NMC
Committed to Nuclear Excellence

Point Beach Refueling Outage Edition

FEEL THE POWER
JOURNEY OF EXCELLENCE
POINT BEACH • U1R28

DAY 34

U1R28 TODAY

May 7, 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

- 1B-42 MCC Horizontal Bracing
- Under Head Equipment Setup
- Radiography on T-26 Blowdown Tank

Schedule Focus Areas/Priorities

- 1B-42 MCC Bucket Work
- CVCS Restoration
- Restoration of 1B-42
- 1P-15B SI Pump Seal Repair
- Reactor Head Repair
- SI System LRPM Testing

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 2
FOIA/PA-2004-0282

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
1.723 R	52.827 R

Dose as of the end of Day 32.

Message from Outage Director

You have heard management stressing that the work areas need to be cleaned up and tools and equipment returned to the proper storage area when the work is complete. This is very important but you also need to be prompt on the completion of the work package when the work is complete. Some important CHAMPS Work Order (WO) Status to know for closeout activities are:

76 – WO Released by the WCC for Work
78 – WORK in Progress/Hold for Mtl, Procedures, or Eng
79 – WORK is Complete/WO on Hold for Work Group PMT
80 – WORK & PMT Complete/WO in WCC for OPS Review
81 – WO Returned to Work Group for Additional PMT
82 – WO in WCC Waiting OPS Inspection/RTS Testing

Don't wait to be pursued by the tracking process and be asked why your Work Order has not been brought to the WCC for closeout. Be proactive on this very important aspect of the outage.

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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	51.104 R
Personnel contaminations	≤ 18 w / >5K CPM	8
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	4
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

OE18158 – 250V Battery Electrical Arc Incident

Two electricians were performing a surveillance to measure resistance of the intercell connectors of the 250V batteries. A step near the end of the procedure requires the measurement of the resistance of the battery feeder cable connection by placing one probe of the Digital Low Resistance Ohmmeter (DLRO) on the battery positive post and the other probe on the connector lug. The electricians became complacent and touched the ohmmeter probes to the positive battery feeder cable and the negative cell post. The resultant arc melted a portion of the lead on the battery post, and the electrical potential applied to the DLRO caused it to fail. **Lessons Learned: The pre-job brief did not discuss this specific situation, even *though the personnel performing the task had not previously performed this specific procedure. Self or peer* checking could have prevented the event**

Safety Snippet

A finger tip - don't leave work without them!

On April 4, 2001, a contract employee at Braidwood Station suffered a fractured right hand when an electric hoist disengaged from a crane hook and fell on to the new fuel storage rack. The electric hoist was being used to drag test new spent fuel racks being installed at the station. Workers attached a load cell and the electric hoist to the auxiliary hoist of the fuel building overhead crane, and then connected the electric hoist to a test gage. As the crane operator lowered the auxiliary hook, the test gage hung up on the fuel rack and caused the rigging to move laterally. The electric hoist became disengaged because the safety latch on the auxiliary hook was not used.

Human Performance

It's OK to ask for help:

had prepared the modification was no longer at Point Beach. The OA routed the work order to a manager who was relatively new to PBNP. The manager signed off the work order based on the note attached. The sign off appeared after the DSS signoff stating that the work order has been installed, tested and is acceptable. Some outstanding documents had not been processed yet.