



May 20, 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

- Reactor Head Pen #33 Honing & Removed Thermal Sleeve
- 2P-28B Feed Water Pump Recirc Line Flange
- 1X03 Transformer H52-20 and H52-05 Breakers
- RM 3200 RE-211/RE-212 Monitor Supply Solenoid

Schedule Focus Areas/Priorities

- Reactor Head Pen #26 Relief Request Issues
- Setup and Prepare Mockup for Rx Head Pen #26 Grinding
- Reactor Head Pen #33 UT
- IT-280A for 1MS-2018 "A" S/G MSIV (Parts)
- Re-Energize 1X03 Transformer
- D106 Battery Cell Replacement and Spare Cell Staging

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
0.174	55.749 R

Dose as of the end of Day 45

U-119

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

May 20, 2004

OUTAGE GOALS

NUCLEAR SAFETY PERFORMANCE	GOAL	ACTUAL	HUMAN PERFORMANCE	GOAL	ACTUAL
Unplanned orange/red paths	None	None	Security Violations	≤ 12 loggable events	3 *
Reactor trips (either unit)	None	None	Station human performance clock resets	None	4
Safeguards actuation (either unit)	None	None	Rework	≤ 1%	On Goal
Loss of shutdown cooling	None	None	SCHEDULE PERFORMANCE		
Loss of Rx vessel level control	None	None	Outage Duration (excludes extensions due to extended head or BMI inspections)	≤ 30 days	Off Goal
INDUSTRIAL SAFETY PERFORMANCE			Mod Implementation	100% of Rev 0	On Goal
Lost time accidents	None	None	Schedule Compliance	> 85% schedule compliance with outage milestone	Off Goal
Personnel injuries (OSHA recordable)	None	1	Emergent work (during implementation)	≤ 2% late additions ≤ 5% Emergent	On Goal
RADIOLOGICAL PERFORMANCE			Scope	Complete ≥ 95% of Rev 0 scope	On Goal
Radiation exposure (Excludes additional dose from any head or BMI repair contingencies)	≤ 75 R	55.749 R	Operator Burdens	100% of Scheduled Operator Burdens complete	On Goal
Personnel contaminations	≤ 18 w / >5K CPM	10	Post Outage availability	≥ 150 days of continuous operation	Available at a later date
Radiological events (defined as unplanned uptake w/assigned dose >10 mrem or dose event based on ED alarms)	≤1 event	1	BUDGET PERFORMANCE	Within -2% to 0% of outage budget	Seriously Challenged
Radmaterial event (defined as any rad material outside RCA ≥ 100 CPM)	≤1 event	0			

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

Human Performance

When Is a Pre-Job Brief Required?

Tasks that pose a risk to:

- Personnel Safety
- Nuclear safety
- Nuclear-safety related SSC (systems, structures, components)
- Plant operation
- Power generation

Tasks identified as:

- Error-likely tasks
- High or medium risk tasks
- IPTE tasks

When requested by the performer.

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

OE14482 – Equipment Inadvertently Mispositioned During Housekeeping Activities

On June 26, 2002, Surry Operations personnel in the Surry Condensate Polishing (CP) Building found the control switch for the Unit 1 CP Building air compressor cooling tower in the "OFF" position versus the "AUTO" position. The normal position for this control switch is 'AUTO' when the associated air compressor is in "AUTOMATIC". CP Building watchstanders observed that the compressor cooling water outlet temperature was at 210 deg F. The cooling tower control switch was returned to 'AUTO' and CP Building watchstanders observed that the CP Building compressor temperature returned to normal. On July 19, 2002, station cleanup activities were performed in all three Emergency Diesel Generator (EDG) rooms. Following completion of these cleanup activities, operations personnel conducted a walkdown of the applicable areas to verify proper alignment and position of valves and switches. During this walkdown, a vent test valve for the number 2 EDG air start subsystem was discovered open with its associated pipe cap installed.

Lessons Learned: In each case, station housekeeping efforts had been conducted on or prior to the dates of discovery for each specific occurrence. The apparent cause for each of these events is work practices as it appears the affected equipment was bumped or inadvertently positioned during housekeeping activities.