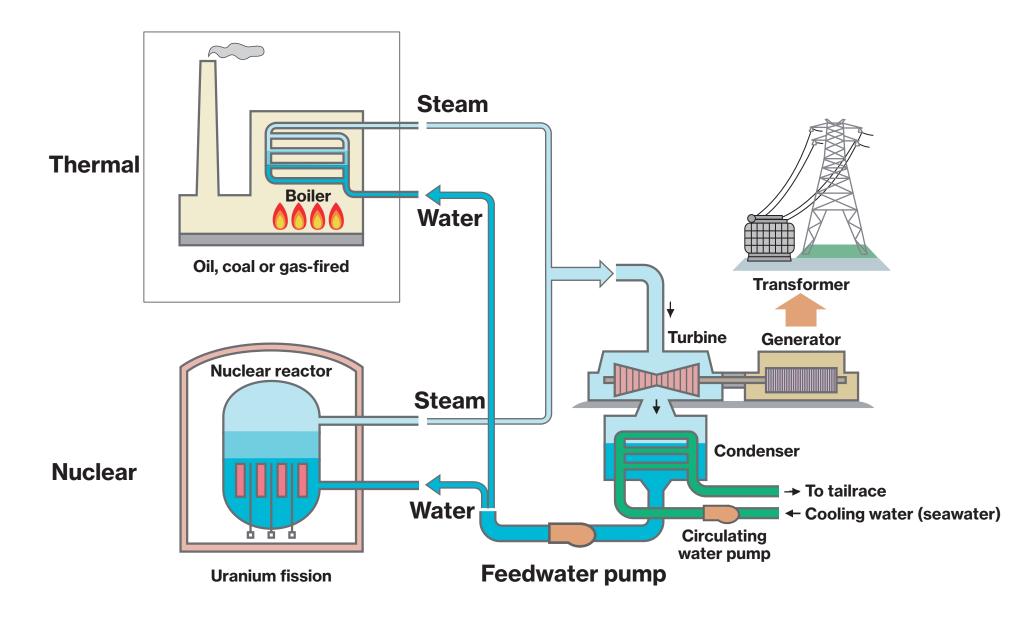
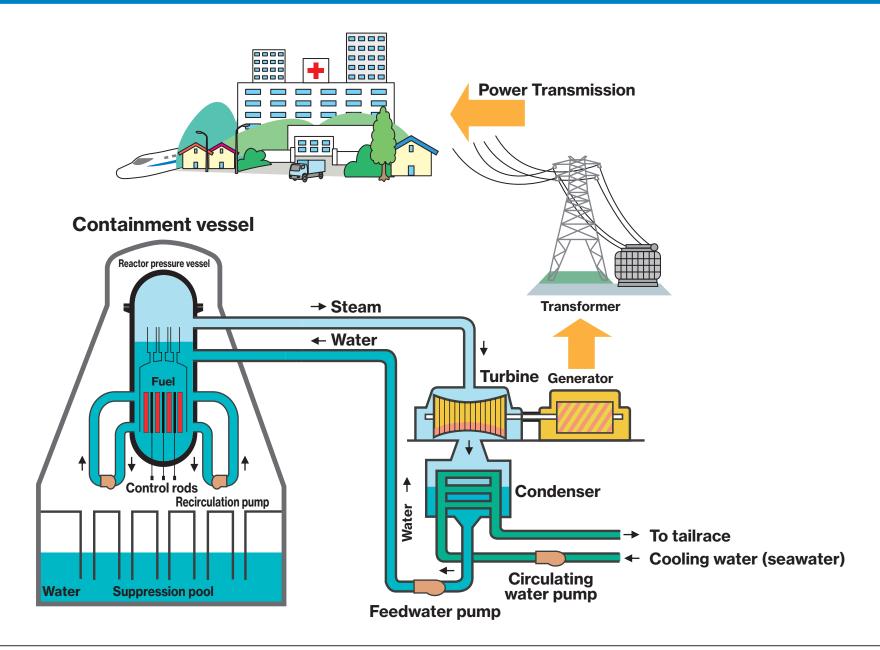
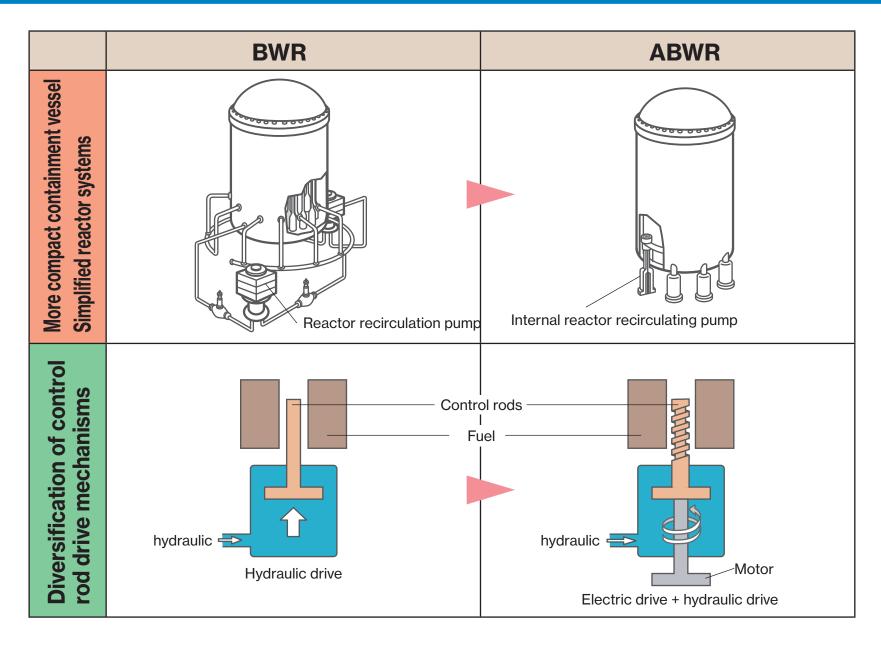
The Differences between Thermal and Nuclear Power Plants



How a Boiling Water Reactor (BWR) Works

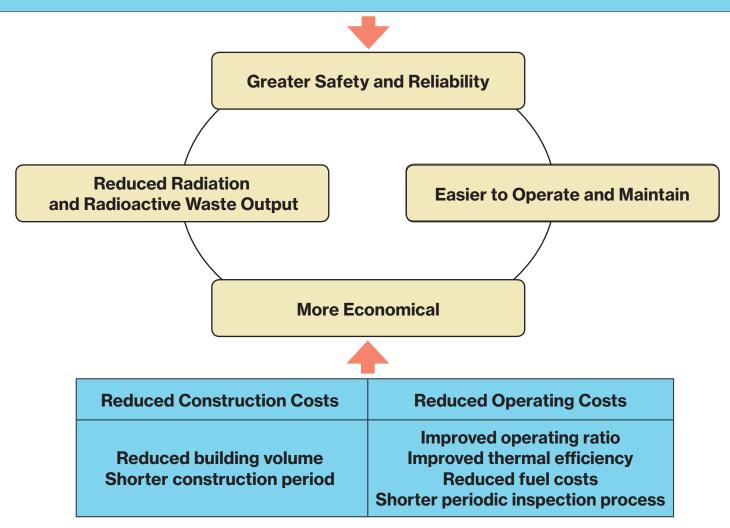


Structural Features of Advanced Boiling Water Reactors (ABWR)

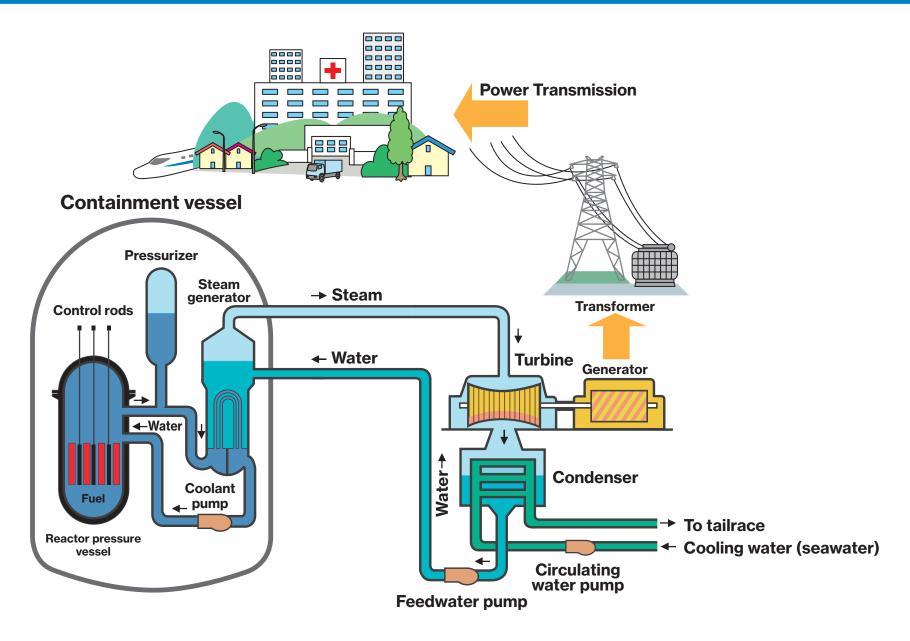


Features of Advanced Boiling Water Reactors (ABWR)

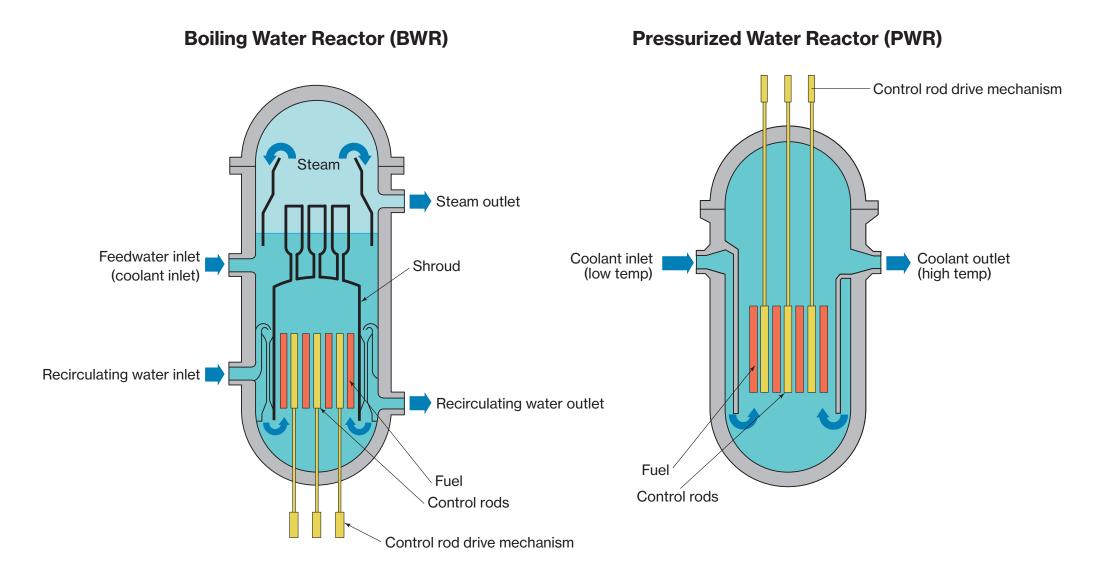
Simplified reactor systems, more compact containment vessel and diversified core control drive mechanisms Improved earthquake resistance and optimized emergency core cooling system



