



# From theory to the field : ASN's considerations on HOF related to contractors

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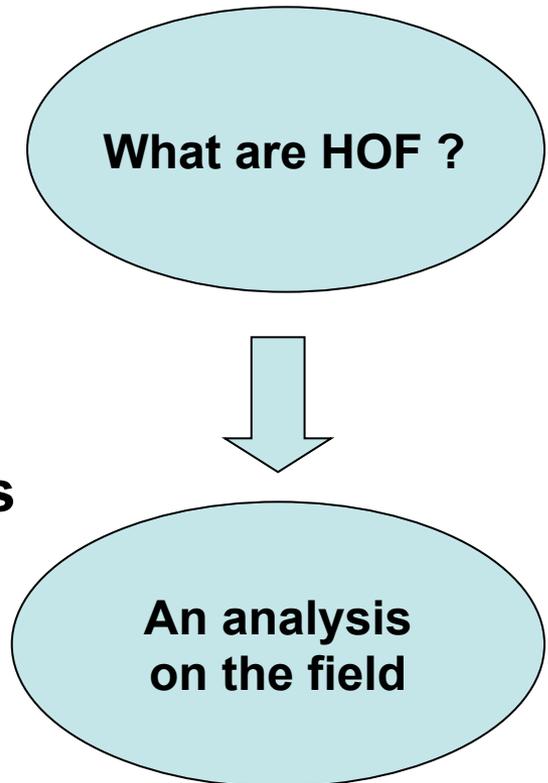
**International Experts' Meeting on Human and Organizational factors  
in Nuclear Safety in the light of the Accident at the Fukushima  
Daiichi Nuclear Power Plant  
Vienna - May 2013**

- **A systemic perspective to improve the human and organizational aspects of nuclear safety**

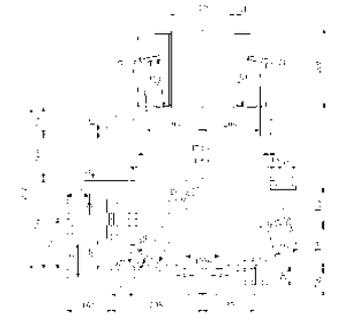
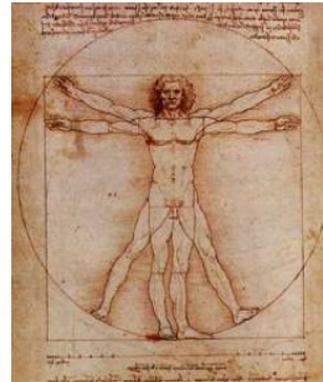
**Inappropriate resources lead to risks**

- **Example on the field : Using contractors in normal operating situations - HOF related to contractors**

**Experience and cooperation are to compensate for the constraints**



# A systemic perspective to improve the human and organizational aspects of nuclear safety



# Socio-technical systems (1)

## Operator

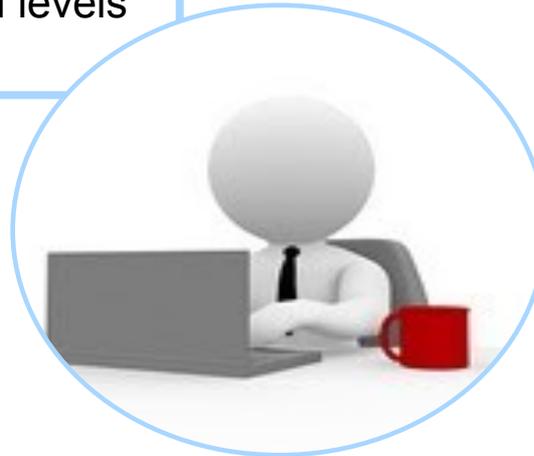
Physiological characteristics  
Skills  
Etc.



HOF factors are particularly concerned with anything that has to do with the **people involved** (physiological characteristic, workforce, skills, motivation, fatigue, etc.),

## Working environment

Light, thermal and sound levels  
Etc.



HOF factors are also concerned with anything that has to do with the **working environment** (light, thermal and sound levels, etc.)

# Socio-technical systems (3)

## Material and technical systems

Tools  
Documents, procedures  
Softwares  
Etc.



HOF factors are also concerned with anything that has to do with the **material and technical systems** (Tools, Documents, procedures, Softwares, etc.)

