NMC
Committed to Nuclear Excellence

Point Beach Refueling Outage Edition

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POINT BEACH • U1R28

DAY 30

U1R28 TODAY

May 3, 2004

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

Accomplishments

- Fuel Motion and Insert Shuffle
- Core Map and Baffle Inspection

Schedule Focus Areas/Priorities

- Close RHR B Loop Work Window
- Start RHR A Loop Work Window
- MOB Packages IWP-037-02 & IWP-037-07
- 1B RCP Motor Work
- 1P-15B SI Pump Seal Repair

Personnel Safety

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

*OSHA Recordable - Back strain.

ALARA

Last 24 Hours	Outage to Date
0.682 R	48.126 R

Dose as of the end of Day 28.

Message from Outage Director

On 5/1/04 the memo "Negative Industrial Safety/Injury Trend-U1R28" was released as a "RED" Level Communication. The OCC has since received comments from numerous groups that they did not know what a "RED" Level Communication was. The following description was contained in the 4/23/04 Plant Manager Correspondence to All Personnel concerning U1R28 Work Release and Control. The communications section explained that management communications would take a graded approach as follows:

RED Level Communication: URGENT - Information that needs to be promptly communicated by calling the personnel out of the field OR by going to the job-site.

YELLOW Level Communication: IMPORTANT - Information that must be communicated prior to the end of shift.

GREEN Level Communication: ROUTINE - Information that can be communicated at the next turnover meeting or at a daily brief.

Attendance will be recorded at each communication session.

U-37 Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 4
FOIA/PA-2004-0282

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
RADIOLOGICAL PERFORMANCE		
Radiation exposure (Excludes additional dose from any head or BMI repair contingencies)	≤ 75 R	48.126 R
Personnel contaminations	≤ 18 w / >5K CPM	6
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	4
Station human performance clock resets	None	3
Rework	≤ 1%	On Goal
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	Seriously Challenged

Operating Experience

OE17921, Main Steam Isolation Valve (MSIV) Bonnet Lifting Eyebolt Failure

While attempting to lift the approximately 2000 pound 1B21-FO28D Outboard MSIV Bonnet from a horizontal to a vertical position for inspection, the single 5/8" x 1-3/4" rigging eyebolt supporting the bonnet failed. The bonnet dropped eight inches to the platform where it was placed following removal from the MSIV body. There were no injuries or equipment damage.

Lessons Learned:

Assumptions and overconfidence caused improper rigging techniques. A contributing cause to this event is the lack of knowledge concerning special tools and past practices developed to execute work in a safe, effective manner.

Safety Snippet

Concerning fingers, do not ignore; Cut one off and you'll grow no more

Limmerk 1999, While lowering a 2000 lb. flow diffuser from the high pressure turbine, a worker lost a substantial portion of one finger when the cribbing and jack used to support the diffuser failed and pinned the worker's hand between the diffuser and an I-beam used as part of the cribbing.

Human Performance

Stop versus STAR, know where you are:

Difference between STAR and Stop When Unsure:

- **STAR** (self checking) is a tool to increase attention to important points in an activity before, during and after a specific task is performed. **STAR** is about paying attention to detail when the person doing the task is qualified, experienced and knows how the task should be done. This tool helps the person avoid unintentional slips and lapses.
- **Stop When Unsure** is a tool to be used when a person is uncertain about how to proceed. With **STAR** a person pauses, focuses their attention, decides what to do next and then moves ahead with the task because they are confident about how to move ahead. **STOP when Unsure** is used when the person is not certain about how to proceed (scope has changed) and needs to stop and find out. Do not proceed in the face of uncertainty and be deliberate about your actions.

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