UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

MAR 22 1985

MEMORANDUM FOR: C. J. Heltemes, Jr., Director
Office for Analysis and Evaluation
of Operational Data

FROM: James M. Taylor, Director
Office of Inspection and Enforcement

SUBJECT: STUDY OF THE NEED FOR AN INDEPENDENT AGENCY TO INVESTIGATE INCIDENTS AT NUCLEAR POWER PLANTS

We find the study to have been generally thorough and we have little argument with the facts as presented. However, we do question the use of certain facts as a basis for findings and recommendations. Second, we question the omission of other relevant facts which could refute or negate some of the findings presented in the report and subsequently alter recommendations made therein. Third, we also question certain very significant assumptions or hypothesis which were used without a factual basis to support recommendations. Specifics with respect to each of these as well as other general comments are enclosed.

Overall, I am concerned that the bureaucratic nature of an independent or quasi-independent investigative organization would inhibit and delay event review and followup. Benefit from such an organization would accrue from investigation of significant events not from real time or onsite screening and evaluation of lesser events. We agree that strong argument is provided for increased independence of an AEOD type organization to focus industry and federal agency conduct of the 10-12 significant events per year. We see serious safety impacts, however, if responsibility for screening, evaluating, and reporting the several thousand events per year were taken from licensees. The line organizations in NRC would be severely handicapped if event reviews were only done by an AEOD type organization. I am concerned that the study significantly underestimates the resources applied to event review by licensees and NRC and does not fully comprehend the beneficial ways that this information is used to upgrade individual licensee performance and to resolve multi-plant problems.

James M. Taylor, Director
Office of Inspection and Enforcement

Enclosure:
As Stated

8504080362 XA
3 PP.

Enclosure 1

Specific Comments on NUREG/CR-4152,
"An Independent Safety Organization"

1. Use of Certain Facts

It is stated in the report that the NRC failed to recognize the Hatch 2 event in a timely manner, and "designated representatives" similar to the FAA plus regional-assigned independent or quasi-independent personnel would solve this problem.

Although the report correctly recognized that AEOD identified this problem, the NRC was criticized for not identifying it sooner. The report failed to recognize that identification of this event by AEOD was exactly why AEOD was established. Therefore, this event should be counted as a success. A more careful examination of the record of NRC response to events could argue that identification of significant events is adequate. Addition of personnel from an independent or quasi-independent organization to the regional offices to assume responsibility for identifying significant events is naive especially if one follows the NTSB patterns of responsibility for reviewing all events. Careful reading of the FAA material shows that NTSB delegates responsibility for many investigations, especially of general aviation accidents, to the FAA. Designated representatives may or may not solve the problem at hand. The NRC staff investigated the FAA Designated Representative Program in conjunction with the preparation of the QA Report to Congress (NUREG 1055) and the Commission decided not to go forward with legislative changes viewed to be necessary if such a program were to be required by the NRC. The Commission did express a desire to test a Designated Representative Program for reactors under construction if a utility were to voluntarily accept a designated representative arrangement. As of this date, no volunteers have come forward.

2. Omitted Findings

The NRC record of feeding back operational experiences thru Bulletins and Information Notices and utilizing industry Regulatory Response Groups and Owners Groups has been highly successful in identifying and communicating problems and their causes and obtaining appropriate corrective actions. It is most doubtful that an independent or quasi-independent organization could have done a better job on the BWR pipe crack problem based on findings of cracked pipe at Nine Mile Point or in identifying the cause and communicating the Hatch torus header cracking problem or the more recent Farley tendon anchor failure. Comparison of success stories with NTSB's record would have been beneficial.

Additionally, the study stated that there are some problems with the NRC's present method of investigating significant safety events, but correction of existing problems to provide an improved method of investigation was not specifically addressed or considered as an alternative to reorganization.

3. Assumptions Without Factual Basis

The report states that the NRC staff may have a conflict of interest when investigating a significant operational event because it may have been caused in part by a previous licensing, regulatory, or enforcement action or inaction.

Despite the statement in the report that there were no cases in which this occurred, this problem appeared to weigh heavily in the recommendations. Further, the study stated that a problem with the present system involved the fact that an inspector investigating the cause of an event may also be involved in preparing enforcement action for the same event. Our experience to date has not identified this as a problem.

Additionally, the study states that a disadvantage of having the proposed Office of Nuclear Safety (ONS) report to the EDO is that ONS would not be in a position to ensure prompt consideration of its recommendations by either NRR or IE. No basis is given in the report to support that position.

4. General Comments

The study emphasizes the issuance of a final report at the conclusion of deliberations by ONS. Presently those issues that may have safety implications are identified to applicable licensees early in the investigation for this action prior to the issuance of a final report. This philosophy should be maintained.

The study states that ONS will investigate significant safety events; however, no definition is given for significant safety events except in broad terms. A clear definition of significant safety events should be stated.