

On emergency
cooling system
inoperable.
alternatively, water



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On March 11th 2011 at 2: 46 PM an earthquake with a magnitude of 9. 0 struck off of the eastern coastal area of Tohoku, Japan (TEPCO, 2012).

Subsequently a massive tsunami ensued, which reached heights of up to thirty meters (Kushida, 2012; Baba, 2013) and in its wake left areas devastated with a total of 20.

500 people dead or missing (Ohnishi, 2012) and a severely damaged infrastructure (Funabashi & Kitazawa, 2012; Figueroa, 2013). In particular, the Fukushima Prefecture received the heaviest blow where multiple nuclear power plants were hit. Although most were inoperative due to maintenance, the Fukushima Daiichi nuclear power station had three active units (Kushida, 2012). The earthquake caused an automatic shutdown of all units, however the external power lines were also severed (TEPCO, 2012). Despite the successful reactor shutdown, the cooling pumps required on-site power to function. As a back-up emergency diesel generators were present, unfortunately the tsunami breached the defences of the power station and carried away fuel tanks (Anzai et al.

, 2011), thus, rendering the emergency cooling system inoperable.

Alternatively, water injection was applied, consequently the combination of steam and core fuel led to the generation of hydrogen (TEPCO, 2012). Over the next three days, the three reactors experienced core meltdowns and hydrogen explosions which destroyed the structure of the buildings and caused the release of radioactive material into the environment (Funabashi & Kitazawa, 2012; Anzai et al., 2011).

Analysis Upon taking a closer look at the Fukushima nuclear disaster, it becomes evident that ultimately a sequence of systemic failures played a crucial role in the deterioration of the Daiichi plant (Kushida, 2012).

Therefore, a system approach rather than a person approach is deemed more appropriate in dissecting the situation, in which no root cause is assumed and errors are consequences of complex and systemic factors (Reason, 2000). In addition, by applying the Swiss cheese model of system accidents a set of latent conditions is revealed (Reason, 2000), such as the roughly six meters tall defensive walls, which were easily bypassed by the fifteen meters tall tsunami, and the refusal to refurbish the plant in 2006 (Hollnagel & Fujita, 2013). Said design deficiencies fall under latent conditions that create long-lasting weaknesses (Reason, 2000), and taking into account that the Daiichi power plant had been designed in the 1960s it is not unreasonable to assume that the buildings which encompass the nuclear reactors had degraded over the years (Kushida, 2012).

Three general systemic factors can be identified, namely the inability to consider structural and functional liability (Hollnagel & Fujita, 2013), a lagged response from an organizational perspective (Pfothenauer et al., 2012), and poor risk communication which led to less informed decisions (Figueroa, 2013). To begin with, in the initial design assessment of the Daiichi power station the anticipation of major earthquakes was made, however the initial appraisal cannot be completed because new information can become available (Hollnagel & Fujita, 2013). For example, in 2004 another nuclear power plant was hit by an earthquake that exceeded its design basis as some geological faults had been overlooked in the initial review. Similarly,

the 2011 Tohoku earthquake exceeded Daiichi's design basis, even though the probability of large earthquakes was known before the actual disaster (Hollnagel & Fujita, 2013). Furthermore, the structures of the buildings were essentially forty years old and couldn't cope with the earthquake (Kushida, 2012).

In addition, the retaining walls standing at approximately 5.7 meters tall were based on the assessment method of the Japan Society of Civil Engineers dating from 2002 (TEPCO, 2012). In hindsight, the walls should have been higher to withstand a fifteen meters tall tsunami, however in 2006 recommendations for refurbishment of the plant were turned down. Since the recommendations were based on a historical study of a much larger tsunami in the ninth century, the evidence was not accepted by specialists (Hollnagel & Fujita, 2013).

Regardless, strategies to respond to unexpected severe situations are critical as stronger defences (Pfothenauer et al., 2012). The total loss of power rendered the cooling systems useless and emergency batteries took over (TEPCO, 2012), however they merely lasted for eight hours (Ohnishi, 2012).

As a result, TEPCO had to resort to the use of electricity trucks, though the tsunami had caused a gridlock and only few could make it (Hollnagel & Fujita, 2013). Concurrently, the government tried flying electricity trucks to the power plant, but the load was too heavy, indicating that preparations for transport of such proportions had not been thoroughly investigated (Hollnagel & Fujita, 2013). Moreover, communication between TEPCO

headquarters and plant personnel was limited as there were no adequate back-up transmitters, and the chairman was absent until twenty hours after the events, thus further slowing down the response (Kushida, 2012). Finally, risk communication failed to help people make more informed decisions, as risks were initially denied.

At 4: 54 PM Prime Minister Kan stated that the Daiichi station was under control, while earlier, the plant manager had declared a nuclear emergency in progress (Figueroa, 2013). In addition, the residents had never drilled for evacuation, and the 'venting' of the plant took many hours since the execution of the procedures was unknown to the personnel. By that point the situation had already exacerbated (Figueroa, 2013). Conclusion and recommendations for the future In conclusion, the disaster was triggered by the earthquake and the tsunami, but essentially was caused by TEPCO design deficiencies (Baba, 2013). In light of the Swiss cheese model, it was first the weakened building structures that allowed for damage from the earthquake, then the inadequate retaining walls that were bypassed by the tsunami and finally the emergency cooling systems that failed to prevent hydrogen explosions.

Given that other nuclear plants like Daini successfully avoided damage to the reactors because of available electricity (TEPCO, 2012), perhaps the most important hindrances to post-measures were lagged operation related response and poor communication (Hollnagel & Fujita, 2013). For the future it is strongly recommended that organisations like TEPCO invest into developing response strategies that prepare for beyond-design-parameter events (Kushida, 2012). Furthermore, policies should leave room
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for discussion of standard and disaster operations, including questioning outdated narratives (Pfothenauer et al., 2012). Lastly, organisations should strive for transparency in risk communication and inclusion of citizens to enhance decision-making in dire situations, and to assure successful evacuation procedures (Baba, 2013).