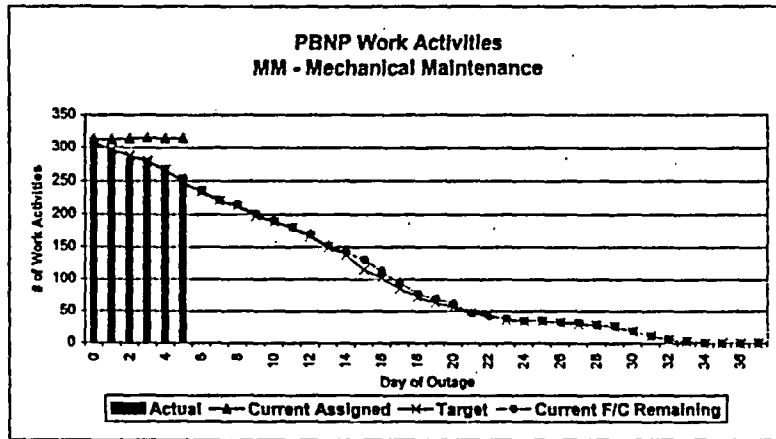
# PBNP U1R28 Workdown Curves

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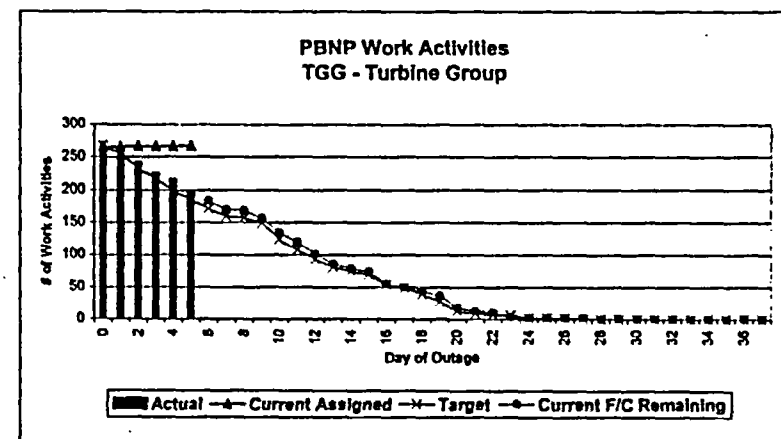
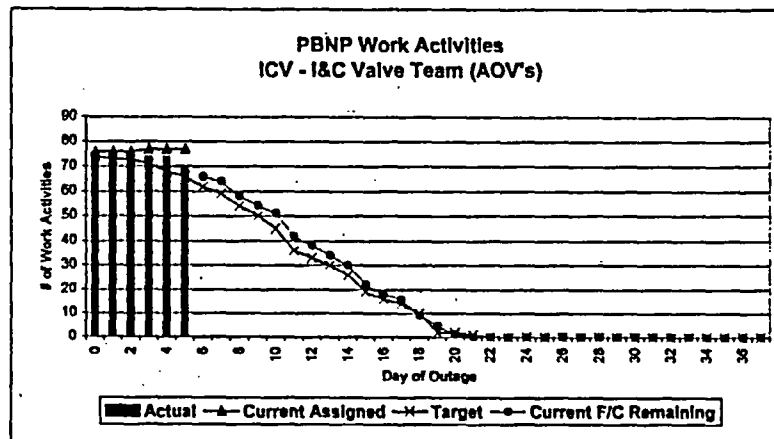