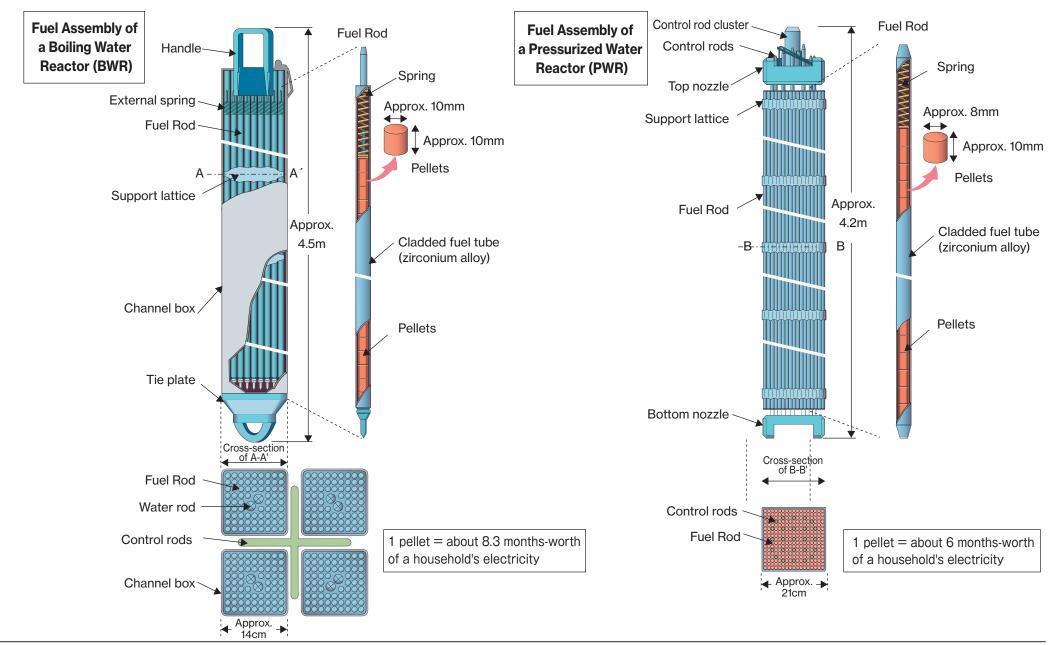
How a Pressurized Water Reactor (PWR) Works



Cross-sections of Reactor Pressure Vessels

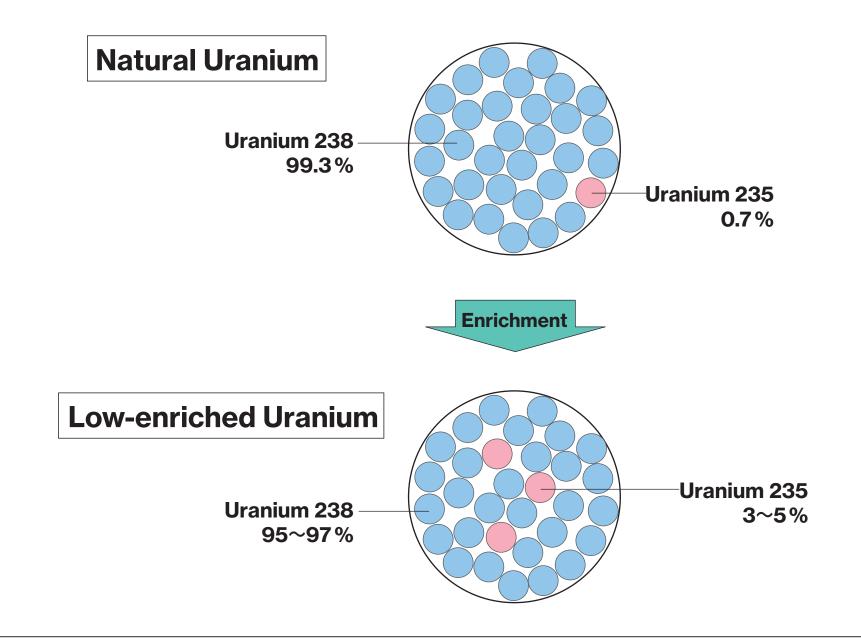


Fuel Assembly Structures and Control Rods

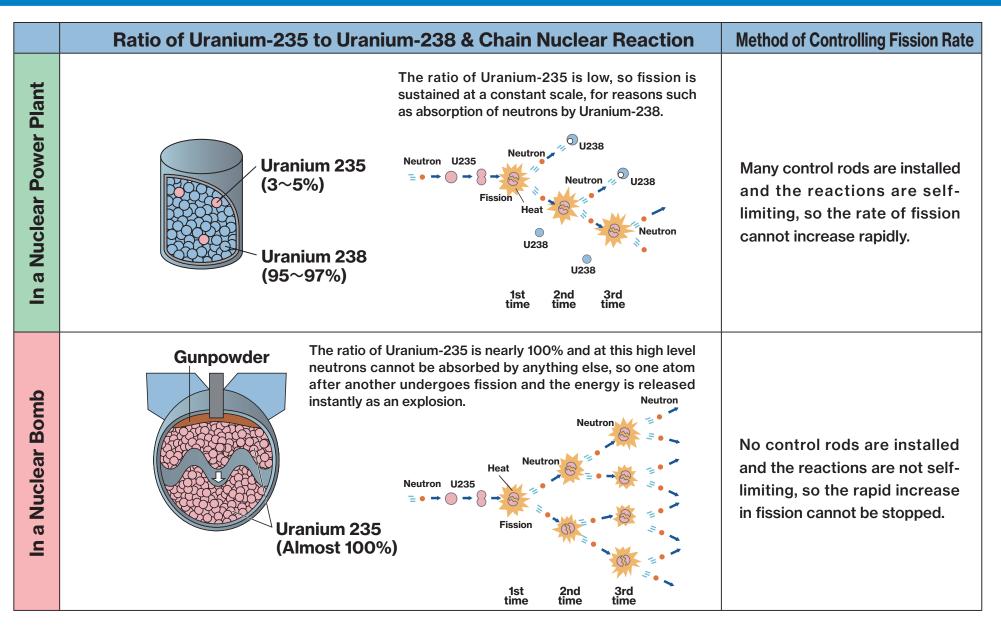


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Natural Uranium & Enriched Uranium

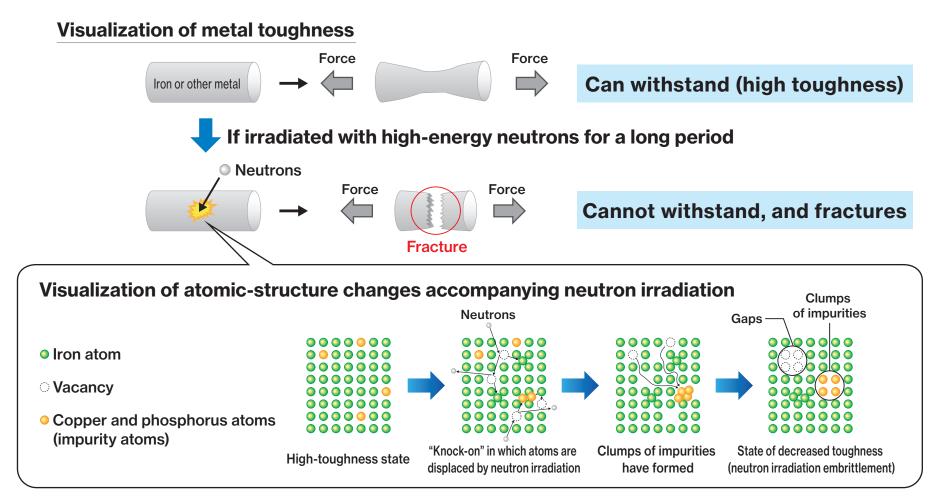


Differences between Nuclear Power and Nuclear Bombs



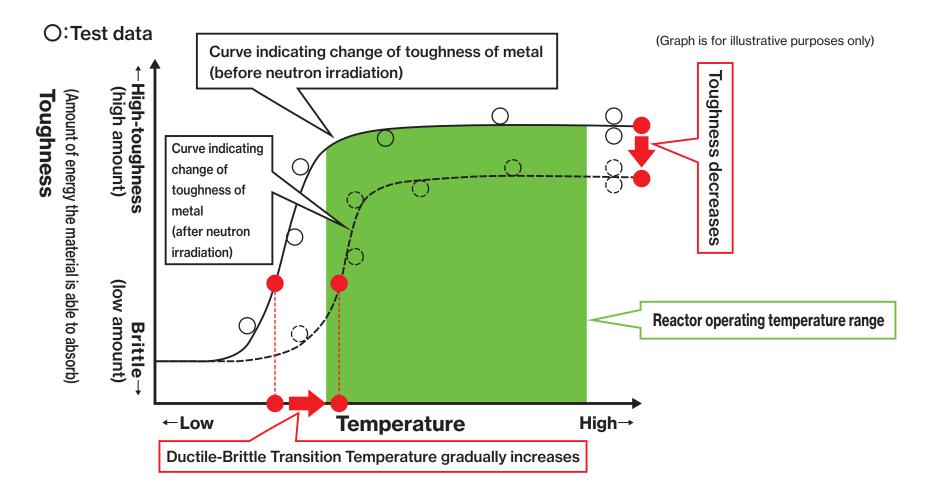
About Neutron Irradiation Embrittlement

Metal doesn't fracture easily, even when a large force is applied. At high temperatures, it keeps this property of not fracturing easily (high toughness), but if its temperature is lowered, its toughness decreases. This phenomenon of toughness decreasing is called embrittlement. Metals like iron become brittle not only when their temperature decreases, but also when they are irradiated with high-energy neutrons. If we look at iron at the atomic level, the atoms are lined up properly in an orderly state which gives it high toughness, but if it's irradiated with high-energy neutrons for a long period, "knock-on" occurs in which some iron atoms are displaced leaving gaps, or some atoms become inserted between the other atoms. Also, in the iron of the reactor vessel, phosphorus, copper, and other substances that exist as impurities may clump together. When the atoms that were lined up in an orderly arrangement become disorderly, the toughness decreases and it is known as "neutron irradiation embrittlement".



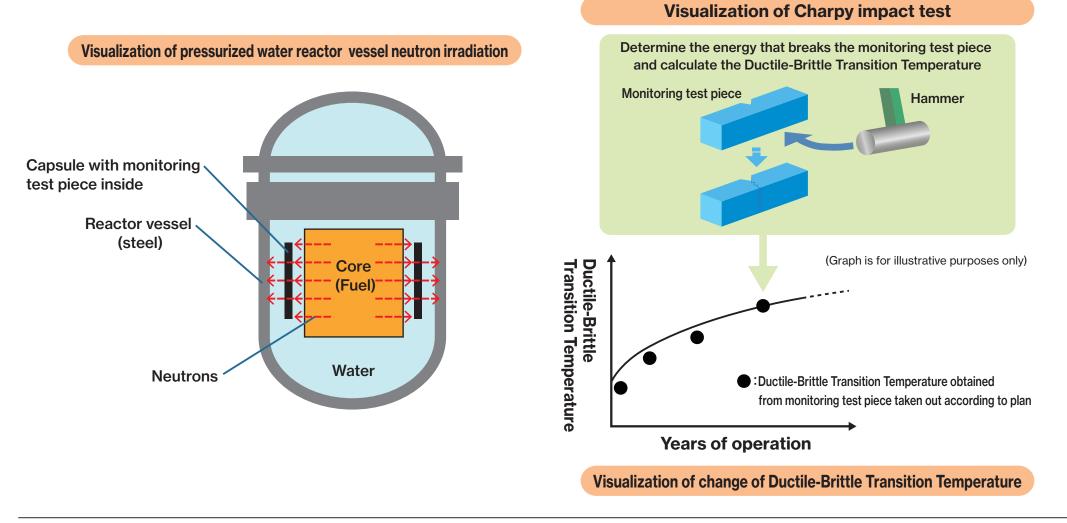
About Ductile-Brittle Transition Temperature

If a metal has low toughness, when stress is applied to a large crack, it will break. Additionally, if it becomes below a certain temperature, its toughness decreases, and the temperature at which the toughness changes is called the "Ductile-Brittle Transition Temperature" (DBTT). The steel used to make reactor vessels often has a DBTT that is extremely low at first (tens of degrees below 0°C), but after a long period of operation, it can climb as high as tens of degrees above 0°C due to continued irradiation with neutrons. If there is a large crack in the reactor vessel within this temperature range and a very large stress is applied, there is a possibility of it being unable to withstand the stress. That's why it's necessary to check for changes in the DBTT, ensure there are no large cracks, and be cautious of stress when operating the reactor at low temperatures.

