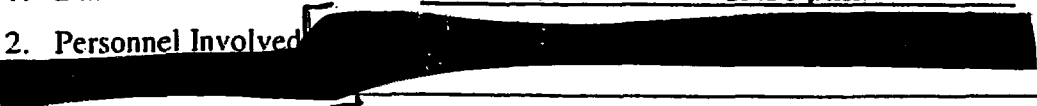


Event Investigation Report

Complete the evaluation of the human performance event using the following, as applicable:

~~7C~~
7C

1. Date and Time of the event: 03/22/05 12:20 p.m.
2. Personnel Involved: 
3. Department/Group Involved: Maint. Installation Services Group / DZNPS.
Program/Work Process/Activity Involved: Scaffold Erection WC#0401229 SI
5. Unit: PBNP Unit 0 PBNP Unit 1 PBNP Unit 2
6. Mode/Power Level: 100% / Mode 1

7. Describe the inappropriate action and conditions that led up to the event. Consider the following in this description:

a. Was a conscious decision made or not made by the individual(s) involved?

Yes (lanyard unavailable); (tool pouches not available). Decision was made to continue work without fabricating a restraining device.

b. Was the event a result of rule non-compliance, misapplication of a rule, or applying an incorrect rule?

Individual chose the desire to keep the job going and complete task over the lanyarding of any of his construction tools.

c. Was the individual fully trained/knowledgeable of the task? **Yes**

d. Did the individual make an error in judgment? **Yes**

e. Was an intended action not performed due to shortcuts taken or inadequate tracking?

f. Was the individual overconfident or was their mental/physical state a factor?
Yes

g. Did the supervisor not identify error likely situations and error precursors?

No - Issue was discussed in the pre-job brief (the tools the individual had previously used (apron) were not available).

h. Was there a process or organizational failure that led to this error (see table on next page)?

D-26
(14)

Information in this record was deleted
in accordance with the Freedom of Information
Act, exemptions 7C
FOIA- 2006-113

8. Summarize the inappropriate action in one sentence as follows:

craftsman did use an un-lanyarded tool during scaffold erection instead of waiting for proper tools (lanyards) to be utilized on the job.

(WHO)

(WHAT)

(THE REQUIREMENT)

as found in Pre-job briefing discussion because individual felt time / schedule pressure (did not want to impact work performance by delaying job to wait for a lanyard).

(Where the Requirement is found)

(WHY if known)

9. Based on what you have learned, describe the error likely situations that were present at the time of the event.

a. What Error Reduction Tools were not used or not used effectively? What Error Reduction Tools could have been used to prevent this event? Clearly state which is the one tool, which if used, would have had the greatest chance of being successful.

Stop when unsure; Are You Ready Checklist; Peer Checking

b. Are these Error Reduction Tools going to provide the barriers to prevent recurrence? Where else should these barriers be applied?

Yes

Human Performance Failure Modes (From the NMC Trend Code Manual)

- Inattention
- **Distracted & Interrupted**
- **Time & Schedule Pressure**
- Spatial Disorientation
- Inadequate Motivation
- Unfamiliar or Infrequent Task
- Inadequate Knowledge of Standards
- Inadequate Knowledge of Fundamentals
- Inadequate Verification
- Inadequate Tracking (Place Keeping)
- Habit/Reflex
- Imprecise Communication
- Bored
- Multi-Tasking
- Fear of Failure
- Mindset/Preconceived Idea
- **Shortcuts Taken**
- Misdiagnosis
- Flawed Analytical Process or Model
- **Over Confident**
- Cognitive Overload
- Tired & Fatigued
- Lapse of Memory
- Wrong Assumptions

- Work Around

- Tunnel Vision

Process Failure Modes (From the NMC Trend Code Manual)

- Critical Actions Not Verified
- Excessive Verifications
- No Process Monitoring
- Only Monitoring Problems
- Person Specified Not Able to Perform Task.
- More Than One Person Specified to Perform Task
- No One Specified to Perform Task
- No Acceptance Criteria

