

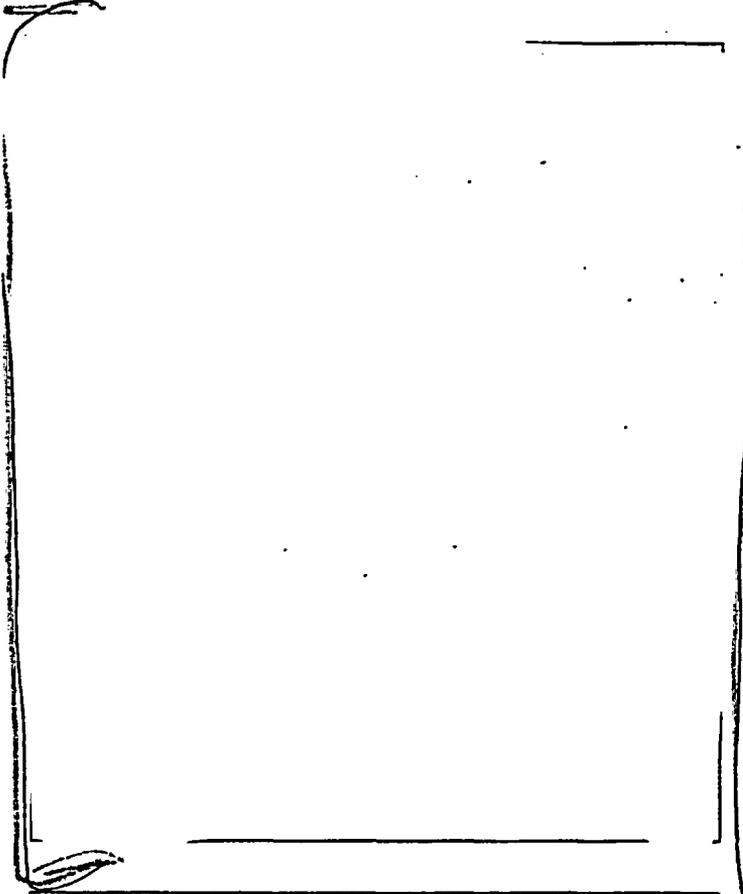
JOURNEY OF EXCELLENCE
POINT BEACH - U1R28



UNITED TODAY

June 4, 2004

Ex4



CONTACT INFORMATION

- Control Room Emergency – x2911
- Work Control Center – x6703
- OCC - x 7190 - Option 1
- Lessons Learned - x7190 - Option 2
- Plant Status - x7190 - Option 3

Accomplishments

- 1SI-852A Injection Valve MOV Maintenance
- TS-30 Leak Check of 1SI-867B Check Valve
- IT-290 TDAFWP Overspeed Test
- Filled Main Generator with Hydrogen
- Established a Vacuum in Main Generator
- 1RH-700 RHR Suction Valve Maintenance
- Enter Mode 3
- RCS Heatup to 370° F
- RCS Heatup to 450-470° F
- Align SI Accumulators

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
0.338	85.948 R

Dose as of the end of Day 60

Schedule Focus Areas/Priorities

- RCS Heatup to NOT/NOP ✓
- IT-230 RCS Pressure Test ✓
- Resolve Leakage on 1MS-228, Header ✓
Drain & Trap Isolation

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

V-74

June 4, 2004

OUTAGE GOALS

NUCLEAR SAFETY PERFORMANCE	GOAL	ACTUAL	HUMAN PERFORMANCE	GOAL	ACTUAL
Unplanned orange/red paths	None	None	Security Violations	≤ 12 loggable events	4
Reactor trips (either unit)	None	1	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)	≤ 92 R	85.948 R	Operator Burdens	100% of Scheduled Operator Burdens complete	On Goal
Personnel contaminations	≤ 18 w / >5K CPM	12	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		
Radmaterial event (defined as any rad material outside RCA ≥ 100 CPM)	≤ 1 event	0		Within ~2% to 0% of outage budget	Seriously Challenged

Operating Experience

OE9804 – Reactor Power Exceeded the Licensed Power Limit

During saturation of a letdown ion exchanger, the operators did not maintain power below 100.0 percent. The Core Operating Limits Supervisory System (COLSS) alarm annunciated at 100.0 percent, and the operators did not take prompt action to reduce power to clear the alarm. Although they were borating frequently, they were not aggressive enough to reduce power sufficiently to clear the alarm. Reactor power was as high as 100.2 percent power with the COLSS alarm in solid for approximately 1 hours. The maximum shift average was 99.97 percent Rx power.

Lessons Learned: Management's expectation was that the COLSS alarm would be promptly cleared. This expectation was not clearly understood by the operating crew. They erroneously felt that since they were actively borating, and reactor power was being controlled, they were meeting the intent of the ARP. In addition, the SRO was frequently distracted by activities he was supervising in support of a refueling outage on the other unit.

Human Performance

Don't be left in the dark:

An RP Tech went to change out air samples on sping-24. Lighting was out in the area. When he went to turn off power to the pump, the switch wasn't working. The RPT was told in the past that if switch wasn't working, that we can open the electrical box on the back of the sping and that you can turn off the pump from there. The darkest area was behind the sping. He opened the electrical box in the dark and saw two switches, but couldn't read them. He then went to get a flashlight. With the flashlight, he read two switches and they both look like they said pump. He turned them both off and changed the samples. When he closed the electrical box with the flashlight, he saw a piece of duct tape on the outside of the door, showing to turn off the top switch. When confronted with the two switches, the RPT should have stopped and asked for help.

Safety Snippet

Never gamble with more than you can handle

Two situations to review here. One was a RP worker and contractor trying to maneuver material through a security door. Rather than calling security, they figured they could "beat the door." They beat it all right. And the contractor suffered a leg injury from the steel hitting him. The second was an OAI carrying a large box through a door. She ended up catching hitting her hand on the doorframe. How can we prevent these injuries?