

RIII VALUE ADDED FINDING

VAF NUMBER:	SITE: Point Beach	RPT NUMBER:	ISSUE DATE:
<p>Failure to Provide An Adequate Vent Path During Nozzle Dam Installation And Failure To Adhere To Prudent Industrial Safety Practices During Nozzle Dam Installation</p> <p>Using IP 71111.20 , the inspectors identified that the licensee failed to provide an adequate Reactor Coolant System(RCS) vent path during Nozzle Dam installation as scheduled in the ongoing plant refueling outage. The inspectors also identified that prudent industrial safety practices were not followed in that multiple air hose disconnects occurred during this activity resulting in two workers being cut out of their bubble hoods and a personnel contamination.</p> <p>In the early morning hours of April 9,2004, the R.C.S. level was at mid-nozzle to allow the steam generator primary and secondary manways to be removed and nozzle dams to be installed in both the hot and cold legs in preparation for flood-up and steam generator inspections. This activity is safety significant since the time to boil is short in this configuration and , accordingly, the plant in an orange risk path during mid-nozzle operation. The inspectors observed numerous actions which appeared to be inconsistent with prudent personnel safety practices and called these to the attention of the project lead as they occurred. These included numerous loss of air events as well as questionable manway entry and exit techniques. In addition, the inspectors noted that significant confusion occurred as to whether or not an adequate RCS vent path was present prior to installation of the final hot leg dam (the outage schedule logic required that the pressurizer manway be removed prior to installation of the nozzle dams). This confusion resulted in a work stoppage of the nozzle dam installation until this concern could be resolved. Following the stoppage of work on this activity , the inspectors , after consultation with appropriate regional personnel, reported their concerns to senior plant management personnel. Senior plant management was not aware of the vent path issue or of the extent of the personnel safety issues.</p> <p>Later in the morning of April 9,2004, the licensee formed an incident response team to investigate the vent path issue and the personnel safety issues. Over the next several days, this team concluded that the plant management erroneously determined that it was acceptable to break the outage schedule logic ties and allow the installation of the hot leg nozzle dams in parallel with the removal of the pressurizer manway. The team also concluded that the personnel safety issues related to loss of air (as well as other issues) , were not brought to the attention of the appropriate plant management by plant personnel. The licensee thus concurred with all the inspectors conclusions and concerns, and identified other concerns during the coarse of their investigations. The licensee took immediate corrective actions action to address all these concerns.</p> <p>This VAF demonstrates the importance of having NRC inspections personnel onsite during critical plant evolutions to observe the behaviors of plant workers and management personnel during these activities, as such behaviors relate to nuclear and personnel safety. It also demonstrates the importance of following up concerns with senior plant management to assure that senior plant management is receiving a timely NRC inspector perspective on safety issues such that, if warranted, prompt corrective action results.</p>			
<p>Distribution: J. Caldwell, G. Grant, M. Dapas, DRPIII, DRSIII, R. Blough, D. Chamberlain, A. Howell, D. Weaver, S. Richards, W. Lanning, C. Casto, V. McCree</p>			

71-33

From: Paul Krohn
To: Higgins, Patrick; Louden, Patrick
Date: 6/1/04 2:12PM
Subject: VAF Comments

Pat and Pat,

Attached are my comments to the nozzle dam/safety practice VAF. Most changes are editorial. I added some words to emphasize that 4 SROs in key outage positions missed the relevance of the logic sequence in the schedule. Also, added some words to discuss the extent to which the bowl jumpers went to facilitate access. Other than that, changed everything to past tense.

Great inspection Pat H., I read the Harden report this afternoon and it amazes me that this actually occurred. A compare version of my comments to Pat's version is included for your information.

Paul Krohn

CC: Kunowski, Michael; Morris, R. Michael

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VAF NUMBER:	SITE: Point Beach	RPT NUMBER: 2004-003	ISSUE DATE:
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Failure to Provide An Adequate Vent Path During Nozzle Dam Installation And Failure To Adhere To Prudent Industrial Safety Practices During Nozzle Dam Installation

Using IP 71111.20-, the inspectors identified that the licensee- failed to provide an adequate Reactor Coolant System (-RCS) vent path during Nozzle Dam installation as scheduled ~~in~~ during the ongoing plant Unit 1 U1R28 refueling outage. The inspectors also identified that prudent industrial safety practices were not followed in that- multiple air hose disconnects occurred during this activity resulting in two workers being cut out of their bubble hoods and a personnel contamination event.

In the early morning hours of -April 9, 2004, the R.C.S.-level RCS inventory was at- mid-nozzlereduced to allow the steam generator primary and secondary manways to be removed and nozzle dams to be installed in both the hot and cold legs in preparation for reactor cavity flood-up and steam generator inspections. This activity is was safety significant since the time-to-boil is was short in this configuration (~38 minutes) and -accordingly, the plant in had been designated as an orange risk path during mid-nozzle operation condition. The inspectors observed numerous actions which appeared to be inconsistent with prudent personnel safety practices and called these to the attention of the project lead as they occurred. These included numerous loss of air events as well as questionable manway entry and exit techniques including lubricating individuals to facilitate manway passage and physical assistance during access attempts. In addition, the inspectors noted that significant confusion occurred as to whether or not an adequate RCS vent path was present prior to installation of the final hot leg dam -(the outage schedule logic required that the pressurizer manway be removed prior to installation of the nozzle dams). This confusion resulted in a work stoppage of the nozzle dam installation until this concern could be resolved. Following the work stoppage-of work on this activity-, the inspectors-, after consultation with appropriate regional personnel, reported their concerns to senior plant management-personnel-. Senior plant management was not aware of the vent path issue or of the extent of the personnel safety issues.

Later in the morning of April 9, 2004, the licensee formed an incident response team to investigate the vent path issue-and-the personnel safety issues. Over the next several days, this team concluded that the plant management-Shift Outage Manager, OCC Operations Representative, WCC Supervisor, and Shift Manager (all SRO qualified) had erroneously determined that it was acceptable to break the outage schedule logic ties and allow the installation of the hot leg nozzle dams in parallel with the removal of the pressurizer manway. The team also concluded that the personnel safety issues related to loss of air -(as well as other issues)-, were not brought to the attention of the appropriate plant management by plant personnel. The licensee-thus concurred with-all the inspectors conclusions and concerns, and identified other concerns during the coarse of their investigations. The licensee took immediate corrective actions action to address all-these concerns.

This VAF demonstrates the importance of having NRC -inspections-personnel onsite during critical plant evolutions to observe the behaviors of plant workers and management personnel- during these activities, as such behaviors relate to nuclear and personnel safety. It also demonstrates the importance of following up concerns with senior plant management to assure that senior plant management is receiving a-timely NRC inspector perspectives on safety issues such that, if warranted, prompt corrective action results. —

For more information on this issue contact Pat Higgins (Kewaukee) or Mike Morris at the Point Beach Resident Office.

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D. Chamberlain, A. Howell, D. Weaver, S. Richards, W. Lanning,
C. Casto, V. McCree**

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C. Casto, V. McCree**

From: Patrick Louden
To: Paul Krohn
Date: 6/1/04 2:24PM
Subject: Re: VAF Comments

ok thanks

>>> Paul Krohn 06/01/04 02:12PM >>>
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Paul Krohn