Organizational Failure Modes (From the NMC Trend Code Manual)

- Inadequate Prioritization
- Inadequate Trust
- Inadequate Self Assessment
- Inadequate Planning
- Inadequate Teamwork
- Inadequate Program Management
- Inadequate Span of Control
- Inadequate Communication among Organizations
- Inadequate Communication within an Organization
- Lack of Commitment
- Inadequate Knowledge
- Inadequate Emerging Issues Management
- Insufficient Staffing
- Inadequate Levels in Organization

Event Investigation Personnel Statement

Name: _____

Position: _____

Event Date: _____

Handwritten statements are acceptable. Include the plant conditions prior to the event, your indications that a problem existed, your action as a result of those indications, noted equipment malfunctions or inadequacies, and any identified procedure deficiencies. Also, include any information you consider important to the review of this event and actions that may prevent recurrence. Use additional paper as necessary.

CAP 062966

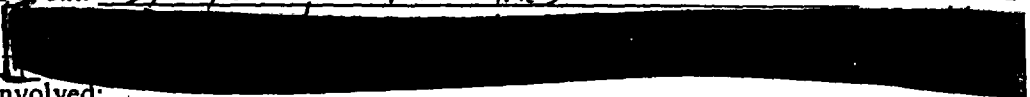
HUMAN PERFORMANCE PROGRAM

ATTACHMENT D
HUMAN PERFORMANCE EVENT INVESTIGATION TOOL

EVENT INVESTIGATION REPORT

Complete the evaluation of the human performance event using the following, as applicable:

(70)

1. Date and Time of the event: 3/22/05 ~ 1220 hrs
2. Personnel Involved: 
3. Department/Group Involved: _____
4. Program/Work Process/Activity Involved: sc 2 hold erection (force 901229SI) DTB
5. Unit: PBNP Unit1 PBNP Unit 2 IST 2282
6. Mode/Power Level: 100% / Mode 1
7. Describe the inappropriate action and conditions that led up to the event. Consider the following in this description:
 - a. Was a conscious decision made or not made by the individual(s) involved? Yes (anyone unavailable) (tool pouches not available) for time
 - b. Was the event a result of rule non-compliance, misapplication of a rule, or applying an incorrect rule? Desire to keep the job going (no lanyards on any tools)
 - c. Was the individual fully trained/knowledgeable of the task? Yes
 - d. Did the individual make an error in judgment? Yes
 - e. Was an intended action not performed due to shortcuts taken or inadequate tracking? Due to desire to prevent work performance safety delay
 - f. Was the individual overconfident or was their mental/physical state a factor? No
 - g. Did the supervisor not identify error likely situations and error precursors? No i.d.d./discussed it
 - h. Was there a process or organizational failure that led to this error (see table on next page)? pre job (discussed) by loss of A-pro (out for tools)

8. Summarize the inappropriate action in one sentence as follows:

Chapman did used an unapproved tool instead of inspected the tool as
expedited / discussed during pre job briefing (WHO) (WHAT) (THE REQUIREMENT)
 as found in _____ because T/S pressure (did not want to
 (Where the Requirement is found) (WHY if known)

impact work performance
by delaying for lanyard or
conduct a (anyone)
CONFIDENTIAL INFORMATION USE

can; over confidence

HUMAN PERFORMANCE PROGRAM

ATTACHMENT D
HUMAN PERFORMANCE EVENT INVESTIGATION TOOL

9. Based on what you have learned, describe the error likely situations that were present at the time of the event.

a. What Error Reduction Tools were not used or not used effectively? What Error Reduction Tools could have been used to prevent this event? Clearly state which is the one tool, which if used, would have had the greatest chance of being successful.

stop when unsure; use the ready checklist; peer checking

b. Are these Error Reduction Tools going to provide the barriers to prevent recurrence? Where else should these barriers be applied?