## Organization

Work shift  
Co-activity  
Task distribution  
Functional and  
hierachical links  
Etc.



HOF factors are also concerned with anything that has to do with the **work organization** (work shift, co-activity, task distribution, functional and hierarchical links, etc.)

# Socio-technical systems

## Organization

Work shift  
Co-activity  
Task distribution  
Functional and hierarchical links  
Etc.

## Operator

Physiological characteristics  
Skills  
Etc.

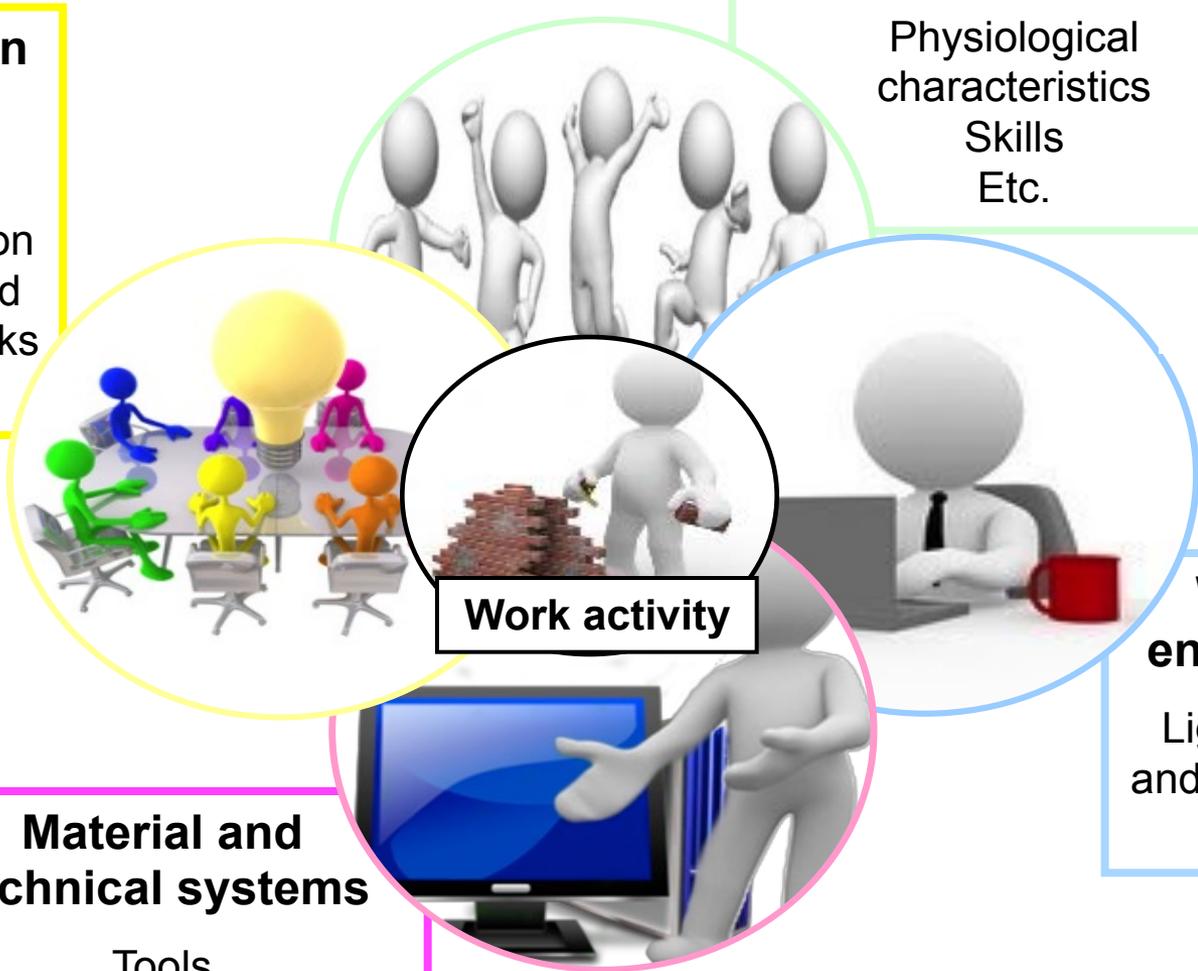
## Work activity

## Material and technical systems

Tools  
Documents, procedures  
Software  
Etc.

