Governing Nuclear Risk: The Interplay of Standardization and Improvisation

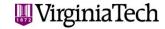
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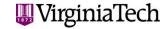
- Organizational theories of disaster, qualitative theories of risk
- 2. "Cultural" explanations for failure (Chernobyl, Fukushima)
- 3. Current common industry practices
- Challenges for international governance of nuclear risk

Outline



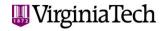
- Normal Accident Theory
- High Reliability Organizations
- Normalization of Deviance
- Culture of Control

1.a Organizational Theories of Disaster



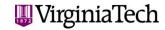
- Accidents as "normal" outcome of a system's high complexity and tight coupling
- TMI as paradigmatic case (Perrow 1984/1999)
- Chernobyl was "an accident waiting to happen"

Normal Accident Theory



Organizations that have succeeded in "avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity."

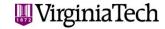
High Reliability Organizations (1)



Characteristics:

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

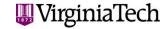
High Reliability Organizations (2)



Diane Vaughan (1996)

- "Dark side of organizations": mistakes, misconduct, disaster
- When "deviant" behavior is no longer recognized as such
- Significance of hindsight
- History as cause

Normalization of Deviance



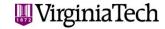
Constance Perin (1998, 2005)

- Limitations of written rules
- De facto constant work-arounds
- Trend toward standardization

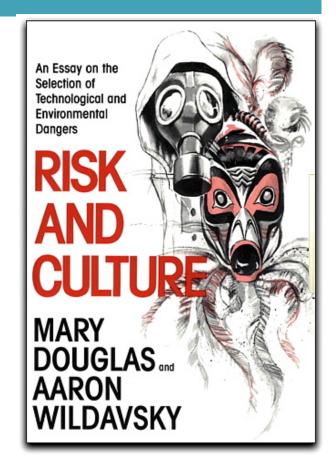
Joy Parr (2006, 2010)

- Self-awareness
- Understanding reasons for rules

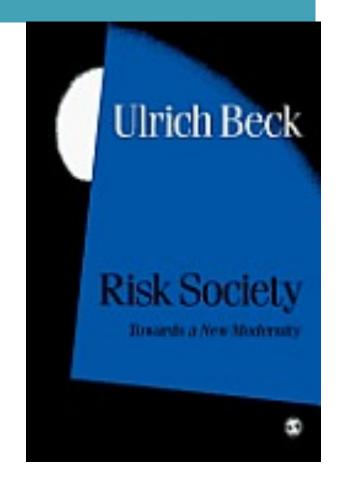
Culture of Control

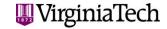


Cultural Theory of Risk

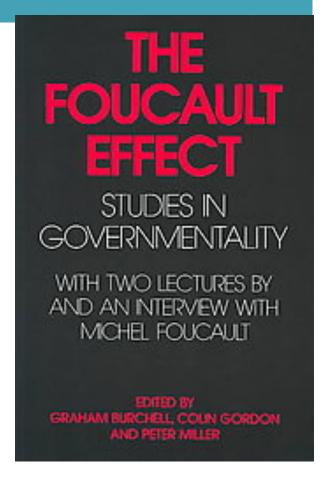


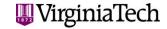
- Cultural Theory of Risk
- Risk Society



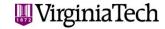


- Cultural Theory of Risk
- Risk Society
- Governmentality



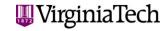


- Cultural Theory of Risk
- Risk Society
- Governmentality



- Soviet officials in 1979: "TMI could have never happened here."
- U.S. officials in 1986: "Chernobyl could have never happened here."
- International summary of Japanese accident investigation reports: "made in Japan." (in other words, "could have never happened here")

2. Cultural Explanations for Failure

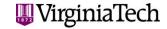


Standardization

Organizational transformation of global nuclear industry after Fukushima

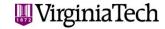
- FLEX
- "Stress tests"

3. Current Common Practices



- A "diverse and flexible coping capability" addressing loss of power and reactor cooling capability
- Stationing vital emergency equipment generators, battery packs, pumps, air compressors and battery chargers — in multiple locations and "secure offsite locations"
 - Portable equipment providing power and water
 - Reasonable staging & protection of portable equipment
 - Procedures for ER personnel use of FLEX capability
 - Programmatic controls to assure viability and reliability of FLEX capability (maintenance, testing, training)





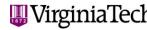


Post-Fukushima European Council mandates

- Carry out EU-wide comprehensive risk and safety assessments of nuclear power plants ("stress tests")
- Review legal and regulatory framework for safety of nuclear installations and propose improvements

"Stress Tests" (1)





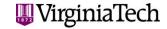
Scope

- Initiating events (earthquake, flooding, other extreme natural events)
- Consequential loss of safety functions (electrical power, including SBO, UHS, combination of both)
- Severe accident management (protect and manage loss of core cooling function, of spent fuel pool cooling function, of containment integrity)

Results

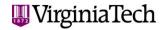
- Recommendations: implementation left to national authorities
- "Technical fixes" to reduce risk of a nuclear disaster
- Miss social expertise and improvisational skills

"Stress Tests" (2)



- Global, trans-boundary dimension
- Traditional emphasis on risk prevention
- Continuing reliance on standardization
- Lack of effective global institutions
- Significance of expert improvisation

4. Challenges for Nuclear Emergency Response



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Thank you!

