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# Point Beach Nuclear Plant U1R28 OCC Interactive Turnover

**Meeting Agenda**  
*Saturday, April 10, 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 # 2004-0282

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## Point Beach Nuclear Plant U1R28 Refueling Outage

Safety Topics for week of April 4-10
<b>Theme for the week</b>
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.
<b>Daily Safety Snippets</b>
<b>Sunday</b>
<b><i>"Fix the danger-save a stranger"</i></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?
<b>Monday</b>
<b><i>"When you fail to report a hazardous condition, you may contribute to employee attrition"</i></b>
<b>Near-miss failure story:</b> 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?
<b>Tuesday</b>
<b><i>"Report and repair or someone may despair"</i></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.
<b>Wednesday</b>
<b><i>"Sidestepping a hazardous condition leaves others at risk of hospital admission"</i></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.
<b>Thursday</b>
<b><i>"Your neglect could result in his broken neck"</i></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?
<b>Friday</b>
<b><i>"Ignoring safety in any way may cause someone else to pay"</i></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.
<b>Saturday</b>
<b><i>"Most obituaries would not be recorded if all close calls were reported"</i></b>
<b>It happened at Prairie Island:</b> 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 5

Path



Picture

Meets



Doesn't Meet Exceeds

## Supporting Operational Excellence

## Outage Radiation Performance

### 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.

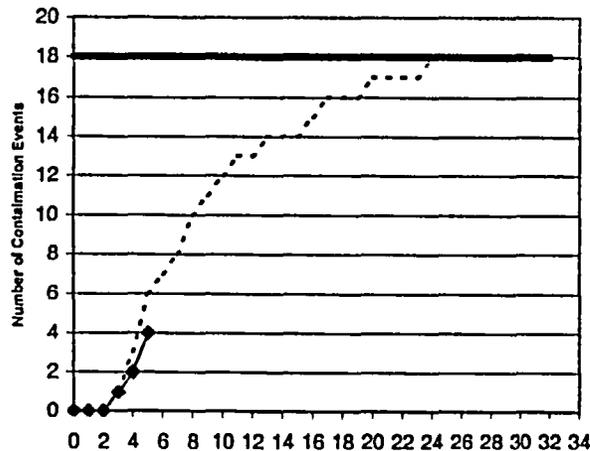
<b>Meets:</b>	<b>&lt;=75 Rem</b>	<b>Actual Cum.</b>	
<b>Exceeds:</b>	<b>&lt;=71 Rem</b>	<b>Dose:</b>	<b>16.534 REM</b>
<b>Meets:</b>	<b>&lt;= 18</b>	<b>Exceeds:</b>	<b>&lt;= 12</b>
		<b>Actual PCE's:</b>	<b>4</b>

PCE's #3 & #4 recorded 4/8/04 - one individual was connecting drain lines on "A" steam generator channel head to drain the channel head bowls and the other was removing the "A" steam generator primary manway. Both had contamination to face, neck & arm. Actions were taken to remove the contamination. CAPs written.

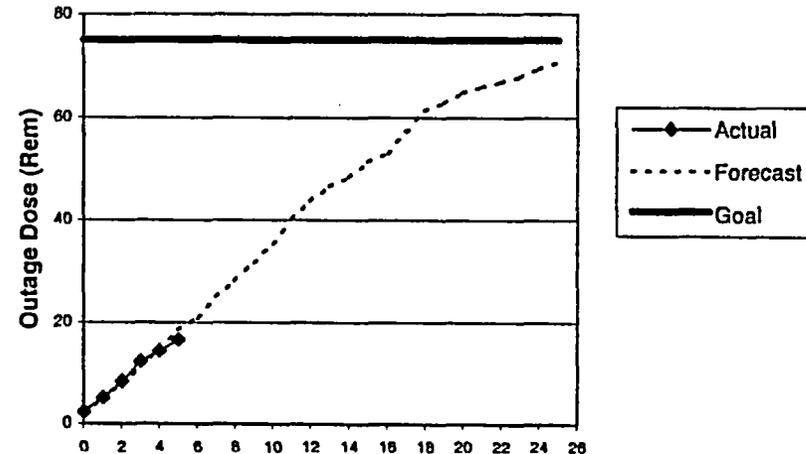
### Responsible Manager/Owner

Stu Thomas

Personnel Contamination Events



Cummulative Dose Exposure



# Outage Status Report

Plant: Point Beach Unit 1 Day: Saturday Today's Date / Time: 4/10/04 / 0400

Outage Duration: Day 7 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:

**Radlological**

Dose outage to date 16.534 Projected to date 18.493 Outage Goal <75 R

Difference -1.95 Number of PCEs 4

Summary: On Forecast

**Nuclear**

Significant human performance errors and events in last 24 hours 1

Summary:

- RCS Hot Leg Vent not properly controlled at Mid-Loop.