## Working environment

Light, thermal and sound levels  
Etc.



# Variability of context



The **situations** actually encountered by individuals in the field **vary constantly** (equipment which does not react as expected, night-work, inexperienced colleague, varying levels of urgency, labour disputes, etc.)

Requiring the workers to **adapt the way they work** to attain the **expected outcome**. This adaptation has a **cost** (in terms of fatigue, stress, health, etc)



It is the licensee's responsibility to ensure that **workers are placed in satisfactory working conditions** and have the possibility to **adapt the way they are carrying out their tasks (room of manoeuvre)** at an **acceptable cost**

# Human cost

**Inappropriate resources can lead to risks. For instance :**

inadequate tools,  
poor design of man-machine interfaces,

cramped or poorly lit working environment,

Inadequate selection of individuals  
insufficient training or practice,  
professional teams destabilised by organisational change,  
under-manning or insufficient time allocated for tasks



An operating situation in which performance is satisfactory but in which this was obtained at **very high human cost** to those involved is a **source of risk**



A **slight variation in the context** or **change of a member of personnel** can be enough to **prevent the required performance level from being reached**

# The operator, a reliability vector, & sometime an unreliable factor

## ➤ The operator as the **unreliable factor** ?

- (too) often considered as the weakest link in the organization
- ➔ Limitation of the operator's contribution (mechanisation)



## ➤ The operator as the **reliability vector** ?

- Detect / correct deficiencies
- Recovers from degraded situations
- Bypass or compensate inefficient rules / process
- Creates solutions

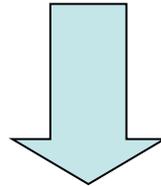


# HOF related to contractors – study on the fields



# Context

- **Considerable use of outside contractors (80% of maintenance activities during reactor outages)**



HOF analysis of the work conditions of service providers during reactor outage maintenance activities

# Framework for the intervention

- The analysis of the **work conditions** of service providers considered:
  - The **work resources** made available to them (equipment, information, human resources)
  - The **organisational framework** within which they work (the unit outages)
  
- The analysis of the **working relations between operators and the service providers** considered:
  - The **supervisory/surveillance relationship** which binds the initiator with the service providers
  - The **cooperative relationship** which exists between operators and the service providers, who form a single working unit



# Analysis of work activity



➤ **Professions studied :**

- Valving
- Logistics
- Scaffolding

- Study of the same activities in the **two nuclear facilities for 2 X 2 weeks**

➤ **The analysis of work activity** involved **observing work** when and where it happens and **asking operators** about what they do (i.e. the task) and how they do it (i.e. the activity)

