



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

MAR 18 1985

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

FROM: John G. Davis, Director
Office of Nuclear Material Safety and Safeguards

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

We have reviewed the final report forwarded by your memorandum of February 15, 1985.

Section 2.5 continues to be filled with factual errors to a degree that makes the entire section misleading to readers of the report. In our comments of December 4, 1984, on the draft report, we pointed out numerous erroneous statements in that section. The final report still contains most of those errors and has acquired some new ones.

At the outset we note that the title of the section has been changed to "Non-Operational NPP and Other NRC-Licensed Facility Events" (emphasis added). Contrary to what the title says, most of the safeguards events referred to in this section occurred at operational nuclear power plants.

The discussion on page 44 states that in the whole of NMSS, which is responsible for almost all non-reactor licensed activity as well as reactor safeguards, virtually the only event evaluation and analysis done is for physical security issues. We pointed out the falsity of this statement in our comments on the draft, yet the final report not only repeats the statement but, more importantly, does so without any effort having been made to verify its accuracy when it had been challenged.

The report spotlights and elevates to major significance reports of medical misadministration. However, misadministration is involved in only approximately 0.01 percent of all administrations of radiopharmaceuticals by NRC licensees. This compares to an overall medication administration error rate of 12 to 15 percent for all prescribed medications in U.S. hospitals. Of the medical misadministrations of radiopharmaceuticals, approximately 98 percent have been diagnostic misadministrations, and in none of those cases have any adverse health effects on the patient been reported. While we do not wish to minimize our continuing concern and our efforts to reduce medical misadministrations even further, the emphasis given to this subject in the study report distorts its relative significance.

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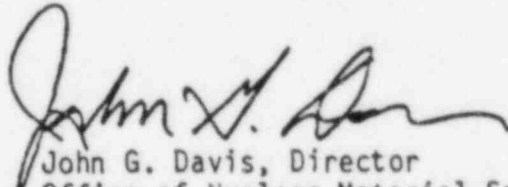
On page 43, paragraph 1, at line 8, the report asserts that NMSS has delegated some of its response authority to the appropriate regions. That is not true. NMSS response authority is not delegated. Some licensing functions have been decentralized, but that is of course irrelevant to the point of the discussion. NMSS cooperates with other offices and the regions but retains all responsibility and authority for policy guidance and technical support.

The plan for NRC response to materials contamination incidents, referred to on page 43 at line 10, was promulgated in a memorandum to Office Directors and Regional Administrators from J. G. Davis, dated October 18, 1984, rather than the note cited in the report. We pointed out this error in our previous comments but it was ignored.

On page 43, paragraph 2, the last sentence is incorrect. IP handles international contacts, but the lead for information collection, evaluation, and response within the United States remains with NMSS, or with the FBI for investigations, not IP. The two references to "investigation" in that paragraph are also incorrect. NMSS' role is one of information collection, evaluation, and response, not "investigation."

A copy of our previous comments on the draft of the study report is enclosed for reference.

The study report addresses NMSS event evaluation activities in a very small section (2.5) which contains only a superficial discussion and conclusion and several factual errors. We find it somewhat disappointing.


John G. Davis, Director
Office of Nuclear Material Safety
and Safeguards

Enclosure: As stated