**Plant Status**

Mode:  Hot Standby (Mode 3)  Hot Shutdown (Mode 4)  Cold Shutdown (Mode 5)  Refueling Shutdown (Mode 6)

RCS: Temperature: 101 Pressure: Vented to Atmosphere RV Level: 70%

Time to Boil: 38 Minutes

**Shutdown Safety Assessment**

Reactivity: Green Core Cooling: Yellow Power Availability: Green

Containment: Green Inventory: Yellow 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)**

Steam Generator Primary Manway Removal	Schedule: Point Beach Human Performance & Communications Timeout
Replace 1SI-845A	
Nozzle Dam Installation	
PZR Manway Removal	
Exited Reduced Inventory at 1554	
Refill RCS to 70% RX Vessel Level	

**Significant Outstanding Issues**

Date	Issue	Due Date	Responsibility
4/03/04	Repair Blowdown Tank Leakage	4/15/04	Scott Manthei
4/04/04	1P2A Charging Pump Troubleshooting (After Orange Path)	4/10/04	Mike Schug
4/08/04	Incorporate Lessons Learned from 1 <sup>ST</sup> Reduced Inventory Orange Path	4/18/04	Dave Dyzak
4/08/04	B RCP Motor Oil Sludge	4/12/04	Jim McGough

**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: 2230

KEY SAFETY FUNCTIONS:

REACTIVITY: GREEN

CORE COOLING: YELLOW

POWER AVAILABLE: GREEN

INVENTORY: YELLOW

CONTAINMENT: GREEN

SFP COOLING: NA

PROTECTED EQUIPMENT:

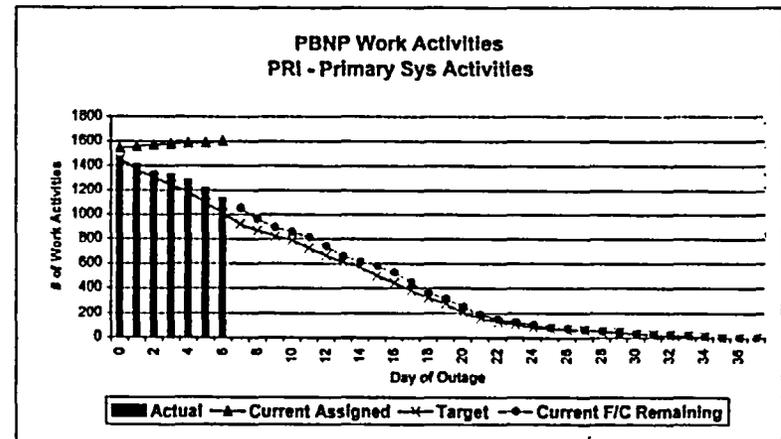
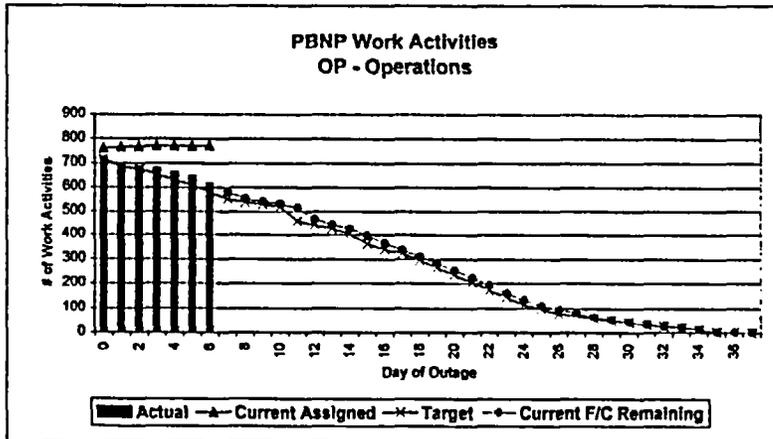
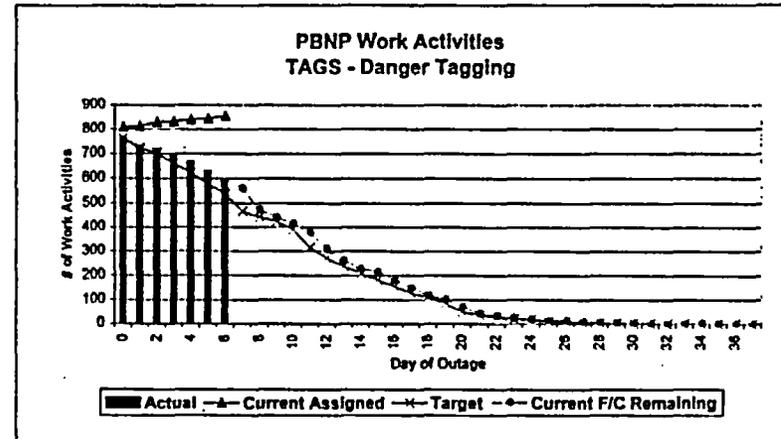
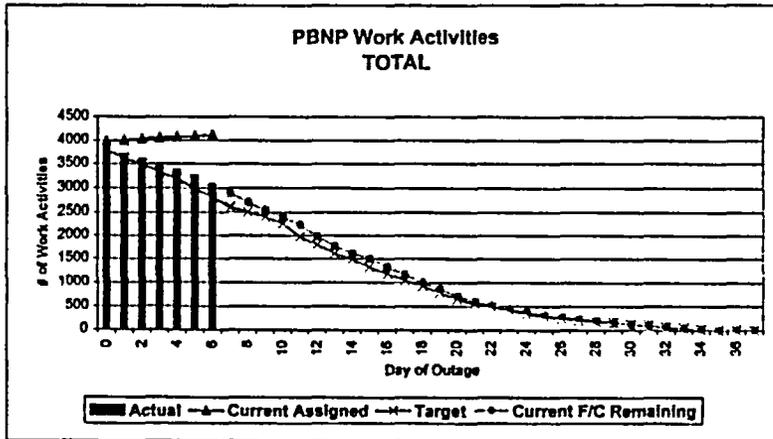
COMMENTS:

