

**NMC**  
*Committed to Nuclear Excellence*

Point Beach Refueling  
Outage Edition



JOURNEY OF  
EXCELLENCE  
POINT BEACH - U1R26

DAY  
45

**U1R26  
TODAY**

May 18, 2004

Ex 4

### 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

- Radiography of T-26 Blow Down Tank Piping
- 1X03 Station Transformer Removed from Service
- Internals Lift Rig Returned to Rx Cavity
- IT-280A for 1MS-2017 A S/G Header Main Steam Stop
- IT-520B, LRPM testing of 1SI-896A & B
- U1 Train A & B UV, DV, & LV Relays

Information in this record was deleted  
in accordance with the Freedom of Information  
Act, exemptions 4  
FOIA/PA-2004-0382

### Schedule Focus Areas/Priorities

#33

- Reactor Head Pen #26 Relief Request Issues
- 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
- Generator 60# Air Test
- 1X03 Transformer H52-20 Breaker (On Hold)
- 1X03 Transformer H52-05 Breaker
- 1MS-2018 S/G Header Main Steam Stop
- 1SI-897B SI Test Line Return
- 1SI-887 SI Test Line Relief

U-112

### 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
0.092	55.334 R

Dose as of the end of Day 43

## 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	55.334 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

## Why do it, if it isn't safe?

The main reason for performing pre-job briefings is to minimize human performance errors. Identification of error-likely situations, and barriers that can prevent errors from occurring increases the safety and effectiveness of job performance.

Pre-job briefs are required for all task assignments and evolutions. Documented briefings are required for high or medium risk in accordance with NP 1.1.7, Managing Work Activity Risk.

## Safety Snippet

## Don't block your vision or you could be headed for a collision

OE12937 – October 2001: Forklift operator at Kewaunee was asked to lift a containment fan coil unit in order that a pallet could be placed underneath it. The approach was from an angle, rather than directly from the front due to 4x4's underneath the unit creating a frontal obstruction. The forklift operator maneuvered close to the area, stopped and asked individuals to move. As they began to move, the back end of the forklift swung around, pinning a security officer to a doorframe.

## Operating Experience

## OE17438 – Mechanic Injured During Air Operated Valve Maintenance

During an outage on Unit 2, a packing leak on a Condensate Booster Pump minimum flow valve was scheduled to be repaired. When mechanical maintenance personnel were disconnecting the air operator from the valve stem, in preparation for repacking, a coupling block was forcibly ejected. The mechanic who was holding on to the coupling block received a dislocated thumb, and was struck in the face. The hard hat protected his head and while the safety glasses protected his eyes the force of the blow drove the glasses into the worker's eyebrow, resulting in sutures being needed.

**Lessons Learned:** Investigation revealed that **direction provided in the work order and clearance special instructions section had not been reviewed.** The directions required I&C technicians disconnect the actuator from the valve before the mechanical work was to begin. One of the most significant human factors in this event was the mindset that this was a "simple job."