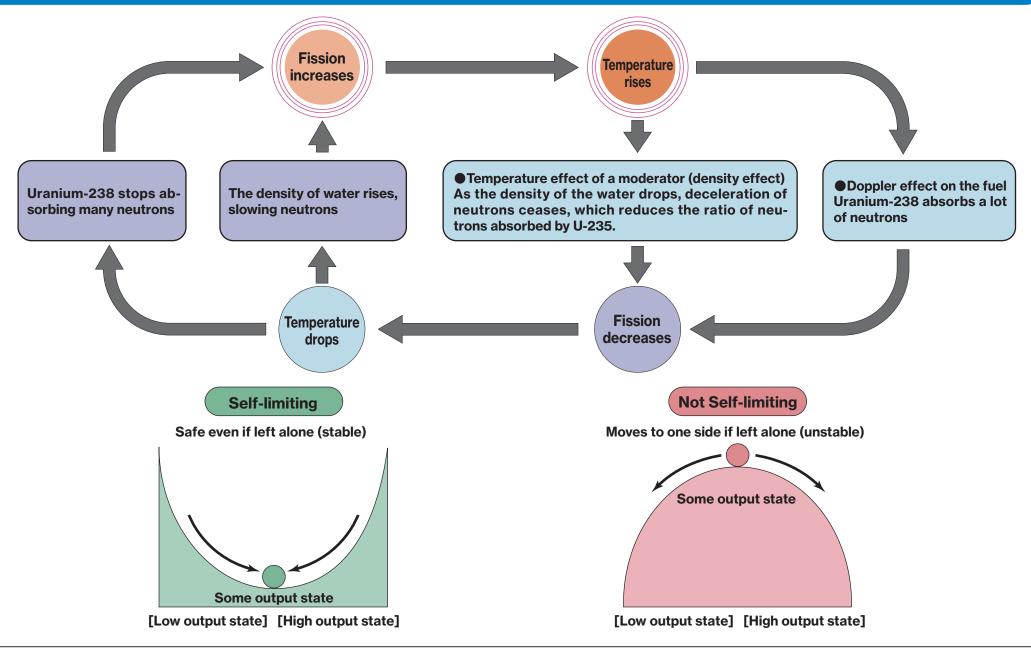


Monitoring Test Piece Inside Reactor Vessel and Ductile-Brittle Transition Temperature

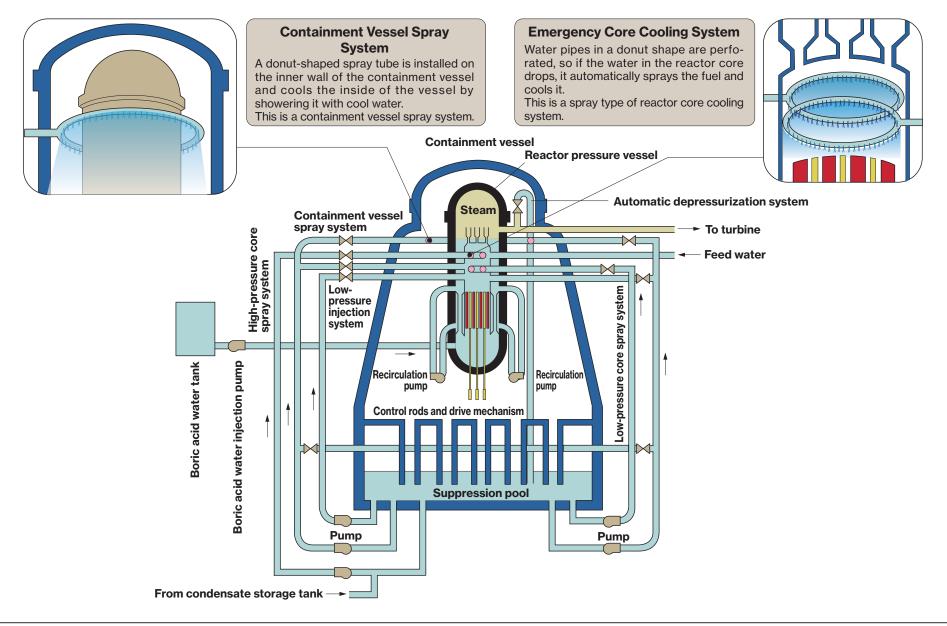
In order to monitor the effect on the reactor vessel from irradiation with neutrons, a "monitoring test piece" made from the same material as the reactor vessel is installed inside the reactor vessel in advance. Changes in the toughness (embrittlement) of the reactor vessel can be evaluated by taking out the monitoring test piece at regular intervals according to the regulations and standards, conducting the Charpy impact test, and finding the change in the "Ductile-Brittle Transition Temperature".



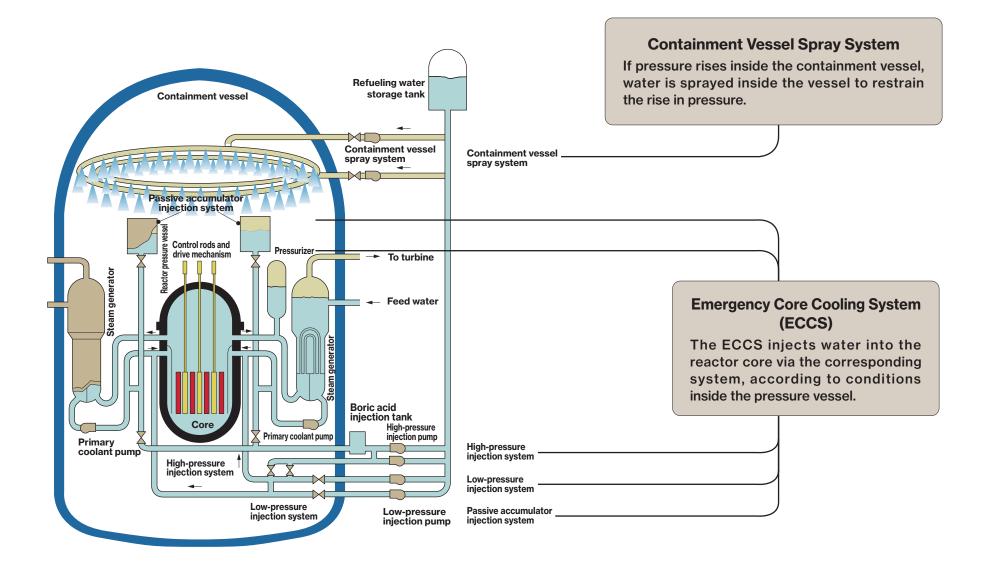
Inherent Safety of Nuclear Reactors (Self-Limiting)



Example of an Emergency Core Cooling System (BWR)



Example of an Emergency Core Cooling System (PWR)



Purposes of Periodic Inspections of Nuclear Power Plants

Check Soundness

- Confirm operational ability and performance of major equipment, plus settings functionality
- Check soundness of equipment via disassembly inspections and leak tests

Maintenance of Functions

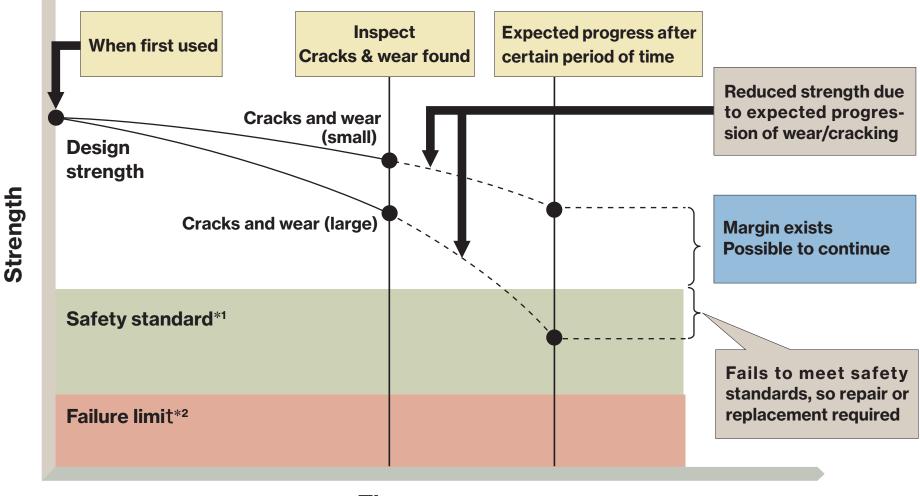
- Regular replacement of consumables
- Measures to prevent deterioration
- Early detection and correction of anomalies

Safe and Stable Operation of the Plant

Increase Reliability

- Inspect and address areas similar to where accidents or incidents occurred at other power plants
- Replace equipment and facilities that introduce the latest technology

Methods for Evaluating the Soundness of Equipment



Time

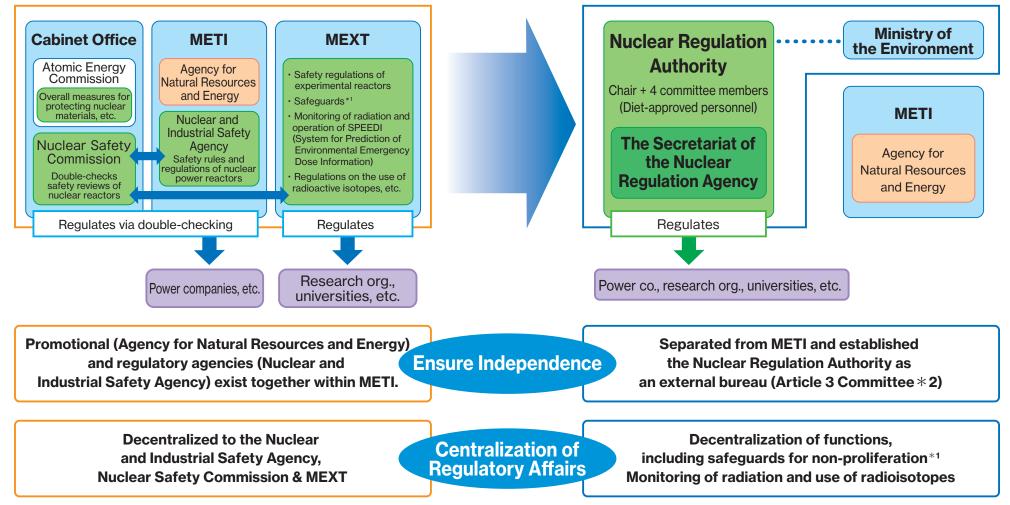
*1: Safety standard includes a tolerance margin over actual failure limit

*2: Minimum strength for equipment to withstand conditions without failing

Changes in the Nuclear Safety Regulatory System

[Former Regulatory System]