Fire Protection Condition III: Credit taken for existing fire rounds  
RCS Time to Boil is 37 minutes  
RCS is at 70% Reactor Vessel Level

ex 4

# PBNP U1R28 Workdown Curves

4/9/2004

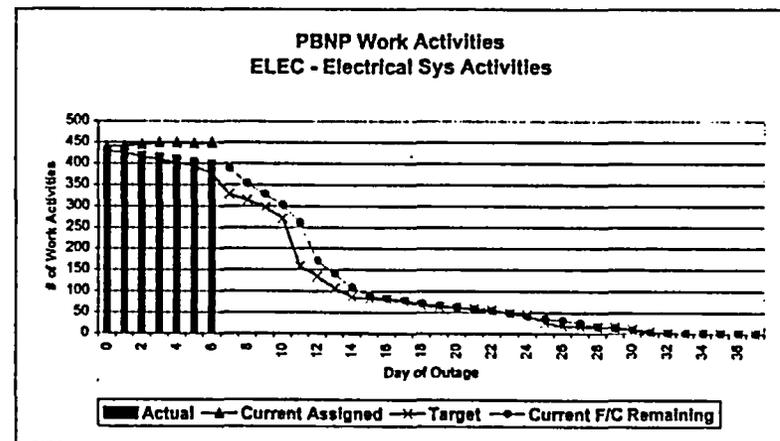
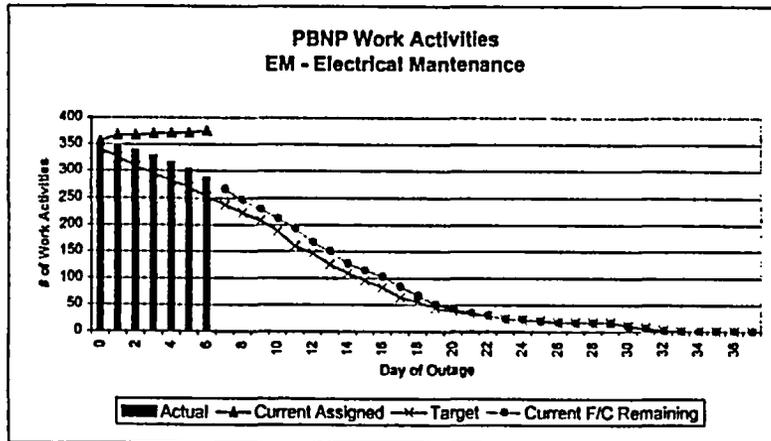
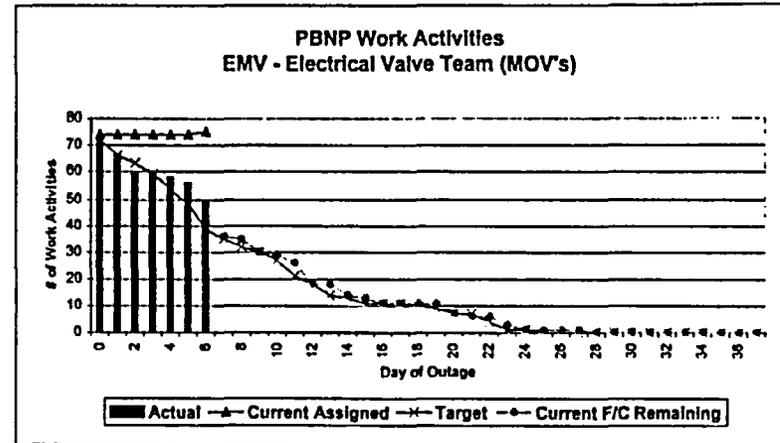
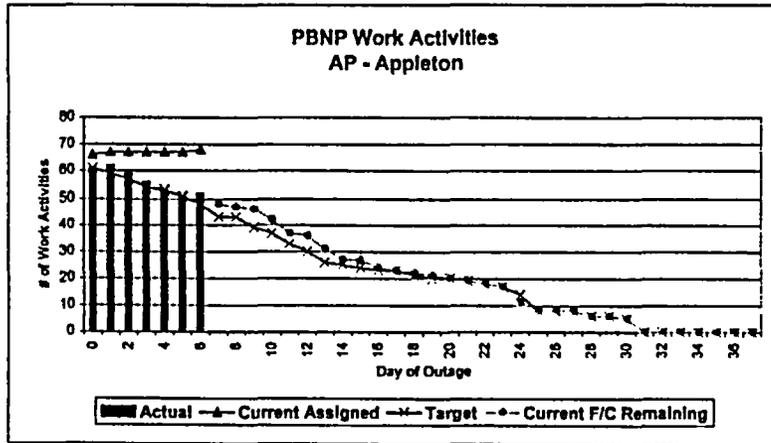


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# PBNP U1R28 Workdown Curves