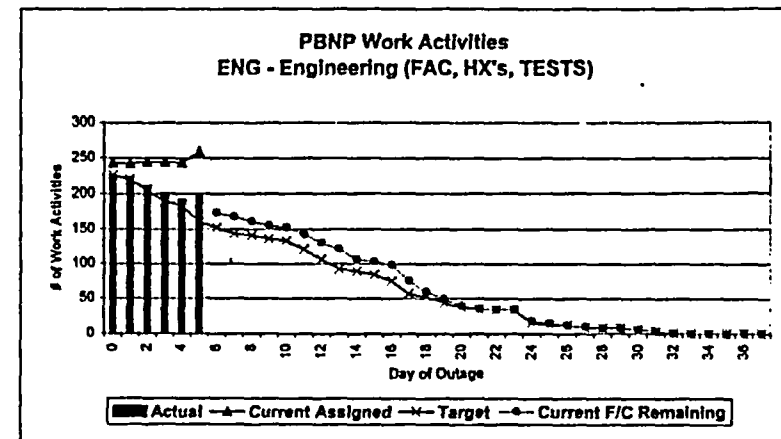
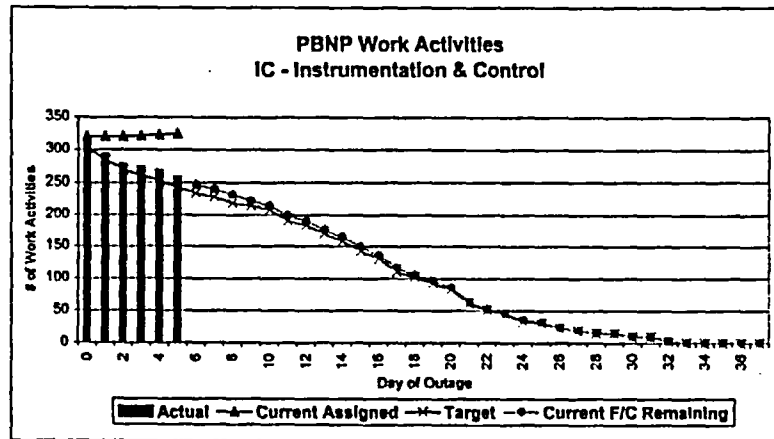
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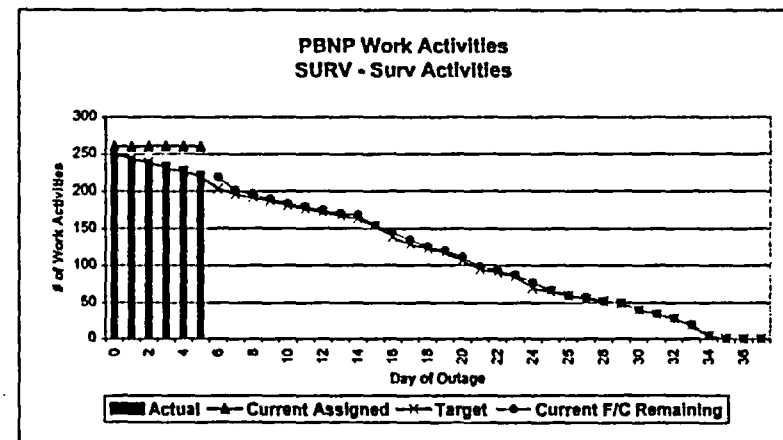
