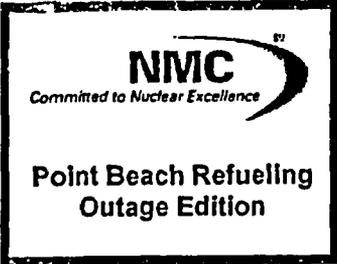


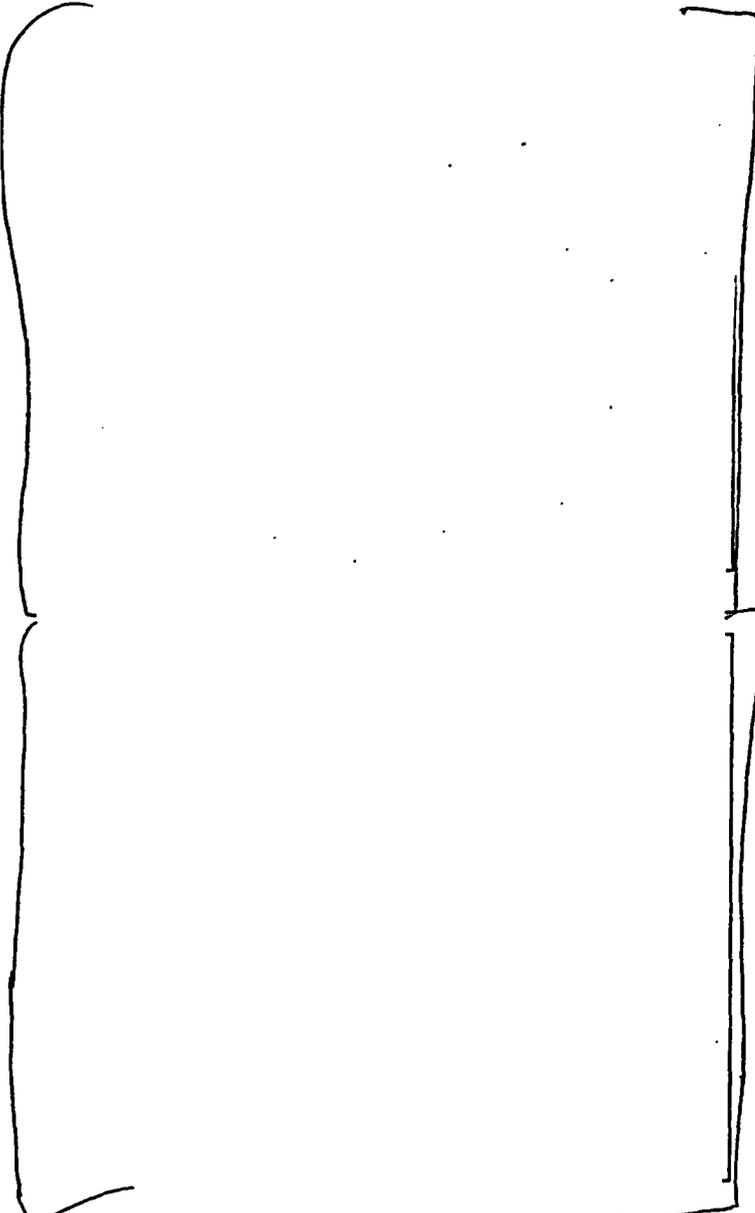
03-243



# U1R28 TODAY

May 19, 2004

EX4



**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**

- Main Generator 60# Air Test ✓
- ORT-24, SI Test Line CIV Leakage Test
- Reactor Head Pen #33 Honing

**Schedule Focus Areas/Priorities**

- Reactor Head Pen #26 Relief Request Issues *pm?*
- Setup and Prepare Mockup for Rx Head Pen #26 Grinding
- Work Package to Grind Out Over Lap on Pen #26
- Reactor Head Pen #33 Thermal Sleeve
- IT-280A for 1MS-2018 A S/G Main Steam Stop
- 1X03 Transformer H52-20 and H52-05 Breakers

<b>Personnel Safety</b> 	<b>Last 24 Hours</b>	<b>Outage to Date</b>
	Recordable - 0 Disabling - 0	Recordable - 1* Disabling - 0

<b>ALARA</b>	<b>Last 24 Hours</b>	<b>Outage to Date</b>
	0.241	55.575 R

Dose as of the end of Day 44

U-118

\*OSHA Recordable - Back strain.  
 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	55.575 R
Personnel contaminations	≤ 18 w / >5K CPM	10
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	3 *
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

\* 5/15/04 Tailgating event: Door 265 #2183

**Human Performance**

Who does what? Senior Line Managers, Department Managers and Supervisors, and all Site Personnel have specific responsibilities associated with briefings.

- Senior Line Managers – Perform briefings for Infrequently Performed Tests or Evolutions
- Department Managers and Supervisors – Establish briefing requirements, and perform briefs for high or medium risk activities

Site Personnel – Request briefings, participate in briefings using Q,V & V, and safely & correctly perform the task or evolution.

**Safety Snippet**

If your load starts to slip, get out of the way - quick

December 1997 An employee at a hospital was pushing a food cart down a ramp when she lost control of it. As she tried to stop the cart, she was crushed between it and a wall. She was hospitalized for a fractured ankle and a lacerated ear.

**Operating Experience**

**OE12590 – Inadequate Piping Modification Controls Causes System Inoperability**

A pre-refuel outage inspection of seismic snubbers found that two snubbers associated with a support on an operable ECCS system were fully extended. The system was declared inoperable pending evaluation. When the snubbers were removed to evaluate their condition, the piping in the vicinity of the snubbers moved in the upward direction. Spring cans associated with this piping were then adjusted to relieve the upward force exerted on the piping. Though these adjustments lessened the upward piping displacement, the piping remained too high for proper reinstallation of the snubbers.

**Lessons Learned:** Work practices that contributed to the event included: design and work concentration at the point of the cut without evaluation of the effect of the cut on the local system piping and supports; the absence of an as-left design verification of affected system piping; not removing snubbers that could be damaged by piping movement; the installation of temporary restraints as determined by the work group with engineering guidance rather than by a preplanned restraint scheme; and not pinning spring cans.