

ONR GUIDE			
SAFETY CULTURE GUIDE FOR INSPECTORS			
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Revision commentary:	<p>Rev 1: A column in the table in Appendix 2 has been re-named and a small number of consequential amendments have been made to the main body of the document to ensure that references to the table and its content are consistent. Bullet-points have been introduced in Appendix 2 to improve readability.</p> <p>Rev 2: Updated review period</p>		

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1 INTRODUCTION

1.1 One of the key factors determining safety performance in organisations is the health of the safety culture. Safety culture is defined by the IAEA (Ref 1) as “the assembly of characteristics and attitudes in organisations and individuals which establishes that, as an overriding priority, protection and safety issues receive the attention warranted by their significance.” In simple terms safety culture can be described as “the unwritten rules that dictate behaviours”, or “how things are done around here”.

1.2 IAEA’s General Safety Requirements (GSR) Part 1 (Ref 2) require regulators to consider safety culture when conducting inspections. This includes management emphasis on the importance of safety, fostering a strong safety culture, open reporting and evaluation of problems, and self-assessment (Ref 3).

2 PURPOSE AND SCOPE

2.1 The purpose of this guidance is to assist inspectors in identifying areas of concern or good practice in a dutyholder’s safety culture through observations and drawing comparisons to the traits and attributes of a healthy safety culture. During the course of an inspection or other interactions such as routine meetings or preliminary enquiries following an event, there will be opportunities to observe behaviours and understand how things are done in an organisation. Observations on safety culture should be considered in the annual intervention planning for nuclear licensed sites by means of the Leadership and Management for Safety (LMfS) review process (NS-TAST-GD-093) and regulatory intelligence reviews.

2.2 This guidance provides a set of expectations which inspectors may refer to, as part of their routine interactions, to gain insights into the safety culture of a dutyholder. Significant observations should be recorded and advice sought from the specialist LMfS inspectors, so that they can be followed up in an appropriate manner.

3 BACKGROUND

3.1 This guidance is one component of ONR’s overall approach to regulating safety culture, as illustrated in Figure 1. Its purpose is to support inspectors in gathering intelligence in their everyday interactions in a proportionate and a consistent manner against a recognised framework. This information should be used in conjunction with the duty holder’s own perspective on their safety culture, derived for example through self-assessment and culture surveys.

3.2 Information should be collected over time as inspectors engage routinely with duty holders. It should then be considered alongside other intelligence, such as licence condition inspection ratings and incident reports, as part of the LMfS review process.

3.3 This guidance complements the specialist analysis and support provided by LMfS inspectors by identifying areas where such support would add most value to interventions. It complements the following ONR guidance:

- NS-OPEX-IN-002, ONR Inspection and Use of Licensee Safety Performance Indicators (includes indicators of a positive safety culture);
- NS-TAST-GD-050, Periodic Safety Reviews (includes ONR expectations for coverage of LMfS aspects in a Periodic Safety Review); and
- NS-TAST-GD-093, Guidance for Undertaking Leadership and Management for Safety Reviews (provides a means of gathering and analysing intelligence related to LMfS, including safety culture).

