Inspection Record – Dutyholder Report

Springfields Organisational Culture Intervention

Inspection ID	IR-53536	**Inspection Date(s)**	07/11/2024 For 2 Days
Dutyholder	Westinghouse Springfields	**Site**	Springfields Works
Inspection Type	Announced Planned	**Site Area / Group**	
ONR Purpose	Nuclear Safety	**Inspection Source**	

Subject (s) of Inspection

Activity	**RAG Rating**
Leadership & Management for Safety	Not Rated

System (s) – where applicable

Inspector(s) taking part in Inspection

Lead Inspector

[redacted]

Attending

[redacted]	[redacted]	Office for Nuclear Regulation
[redacted]	[redacted]	Office for Nuclear Regulation
[redacted]	[redacted]	Office for Nuclear Regulation
[redacted]	[redacted]	Office for Nuclear Regulation

This report is an automated extract of data from the ONR WIReD Inspection database.

1. Scope

1.1 Aim of Inspection

Over the last few years the site has been undergoing significant change following global evolutions affecting the operational landscape. ONR seek to enable the successful, safe and secure delivery and operation of the new facilities, as well as the extant operations. The aim of the inspection is to:

understand how cultural factors affect safety performance,
provide a baseline of such cultural factors, and identify any relevant learning to support SFL moving forward;
provide our understanding of the adequacy of the SFL response to address safety performance going forward.

1.2 Inspection Scope

The safety culture intervention will be a day and a half on site. The inspection will focus on the two main facilities, OFC and EDF and is focused on its operations and leadership. Activities will include observations and interventions with a vertical cross section of employees.

We will consider:

the behaviours and culture in the facilities;
how weak signals of performance are monitored;
the specific action plans to improve culture across the site.

Proposed session breakdown was shared during a site presentation in July 2024

1.3 Relevant Regulatory Guidance

The following regulatory guidance corresponds with this inspection

Name
NS-INSP-GD-070 - Safety Culture Guide for Inspectors

2. Summary Statement

This inspection sought to gain an understanding of safety culture across Springfields Fuels Limited (SFL). As part of the inspection, SFL leadership presented on a number of relevant topics, linking to safety KPIs, strategy, and plans. We also carried out a series of interviews and focus groups with a sample of employees, as well as observing / holding discussions with some employees on plant. This was an unrated inspection focused on Leadership and Management for Safety.

The inspection was well supported by site leadership, and we did not identify any significant areas of concern. Some opportunities for learning and assurance were identified, in particular:

Maintaining a proportionate focus on competence assurance, especially due to changes in operational strategy.
Ensuring proportionate focus on ageing plant and associated ALARP justifications.
Ensuring appropriate / manageable workloads, with clear responsibilities and prioritisation for nuclear safety critical personnel.

The SFL leadership team were receptive to the feedback and opportunities for continued improvement at the close out of the inspection.

3. Record & Judgement

3.1 Staff seen as part of Inspection

The following principal staff were seen as part of this inspection

Name	Role	Company
[redacted]	[redacted]	Westinghouse
[redacted]	[redacted] -	Westinghouse
[redacted]	[redacted]	Westinghouse
[redacted]	[redacted]	Westinghouse
[redacted]	[redacted]	Westinghouse

[redacted]	[redacted]	Westinghouse
[redacted]	[redacted]	Westinghouse

3.2 Record

Evidence

Method
The intervention involved a site visit over a period of two days (6-7 November 2024) by the nominated ONR site inspector, and 3 Leadership and Management for Safety (LMfS) inspectors. Evidence was gathered via a range of presentations from SFL, discussions/interviews, focus groups, and shadowing/observations with plant operators. Site observations took place at OFC (fuel production) and EDF (residues recycling or disposal), including a morning shift handover. Input was received from employees spanning from executive leadership, through to operators. SFL employees involved in the intervention had experience ranging from circa 40 years through to just several days at site. The evidence summarised is a reflection of the sample of information and views of employees involved in the intervention.

Evidence was collected primarily in relation to the nine warning flags identified in ONR NS-INSP-GD-070. These being:

Overconfidence, lack of healthy unease and drift in standards

Decision-making – priorities unclear and conflict

Regulatory relations – internal and external

Deviation from established arrangements

Impaired sharing and isolationism

Management of change - continual change, downsizing or out-sourcing

Missed learning

Leaders not maintaining visible presence

No ownership, engagement, or involvement

At a high level, there were no ‘red flags’ / areas of significant concern. A summary is provided below and includes positive signs alongside a number of observations.

An overarching observation from the intervention (Observation 1) was that there is likely an opportunity for SFL to consider aligning culture strategy across performance for all aspects of safety (nuclear and conventional), as well as security, safeguards, and transport. This could also incorporate the broader organisational culture in terms of current and future organisational growth goals. By considering the overarching culture that is desired, this may help focus and prioritise actions for continuous improvement, ensuring that any potential frictions are resolved, and synergistic opportunities are aligned.

