Contribution ID: **124** Type: **Invited Presentation**

Fukushima Daiichi Nuclear Accident: A Matter of Unchallenged Basic Assumptions

Tuesday, 23 February 2016 13:30 (30 minutes)

Synopsis

As part of the IAEA Fukushima Daiichi Accident Report published in September 2015, a systemic analysis of the Human and Organizational Factors based on the IAEA Safety Culture Assessment Methodology was conducted by 11 international experts to answer the question of why the accident happened. This accident occurred under the backdrop of the international nuclear community's progress in nuclear safety, brought about by internationally agreed upon safety standards, comprehensive review services, and the development of sound regulatory frameworks.

The assumptions on nuclear safety by the main organisational stakeholders involved in the accident at the Fukushima Daiichi NPP were examined in detail. Through the systemic analysis, it was shown how the actions of these stakeholders were interrelated and interconnected, and thereby reinforced basic assumptions about nuclear safety that prevented from adequately preparing for and preventing the accident on 11 March 2011. These basic assumptions corresponded to the deepest level of safety culture and which formed the basis of safety culture from which the stakeholders acted upon —and hence the basis from which decisions and actions were taken well before the March 2011 events. The analysis presented in the report is concluded by two main observations and 7 lessons learned deriving from these. The presentation will also include further details on these findings.

Analysis conducted as part of 'The Fukushima Daiichi Accident', Technical Volume 2 –'Safety Assessment' Report Published September 2015, IAEA, Vienna.

Country or International Agency

IAEA, Canada

Primary author: HAAGE, Monica (IAEA)

Co-author: HEPPELL-MASYS, Kathleen (Canada)

Presenters: HEPPELL-MASYS, Kathleen (Canada); HAAGE, Monica (IAEA)

Session Classification: SA1: Systemic Approach to Safety