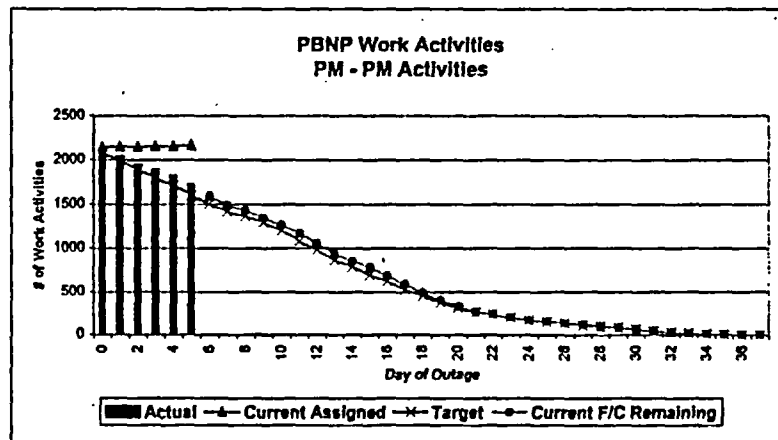
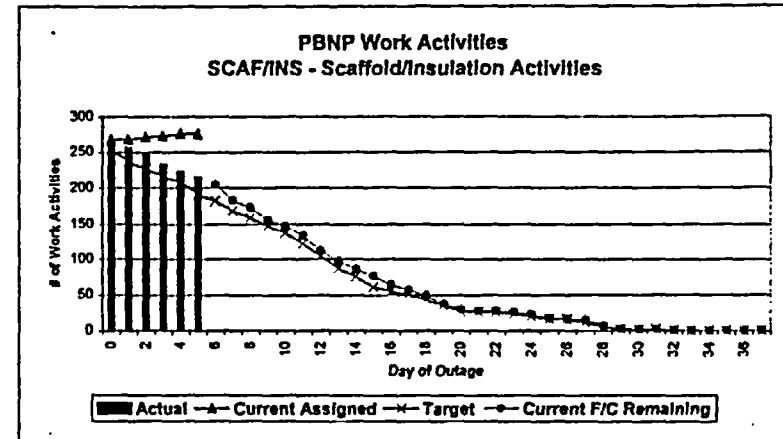
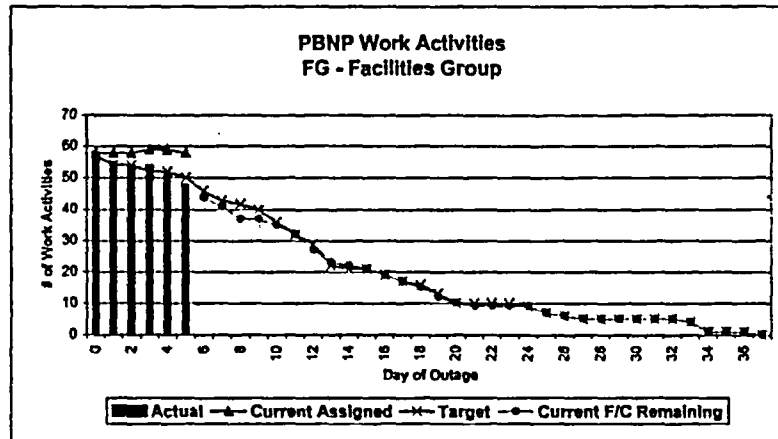
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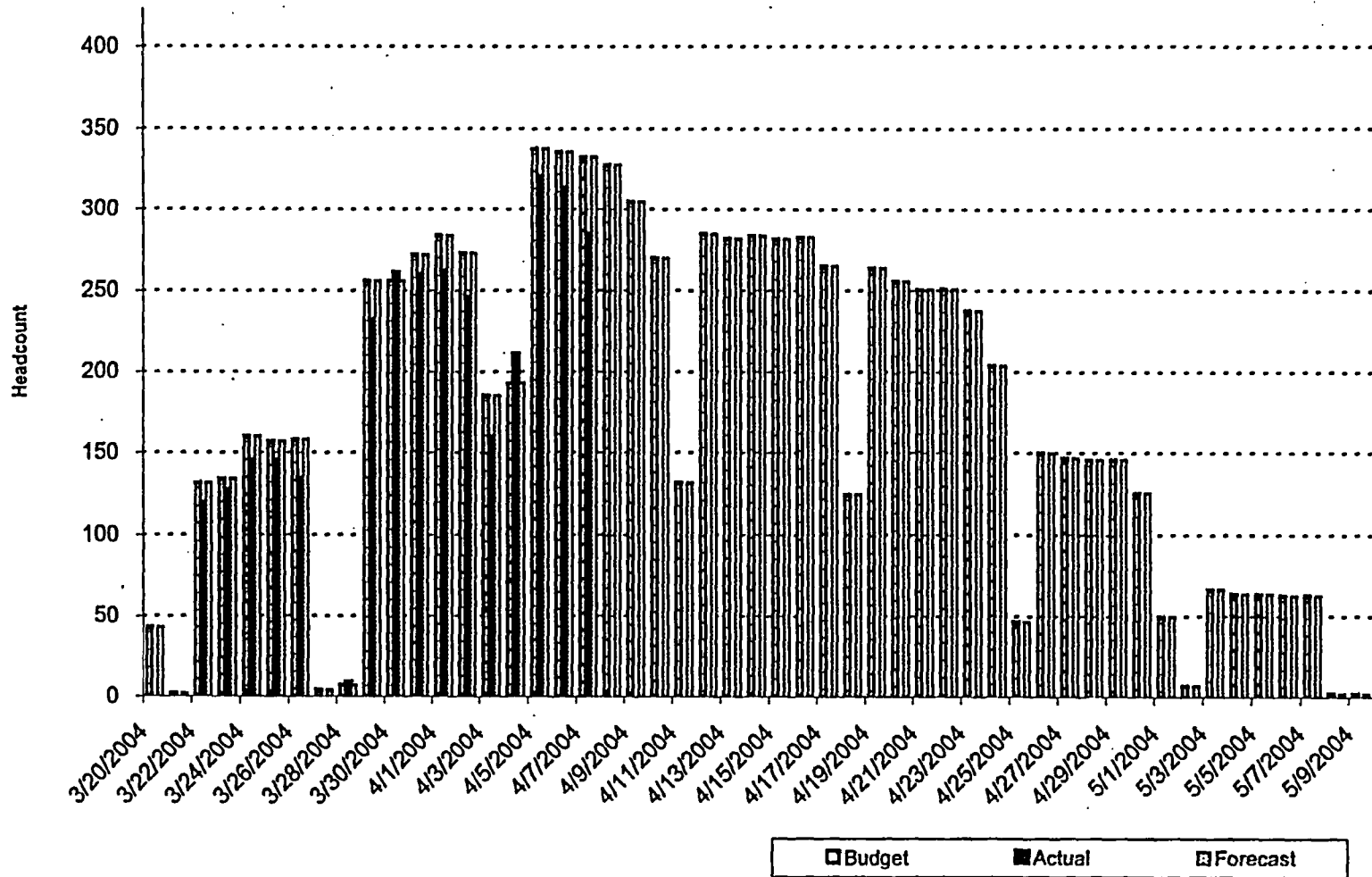