Warning Flag 1: Complacency and overconfidence
There were a number of positive signs that workers were comfortable in raising concerns/challenge as appropriate. The health and safety function at site collect and review incident data, with investigations conducted to seek out causal factors to assist with learning and improvement.

Information / data presented by SFL tended to have a focus on personal safety issues at a lagging indicator level, for example hand injuries. There may be an opportunity for SFL to ensure other (leading) indicators for process safety and nuclear safety are appropriately identified and monitored to detect early signs / ‘weak signals’ (Observation 2).

Workers in numerous roles identified that plant / equipment was in need of frequent reactive maintenance / attention. There were difficulties in obtaining spares for obsolescent equipment. Whilst it is acknowledged that some processes and related equipment have limited time to run until decommissioning; there is a risk that a reactive approach becomes increasingly normalised, and time to decommissioning may drift further. It may help for SFL to explicitly record the strategy for ageing plant, and clearly define the role and limits of reactive maintenance vs replacement, clearly justifying that the strategy adopted continues to reduce risk ALARP (Observation 3).

Warning Flag 2: Compromised decision-making
Views of employees were that safety is given suitable prioritisation, with none of the workers involved in the intervention indicating a friction with productivity. Indeed, resolving plant issues (with necessary reactive maintenance) was noted to be given the appropriate time, and detrimental impact on production was accepted without question. There was some overlap here with Warning Flag 1, Observation 3, whereby clearer strategy would likely help support more objective and robust decision making; in essence helping to reduce the likelihood of 'drift' in terms of plant standards, and the supporting organisational culture.

Warning Flag 3: Ineffective Regulatory Relations
The intervention was well supported by site leadership. The agenda was well planned, incorporating meetings with a range of employees. Discussions were open and honest, with good levels of engagement with employees from across the site, including on plant visits. The leadership team were receptive to feedback during the close-out meeting, and expressed keenness to continue to improve.

Warning Flag 4: Deviation from standards and behaviours
There were several signs of good discipline, for example during shift handovers. Some aspects of work appeared less formal/structured, such as the training/mentoring of newer employees.

The site have a number of tools and behavioural standards related to human performance in order to support safety culture. Numerous employees had limited knowledge of these. It may be that some of the practices have become embedded in daily routines. However, for less experienced personnel, this may result in a lack of awareness. There is potential here for such tools and standards to become more embedded, particularly for newer/less experienced personnel.

Changes to the permit system (covered in more detail in Warning Flag 6), resulting in a perception of more work requiring permit issuing may benefit from review/evaluation. Whilst there were no signs of deviation from permits; there may be a potential in the future for a drift from standards, particularly if workers feel that some systems of work are not targeted to reducing risk proportionately (Observation 4). This is not to suggest the permit system should change, only that the current approach is reviewed. If it is deemed appropriate /proportionate, then further engagement and buy-in may be sought with those applying the system.

Warning Flag 5: Impaired sharing and isolationism
Current activity was being undertaken with regards to an independent review of the board (following recommendations from an ONR board intervention) and governance arrangements, demonstrating that there was interest by senior leadership for improvement. It was also expressed that learning was being sought from similar sites in the UK; the parent body; and, other parts of the organisation situated around the globe. Data on culture had been collected, and there was a keenness to use the outputs for improvement. There may be an opportunity to build knowledge and expertise in culture and use of related data in order to contribute further to culture strategy, planning and improvement implementation (Observation 5).

Warning Flag 6: Poorly managed change
The site has been through various changes, and many employees involved in the culture intervention felt that communication from leadership regarding change had improved in recent times. This left many feeling positive and optimistic regarding change, particularly due to potential for future growth including recruitment activity having taken place / taking place.

Some changes may benefit from further reviews / evaluation. Linked to Observation 4, the current permit system was considered by a number of employees to be less targeted and proportionate than it could be, which in turn was felt to detract time of OTMs from other activities. Supervisors also felt there was demand on their time (e.g. training/ developing others), making focus/prioritisation more challenging. There may be opportunities to review changes to ensure there are sufficient resources and time to complete activities to required standards, particularly where leaders and supervisors have expectations to be visible / available to their teams (Observation 6).

With ongoing loss of experienced personnel, development of SQEP capability may benefit from considering if the current approaches continue to align with good practice, particularly in terms of the systematic nature of identifying competence gaps and matching these to structured development plans (Observation 7).

Warning Flag 7: Missed learning
Many felt that the process for raising concerns or reporting incidents was clear, with a perception that there was focus on learning rather than blame. Some noted that personal accountability was also important.