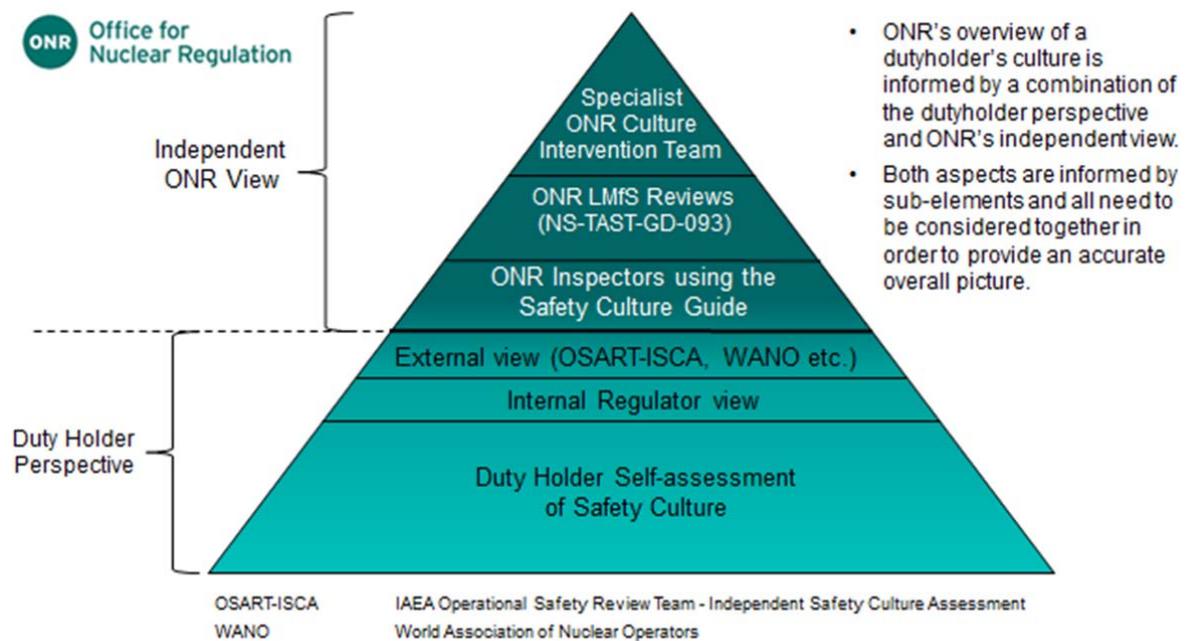


Figure 1: ONR's Approach to Regulating Safety Culture

3.4 Observations on safety culture should be considered as part of the annual intervention planning for nuclear licensed sites or other dutyholders (ONR-INSP-GD-059). A dutyholder in this context may include those in the process of applying for a licence or those participating in a generic design assessment.

4 SAFETY ASSESSMENT PRINCIPLES

4.1 Good safety leadership is the primary driver for a positive safety culture. ONR's LMfS Safety Assessment Principles (SAPs) MS.1-4 encompass the characteristics of a positive safety culture, as follows:

- **MS.1 Leadership: Directors, managers and leaders at all levels should focus the organisation on achieving and sustaining high standards of safety and on delivering the characteristics of a high reliability organisation.** This includes the role of leaders at all levels in:
 - providing direction, governance and oversight to establish and foster a positive safety culture that underpins safe operation;
 - demonstrating a visible commitment to safety through their activities;
 - ensuring that any reward systems promote the identification and management of risk, encourage safe behaviour and discourage unsafe behaviours or complacency; and
 - monitoring and regularly reviewing safety performance and culture.

The management system should also support a positive safety culture.

- **MS.2 Capable Organisation: The organisation should have the capability to secure and maintain the safety of its undertakings.** This includes processes and systems which secure and assure maintenance of appropriate technical and behavioural competence of directors (both

executive and non-executive), managers, leaders and all other staff and contractors with safety roles and responsibilities.

- **MS.3 Decision Making: Decisions made at all levels in the organisation affecting safety should be informed, rational, objective, transparent and prudent.** This includes active challenge as a part of decision making throughout the organisation, including at board and senior management levels.
- **MS.4 Learning: Lessons should be learned from internal and external sources to continually improve leadership, organisational capability, the management system, safety decision making and safety performance.** This includes:
 - Using near misses as opportunities to learn and fostering a culture of open reporting;
 - Identifying cultural factors in the investigation of accidents and incidents; and
 - Using both internal and external sources of information to identify trends and issues, including the influence of human and organisational factors, such as leadership and culture.

5 RELATIONSHIP TO LICENCE CONDITIONS

5.1 In addition to leadership, there are other factors which shape safety culture, such as organisational structure, governance and the management system. These are tangible facets of the organisation that can be easily recorded and measured. Safety culture cuts across all aspects of an organisation, but is harder to measure and to benchmark. It can be understood however through observations and drawing comparisons to the traits and attributes of a healthy safety culture.

5.2 To assist inspectors in making observations on safety culture during routine inspections or other interactions with a dutyholder, Appendix 1 maps the relevant LCs to the LMfS SAPs.