# PBNP U1R28 Workdown Curves

4/8/2004



**Contractor Mobilization / Demobilization**  
**Total Site**  
**04/08/04**



## Point Beach Nuclear Plant U1R28 Operating Experience

*Friday, April 9, 2004  
(for work Sunday, April 11, 2004)*

**OE subject:**

SER 1-04 Continued Problems with Unplanned External Radiation Exposures

**Purpose:**

Provide a reminder to personnel that they are the first line of defense for dose monitoring and control.

**Why we chose this OE for today:**

Reinforce expectations for achieving dose ALARA

**Discussion:**

INPO in publishing SER 1-04 has identified multiple events, including three significant events involving unplanned external radiation exposure. Among the causes of these events were the following: station requirements were not followed (sometimes deliberately violated); difficulties existed in monitoring personnel exposure; stay times were not used; communication problems were noted between radiological protection personnel and workers; and management and supervisory involvement was lacking.

The difficulties with monitoring personnel exposure included problems with the use of telemetry equipment and workers not monitoring their own exposure. In two of the events placement of personnel dosimetry (such as inside of Protective Clothing) inhibited periodic self-monitoring. Workers not hearing dosimeter alarms was also a factor. Workers could not hear the alarms associated with their personal electronic dosimetry in all three events. Area noise conditions were factors at two of the sites involved. The workers at one of the sites were also wearing headsets, which further diminished their ability to hear dosimetry alarms.

Radiological protection personnel did not closely monitor workers. In one case the placement of an electronic dosimeter in a body location other than where the highest exposure was expected was due to an error by a radiological protection technician; however, it was noted and left uncorrected by another technician.

In each case, problems were noted but not corrected during the activity.

In addition, for the three significant events, stay times were not used. For two of the events, stay times were not established. For the third event, a stay time was established for the work however, the worker continued working after it was exceeded.

**Questions:**

How frequently should you check your dose?

How can environmental conditions (noise, heat, contamination) affect your ability to monitor dose?

Who can you voice your concerns to?