

# Quantifying the Unimaginable Human Performance Limiting Values

What is the maximum human reliability of a single human operator?  $10^{-3}$ ?  $10^{-4}$ ?  $10^{-5}$ ?



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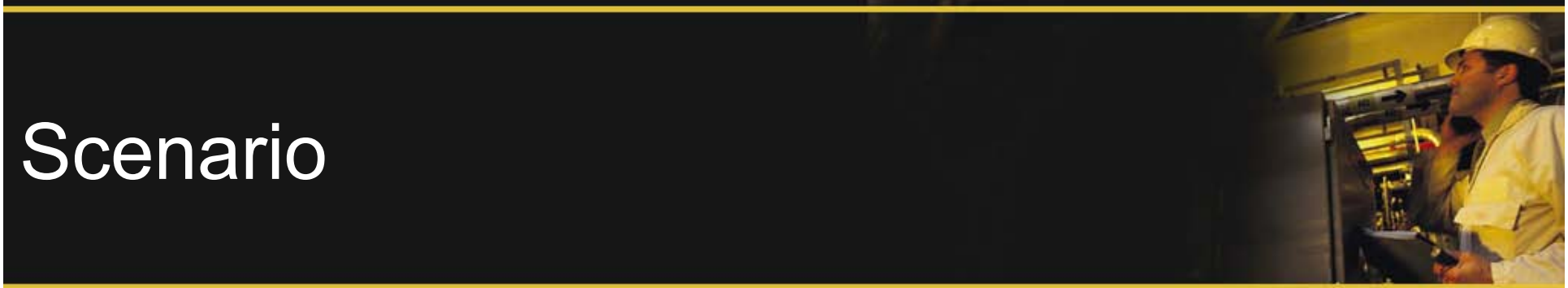
# Overview



- The Problem Area
- HPLVs
- Guidance

# Scenario

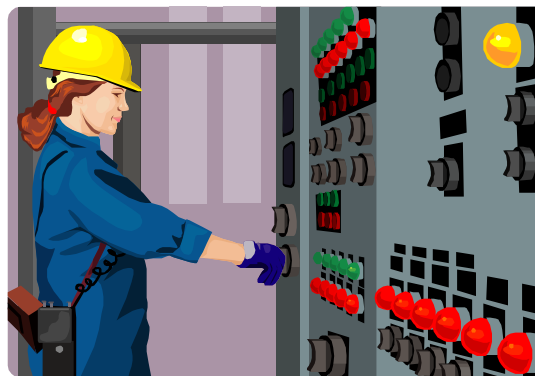
- Nuclear Power Plant
- Loss of feedwater
- Operating team fail to recognise need to commission boiler feed for post-trip cooling (1.5hrs after trip)
- Continues to fail for further 8 hrs
- What is the failure probability?
- What is the failure mechanism, anyway?