6 GUIDANCE ON INSPECTION OF ARRANGEMENTS AND THEIR IMPLEMENTATION

6.1 This section provides guidance for inspectors in identifying and assessing the principal characteristics of a dutyholder's safety culture through their normal interactions. Recent work under the auspices of the IAEA (see workshop output at Ref 4) has harmonised several existing models of safety culture into a single model. This provides nine traits of a safety culture and their associated attributes. The nine traits are set out below, mapped to the relevant LMfS SAPs and LCs.

<p>Personal Accountability: All individuals take personal responsibility for safety (MS.1; LC12; LC17; LC24)</p>	<p>Leadership Accountability: Leaders demonstrate a commitment to safety in their decisions and behaviours (MS.1; MS.2; LC12; LC17; LC26; LC28; LC36)</p>	<p>Communication: Communications support a focus on safety (MS.1; LC12; LC17; LC26; LC28)</p>
<p>Respectful work environment: Trust and respect permeate the organisation (MS.1; MS.3; LC7; LC12; LC26; LC28)</p>	<p>Problem identification and resolution: Issues potentially impacting safety are systematically identified, fully evaluated, and promptly resolved according to their significance (MS.3; MS.4; LC7; LC12; LC26; LC28)</p>	<p>Work planning: The process of planning and controlling work activities is implemented so that safety is maintained (MS.1; MS.2; LC12; LC26; LC28)</p>
<p>Decision-making: Decisions are systematic, rigorous, thorough, and prudent (MS.3; LC13)</p>	<p>Continuous learning: Learning is highly valued (MS.4; LC7)</p>	<p>Questioning Attitude: Individuals remain vigilant for assumptions, anomalies, conditions, behaviours, or activities that can adversely impact safety and then appropriately voice those concerns (MS.3; LC12; LC26; LC28)</p>

6.2 Based on the above traits and their respective attributes, a set of indicators and questions has been developed (Appendix 2) for inspectors to use in identifying areas of concern or good practice in a dutyholder's safety culture.

6.3 Practical tips on using the traits, attributes, indicators and questions are as follows.

- The traits, attributes, indicators and questions can be used in whole or in part according to the nature of the interaction. It is meant to be used as a menu rather than an exhaustive list to be worked through.
- A single observation or a small set of observations should not be considered typical of the safety culture. Observations should be collected and considered over a period of time and with regard to the other data points that are available (see Figure 1).
- The questions in Appendix 2 can be directed at personnel at different levels in the dutyholder's organisation to provide more rounded information.
- Significant observations (positive or negative) should be recorded in the inspector's intervention / contact record and fed into the LMfS review process during the review meetings.
- Where significant observations are made, advice should be sought from specialist LMfS inspectors (without waiting for the review process) so that they can be followed up in an appropriate manner. Such follow-up could include one or more of the following:

- integrating the inspector's observations with other intelligence available to ONR to identify any broader patterns or trends;
- challenging the dutyholder as to whether it has observed similar patterns, and if, so, what action it has taken in response;
- carrying out a targeted inspection to identify the factors underpinning the observed behaviours and / or testing the effectiveness of the improvements which the dutyholder has put in place;
- sharing good practices with colleagues.

7 REFERENCES

1. IAEA Safety Glossary, 2018 Revision, https://www-pub.iaea.org/MTCD/Publications/PDF/PUB1830_web.pdf
2. IAEA General Safety Requirements, Part 1, Governmental, Legal and Regulatory Framework for Safety, 2016, <https://www-pub.iaea.org/MTCD/Publications/PDF/Pub1713web-70795870.pdf>
3. Functions and Processes of the Regulatory Body for Safety, GSG-13, IAEA, 2018, <https://www-pub.iaea.org/MTCD/Publications/PDF/Pub1713web-70795870.pdf>
4. Harmonisation Workshop Output, K Koves, WANO Tokyo Centre, Workshop on the Use of a Harmonised Safety Culture Framework, IAEA, October 2017 (available on IAEA website)

