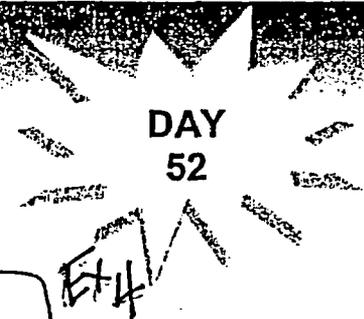
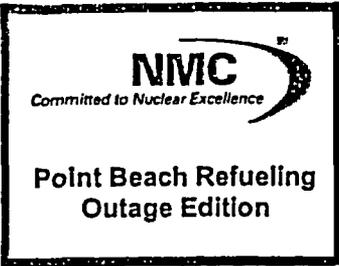


3-2-10



U1R2B TODAY

May 25, 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

- Nozzle Dam Removal
- Move 1P-1B RCP Motor to Pump Cubicle
- Upper Cavity Decon
- 'B' S/G Primary Manway Installation
- Cavity Seal Ring Removal

Schedule Focus Areas/Priorities

- Reactor Head Penetration #26 Relief Request Issues
- 'A' S/G Primary Manway Installation
- Exit Midloop and Reduced Inventory Orange Path
- Commence Reactor Head Assembly

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
3.119	77.202 R

Dose as of the end of Day 50

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

V-26

OUTAGE GOALS

NUCLEAR SAFETY PERFORMANCE	GOAL	ACTUAL
Unplanned orange/red paths	None	None
Reactor trips (either unit)	None	1
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	77.202 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

Human Performance

Who does job observations? Everyone! Supervisors and managers normally perform formal job observations, but anyone can perform an informal job observation. Each one of use probably does this daily through things like co-worker coaching. It could be when we are giving OJT or watching TPE, it could be when we are performing a peer check, or maybe it was when a co-worker asked us to help them perform a task. Job observations are always being performed at PBNP. They can be performed anywhere and are done everywhere to help improve the entire PBNP organization.

Safety Snippet

Peer checks – do we use them?

December 1997, Byron: An electrician was taken to the hospital for treatment of second-degree burns on his hand and flash burns to his eyes as a result of a mishap. He was one of three electricians assisting a system engineer during a battery discharge test on a new battery bank when he accidentally shorted across the battery with one of the cables used to connect the battery to a resistor bank. An investigation showed that the electricians and the system engineer had not verified the correct cable configuration. Also, the injured electrician was not wearing low voltage gloves and had rolled up the sleeves of the long-sleeve shirt he was required to wear for this job. What PPE do we wear during battery work?

Operating Experience

OE11315 - Unplanned Internal Contamination During Reactor Cavity Decon

On Wednesday, March 29, 2000, at 0815 (all times are approximate), with the reactor coolant system level just below the reactor vessel flange and the reactor head suspended approximately two feet above the flange, two ComEd Radiation Protection Technicians (RPTs) entered the reactor cavity to survey and begin cleaning the vessel flange. At 0845, a Maintenance Supervisor and QC inspector inspected the flange for cleanliness. At 0915, the reactor head was set on the flange and two laborers entered the cavity to decon the lower walls. At 0920, vessel level began to be reduced for subsequent maintenance work. Other personnel entered the cavity to remove equipment and begin pressure-washing portions of the cavity. At 1000, after the completion of one rinse of the upper portion of the cavity, the RP Supervisor (RPS) contacted the station ALARA analyst to report that the rinse did not appear to be reducing dose rates, and that dose rates following the first rinse were approximately twice normal. At 1020, the two RPTs exited the cavity due to reaching 80% of their RWP-allowed daily exposure. At 1030, the ALARA analyst notified the Radiation Protection Manager (RPM) about higher than expected dose rates after the first rinse. At 1045, the RPS and the RPM discussed the potential reasons for the higher than expected dose rates, including reduced vessel level and high remaining contamination levels. It was subsequently decided to observe the effects of further draining and decon efforts to determine the cause. At 1115, the RPS became aware that the two RPTs had experienced internal contamination. Over the next 30 minutes, others were reported as having external or internal contaminations. At 1150, the RPS contacted the RPM and stopped work in the cavity based on the contamination events and the unknown conditions. Evaluation of the potential cause was discussed at the Senior Management level. A recovery plan was developed and work in and around the area was resumed approximately 2 hours later. Off site ComEd Generation Support Radiation Protection personnel were brought in to assist and provide recommendations.

Lessons Learned: The root cause of this event was failure to perform adequate surveys to characterize the radiological conditions before allowing work to be performed, due to a lack of management reinforcement of standards, a mindset based on historical data, and improper focus on completing work.