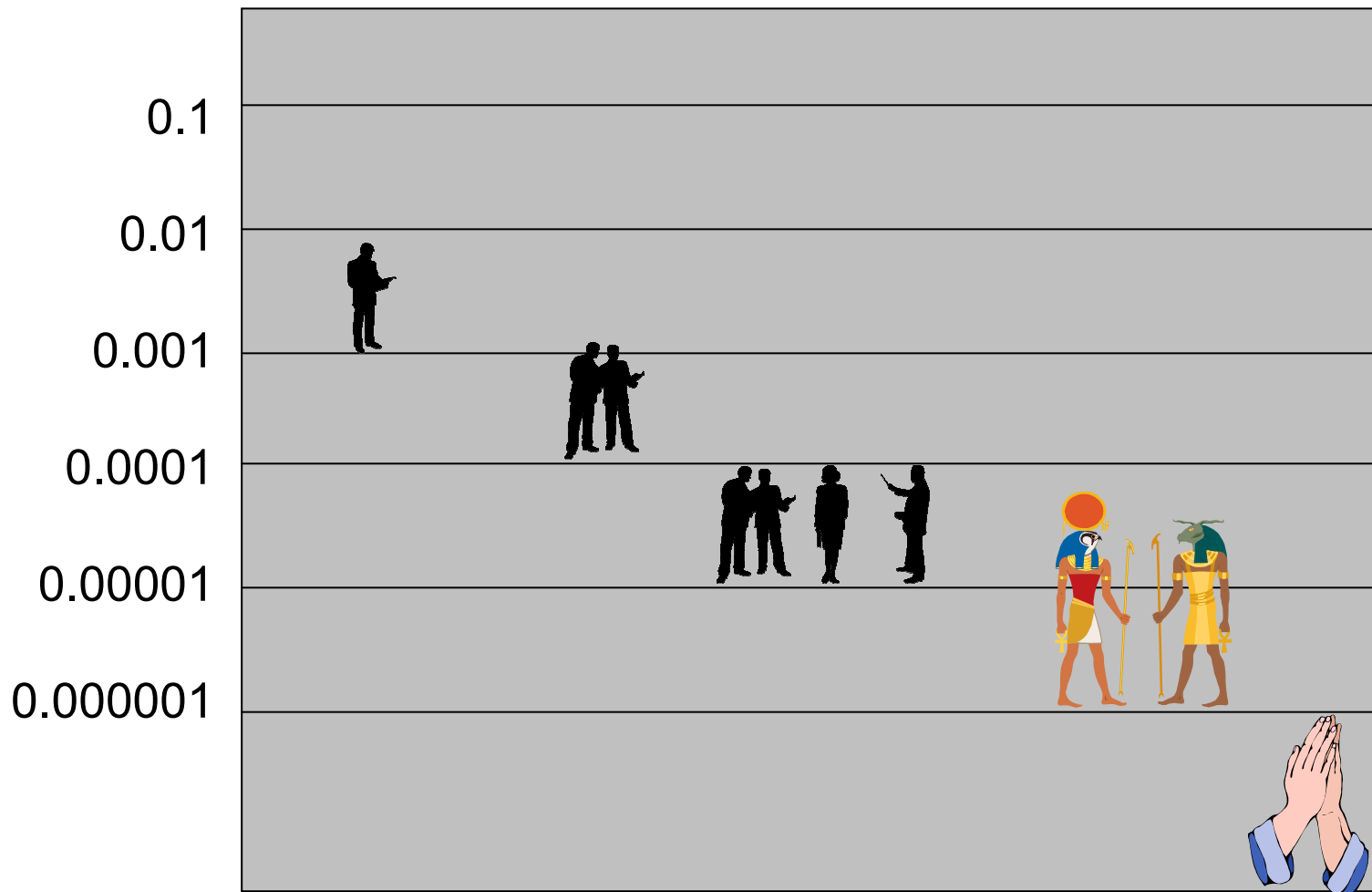
# Human Error Probabilities in Cutsets

- Operator 1 fails to do it right
- Operator 2 fails to check operator 1
- Supervisor fails to detect error
- Operator 3 fails to respond correctly
- Operator 4 fails to correct
- Supervisor fails to oversee

Whoa !!!