8 APPENDIX 1: MAP OF LICENCE CONDITIONS TO LEADERSHIP AND MANAGEMENT FOR SAFETY SAPS (MS.1 TO MS.4)

Licence Condition	SAP	Factors relevant to safety culture
LC7 - Incidents on the site	MS.4 - Learning	Reporting and investigation of incidents
LC10 - Training	MS.2 – Capable organisation	Training related to safety leadership and culture
LC12 – Duly authorised and other suitably qualified and experienced persons	MS.2 - Capable organisation	Competence of persons performing duties which may affect the safety of operations Competence of Duly Authorised Persons to control and supervise operations which may affect safety
LC13 - Nuclear safety committee	MS.3 - Decision making (aspects related to challenge)	Effectiveness of Nuclear Safety Committee in fulfilling its advisory role
LC17 - Management Systems	MS.1 - Leadership	Ownership and leadership of the management system Effectiveness of management processes Visibility, accessibility and use of the management system
LC26 - Control and supervision	MS.1 - Leadership	Control and supervision of operations which may affect safety, including: <ul style="list-style-type: none"> - Resourcing - Competence - Arrangements for work planning and execution - Interfaces and communications
LC28 - Examination, inspection, maintenance and testing	MS.1 - Leadership	Control and supervision of examination, inspection, maintenance and testing which may affect safety
LC36 - Organisational capability	MS2 - Capable organisation	Adequacy of human resources Organisational design Management of organisational change

9 APPENDIX 2: SAFETY CULTURE – TRAITS, ATTRIBUTES, INDICATORS AND QUESTIONS

ID	Traits and Attributes*	Indicators and Questions
LA	Leadership Accountability: Leaders demonstrate a commitment to safety in their decisions and behaviours	
LA.1	Strategic alignment. Leaders establish and promote safety as an organisational priority.	<ul style="list-style-type: none"> Conflicts between safety and other goals are identified and managed. Safety risks have the same prominence as other business risks.
LA.2	Leader behaviour. Leaders set a positive example on safety.	<ul style="list-style-type: none"> Leaders set an example on safety by their actions, decisions and behaviours. Leaders establish and focus improvement on safe behaviours. Managers and supervisors are 'visible leaders' for safety. Leadership development programmes include leadership for safety as a core theme.
LA.3	Employee engagement. Leaders develop an aligned and engaged workforce that creates a positive environment for safety. Leaders seek the active involvement of people at all levels in identifying and resolving issues. Factors affecting work motivation and job satisfaction are considered when making decisions.	<ul style="list-style-type: none"> Leaders encourage challenge to work practices. Staff show engagement by asking questions at meetings, eg tool-box talks and safety briefings. Decisions on safety are influenced by feedback from workforce consultation. <i>Ask: When did you last engage staff in how safety could be improved? What happened as a result?</i>
LA.4	Resources. Leaders ensure that personnel, equipment, procedures, and other resources are available and adequate to support safety. Human Resources policies, including recruitment, succession planning and promotions, place a high priority on behaviour and decisions aligned with safety.	<ul style="list-style-type: none"> There is an emphasis on the behavioural as well as the technical competences of managers and staff <i>Ask: Do you have the resources and time to carry out your role safely? If not, have you challenged this? What happened as a result?</i>
LA.5	Field presence. Leaders are frequently present in all areas of the organisation observing work and material conditions. They ask questions, communicate, coach and reinforce standards and expectations. Leaders listen to and act on the concerns and feedback from the workforce.	<ul style="list-style-type: none"> Leaders routinely engage with their teams at the workplace, encouraging and coaching the behaviours that support the safe delivery of tasks. Managers and supervisors are a familiar sight on plant, seeking and giving constructive feedback to ensure adherence to procedures and standards for safety. <i>Ask: How do you know what the safety issues on your facility are?</i> <i>Ask: When was a safety issue last raised with you? What did you do about it? What feedback did you give the person reporting the matter?</i>
LA.6	Rewards and sanctions. Leaders ensure rewards and sanctions encourage attitudes and behaviours that promote safety. People are answerable not only for results but also how they achieve those results.	<ul style="list-style-type: none"> <i>Ask: When did you last praise or reward someone openly for taking appropriate action in the interests of safety?</i>
LA.7	Change management. Leaders use a systematic approach for communicating and implementing change to ensure safety is not compromised. The rationale for change is clearly communicated. The impact of change on safety is assessed before, during, and after the change.	<ul style="list-style-type: none"> Change is properly planned and resourced and includes meaningful engagement with staff and other stakeholders.
LA.8	Roles, responsibilities, authorities and accountabilities. Leaders ensure that roles, responsibilities, authorities and accountabilities are clearly defined and understood.	<ul style="list-style-type: none"> <i>Ask: Are your roles and responsibilities clear? How are you held to account for them? How do you hold others to account?</i>
CO	Communication: Communications support a focus on safety	
CO.1	Free flow of information. People communicate openly and freely across the organisation. The flow of information up and down the organisation is equally as important.	<ul style="list-style-type: none"> Safety is a normal, everyday part of communication within and between teams. People share information and identify learning opportunities. People report issues promptly and honestly through formal and informal reporting structures.
CO.2	Transparency. Communication and engagement with oversight, audit, regulatory organisations, the public and other stakeholders is appropriate, professional and accurate.	<ul style="list-style-type: none"> People are empowered to communicate and engage with oversight and regulatory organisations openly and transparently.
CO.3	Reasons for decisions. Leaders ensure that the reasons for technical and administrative decisions are communicated to the appropriate people in a timely manner.	<ul style="list-style-type: none"> Leaders explain the safety rationale for their decisions.
CO.4	Expectations. Leaders frequently communicate and reinforce the expectation that safety is emphasised over competing goals.	<ul style="list-style-type: none"> Leaders use diverse methods of communication and engagement to give clear and consistent safety messages.