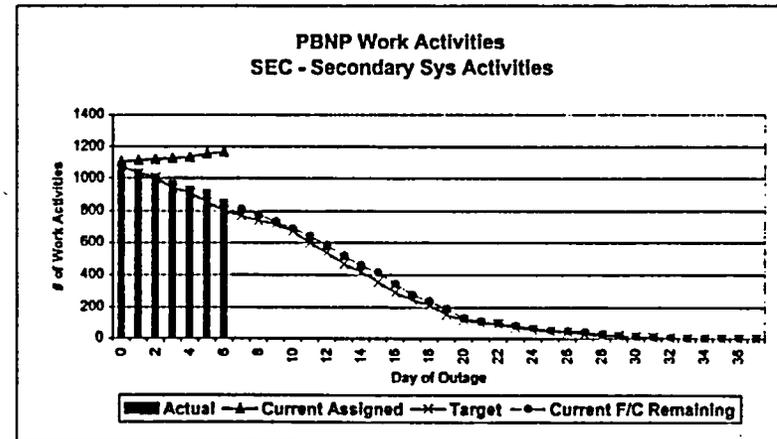
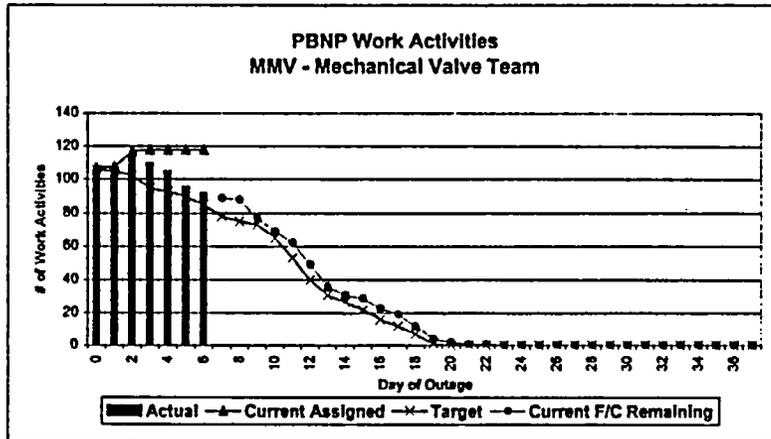
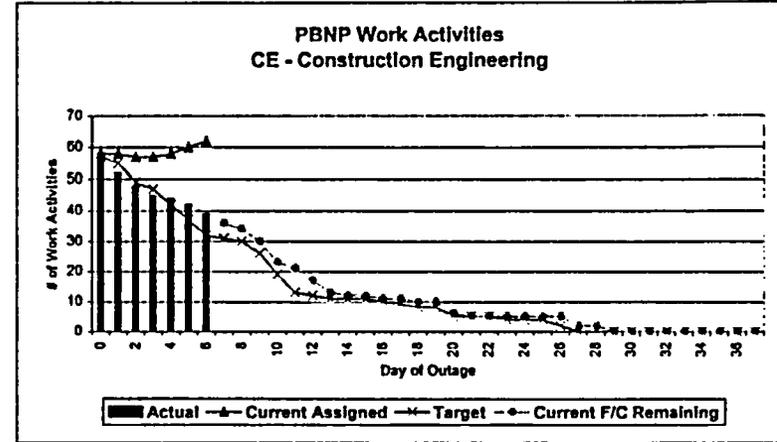
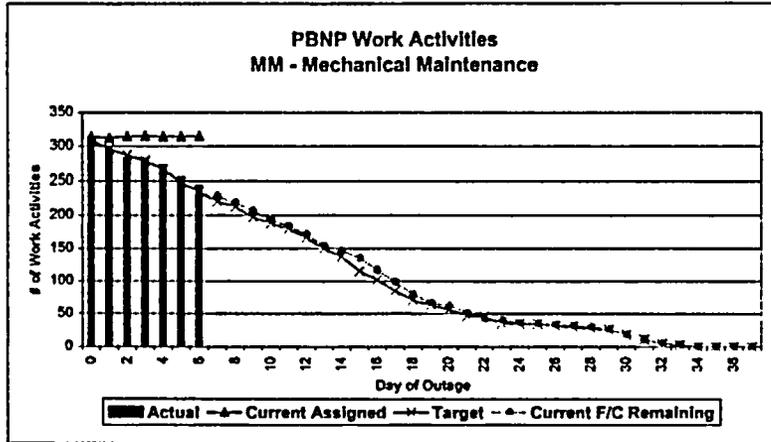
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# PBNP U1R28 Workdown Curves