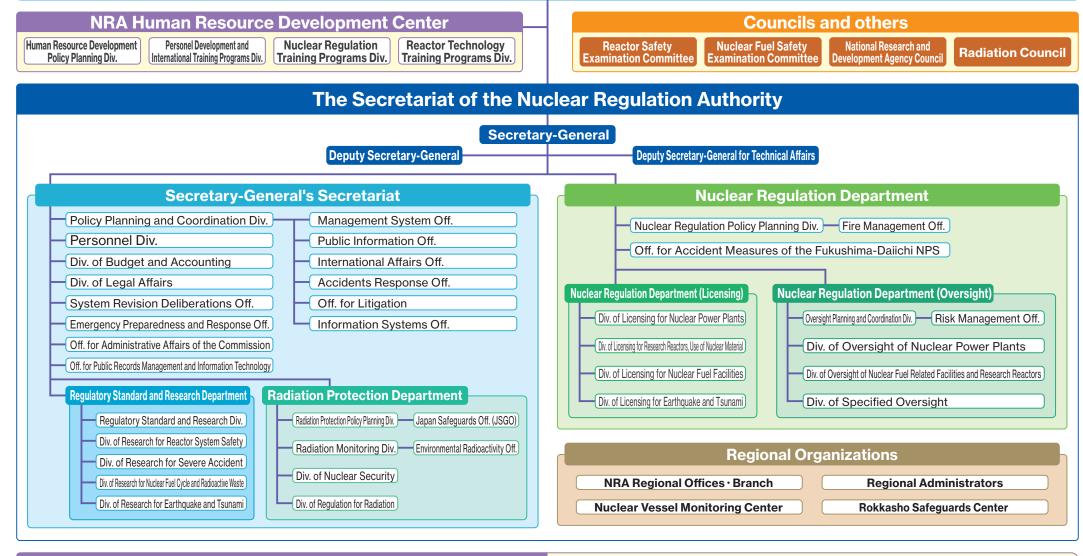
[New Regulatory System]



- *1 Refers to verification measures to ensure that nuclear materials are only used for peaceful purposes and not diverted to military use, such as for weapons.
- *2 Commissions of the so-called Article 3 (of the National Government Organization Law, Article 3, Paragraph 2, Establishment of Administrative Organs) are not under the command or supervision of top level organs (e.g. set up under the minister of a cabinet) and are independent, with exercise of their authority guaranteed by mechanisms of the Diet.

Nuclear Safety Regulation System

The Nuclear Regulation Authority



Incorporated Administrative Agencies < Partial Juriadiction>

Japan Atomic Energy Agency (JAEA)

National Institutes for Quantum and Radiological Science and Technology (QST)

New Regulatory Requirements for Nuclear Power Plants

〈 Previous Regulatory Requirements 〉

Design basis to pre (Confirm that a sin lead to co

Consideration of natural phenomena	Beinforcement of 1	Fire Protection	Reinforced or newly introduced
Fire Protection	Expansion of	(Use of flame retardant cable. other) Reliability of power supply	nowly initiation
Reliability of power supply	consideration for external events	(Secure two independent lines. other) Function of other SSCs	
Function of other SSCs*	>	(Enhance communication facilities. other)	
Seismic/tsunami resistance		Seismic/tsunami resistance (Setting of lake bank. other)	Reinforced

A New Regulatory Requirements
 A

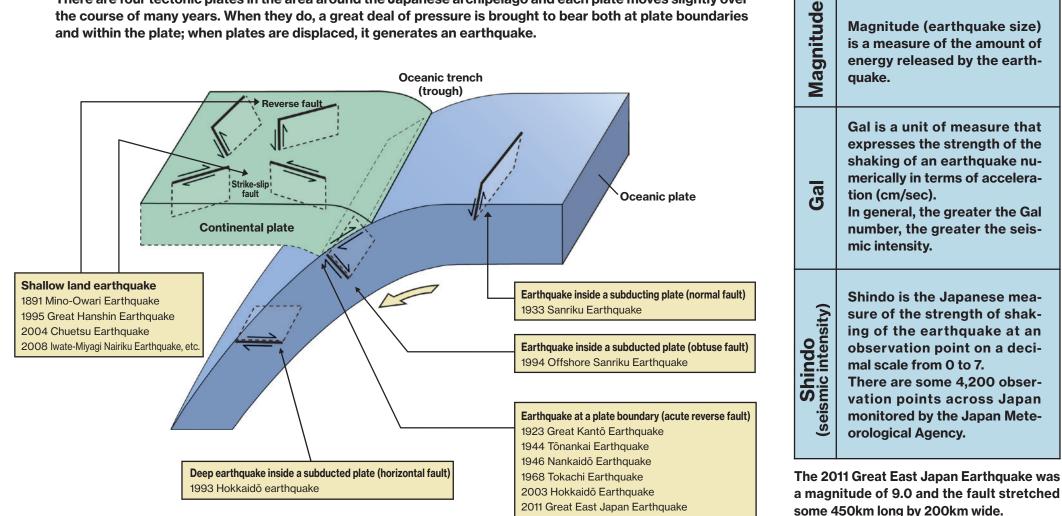
		Response to international aircraft crashes	Newly introduced (measures against terrorism)
		Measures to suppress radioactive materials dispersion	
		Measures to prevent containment vessel failure	Newly introduced (measures against severe accidents)
		Measures to prevent core damage (Postulate multiple failures)	severe accidents)
vent severe accidents	s7	Consideration of internal flooding (newly introduced)	
ngle failure would not pre damage)		Consideration of natural phenomena in addition to earthquakes and tsunamis-volcanic eruptions, tornadoes and forest fires	
natural phenomena	Reinforcement of	Fire Protection (Use of flame retardant cable. other)	 Reinforced or newly introduced
rotection	design criteria Expansion of	Reliability of power supply	
f power supply	consideration for	(Secure two independent lines. other)	
f other SSCs*	external events	Function of other SSCs (Enhance communication facilities. other)	
nami resistance	/	Seismic/tsunami resistance (Setting of lake bank. other)	Reinforced

*SSC: Structure, Systems and Components

Our Knowledge About Earthquakes

©Earthquake Mechanisms

There are four tectonic plates in the area around the Japanese archipelago and each plate moves slightly over the course of many years. When they do, a great deal of pressure is brought to bear both at plate boundaries and within the plate; when plates are displaced, it generates an earthquake.



OScale of Earthquakes

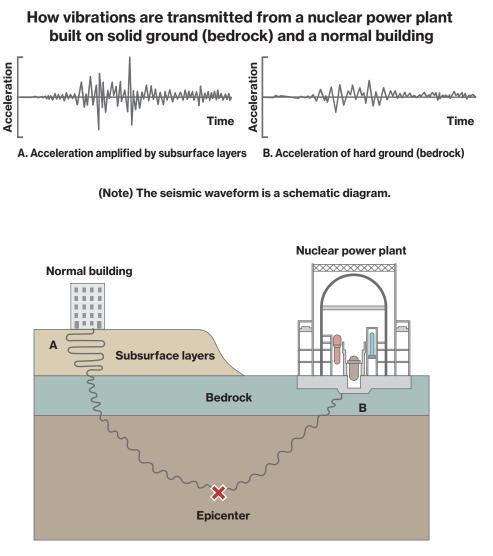
Magnitude (earthquake size)

is a measure of the amount of

OActive Faults

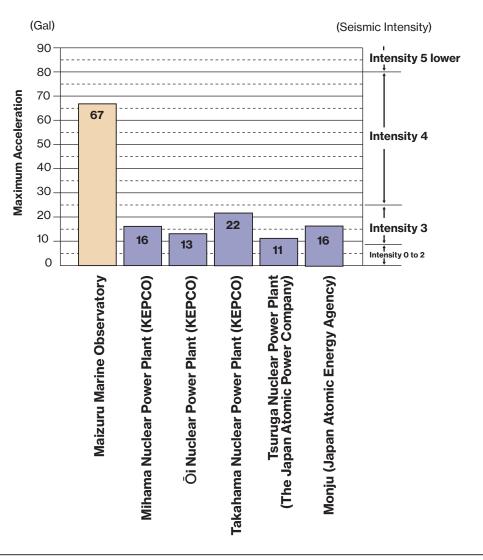
This refers to a fault that has been active repeatedly in recent geological history and may be active again in the future.

Differences in Vibrations between a Nuclear Power Plant and a Normal Building

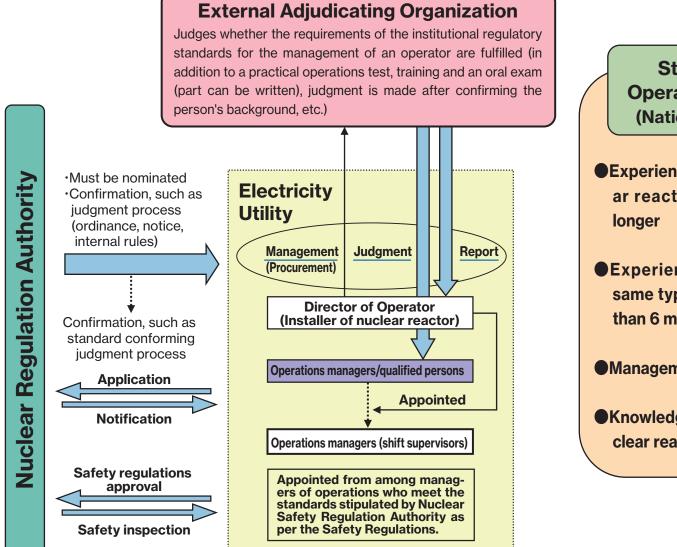


Vibration of hard ground (bedrock) is 1/3 to 1/2 that of subsurface layers.

Maximum accelerations observed around Wakasa Bay during the 1995 Great Hanshin Earthquake