There were multiple ways to raise concerns and report incidents. Not all employees spoken to were aware of all the reporting mechanisms, for example fewer people seemed to be aware of a route via a mobile phone app and a phone line. There may be an opportunity to raise awareness here (Observation 8).

Warning Flag 8: Inconsistent leadership
Leadership was largely viewed in a positive light, both in terms of senior management, and local plant leadership through to supervisors.

Some employees, including leaders themselves, felt that leadership could have greater visibility/ time with teams, but there was recognition that paperwork activities can often be a barrier to achieving this.

There was recognition that there needed to be a good focus on DAP competence, particularly as experienced personnel retire, and the pool of highly experienced people (to train up the next generation) becomes smaller. Ensuring key leadership roles are appropriately staffed to SQEP level would benefit from continued focus (Observation 9).

Warning Flag 9: Lack of personal ownership and engagement
During interviews, focus groups, and on plant; employees largely presented as engaged and had a positive mindset. Many were proud to work at the site, with a number having

worked there for several decades. There were signs of good camaraderie, and willingness to support one another.

There were some indications that engagement was not always high, for example, with response rates to staff surveys. It was recognised that this may be partly due to: (i) limited response timeframes to complete surveys, (ii) lack of/limited access to appropriate IT to complete the survey, and; (iii) ‘survey fatigue’. It was noted that ways to increase engagement in surveys was being explored. When on plant, access to computers for use in completing staff surveys was demonstrably slow/challenging.

Judgement

This is an unrated inspection and has not identified any shortfalls in legal compliance. The Observations provided offer advice/opportunities for SFL to consider in terms of continued learning and improvement.ONR will monitor as part of normal business.

The culture intervention has highlighted a number of areas where perceptions were positive, and aspects regarding culture are largely deemed satisfactory. Many of the observations/advice have a link to key changes at the site. These changes have been significant at a strategic level, ultimately in essence, moving from a horizon of decommissioning, switching to life extension, and potential future growth opportunities.

Observations / Advice

The observations provided align to the sequence of the warning flags, rather than being in priority order. To assist SFL in targeting actions, we would propose the following as requiring consideration in the near term:Ensuring processes for supporting competence assurance / SQEP, including for DAPs are robust and appropriate / align to good practice (Observations 7 and 9).Ensuring ALARP justifications are appropriate with regards to ageing plant, and that there are clear indicators to enable personnel to raise concerns where ‘drift’ / ‘normalisation’ of issues may increase risk (Observation 3).Ensuring the workloads of nuclear safety critical personnel are manageable, with appropriate time dedicated to safety critical tasks and supervisory / oversight activities, and/or supporting competence development of others (Observations 4 and 6).

Observation 1: Currently SFL do not have aligned expectations and standards around safe and secure behaviours. SFL would likely benefit from developing a strategic goal for the

broader organisational culture; spanning safety, security, safeguards, transport, as well as wider organisational goals.Observation 2: There was limited evidence of targeted process safety and nuclear safety leading indicators, and reliance on lagging indicators. These could be integrated across safety, security, and safeguards.Observation 3: Plant and equipment reliability is an ongoing challenge to SFL; this is considered a threat as it can lead to tolerance of defects and deviance and may lead to organisational drift. Observation 4: Following an incident at site, changes were made to the permit system. This was reported to be time consuming and disproportionate, as well as distracting supervisors from their key duties. A review / evaluation of this change would help to determine if the approach is proportionate; and/or whether the change introduces significant workload.Observation 5: The site have a range of data available on culture from a variety of sources. There may be an opportunity to enhance skills in use of these data to help focus on priority areas (reduce the 'noise' / information volume), as well as feed this into strategy on further culture improvement.Observation 6: With some links to observation 4; supervisors also reported high workloads; one contributor is the burden of training and developing new personnel. This can also distract from their responsibilities for supervision and safety. A review of the roles and responsibilities of supervisors may bring value to understanding whether staffing levels are considered sufficient, and/or whether rationalisation of activities may support more focused use of time on priority activities. Checks here may also benefit from considering the level of direct oversight/checks/ supervision of operators which are required to maintain safe operations.Observation 7: There is a threat to the organisation with the loss of experienced personnel, this needs active management and engagement to ensure the risks are controlled to ALARP.Observation 8: General awareness of incident reporting was good, but not all employees were aware of the various methods to do this.Observation 9: There was recognition that there needed to be a good focus on DAP competence, particularly as experienced personnel retire, and the pool of highly experienced people (to train up the next generation) becomes smaller. Ensuring key leadership roles are appropriately staffed to SQEP level would benefit from continued focus.

3.3 Regulatory Issues

The following regulatory issues were raised, reviewed or closed as a result of this inspection.

Issue	Title