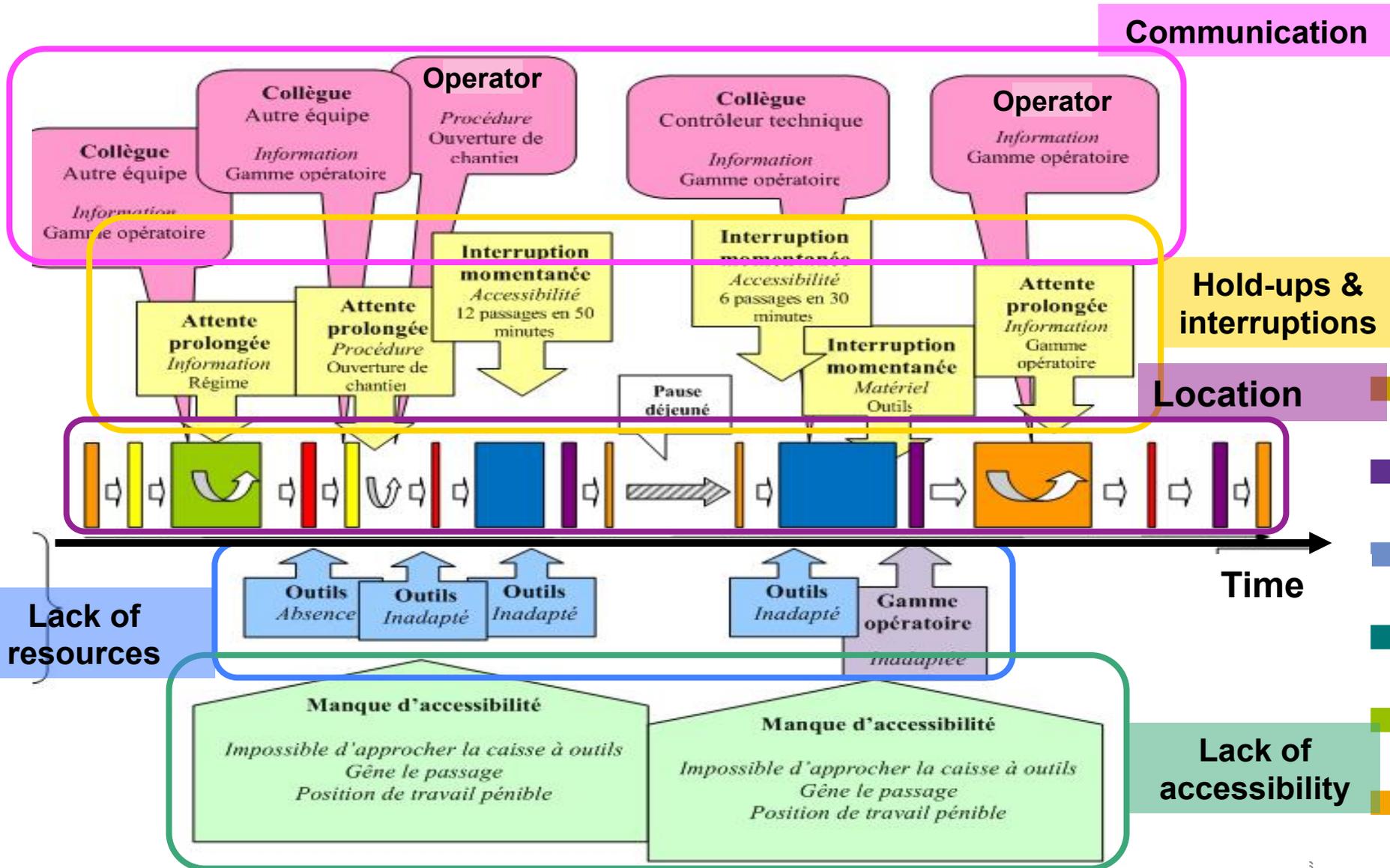
➡ understanding how an operator reaches a set objective (the prescribed task) and if he fails to do so, why

➤ **17 systematic observations** (Valves, logistics, scaffolding)

