to identify problems with fuel movement, including precursors to later events; (B) the NRC's inspection practices often lacked direct observation of activities important to safety; (C) RTRs other than the NIST reactor experienced significant fuel oversight issues; and (D) the agency's RTR program has not been substantively updated for at least two decades, and does not reflect the agency's risk-informed and safety culture positions."

According to the report, the NRC didn't follow up on NIST audit committee reports identifying deficiencies with safety culture and operator training and requalification. Additionally, "the NRC had not directly observed the fuel element latch checks following fuel movement at the NIST test reactor in the five years prior to the event."

An NRC Safety Assessment Committee (SAC) carried out audits of the NCNR prior to the February 2021 incident and identified at least four safety culture and/or complacency issues, according to the OIG report, and some of these issues the NRC "did not capture in its inspection reports." For example, "in 2019, the SAC noted that there was a complacency issue at NCNR and recommended a periodic Safety Conscious Work Environment (SCWE) survey be performed across the NCNR to assess the underlying safety culture and general attitude toward safety. The report stated, 'NIST and the NCNR are fortunate and have not had a recent major safety incident. . .'."

The OIG *Special Inquiry* concluded that "the agency's RTR inspection program policy and guidance are outdated because they do not implement risk-informed approaches and safety culture elements. The last major revision to the safety inspection program was in 2004." The NRC is currently responsible for oversight of 30 operating RTRs and anticipates future oversight of advanced reactor prototype test reactors.

Continued