ID	Traits and Attributes*	Indicators and Questions
		<ul style="list-style-type: none"> Ask: What are the safety expectations of managers and supervisors? Ask: How do managers and supervisors demonstrate their commitment to safety?
CO.5	Workplace communication. Communication about safety is included in all work activities to ensure everyone has the information necessary to work safely and effectively.	<ul style="list-style-type: none"> Due consideration is given to safety in pre-job briefs, shift handovers and communications with contractors.
PA	Personal Accountability: All individuals take personal responsibility for safety	
PA.1	Adherence. People understand and accept the importance of standards, processes, procedures, expectations and work instructions. People at all levels of the organisation adhere to these standards and expectations.	<ul style="list-style-type: none"> Procedures, processes and standards are useful, respected and complied with. Ask: What do you do when a procedure is not correct?
PA.2	Ownership. People demonstrate personal commitment to safety in their behaviours and work practices. They promote safe behaviours in all settings and coach others when necessary.	<ul style="list-style-type: none"> Ask: When did you last stop a job for safety reasons? What happened as a result?
PA.3	Collaboration. People and work groups help each other obtain goals by communicating and coordinating their activities across the organisation. People understand and value diverse thinking to optimise safety.	<ul style="list-style-type: none"> Safety is seen as a team effort. Functions and layers of the organisation cooperate rather than blaming each other for problems.
WE	Respectful Work Environment: Trust and respect permeate the organisation	
WE.1	Respect is evident. All people are treated with dignity, respect and openness. People's contributions are recognised and welcomed.	<ul style="list-style-type: none"> There is trust between managers, workers and functions. Blame is avoided and constructive approaches are taken in response to events and issues. Leaders are aware of and avoid behaviours that have a negative effect.
WE.2	Opinions are valued. People are encouraged to ask questions, raise concerns and provide suggestions. Differing opinions are sought and respected.	<ul style="list-style-type: none"> People feel comfortable challenging the status quo. Contributions are encouraged from all attendees at meetings. Ask: When did you last challenge an unsafe act or work practice? What happened as a result? Ask: When did you last seek a differing opinion on a matter related to safety? What did you do with this information?
WE.3	Trust is cultivated. Trust, openness and honesty are fostered among people and work groups throughout the organisation.	<ul style="list-style-type: none"> Managers actively seek out and encourage "bad news".
WE.4	Conflicts are resolved. Fair and transparent methods are used to resolve conflicts in a timely manner.	<ul style="list-style-type: none"> People trust that management decision-making is professional and fair.
WE.5	Facility conditions reflect respect. Housekeeping and material conditions reflect respect for both people and equipment. Facilities are conducive to a productive work environment and housekeeping is maintained.	<ul style="list-style-type: none"> People respect each other and their work environment. High standards of housekeeping are maintained. Degraded conditions are not tolerated.
WE.6	Supportive policies are implemented. The organisation has a clear and effective policy that supports individual's to raise safety concerns. The organisation does not tolerate harassment, intimidation, retaliation or discrimination for raising concerns.	<ul style="list-style-type: none"> Everyone is expected to have an input to safety, challenge is encouraged and responses are constructive Ask: When did you last challenge safety standards or make a suggestion for improvement? What was the response? What changed a result?
WE.7	Confidential reporting is possible. The organisation implements an effective method for raising and resolving concerns that is confidential and independent of line management influence. Timely feedback is provided to the concerned individual.	<ul style="list-style-type: none"> Concerns are dealt with confidentially with timely feedback.
PI	Problem Identification and Resolution: Issues potentially impacting safety are systematically identified, fully evaluated and promptly resolved according to their significance	
PI.1	Identification. A method for collecting issues is implemented. The issues collected are not only major issues but also minor issues (which may become major issues). People identify issues in a timely manner. Self-reporting is expected and valued by the organisation.	<ul style="list-style-type: none"> People at all levels recognise and report deviations from standards
PI.2	Evaluation. Issues are thoroughly evaluated to determine underlying causes and whether the issue exists in other areas. Issues are evaluated in an appropriate time frame.	<ul style="list-style-type: none"> Issues are thoroughly evaluated in terms of root causes and extent of condition. Consideration is given to why any similar previously reported issues were not adequately resolved.

