

DINT BEACH • U1R28

		OUTA
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)	≤ 92 R	73.049 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 e vent	0

GOALS		
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

Human Performance

Briefings in Review

- Guidance is found in NP 1.6.10
- Briefings are required for all jobs and evolutions
- The level of discussion and documentation is dependent on
 - o Risk of the job
 - o Error-likely situations involved with the job
 - o Past-performance experience
 - o Consequences of improper performance

Safety Snippet

Is there an obstruction in your way that might not stay?

OE13857 May 2002, Fort Calhoun – While moving the reactor vessel head assembly during a refueling outage, the control pendant for the polar crane caught a handrail vertical support pipe, lifting the pipe out of its mount and causing it to fall 20 ft to the walkway below. Individuals were in the area at the time, but not injured. A review indicated the pendant caught on nearby equipment many times during past refueling outages and corrective actions were not put in place. Are there any items were our equipment gets caught during moves that we have not resolved?

Operating Experience

OE11214 - 22 Steam Generator Cold Leg Bowl Drain Plug Installed in the Wrong Drain Hole

Unit 2 was shutdown for refueling with the Reactor Coolant System (RCS) in a reduced inventory condition. The RCS level was being maintained below the top of the hot leg for removal of the Steam Generator (SG) primary manways and installation of nozzle dams. At the completion of SG nozzle dam installation RCS fill was started in accordance with 2D2, "RCS Reduced Inventory Operation," to return RCS level to 1 foot below the Reactor Vessel Flange to bring the RCS out of the reduced inventory condition. While filling the RCS, water started coming out of 22 SG cold leg manway. The control room was immediately contacted when discovered. The control room operators stopped filling the RCS and opened the RCS drain valves per 2D2 to lower the RCS level. The RCS level was lowered until water stopped coming out of the SG manway. Containment workers also started a Randolph pump to pump water out of the SG channel head to minimize the water spilling out of the manway while the RCS level was being lowered.

Lessons Learned: Causes were determined to be inadequate procedures and insufficient hands-on training. Stop When Unsure!