# The Problem – human performance limits



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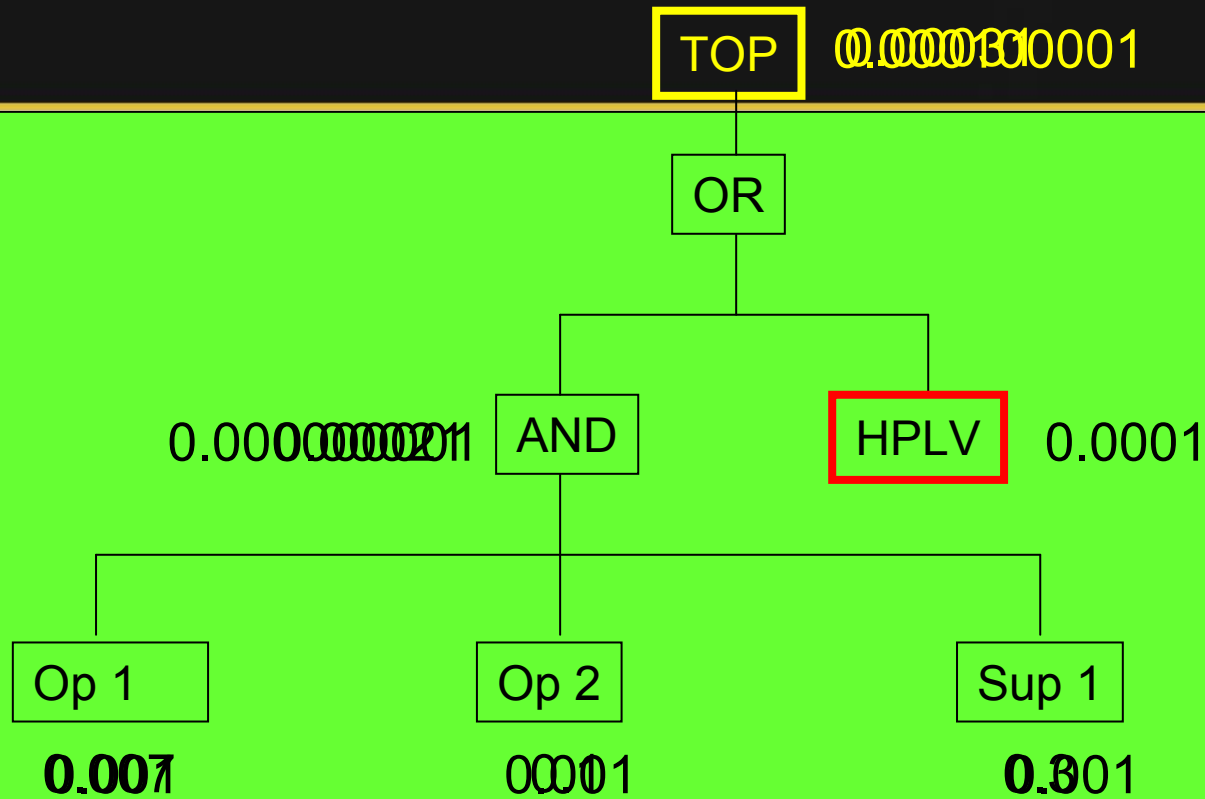
# Human Performance Limiting Values (HPLVs) cutset 'cut-off' values



- Circa 1990, BNFL THORP Safety Case Methodology
- Reviewed human error data  $< 10^{-5}$
- Concerned over optimism
- 3 HPLVs:
  - $10^{-4}$  Single operator
  - $10^{-5}$  (one operator) in plant (e.g. transfer of control from
  - $10^{-6}$  (two operators) – exceptional C/R conditions
- Some other utilities use them (e.g. PSI)

**A HPLV is NOT a HEP**

# Example



# Utility of HPLVs: BNFL experience



- Checked optimism
- Straightforward for assessors
- BNFL interpretation of NII SAPs discontinued use of  $10^{-6}$
- HPLV Sheets & Review by HF Team
- Highlight issues to internal Safety Committee
- Use of 'Non-credible' argument in some cases
- If have data (e.g.  $<10^{-5}$ ) then use data
- Approach allows focus of safety effort where needed



# UK Nuclear Industry Workshop on HPLVs (2007)



British Energy; British Nuclear Fuels; Atomic Weapons  
Research Establishment; Nuclear Installations Inspectorate  
NARA Project Team

# Usage of HPLVs in UK



- **Reprocessing**

- Less diagnosis; many small fault trees; assessors have HF training; **HPLV process clear to assessors**
- Some events not modelled if HD or CD
- Assessors model and choose value of HPLV in (small) FT
- Justification sheets (HPLV)
- HF Review – if  $10^{-5}$  consider task analysis; determine impact on risk target; consider pessimisms; identify improvements (ALARP)
- Can designate ‘non-credible’ argument

- **Defence**

- [No diagnosis; very many very short fault sequences; criticality]; long FT under an OR gate; focus on initiating events
- Quantify using THERP or historical data
- Consider direct dependence (THERP)
- **If  $< 10^{-5}$  then apply HPLV cut-off  $10^{-5}$  for group or  $10^{-4}$  for single person**
- If risk sensitive try qualitative approach / ALARP