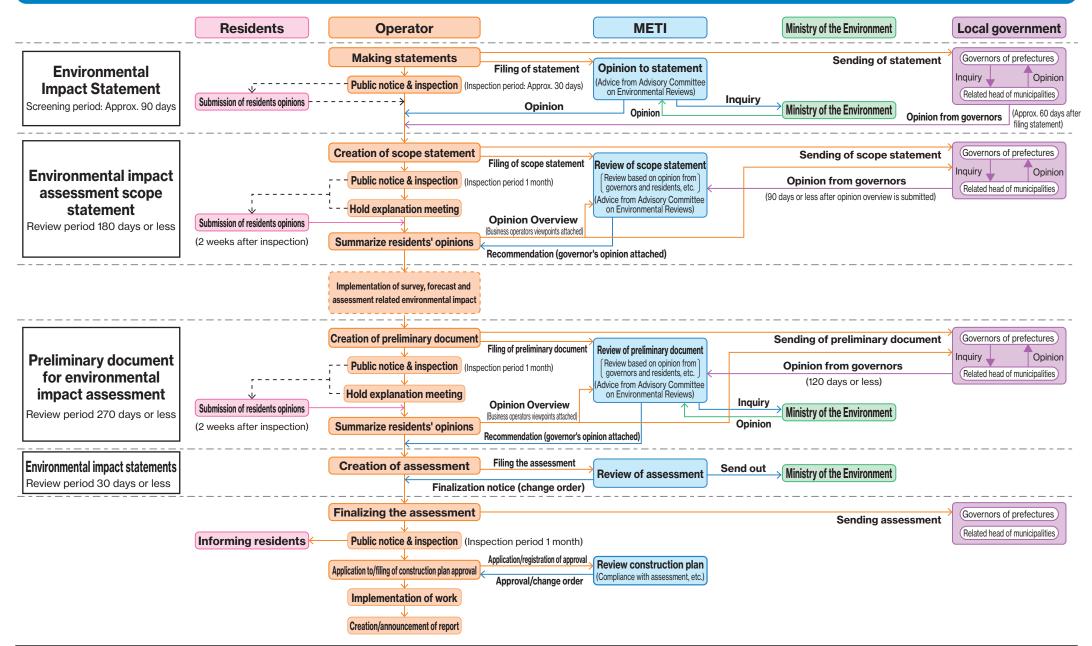
Appointment of Operations Manager



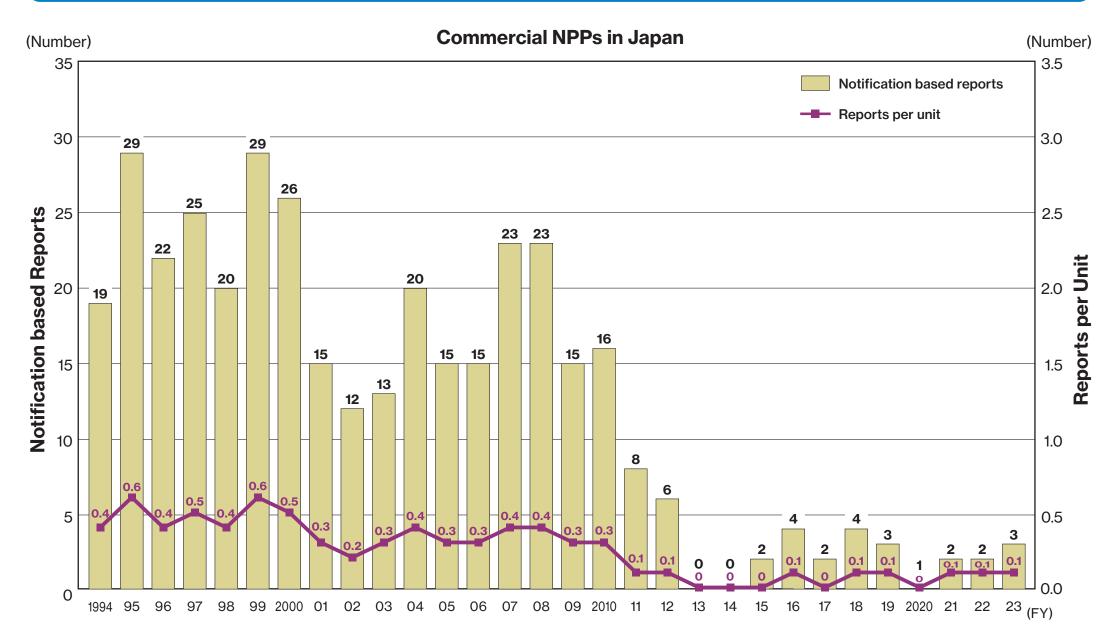
Standards for Operations Manager (National Standards)

- Experience of operating nuclear reactors for five years or longer
- Experience of operating the same type of reactor for more than 6 months in past 1 year.
- Management supervisor rank
- Knowledge/skills related to nuclear reactors

Environmental Assessment System Leading Up to Construction of Power Station

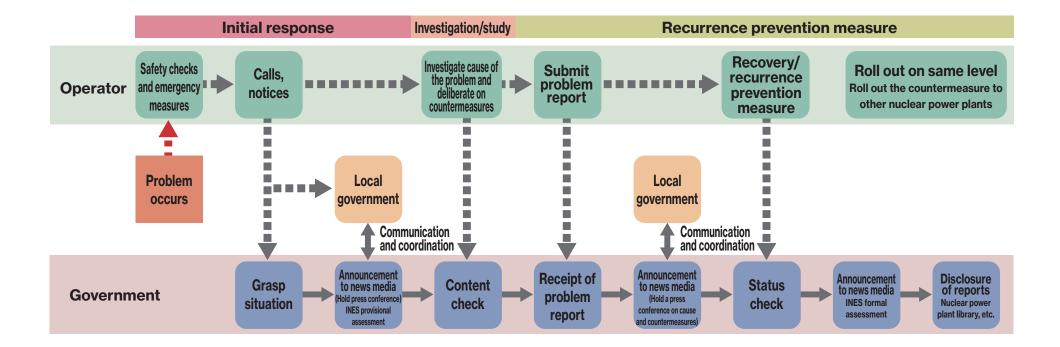


Historical Trends in Reported Incidents and Failures at NPPs in Japan

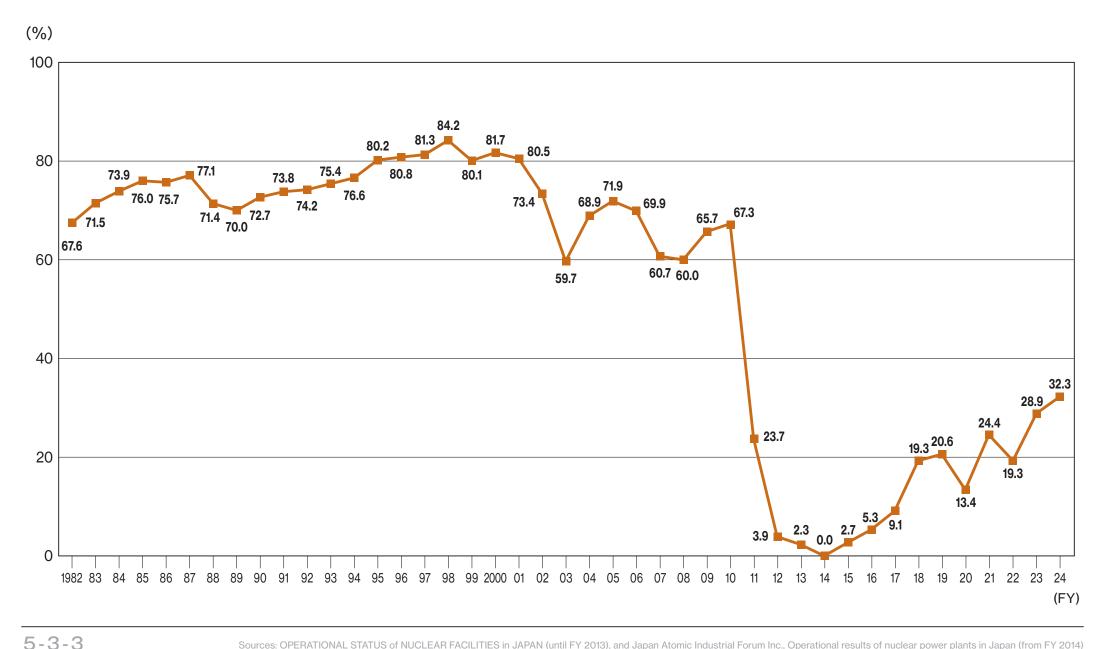


Source: Nuclear Regulation Authority

Troubleshooting



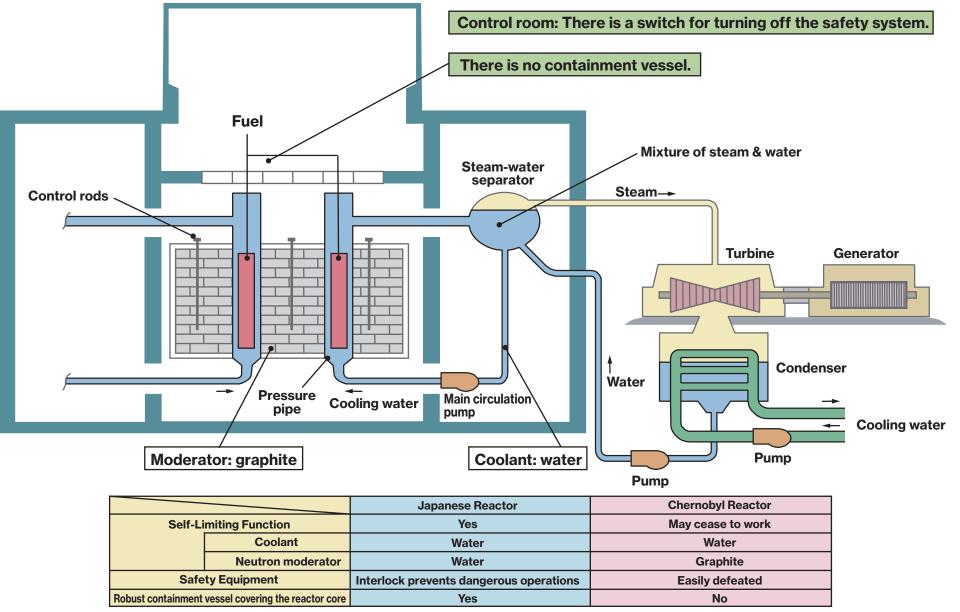
Equipment Utilization Rate of Nuclear Power Plant



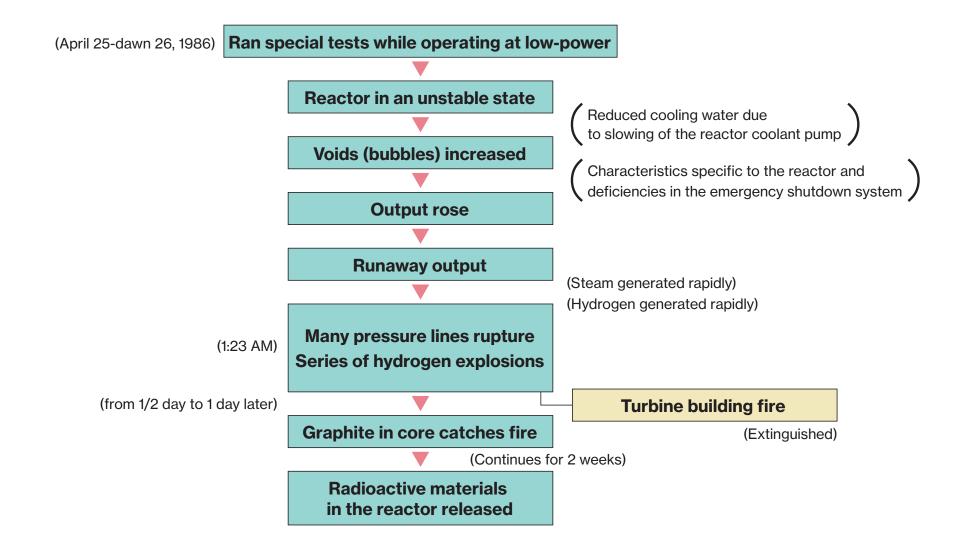
Sources: OPERATIONAL STATUS of NUCLEAR FACILITIES in JAPAN (until FY 2013), and Japan Atomic Industrial Forum Inc., Operational results of nuclear power plants in Japan (from FY 2014)

Structure of the Chernobyl Nuclear Power Plant

(Light Water Cooled Graphite-Moderated Reactor RBMK)



Course of Events of the Chernobyl Nuclear Accident



Causes of the Accident at Chernobyl Nuclear Power Plant

Lack of Safety Culture

Design Defects

- No containment vessel
- Designed to easily turn off safety equipment
- Positive void coefficient; during low power operation, the more voids (froths) in cooling water, the more output, etc.

Operator Regulation Violation

- Withdrew control rods more than regulated
- Operated with Emergency Core Cooling System (ECCS) turned off
- Conducted a special test at lower power than planned

Continuous operation was prohibited due to instability at low power range (less than 20% of total output), etc.

Operational Mismanagement

- Managed by a non-reactor-specialist
- A special test was conducted without due processes or approval throughout the power plant
- · Inadequate examinations on safety measures, etc.