ID	Traits and Attributes*	Indicators and Questions
PI.3	Resolution. Identified issues are corrected as appropriate. The effectiveness of the actions is assessed to ensure issues are adequately addressed. Important lessons are shared.	<ul style="list-style-type: none"> Corrective actions are timely and checked for their effectiveness in solving the original problem.
PI.4	Trending. Issues are analysed to identify possible patterns and trends. A broad range of information is evaluated to obtain a holistic view of causes and results.	<ul style="list-style-type: none"> The organisation periodically takes a 'stand-back' view of trends and identifies threats or weaknesses in plant, processes and people.
WP	Work Planning: The process of planning and controlling work activities is implemented to ensure safety is maintained	
WP.1	Work management. There is a systematic approach of selecting, scheduling, coordinating and completing work activities to emphasise safety. The work process considers the identification and management of relevant factors including risk.	<ul style="list-style-type: none"> Work is planned with adequate consideration of nuclear and conventional safety. Managers are willing to change schedules or resources to ensure that safety issues are adequately addressed. Work planning actively involves those responsible for executing tasks. Control and supervision of staff and contractors is appropriate to the hazards and risks.
WP.2	Safety margins. Work is planned and conducted to ensure safety margins are preserved. Safety margins are understood, carefully maintained and changed only through a systematic and rigorous process.	<ul style="list-style-type: none"> Work is planned with an overriding priority on safety, informed by the safety case. <i>Ask: Do you have the knowledge, skills and experience necessary to carry out your role safely? How do you know?</i>
WP.3	Documentation and procedures. Documentation, including procedures, is complete, accurate, accessible, user-friendly, understandable, and up-to-date. Changes are tracked.	<ul style="list-style-type: none"> Safety cases are adequately maintained, associated limits and conditions are clear and reflected in procedures. <i>Ask: How easy are procedures to understand and follow? What happens if a procedure is not followed?</i> <i>Ask: Do "work-arounds" exist? What is being done to address them?</i>
DM	Decision Making: Decisions are systematic, rigorous, thorough and prudent	
DM.1	Systematic approach. People use a consistent, systematic approach to evaluate relevant factors (including risk) and make decisions. Using a systemic approach supporting information is collected from all relevant sources.	<ul style="list-style-type: none"> Structured decision-making processes are in place, eg operational or conservative decision-making, to deal with events and anomalies. These processes involve suitably qualified and experienced persons, plus active and independent challenge. All relevant data and opinions are collected and considered. Differing views are encouraged.
DM.2	Conservative approach. People make prudent choices over and above those that are simply allowable. Actions are determined to be safe before proceeding, rather than proceeding until proven unsafe.	<ul style="list-style-type: none"> Decision-making is demonstrably conservative in the face of uncertainty or unforeseen situations. Assumptions are questioned.
DM.3	Clear responsibility. Authority and responsibility for decisions is specific and well defined.	<ul style="list-style-type: none"> People are empowered to make timely decisions in the interests of safety
DM.4	Resilience. Prudent decision-making is always used. However, in unforeseen situations, when no procedure or plan applies, the organisation develops the ability to adapt.	<ul style="list-style-type: none"> The organisation develops the ability to adapt, eg by providing more than enough training for the kind of work individuals have to perform.
CL	Continuous Learning: Learning is highly valued	
CL.1	Constant examination. Safety is regularly monitored and assessed through techniques including independent and self-assessments of programs and practices. Safety culture is regularly assessed and enhanced.	<ul style="list-style-type: none"> There is an open and fair reporting culture at all levels. The organisation uses a meaningful set of leading and lagging indicators of safety performance, supplemented by qualitative intelligence. Managers give a balanced picture of "good" and "bad" news on safety. <i>Ask: How would you describe your current performance on safety? What improvement actions are you taking forward? How will you know whether these are effective?</i>
CL.2	Learning from experience. The organisation systematically and effectively collects, evaluates, shares and implements relevant internal and external lessons learned in a timely manner. Lessons learned are also shared with relevant organisations.	<ul style="list-style-type: none"> Leaders show a willingness to learn and commit resource and time to ensure learning happens in the organisation. Leaders have an understanding of the lessons from major events and how they have been considered and applied. Diverse sources of learning are identified and used. Learning opportunities are realised through managed change, ie through integrated, effective and prioritised action to improve safety.

