NMC
Committed to Nuclear Excellence

Point Beach Refueling Outage Edition

FEEL THE POWER
JOURNEY OF EXCELLENCE
POINT BEACH - U1R28

DAY 16

U1R28 TODAY

April 19, 2004

Accomplishments

- Z-13 Polar Crane Main Hoist Return to Service
- IT-300B "B" SG Main Feed Check Valve Testing Portion
- "A" SG Hand Hole Removal

Schedule Focus Areas/Priorities

Activities Required to Exit Yellow SSA Conditions

- Complete Repairs & PMT on Z-13 Polar Crane Aux Hoist
- Reactor Vessel Head Stud Removal
- B RCP Motor Move
- Install Cavity Seal Ring
- Reactor Vessel Head Lift

Message from Outage Director

Containment Polar Crane Update

Repairs have been completed on the controls for the Main Hoist of the Polar Crane. The post maintenance testing results have been reviewed and accepted by Maintenance, Engineering and the Vendor Representative. The Main Hoist was released for use as of 1710 on Sunday. The remaining problem facing us is that the Aux Hoist has been lowered approximately 15 feet and will no longer move. This position could interfere with operation of the Main Hoist so it will need to be raised to a position where it will not be an obstruction. Based on the Vendor recommendations new work plans have been developed to replace some additional electrical components in the Aux Hoist Control System. Maintenance and Engineering will work through the night with the goal to have the repairs made and have the Post Maintenance Testing results available for the Vendor to review early on day shift. Once the results have been accepted the crane will be released for use to continue with our priority of increasing RCS Inventory to exit the safety assessment yellow conditions on Core Cooling and Inventory.

Personnel Safety

Last 24 Hours	Outage to Date
Recordable - 0 Disabling - 0	Recordable - 1 Disabling - 0

OSHA Recordable Pending – Back strain

ALARA

Last 24 Hours	Outage to Date
0.224R	24.510 R

Dose as of the end of Day 14

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

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

S-88

[redacted]

April 19, 2004

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	1 Pending
RADIOLOGICAL PERFORMANCE		
Radiation exposure (Excludes additional dose from any head or BMI repair contingencies)	≤ 75 R	24.510 R
Personnel contaminations	≤ 18 w / >5K CPM	5
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	2
Station human performance clock resets	None	1
Rework	≤ 1%	<1%
SCHEDULE PERFORMANCE		
Outage Duration (excludes extensions due to extended head or BMI inspections)	≤ 30 days	Off Goal
Mod Implementation	100% of Rev 0	On goal
Schedule Compliance	> 85% schedule compliance with outage milestone	Off 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 Goal
Post Outage availability	≥ 150 days of continuous operation	Available at a later date
BUDGET PERFORMANCE	Within –2% to 0% of outage budget	Challenged

Operating Experience

4/19 SER 2-00 **Recurring Operational Events During Outages Fitzpatrick** – December 2, 1998. Operators inadvertently lowered reactor vessel level 100 inches below the vessel flange while attempting to maintain a constant indicated vessel level. Unknown to the crew, mechanics loosened a temporary reactor water level reference leg flange on the refuel floor as part of vessel head reassembly work. Control Room Operators assumed that the level increase in Reactor Vessel level was due to filling of the feedwater system. This assumption caused them to increase draining of the reactor vessel to the hotwell to maintain a constant Reactor Vessel level. Increasing hotwell level and high level alarms were not identified by the crew as unusual. Level indication errors were not recognized until the normal flood-up range level indicator reference leg was backfilled and indicated level had decreased 102 inches. **Lesson learned**: Verify assumptions!

Safety Snippet

Three way communication is a key communication tool

I understand Three way communication is a key communication tool

That is correct

Three way communication is not just a good idea it is a great process that we can use to clearly define the message sent was in fact the message heard. Hold each other accountable for the use of this practice and soon it will become standard.

Human Performance

If the procedure step is taboo, what should I do?

If the procedure user cannot safely perform the procedure or the procedure is technically incorrect, THEN the User shall:

- Stop use of the procedure
- Ensure the systems or components are in a safe or stable condition

Notify the group supervisor of the problem and recommend corrective action. The supervisor shall evaluate the situation and determine the required corrective action.