

NMC
Committed to Nuclear Excellence

**Point Beach Refueling
Outage Edition**

FEEL THE POWER

**JOURNEY OF
EXCELLENCE**
POINT BEACH - D'ARZ

**DAY
40**

OUTAGE TODAY

May 13, 2004

E74

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

- Latch Control Rods
- P-26 Install Nozzle Extension and Tack Weld
- 1B01/1B03 Cross Tie
- CVCS Recovery

Schedule Focus Areas/Priorities

- P-26 – Perform Repair Welding of Nozzle
- 1X-11 XFMR Hi/Low Side Bkr Maintenance
- Move Upper Internals Lift Rig (to 66' LDA)


Safety Snippet

What number do you call if your co-worker takes a serious fall?

What is the plant's emergency number? **2911**. This number is only to be used for emergency situations. Two weeks ago a work group was having trouble getting through to operations to communicate a change in equipment status. Rather than waiting, the individual involved decided to contact the control room via the emergency number. Needless to say this was not an appropriate use of 2911.

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 4
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
0.277 R	54.448 R

Dose as of the end of Day 38.

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	54.448 R
Personnel contaminations	≤ 18 w / >5K CPM	9
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

OE10467 – Personnel Received a Radiation Dose Higher Than Planned

On Saturday, November 27, during the Unit 2 13th refueling outage, work was begun to move the reactor vessel lower internals back into the reactor vessel. A laser/camera system was in place to monitor the internals' elevation, and a mini-sub camera was to be used as a backup to the laser/camera system. It was later determined that the mini sub operator did not understand his role as backup to the laser/camera system for monitoring internals elevation. During the move, the laser/camera system failed, however the internals move was continued. As the move progressed, Health Physics personnel noted dose rates increasing to values higher than expected. The internals were determined to be positioned higher out of the water than was normal, and as a result the polar crane operator received approximately 700mR. The reactor vessel internals move was completed and dose rates returned to expected levels.

Lessons Learned: Initial review of this event indicates that poor communication, poor job scope delineation, an inadequate pre-job briefing, and lack of contingency planning may have been the primary causes.

Human Performance

Place Keeping – Not Just for Procedures

Place keeping is a form of action tracking and can be used in situations other than executing procedures. Some recent events where action-tracking failures occurred are:

- A worker failed to complete the review of a document in the required time frame after he had been notified that the document was ready for review.
- An individual missed training because he got involved in resolving a plant problem.
- A manager failed to approve an overtime extension because he became involved in outage activities.

When critical tasks need to be performed by a specified time (Time Pressure), that is an indication that action tracking (Place Keeping) should be used to avoid an error-likely situation.