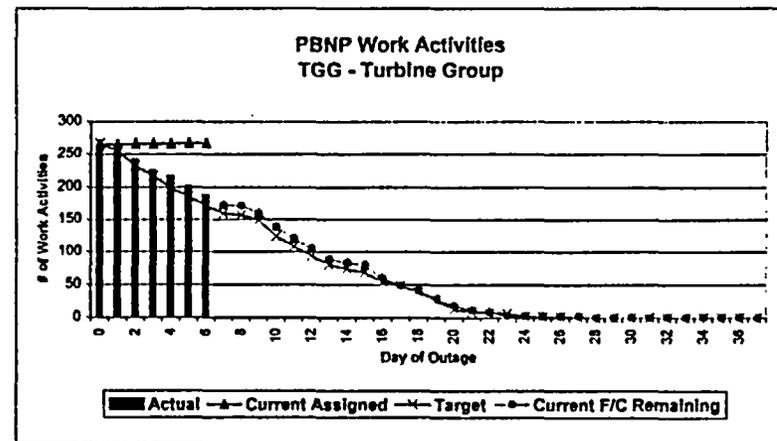
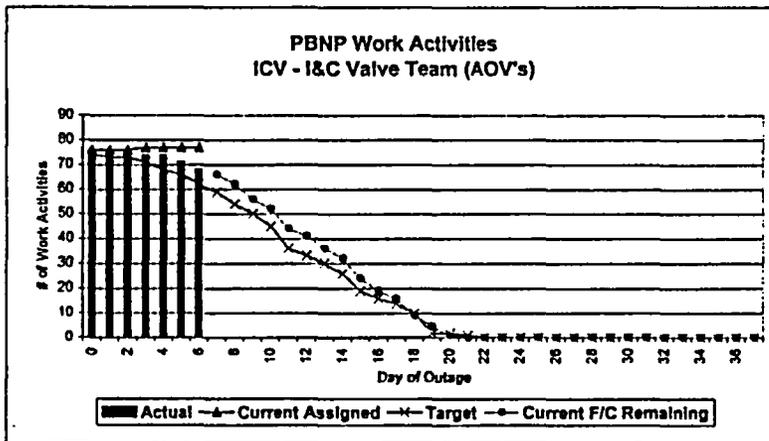
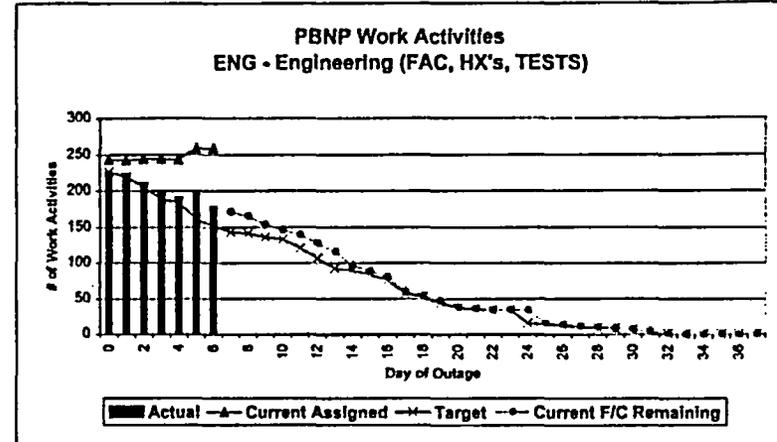
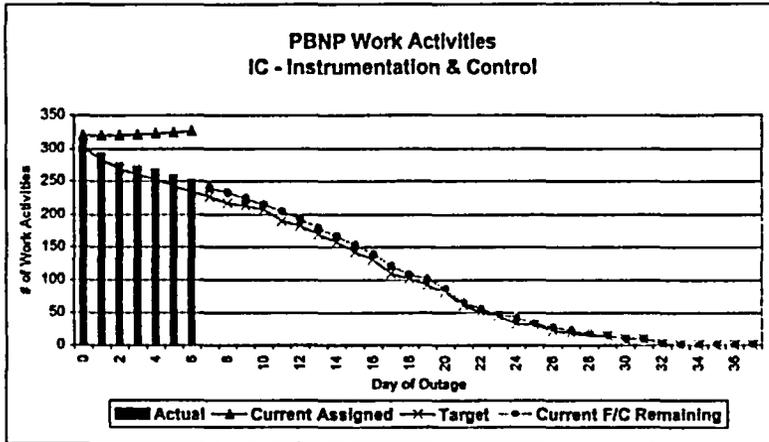
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# PBNP U1R28 Workdown Curves