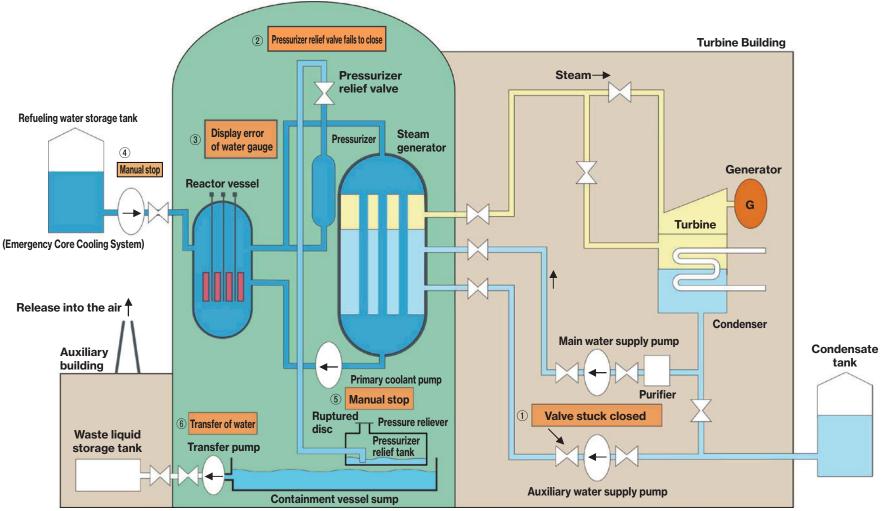
Overview of the Three Mile Island Nuclear Accident

OMain Events in the accident

On March 28, 1979, the main feedwater pump stopped in reactor 2 of the Three Mile Island (TMI) nuclear power plant in Pennsylvania in the United States. Although the auxiliary feedwater pump started up automatically, the secondary cooling water failed to circulate due to a closed pump outlet valve; in addition, an operator misunderstood the Emergency Core Cooling System (ECCS) and manually stopped it. The result of equipment failure and operator error caused a partial meltdown of structures inside the reactor.

OImpact on the environment

The dose of radiation received by the public in the area was a maximum of 1 mSv and an average of 0.01 mSv, which is an extremely low level in terms of impact to health.



Containment vessel / Reactor Building

Overview of Accident at Mihama Nuclear Power Plant, Unit 2

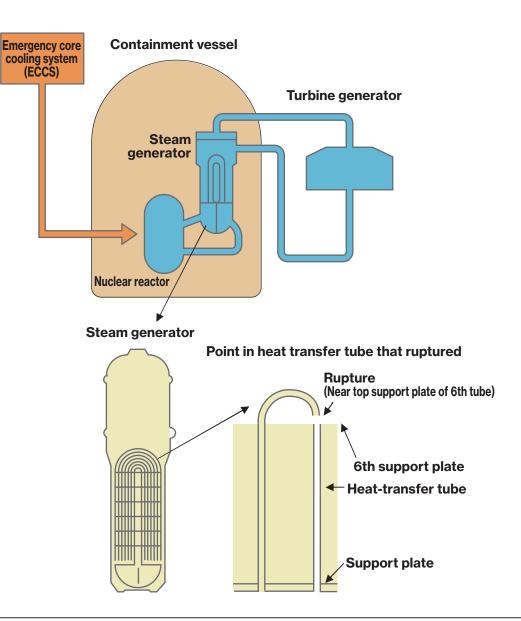
Overview of the accident

On February 9th, 1991, one heat-transfer tube on Unit 2 of Kansai Electric Power's Mihama Nuclear Power Plant ruptured, initiating automatic shutdown of the reactor and activating the Emergency Core Cooling System (ECCS). The results of the ensuing investigation showed that a fixture designed to suppress vibration to the heat-transfer tube had not been inserted as far it was designed to be, resulting in abnormal vibrations of the tube.

As a result, it was found that this high cycle fatigue (force repeated over 100,000 times) led to the material not being able to withstand the force, and the pipe rupturing.

\bigcirc Impact on the environment

Although this was the first time in Japan that an emergency core cooling system (ECCS) had been activated due to spillage of primary coolant, the amount of radioactive materials released in the event was negligible and no impacts on the environment were observed.



Overview of Accident in Secondary Piping at Mihama Nuclear Power Plant, Unit 3

Overview of the accident

On August 9th, 2004, an accident occurred in Unit 3 of the Mihama Nuclear Power Plant owned by Kansai Electric Power Co., in which pipes in the secondary system ruptured.

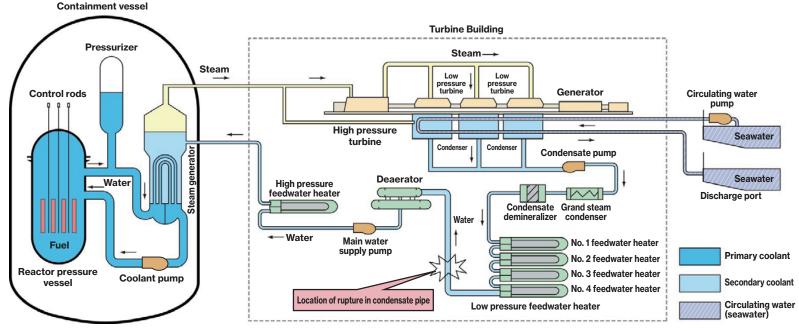
At the time of the accident, contracted workers were inside the building that housed the turbines of the Mihama 3 reactor preparing for the 21st periodic inspection that was scheduled to start from the 14th of August.

With the workers inside, a condensate pipe ruptured near the ceiling on the 2nd floor inside the building housing the turbine, causing hot water at 140°C and 9 atmospheres of pressure to blast out as steam.

Operators who were in the building for inspections immediately found victims who had passed out in front of the elevator on the 2nd floor of the turbine building.

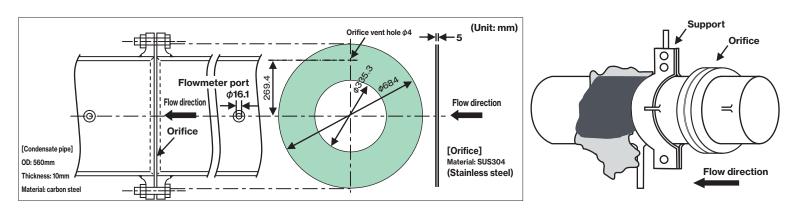
Although the 11 victims of the contracted company were transported to a hospital, 5 died and the other 6 were seriously injured.

However, the accident in the secondary and main cooling systems did not affect the public or nearby workers with radioactive materials.

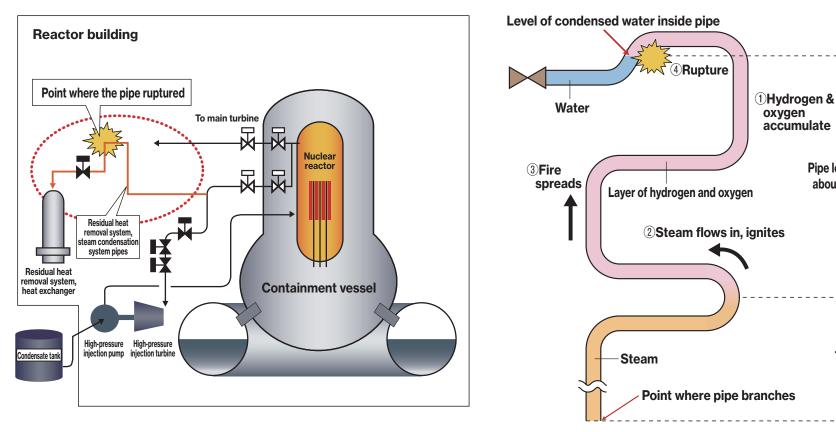


$\bigcirc \mbox{Cause}$ of the accident

A large rupture was found downstream of an orifice (flowmeter) for measuring condensate pipe water flow. The investigation found that turbulence was likely to occur at points downstream of the orifice and an internal inspection of the part that ruptured found that the so-called erosion-corrosion process had gradually reduced the thickness of the pipe, thus weakening it to the extent that it ruptured due to the load during operation at the time. Management guidelines were established in 1990 for the wear of secondary piping in PWR, and from that time parts of pipes that were anticipated to be corroded had been measured according to plan. However, the part of the pipe that ruptured (A line) was from the very beginning supposed to be measured, but it had been missed and the thickness of the pipe had never been measured at the time of the accident.



Overview of Pipe Rupture in the Accident at Hamaoka Nuclear Power Plant, Unit 1



Residual heat removal system, steam condensation system pipes

Pipe length

about 7m

Total length

about 50m

Overview of the accident

During a manual inspection at 5:02pm on November 7, 2001 of the high-pressure injections system of reactor 1 at the Chubu Electric Power Co., Inc., Hamaoka Nuclear Power Plant, a condensed steam pipe in the residual heat removal system ruptured.

○Cause of the accident

- ①Steam condenses in the upper part of the pipe. A high concentration of hydrogen and oxygen accumulated at a point about 7m from the surface of the water.
- ⁽²⁾During the manual inspection of the high-pressure injection system, the change in pressure caused super-hot steam to flow into the layer of hydrogen and oxygen, igniting it. Precious metals may have acted as a catalyst.

③Once ignited, the flame spread into the layer of hydrogen and oxygen (combustion state: deflagration \rightarrow detonation)

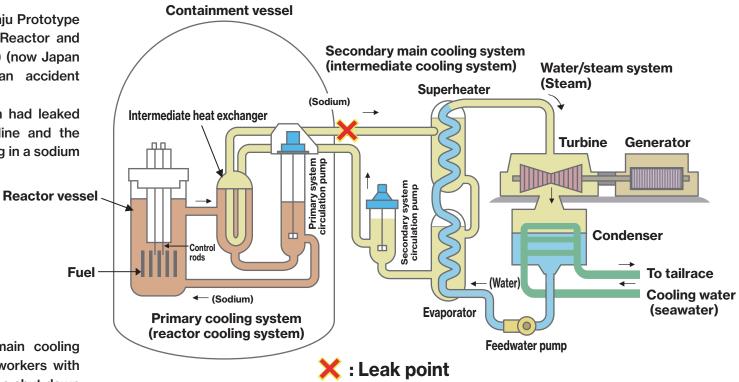
(4) The pressure inside the pipe rose precipitously, rupturing an elbow near the surface of the water (about 3,000 atmospheres of pressure). Other parts of the pipe were deformed.

Overview of the Sodium Leak Accident at the Prototype Fast Breeder Reactor

\bigcirc Overview of the accident

On December 8, 1995, while bringing the Monju Prototype Fast Breeder Reactor of the former Power Reactor and Nuclear Fuel Development Corporation (PNC) (now Japan Atomic Energy Agency) into operation, an accident occurred, resulting in a sodium leak.

The ensuing investigation found that sodium had leaked from a temperature gauge in the sodium line and the sodium reacted with oxygen in the air, resulting in a sodium fire.

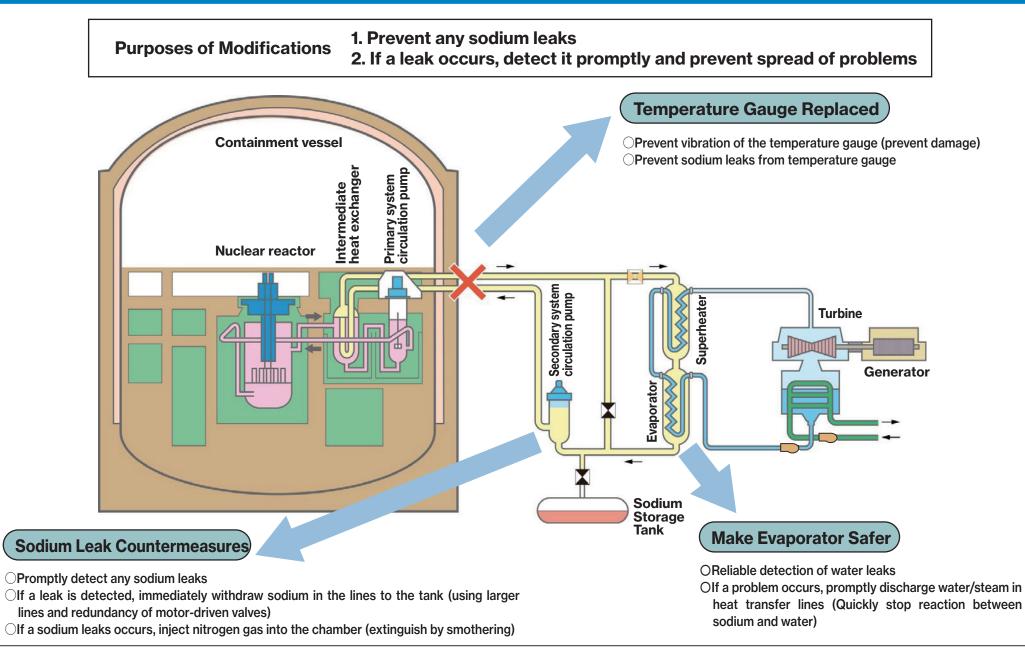


\bigcirc Impact of the accident

However, the accident in the secondary main cooling system did not affect the public or nearby workers with radioactive materials. The nuclear reactor also shut down safely and the reactor core was unaffected.