➤ **Observation of 4 half-days of activity steering**

➤ **Interviews** with licensee managers and the sub-contractors employees

# Contractor's work activity: a variety of constraints



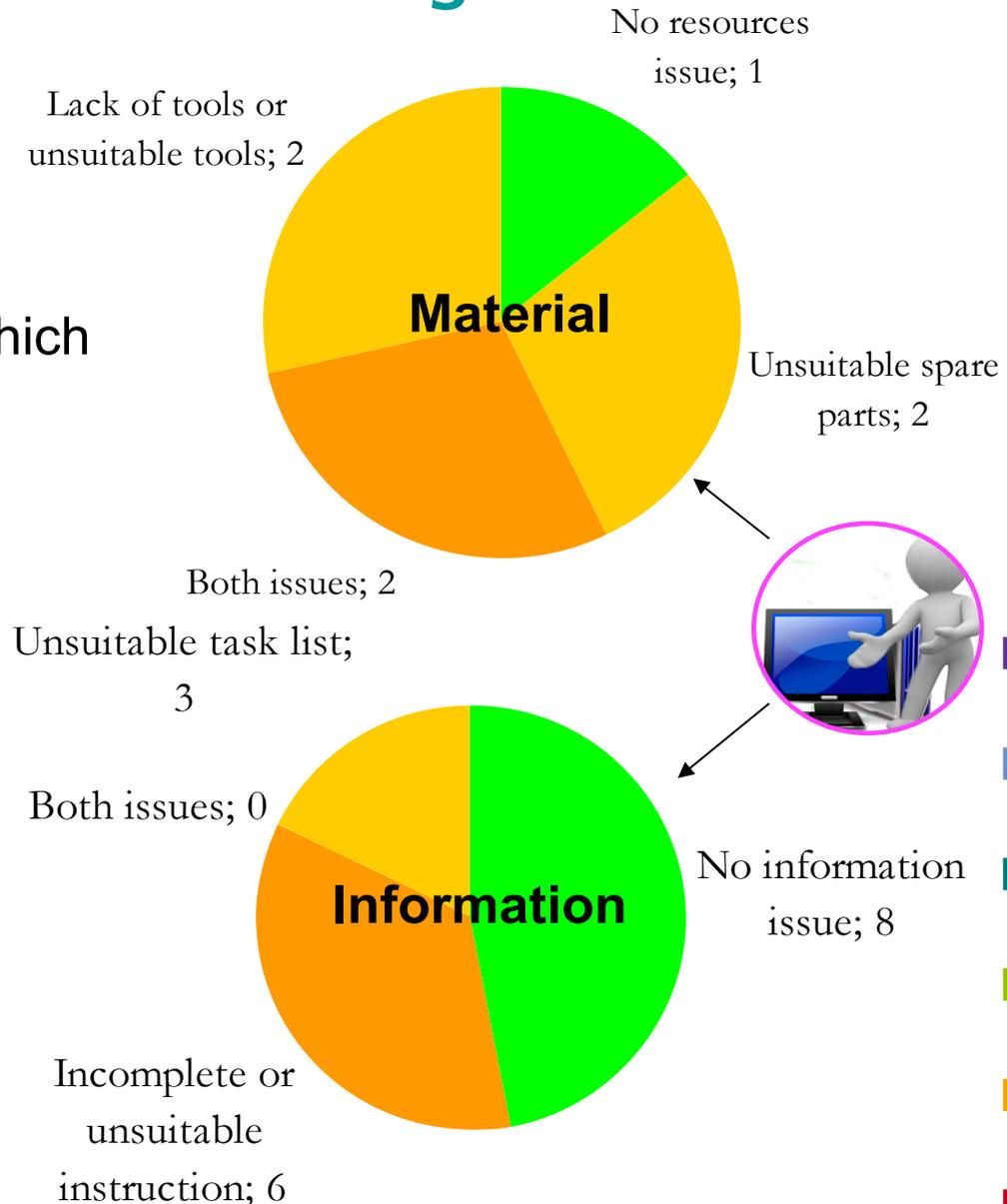
## Results (1)

**The constraints which disturb the activities  
of contractor employees**



# Insufficient material resources / Insufficient or misleading information

- Tools and spare parts: major resource problems for valve contractors
- A lack of material resources which affects every trade
- 7 valve tasks observed :
  
- Task lists not always reliable for valve contractors
- Instructions often vague for logistics, scaffolding
- 17 tasks observed (valve, scaffolding, logistics)

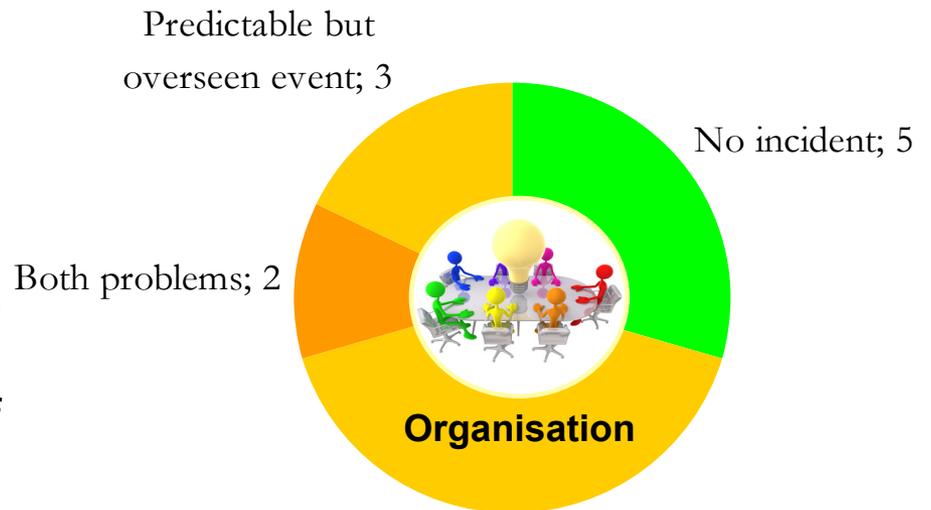
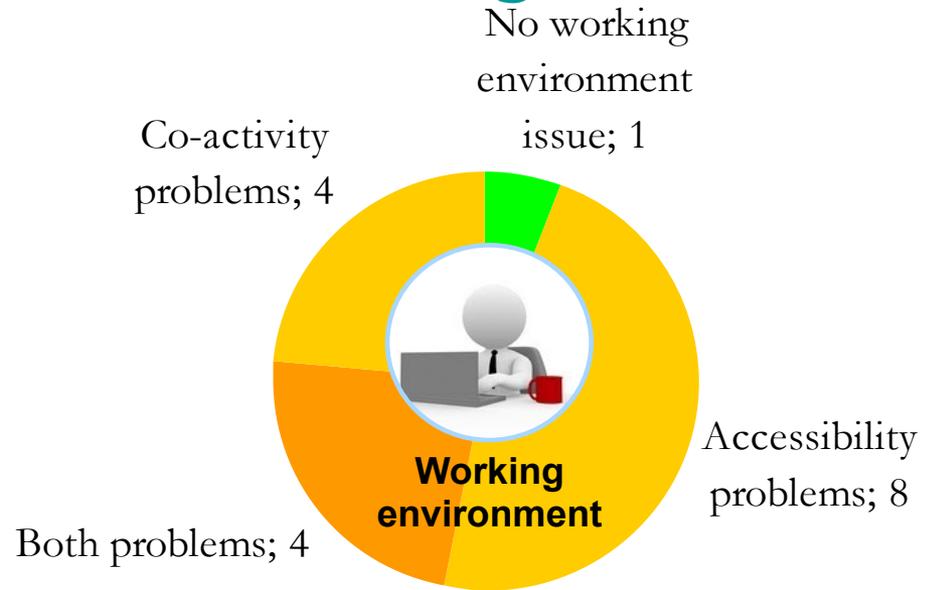