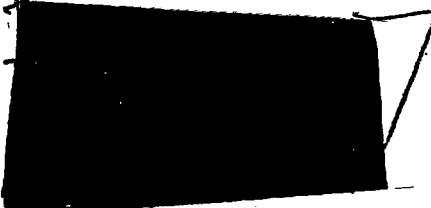
Yes

Human Performance Failure Modes (From the NMC Trend Code Manual)

Inattention * Distracted & Interrupted ** Time & Schedule Pressure	Bored Multi-Tasking Fear of Failure	Habit/Reflex Lapse of Memory Imprecise Communication	Tired & Fatigued Inadequate Tracking (Place Keeping)
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Cognitive Overload

Spatial Disorientation	Mindset/Preconceived Idea	Wrong Assumptions	Inadequate Verification
Inadequate Motivation	<i>Shortcuts Taken</i>	<i>Work Around</i>	* Over Confident
Unfamiliar or Infrequent Task	Misdiagnosis	* <i>Tunnel Vision</i> *	Inadequate Knowledge of Fundamentals
Inadequate Knowledge of Standards	Flawed Analytical Process or Model		

Crew 

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HUMAN PERFORMANCE PROGRAM

**ATTACHMENT D
HUMAN PERFORMANCE EVENT INVESTIGATION TOOL**

Process Failure Modes (From the NMC Trend Code Manual)

- Critical Actions Not Verified
- Excessive Verifications
- No Process Monitoring
- Only Monitoring Problems
- No Acceptance Criteria
- No One Specified to Perform Task
- More Than One Person Specified to Perform Task
- Person Specified Not Able to Perform Task.

Organizational Failure Modes (From the NMC Trend Code Manual)

- Inadequate Communication within an Organization
- Inadequate Communication among Organizations
- Inadequate Prioritization
- Inadequate Planning (*contributor*)
- Inadequate Emerging Issues Management
- Inadequate Program Management
- Inadequate Span of Control
- Inadequate Levels in Organization
- Insufficient Staffing
- Inadequate Teamwork
- Inadequate Knowledge
- Lack of Commitment
- Inadequate Self Assessment
- Inadequate Trust

Event Investigation Personnel Statement

Name



Position: FORMAN

Event Date: 3-22-05

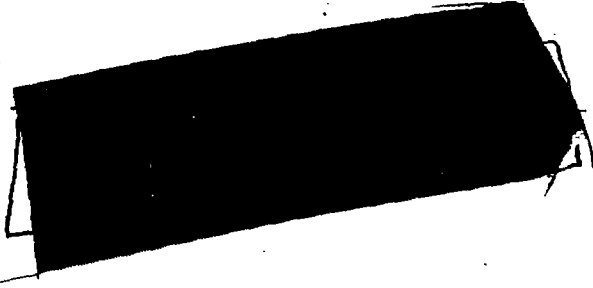
70

Handwritten statements are acceptable. Include the plant conditions prior to the event, your indications that a problem existed, your action as a result of those indications, noted equipment malfunctions or inadequacies, and any identified procedure deficiencies. Also, include any information you consider important to the review of this event and actions that may prevent recurrence. Use additional paper as necessary.

PLANT CONDITION WAS GREEN, PRIOR TO AND AFTER.

TOOL WAS DROPPED. NO LANYARD ON TOOL.

HAVING TOOLS ON A LANYARD WAS DISCUSSED IN THE PREJOB BRIEF TO PREVENT THIS. WE WILL TIE OFF TOOLS WITH STRAP UNTIL WE GET LANYARDS IN.



70

Event Investigation Personnel Statement

Name: [REDACTED]
Position: CARP.
Event Date: 3-22-05

7C

Handwritten statements are acceptable. Include the plant conditions prior to the event, your indications that a problem existed, your action as a result of those indications, noted equipment malfunctions or inadequacies, and any identified procedure deficiencies. Also, include any information you consider important to the review of this event and actions that may prevent recurrence. Use additional paper as necessary.