However, sodium did leak and the sodium fire did in fact broaden the impact. And because the operator, PNC at the time, clearly mishandled informing the public, it made many people, especially those living in the region, worry and mistrustful.

Overview of Modifications to the Monju Prototype Fast Breeder Reactor



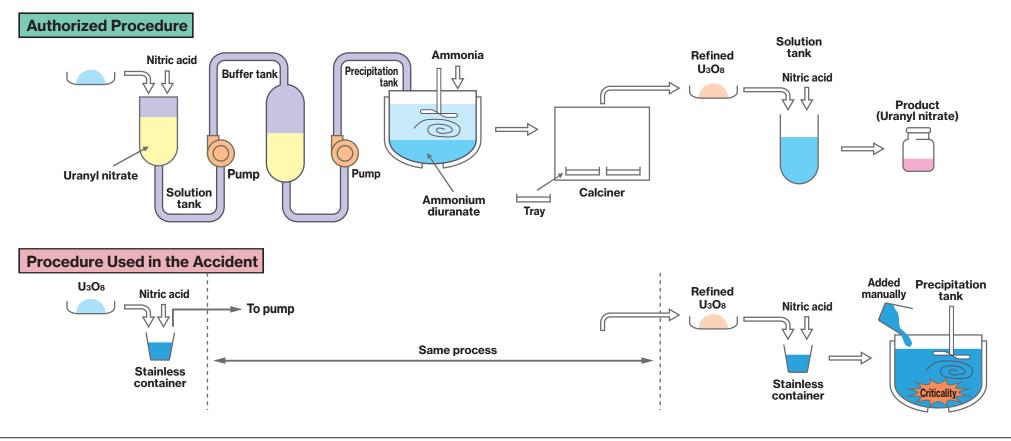
Overview of the Criticality Accident at the JCO Uranium Processing Plant

\bigcirc Overview of the accident

On September 30, 1999, while equalizing a solution of enriched uranium at the JCO uranium processing plant, workers poured a solution containing uranium into a settling tank not designed for that purpose beyond its critical mass, initiating a criticality accident. They were acting in accordance with an illegal company manual. The critical state continued for some 20 hours and resulted in the 2 workers dying.

\bigcirc Impact on residents

In addition to the radiation emitted to the environs during the criticality period, a small amount of radioactive gas was also released into the air and some 319 people were estimated to have received a dose of radiation exceeding 1 mSV, the annual effective dose limit for the general public; those exposed include workers, disaster responders and the residents of the surrounding area (130 residents).



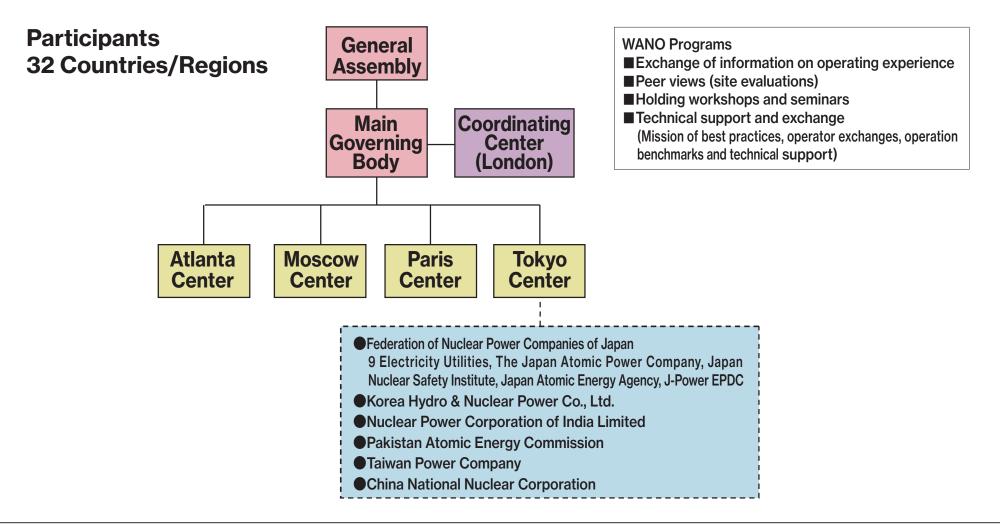
International Nuclear Event Scale (INES)

Level			Reference cases			
	Levei	Standard 1: People & Environment	Standard 2: Radiological Barrier & Control	Standard 3: Defense in Depth	(includes material that has not been officially assessed via INES)	
Accident	7 (Major Accident)	• Major release of radioactive material with widespread health and environmental effects.			Chernobyl nuclear accident (1986) in former Soviet Union Tentative Assessment Fukushima Daiichi nuclear accident resulting from the Tohoku earthquake (2011)	
	6 (Serious Accident)	Significant release of radioactive material				
	5 (Accident with Wider Consequences)	Limited emission of radioactive material Several deaths from radiation	 Severe damage to reactor core Release of large quantities of radioactive material within an installation with a high probability of significant public exposure 		• Three Mile Island nuclear accident, U.S. (1979)	
	4 (Accident with Local Consequences)	 Minor release of radioactive material At least one death from radiation 	 Fuel melt or damage to fuel resulting in more than 0.1% release of core inventory Release of significant quantities of radioactive material within an installation with a high proba- bility of significant public exposure 		• JCO criticality accident (1999)	
Incident	3 (Serious Incident)	 Exposure in excess of ten times the statutory annual limit for workers Non-lethal deterministic health effect from radiation 	 Exposure rates of more than 1 Sv/h* in an operating area. Severe contamination in an area not expected by design, with a low probability of significant public exposure 	 Near-accident at a nuclear power plant with no safety provisions remaining Lost or stolen highly radioactive sealed source 		
	2 (Incident)	 Exposure of a member of the public in excess of 10 mSv Exposure of a worker in excess of the statutory annual limits 	 Radiation levels in an operating area of more than 50 mSv/h Significant contamination within the facility into an area not expected by design 	 Significant failures in safety provisions but with no actual consequences 	Mihama Power Plant, Unit 2 Steam generator heat-transfer tube rupture accident (1991) Radiation exposure accident of workers in the Plutonium Fuel Research Facility (PFRF) of the Oarai Research & Development Center (2017)	
	1 (Anomaly)			Overexposure of a member of the public in excess of statutory annual limits Low activity radioactive source lost or stolen	Monju sodium leak accident (1995) Primary coolant leak at the Tsuruga Power Station Unit 2 (1999) Hamaoka Nuclear Power Plant, Unit 1 residual heat removal system rupture accident (2001) Mihama Nuclear Power Plant, Unit 3 second- ary system pipe rupture accident (2004)	
Below scale	O (Deviation)	No safety sig	gnificance	O+ Event with safety significanceO- Event with no safety significance		
N	Not Subject to Evaluation Event unrelated to Safety					

*Sievert (Sv): Unit representing the effect of radiation on the body. (1 mSv = 1/1,000 Sv)

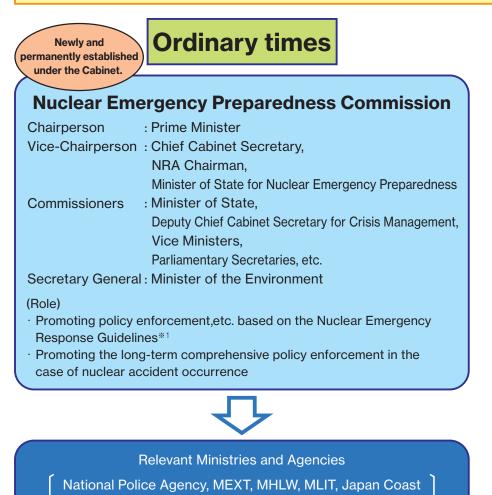
World Association of Nuclear Operators (WANO)

WANO is a private organization comprised of members who are companies in the nuclear power industry. WANO aims to maximize the safety and reliability of nuclear power plants worldwide by working together to assess, benchmark and improve performance through mutual support, exchange of information and emulation of best practice (established May 1989).



Enhancement of the Nuclear Emergency Preparedness System

As a precaution against emergencies, a new Nuclear Emergency Preparedness Commission (NEPC) will be permanently established under the Cabinet to promote nuclear emergency preparedness measures throughout the government during normal times.



Guard, Ministry of the Enviroment, Ministry of Defense, etc.

Nuclear Emergency Response Headquaters (Provisional installation under the Cabinet Office at the time of Declaration of the State of Nuclear Emergency) Director-general : Prime Minister Deputy Director-generals : Chief Cabinet Secretary, Minister of State for Nuclear Emergency Preparedness, **NRA** Chairman Members : Minister of State. Deputy Chief Cabinet Secretary for Crisis Management, Vice Ministers, Parliamentary Secretaries, etc. (Role) · General coordination of nuclear emergency response measures and post accident measures.

Emergency

Relevant Ministries and Agencies

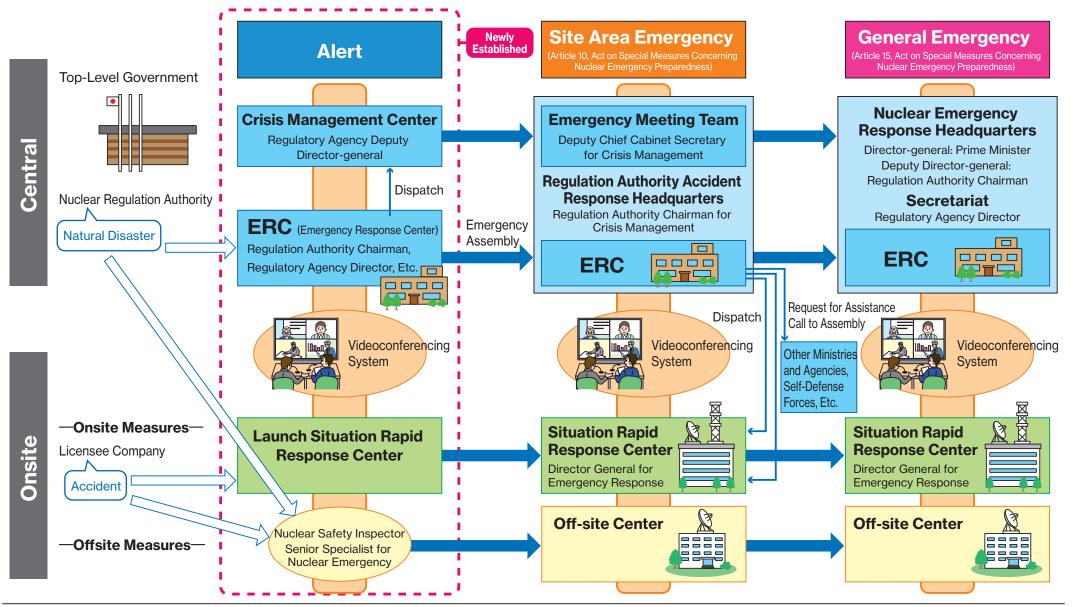
National Police Agency, MEXT, MHLW, MLIT, Japan Coast

Guard, Ministry of the Enviroment, Ministry of Defense, etc.