4/9/2004

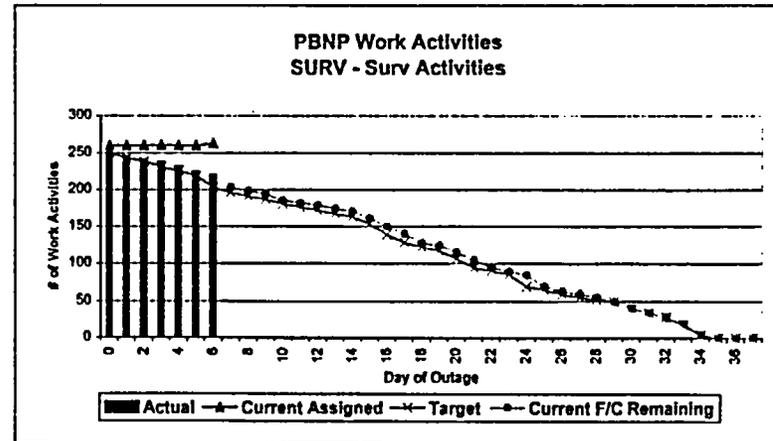
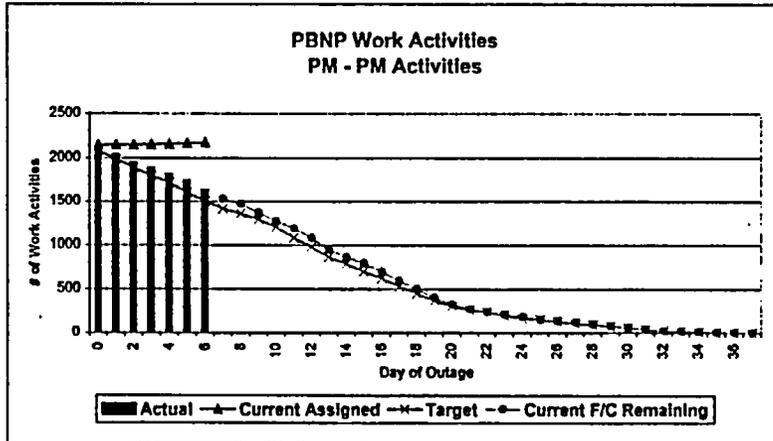
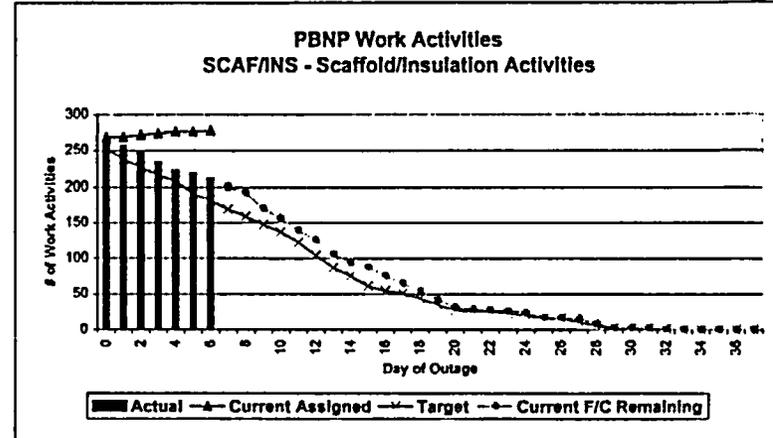
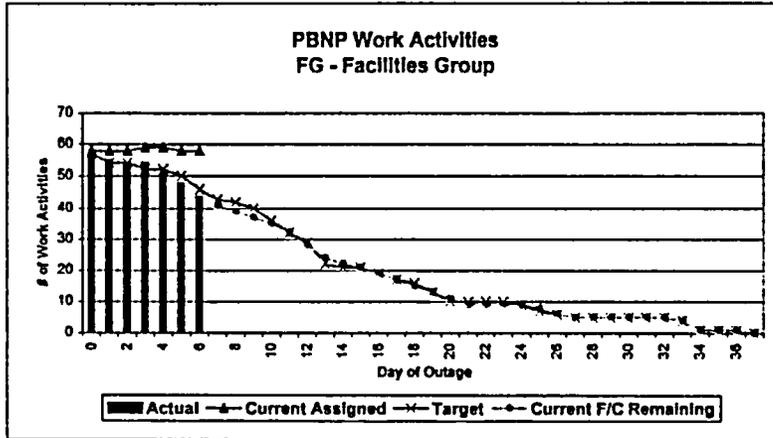