# Activities interrupted and delayed because of a lack of resources

- **Hold-ups and interruptions because of a lack of resources**
  - *Spare parts, tools and other material resources*: work site interruptions, storehouse delays and deadlines missed
  - *Search for information and waiting for consignment regimes*
  - *Unavailability of certain interlocutors (e.g.: surveillance officer)*
  
- **Strategy and know-how to compensate for the lack of resources**
  - *Transfer of equipment, “coping and getting by”, tool “retention”, “theft” between companies, “loans” between colleagues, use of unsuitable tools*
  - *Search for information from the people who initiated the request for intervention and experience and know-how making it possible to detect errors and compensate for the lack of information*
  
- **Insufficient resources, but know-how and experience often make up for them**

- Lack of accessibility to work premises and equipment
- Co-activity which leads to additional difficulties
  
- Numerous **unpredictable incidents** increasing delays & interruptions
- Changes in priorities and emergencies on a daily basis
- Incident management strategies which cost time and energy and are sometimes to source of tension for workers





## Results (2) : A supervisory relationship combined with a cooperative one

- **Interviews : A supervisory system which is seen as constrictive and sometimes counter-productive**
    - A supervisory system that can lead to interruptions and extended hold-ups, controls which are seen as superfluous, especially for the valve engineers
- ⇒ Precipitation and risk of mistakes
- **BUT : Relationships of trust and solidarity, as well as daily cooperation, which make activities easier to manage**
    1. **Collective strategies** (sometimes involving the project leader) make it possible to compensate for the lack of material and informational resources
    2. **Long-term partnership relations** help advance activities despite the procedural difficulties and the constraints of the organisation (the observations confirm this day-to-day relationship between providers and initiators)

