

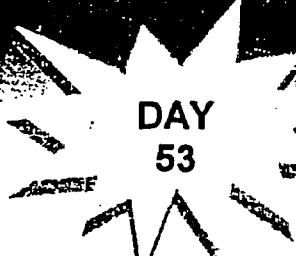
NMC
Committed to Nuclear Excellence

**Point Beach Refueling
Outage Edition**



FEEL THE POWER

**JOURNEY OF
EXCELLENCE**
POINT BEACH • 01020

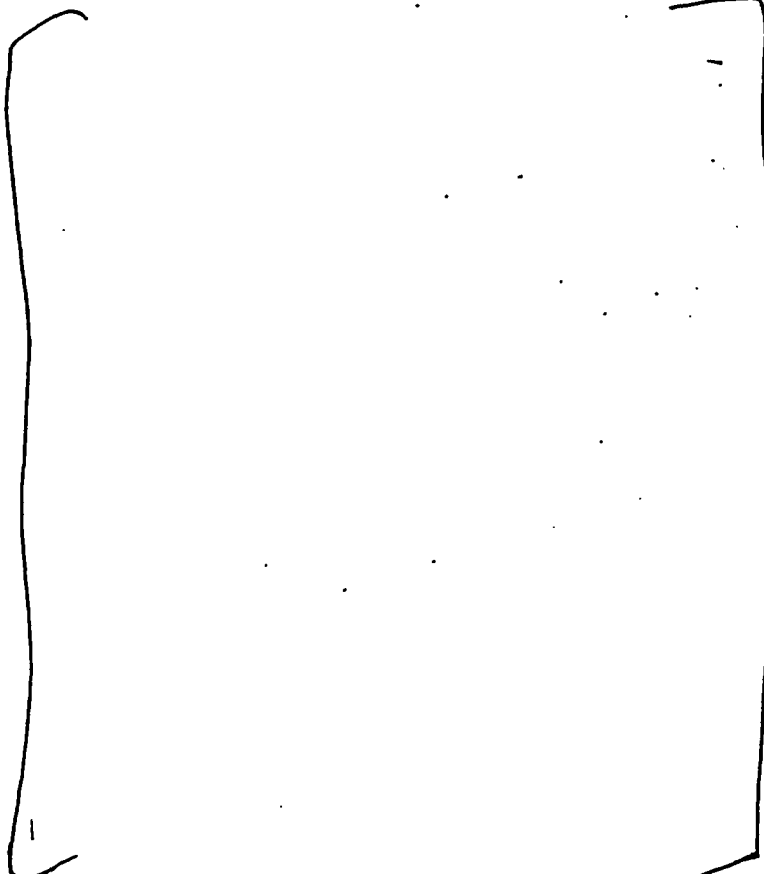


**DAY
53**

Ex 4

**UNITED
TODAY**

May 26, 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

- S/G Primary Manway Installation
- Cavity Seal Ring Removal
- Exit Reduced Inventory
- Installed Thimbles
- Removed Reactor Head Stud Hole Covers
- Installed Reactor Head Bolts
- Aligned 1P1B Reactor Coolant Pump


**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
1.987	79.189 R

Dose as of the end of Day 51

Schedule Focus Areas/Priorities

- Reactor Head Penetration #26 Relief Request Issues
- Seal Table Restoration
- Tension Reactor Head Studs
- Enter Mode 5
- Install Pressurizer Manway
- Couple 1P1B Reactor Coolant Pump
- Install Conoseals

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



FEEL THE POWER

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V-31

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	79.189 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

Job observations are the "trendy" thing to do. So what happens to all of the information collected in observations? We are able to collect the data and trend it to see where areas for improvement may lie. This done using the PACE program. The PACE database provides us with focus areas for improvement that may allow us to prevent a more serious problem in the future. These trends also show us what we are doing well.

Safety Snippet

Just a reminder to be told, balance that load!

OE10902 March 2000, Seabrook – Electricians were offloading battery cells from a metal pallet on a forklift. The offload sequence went from inside, closest to the forklift, to the outside, furthest from it. The result - instability in the load and the pallet tipped under the weight of the batteries. The cells fractured spilling 19 gallons of sulfuric acid/water electrolyte in the switchgear room. *This OE is not just for battery removal. Balance all your loads.*

Operating Experience

OE12440 - Reactor Vessel Conoseal Leakage And Assembly Issues

On March 15, 2001, in response to indications of elevated RCS leak rate, technicians entered the Containment Building and noted crystallized boric acid accumulation around the perimeter of the lower Conoseal clamp of Conoseal Assembly Number 4 on the Reactor Vessel head. Engineering evaluated the leakage in accordance with guidance provided by EPRI and determined that the leak rate was minor, established monitoring and acceptance criteria, and judged continued operation until an impending refueling outage scheduled to start on April 27. Upon disassembly of the mating surfaces and gasket during the outage it was noted that the gasket had a dent mark and an apparent crushed burr on the outer edge. There were no apparent deformations on either the male or female flange surfaces of the assembly, and it was determined the leakage was likely due to the introduction of metal particulate/grit between the mating surfaces during reassemble the previous refueling outage.

Lessons Learned: The root cause was determined to be inadequate procedural guidance in both oversight and verification of the assembly process. Also, the procedure did not contain adequate guidance for the torque sequence for the final assembly.