While working on the west side of the water boxes
24' EL. DTS 2282 A a combination
box wrench slipped out of my hand. to the 8' level.
my labour [REDACTED] got the wrench at 8' 7C
no instrument was hit and to the best of my knowledge
nothing else was damaged. the 8' level was barricaded
I reported to [REDACTED] about the incident at the 12:30
break, It happened right before break.
break

W.O # C 240122951

[REDACTED]

7C

2006

**PBNP Maintenance Department
Event Clock Blue Sheet
CAP**

Days Since Last Clock Reset: 12 days

Goal: 20 Days

The following information is to be used at Maintenance Dept. shift briefs to present timely OE on an event that reset the Maintenance Human Performance Clock.

Clock Reset Based On: Personal Safety Issue / Near Miss

CAP Number:

Background:

Event Outline:

Corrective Action Taken: The workers stopped, placed their work area in a safe condition and notified their Supervisor. The Supervisor then contacted the following personnel:

**NMC Contractor Manager
Operations Department Manager
Maintenance Department Manager
Industrial Health and Safety Manager**

Corrective Action Taken: (cont.) An Operations representative performed a walk down of the area to ensure that no equipment had been damaged during this incident.

The Contractor Site Manager and Responsible Contractor Liaison then held a Briefing / Safety Stand down with all Craft Scaffolding personnel. A lessons learned briefing was also held with all Supervisors.

A Human Performance Investigation was performed.

Operating Experience: N/A

References: N/A

Error Reduction Tools that may have helped in this event: STAR (Worker adjusting the decking), Challenging Information (How am I verifying the loose plate is not being allowed to fall), Communications

Human Performance Failure Modes: (A1) - Inattention, (A5) - Distracted, (A6) - Multi-Tasking, (A8) - Inadequate Tracking, (J5) - Inadequate Verification

ACEMAN Barrier Not Met: Worker Practices, Job Planning/Preparation, Verification/Validation, Peer Checking

Attachment: N/A

Event Investigation Personnel Statement

Name: _____

Position: _____

Event Date: _____

Handwritten statements are acceptable. Include the plant conditions prior to the event, your indications that a problem existed, your action as a result of those indications, noted equipment malfunctions or inadequacies, and any identified procedure deficiencies. Also, include any information you consider important to the review of this event and actions that may prevent recurrence. Use additional paper as necessary.

Event Investigation Personnel Statement

Name: [REDACTED] 7C
Position: Carpenter
Event Date: 03-22-05

Handwritten statements are acceptable. Include the plant conditions prior to the event, your indications that a problem existed, your action as a result of those indications, noted equipment malfunctions or inadequacies, and any identified procedure deficiencies. Also, include any information you consider important to the review of this event and actions that may prevent recurrence. Use additional paper as necessary.

[REDACTED] Said He Drop a wrench ON Tuesday March 22 2005. 7C
The wrench was lying ON The 8' Turbine Floor. The wrench
Fell from 26' Worker Box NOT Harming plant Equip.
Pre Outage. After notice put in safe condition and stop
work. Then a Safety stand down.

Event Investigation Personnel Statement

Name: [REDACTED]

Position: Laborer - NP-5

Event Date: 3-22-05

7C

Handwritten statements are acceptable. Include the plant conditions prior to the event, your indications that a problem existed, your action as a result of those indications, noted equipment malfunctions or inadequacies, and any identified procedure deficiencies. Also, include any information you consider important to the review of this event and actions that may prevent recurrence. Use additional paper as necessary.

We were working on the west side of the water boxes on the 26' level. A wrench was dropped and fell to the 8' level. [REDACTED] informed us that it was dropped. It was before the outage. We stopped the job and had a stand down. Supervisors were also notified.

AMS File No. R111-05-0062

I filed a complaint with the D.O.L.
on Sat. Aug. 20th.

This a copy of the correspondance I made
to them.

[REDACTED] 7C

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AUG 25 2005