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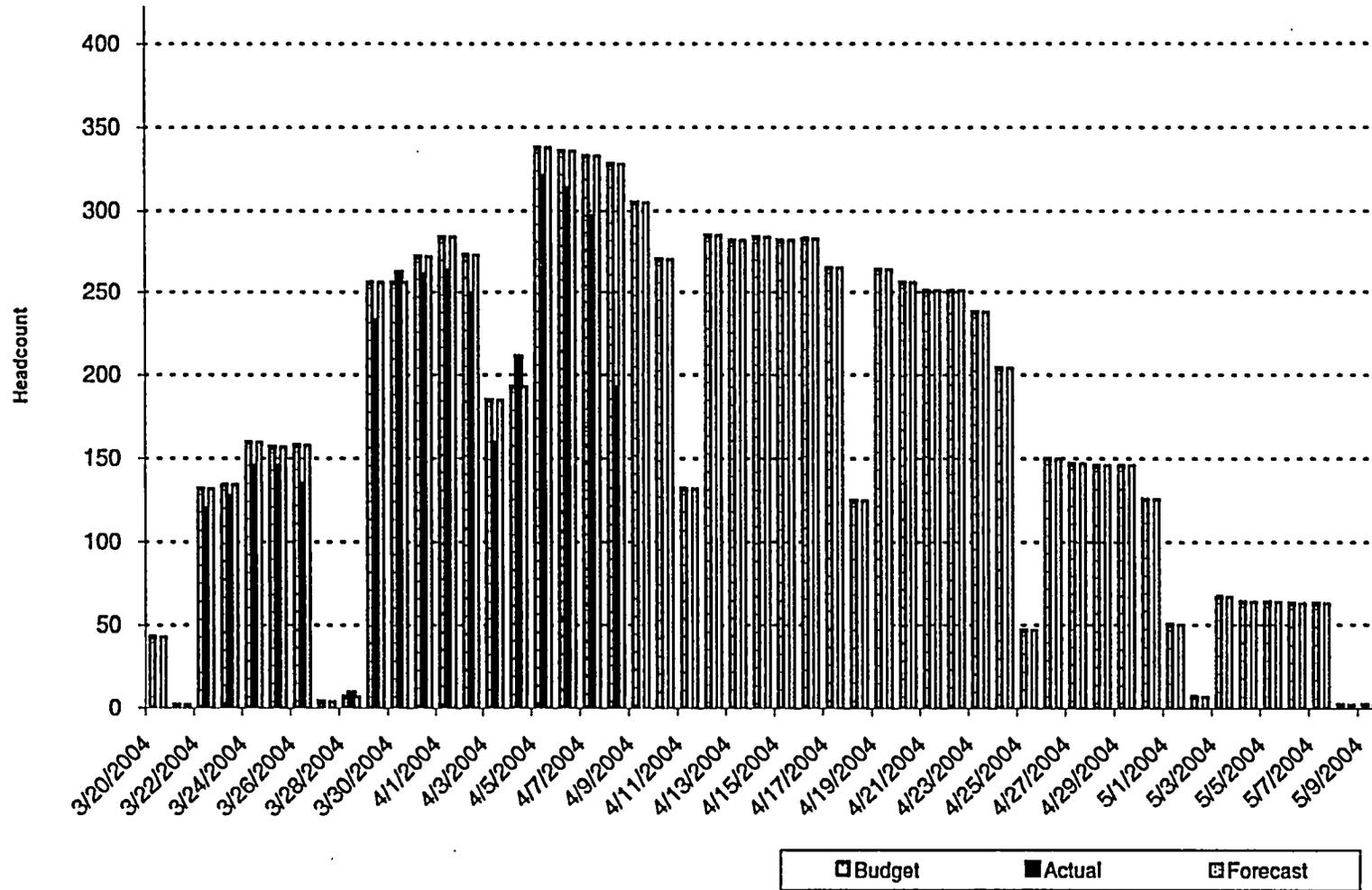
# PBNP U1R28 Workdown Curves

4/9/2004

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**Contractor Mobilization / Demobilization  
Total Site  
04/09/04**



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## Point Beach Nuclear Plant U1R28 Operating Experience

*Saturday, April 10, 2004  
(for work Monday, April 12, 2004)*

**OE subject:**  
OE17955 - Loss of Offsite Power Circuit

**Purpose:**  
Visual inspections may be the first indication of degraded cables.

**Why we chose this OE for today:**  
Cable Determination and Doble testing on 1X-04 is scheduled for Monday April 12<sup>th</sup>, 2004

**Discussion:**  
On March 6, 2004, Wolf Creek experienced a loss of one offsite power circuit. The initial indication was a loss of power from the west switchyard bus. Following the loss of this offsite circuit, a signal to start the 'B' emergency diesel generator (EDG) was initiated. The 'B' train essential loads were then loaded back onto the bus being carried by the EDG. These loads include the essential service water (ESW), centrifugal charging and motor driven auxiliary feedwater pumps. The required technical specification (TS) action to restore the offsite circuit to operable within 72 hours was entered.

A visual inspection of the start-up transformer identified one damaged cable requiring replacement. The damaged cable accumulated water inside the cable insulation. The apparent cause is that this moisture caused the cable to short to ground, resulting in the damage.

The damaged cable and five other similar cables on the start-up transformer were replaced. Doble testing was performed on the transformer to identify if there are other damaged components - such as bushing damage that would not be seen in a visual inspection - or damage to the transformer internal windings. The Doble testing was completed satisfactory indicating the transformer did not sustain any detectable damage internally to the windings nor to the low side bushing.

**Questions:**  
Have we reviewed the acceptance criteria for these inspections?