* These are guidelines prepared by the Nuclear Regulation Authority for nuclear operators and local governments, etc. to ensure smooth implementation of nuclear emergency preparedness measures, emergency response measures, and measures for restoration from a nuclear emergency.

Clarification of Nuclear Emergency Categories (3 Stages)

Operational Chart – From Alert to General Emergency

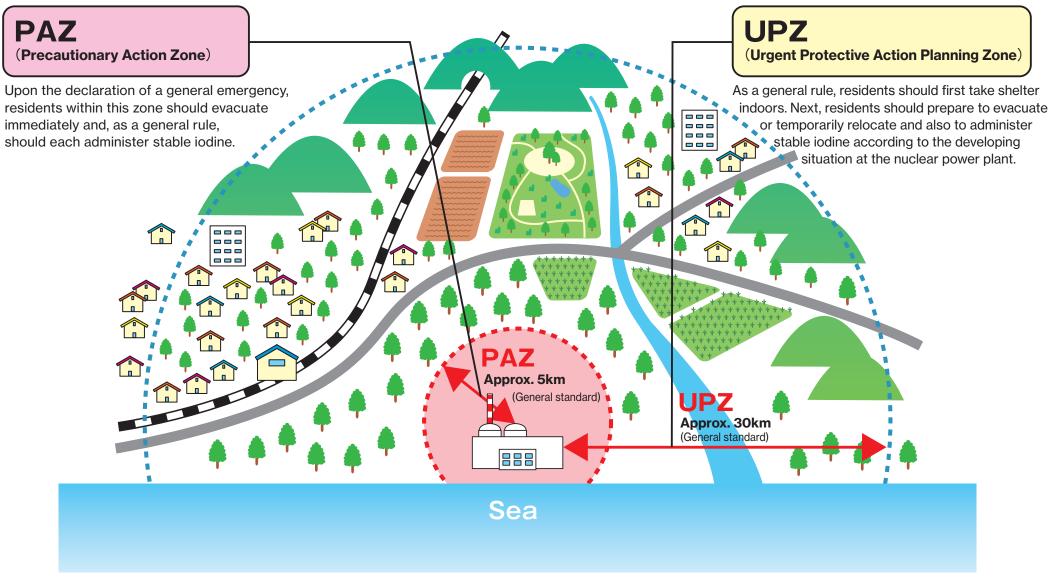


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Expansion of Nuclear Emergency Response Action Zone

Approx. 5 km Radius

Approx. 30 km Radius



Radiation Protection for Residents

Extent of Emergency	PAZ (-5 km)	UPZ (5–30 km)	30- km		
According to the situation at the facility, the nuclear power plant operator reports the emergency category to both the national government and local authorities.		t necessary evacuations in response to instruction orities may issue instructions to residents to prep	•		
Alert (EAL1*) (Ex.) Occurrence of large tsunamis, earthquakes with seismic intensity of 6 or higher, etc.	 Preparations for evacuation of persons requiring support. (those who are ill or injured, the elderly, physically challenged persons, infants, expectant and nursing mothers, etc.) 		Assistance with preparations for the evacuation of persons requiring support.		
	Evacuation of persons requiring support.	Preparations for indoor sheltering.	Reception of persons requiring support.		
Site Area Emergency (EAL2*) (Ex.) Station Blackout over 30 minutes beyond, etc.	 Preparations for general evacuation. Preparations for administration of stable iodine. 	Start of emergency monitoring by national government, local authorities and nuclear power plant operator.	Start of emergency monitoring by national government and local authorities.		
↓	Administration of stable iodine.	Indoor sheltering.	 Reception of evacuees. Assistance with evacuation, etc. Preparations for administration of stable iodine. 		
General Emergency (EAL3*) (Ex.) Station Blackout over 1 hour, etc. No Emission of Radioactive Materials	Evacuation of residents to outside the PAZ following the instructions of the national government.	 Preparations for administration of stable iodine. Preparations for evacuation, etc. 			
Emission of Radioactive Materials		Based on the results of emergency monitoring, the national government will implement necessary protective measures, such as evacuations, on the basis of air dose rates or other appropriate standards.			
Outside of the Facility	e of the Facility	OIL * 1 Evacution Air dose rate of 500 microsieverts per hour. Temporary OIL 2 Temporary Air dose rate of 20 microsieverts per hour. Restrictions of local provide the second	Relocation On the intake oduce, etc. Oduce, etc.		

*OIL: Standard for determining the necessity and extent of measures to be implemented for the protection of residents when radioactive materials have been emitted, based on the results of monitoring, etc.

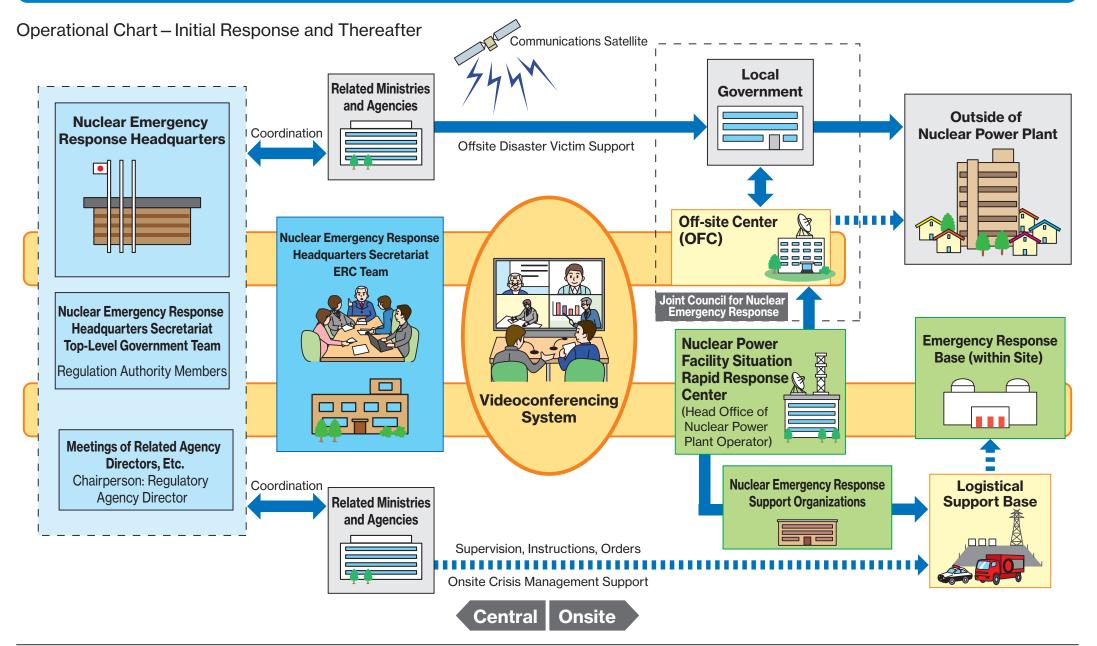
Operational Intervention Level (OIL) and Protective Measures

	Type of Criteria	Overview of Criteria	Default Value *1		Overview of Protective Action	
protective action	OIL1	Criteria whereby residents are told within a few hours to evacuate or stay indoors to prevent effects due to radiation from the ground, inhalation of airborne radio- active material or inadvertent ingestion.	500µSv/h (radiation dose rate measured at 1m above the ground)		Specify an area and conduct evacuation within a few hours. (Including persons with limited mobility to temporarily stay indoors)	
nt prot		Decontamination criteria to take pre- cautions to prevent external exposure	Beta rays: 40,000 cpm (count rate from detector a few cm from the skin)		Based on the criteria of evacuation or tempo- rary relocation, carry out inspection of evacu-	
Urgent	OIL4	from inadvertent ingestion and skin contamination.	Beta rays: 13,000 cpm [Value after 1 month] (count rate from detector a few cm from the skin)			ees at shelters, and quickly carry out simple decontamination if the criteria are exceeded.
Early protective action	OIL2	Criteria to restrict consumption of local products ^{*2} and temporarily transfer residents within approximately 1 week to prevent effects due to radiation from the ground, inhalation of airborne radioactive material or inadvertent ingestion.	20 µSV/h (radiation dose rate measured at 1m above the ground)			Specify the area within approxi- mately 1 day, restrict the con- sumption of local products, and carry out temporary transfer within approximately 1 week.
drink intake	Screening standards for food and beverages	As criteria to determine restriction of food and drink consumption through OIL6, criteria used when specifying the area to carry out measurement of radionuclide concentrations in food and drink.	0.5 µSV/h (radiation dose rate measured at 1m above the ground)			Specify the area in which to mea- sure radionuclide concentrations in food and drink within a few days.
and	Criteria used for restricting consumption of food and drink to avoid effects due to radiation from ingestion.	Nuclide	Drinking water Milk and dairy products	Vegetables, cereals, meat, eggs, fish, other	Measure and analyze radionuclide concentrations in food and drink within approximately one week, and swiftly implement restrictions	
Restrict food		Radioactive iodine	300Bq/kg	2,000Bq/kg*3		
ict f			Radioactive cesium	200Bq/kg	500Bq/kg	on consumption of items that
estr			Alpha nuclides of plutonium and transuranium elements	1Bq/kg	10Bq/kg	exceed the criteria.
Å			Uranium	20Bq/kg	100Bq/kg	

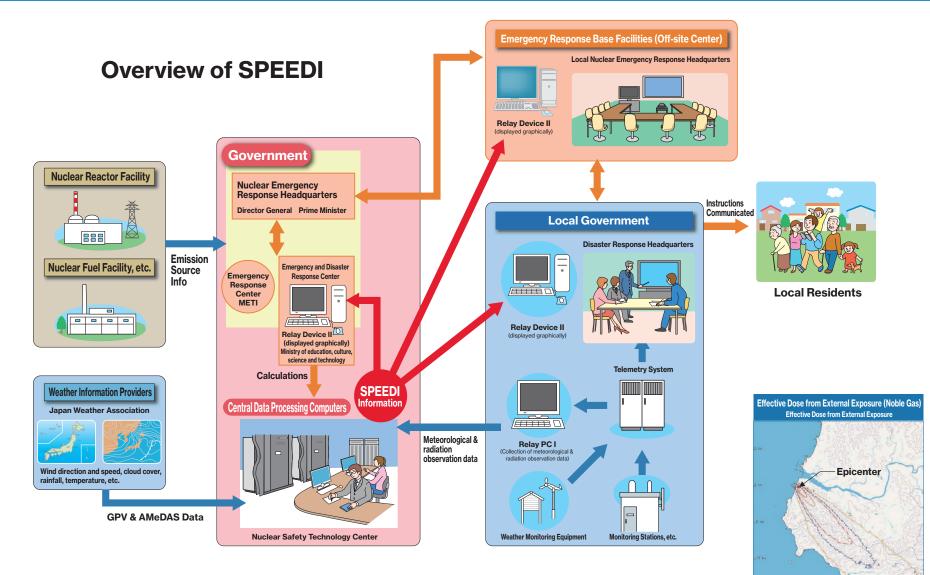
*1: The "default value" is the OIL value used at the start of an emergency situation, and when the radionuclide composition deposited on the ground becomes clear, the default OIL value is revised if required.

*2: "Local products" are food products that were produced outdoors in areas directly contaminated by radioactive materials that are consumed within a few weeks (for example vegetables or milk from cows that ate grass in the area). *3: Vegetables are included apart from root vegetables and types of potato.

Reinforcement of Network between Government and Nuclear Power Plant Operators



System for Prediction of Environmental Emergency Dose Information (SPEEDI)



SPEEDI Map Information

Nuclear Damage Compensation System