# Interpreting the results

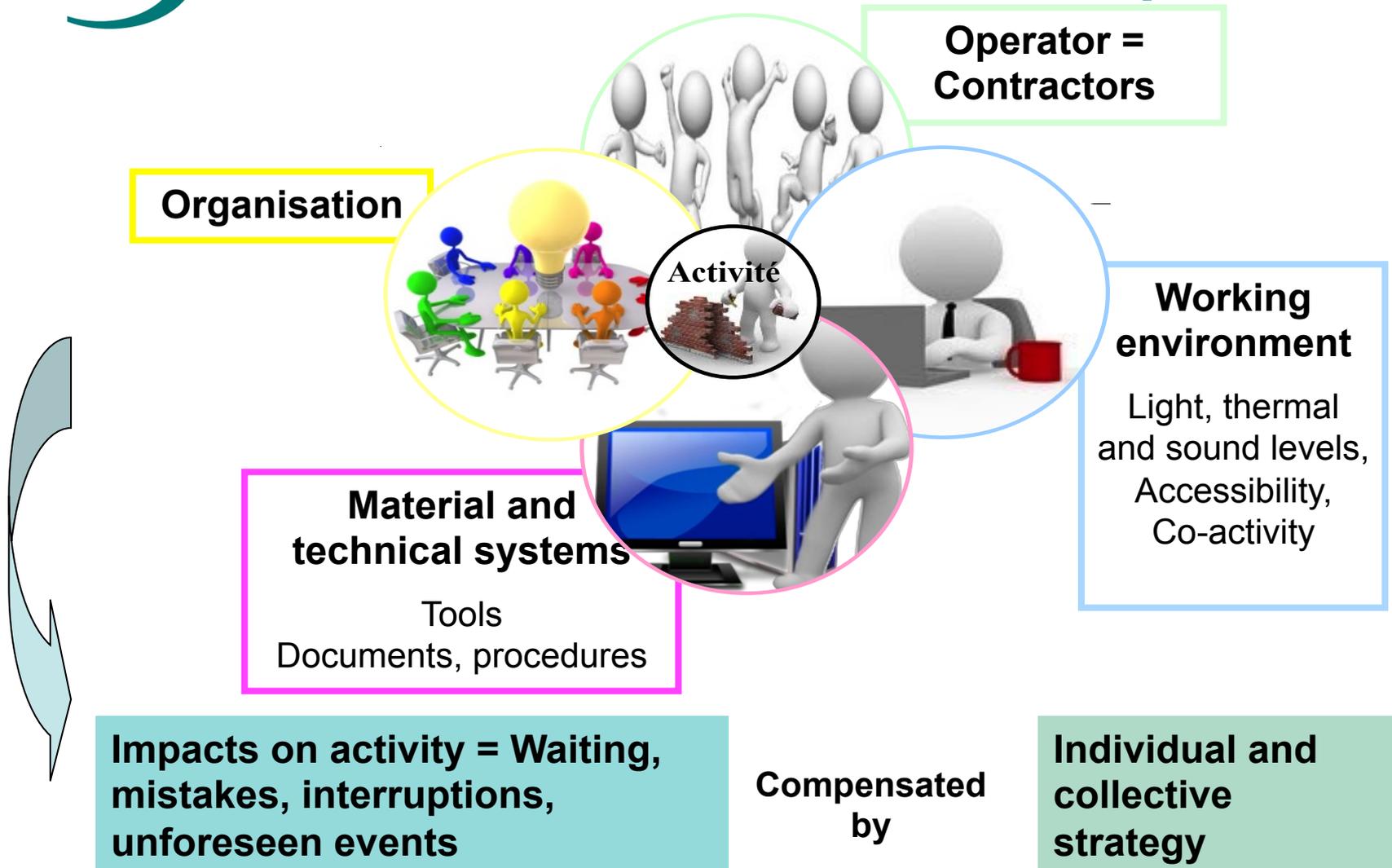
## ➤ **Result 1 :**

- Working resources with **room for improvement** with regard to the simultaneous requirements of quality, safety and timeframe
- There are various **positive examples**
- Maintenance activities require **time and expertise**, which are probably underestimated

## ➤ **Result 2 :**

- **Experience and cooperation** to compensate for the constraints of the work situation, potentially threatened by the instability of working groups

# Result of the study



**Need for a pluralistic approach in order to develop these issues + need for time : Steering committee CoFSOH**



# Social, organisational and human factors steering committee

- Pluralistic approach (alike steering committee for Post Nuclear Accident Management or waste management)
  
- Participants
  - the licensees
  - the trades union organisations
  - NGO representatives
  - the French High Committee for Transparency and Information on Nuclear Security
  - the Ministry for Labour and the Ministries responsible for nuclear safety
  - HOF experts and researchers
  
- 3 working groups started in January 2013
  - Using contractors in normal operating situations: work organisation and conditions
  - Use of subcontracting: legal aspects
  - Management of emergency situations

# asn Conclusion / relation with Fukushima

- Normal operation (or outage) vs. Emergency situation
- « Prepare to be unprepared » - whatever the situation, a proper working environment, training, tools, communication means etc. will be crucial in case of an unpredicted situation
- Get rid of the « superman fallacy »



# asn Conclusion / relation with Fukushima