ID	Traits and Attributes*	Indicators and Questions
CL.3	Training. The organisation provides effective training and ensures knowledge transfer to maintain a knowledgeable and competent workforce.	<ul style="list-style-type: none"> Learning is captured in updates to training and procedures.
CL.4	Leadership development. Competent leaders are developed through training and succession planning processes.	<ul style="list-style-type: none"> Managers at all levels receive the necessary training, coaching and mentoring to develop as safety leaders.
CL.5	Benchmarking. The organisation learns from other organisations' safety practices, including other industries.	<ul style="list-style-type: none"> Benchmarking is not restricted to the nuclear sector, other sectors are consulted. Managers seek opportunities to learn and encourage others to do the same.
QA	Questioning Attitude: Individuals remain vigilant for assumptions, anomalies, conditions, behaviours or activities that can adversely impact safety and then appropriately voice those concerns	
QA.1	Recognise unique risks. People understand the unique risks associated with nuclear and radiation technology. They understand that the technologies are complex and could potentially fail in unforeseen ways with significant consequences.	<ul style="list-style-type: none"> Managers play close attention to day-to-day operations. <i>Ask: What are the nuclear safety hazards and risks associated with your work? What are the associated risk controls? What is your role in implementing these controls?</i>
QA.2	Avoid complacency. People recognise and plan for the possibility of mistakes, unforeseen problems and unlikely events, even with past successful outcomes. People recognise that complacency often comes with success and continually strive to avoid it in themselves and others.	<ul style="list-style-type: none"> Questioning is encouraged at all levels. People listen to and respect others' views.
QA.3	Question when uncertain. People stop when uncertain and seek advice. The situation and risks are evaluated and managed before proceeding.	<ul style="list-style-type: none"> People stop and seek advice if they are uncertain, to ensure that risks are properly evaluated and controlled <i>Ask: Do you know who to go to for advice on safety matters? When did you last do this? What happened as a result?</i>
QA.4	Recognise and question assumptions. People question assumptions and may offer different perspectives when they believe something is not correct.	<ul style="list-style-type: none"> People feel free to challenge and alternative views are sought.

*Based on Harmonised Model of Safety Culture (Ref 4)