# Process



- **Gas-Cooled Reactors**

- Initiating events give auto trips (high level of redundancy): focus on post-trip – need operator support after 1-2 hrs; massive fault trees; some latent failures; SRV lift is major milestone
- Identify required actions – focus on key actions (do task analysis)
- 2 periods – initial and long timeframe: assumptions of different shifts, continued need for action
- Raise all HEPs to 0.9 and review cutsets

- **PWR**

- Some long timeframe actions – assumption about shift changes; PWR has a shutdown PSA where more dependent on operator diagnosis/action
- No HPLV usage
- Latent errors are in – do not see need for dependency across latent/active boundary
- THERP & Direct dependence using modified formula – slightly less pessimistic
- Raise all HEPs to 0.9 (prioritisation analysis)

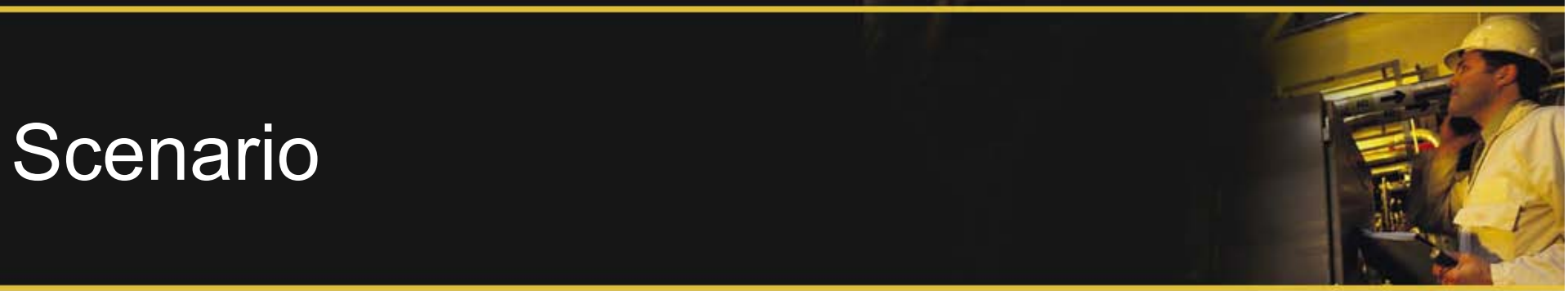
# Workshop Approach

- Scenarios considered by all parties
- Usage & non-usage of HPLVs discussed
- Frank & honest discussion, regulator present
- Differences in plant type, and assessment approach has an effect
- Idealised process evolved after the workshop



# Scenario

- Ops fail to recognise need to secure continuous boiler feed for post-trip cooling within 2.5 hrs of reactor trip
- Fail to respond to a break in boiler feed and issue instructions to re-instate boiler feed within *a further 12.5 hrs*
- Various alarms; SRV lifts 4.5 hrs into scenario; change of shift; Symptom-Based Emergency Response Guidance



# Scenario 3 - Glove-box Scenario



- Build up of powder – fail to detect in one month
- Process related check (2)
- Weekly check (3)
  
- 2 different people
- Same check
- Administrative control
- HPLV  $10^{-4}$

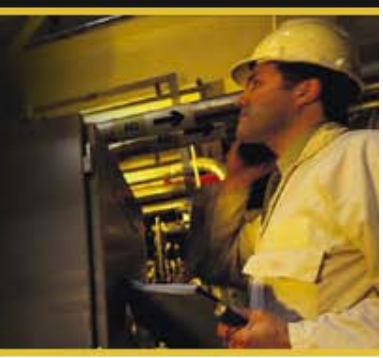
# Principles



- An HPLV is not a Human Error Probability (HEP), and is only used to bound a cutset, preventing optimism
- Direct dependence should be modelled before HPLV application – HPLVs should not be a short-cut for modelling or understanding
- An HPLV acts as a ‘flag’ to assessors that a deeper look needs to be taken to determine risk significance
- Indiscriminate use of HPLVs distorts the risk picture
- A utility’s Risk Management processes should include dependence counter-measures
- HPLVs are not a solution to errors of commission – separate searches for EOCs (latent and post-trip) should occur
- Whatever the approach taken for dependence, it needs to be transparent and defensible
- The lowest credible HPLV appears to be  $10^{-6}$
- Positive Safety Culture must also be assured separately



# Guidance

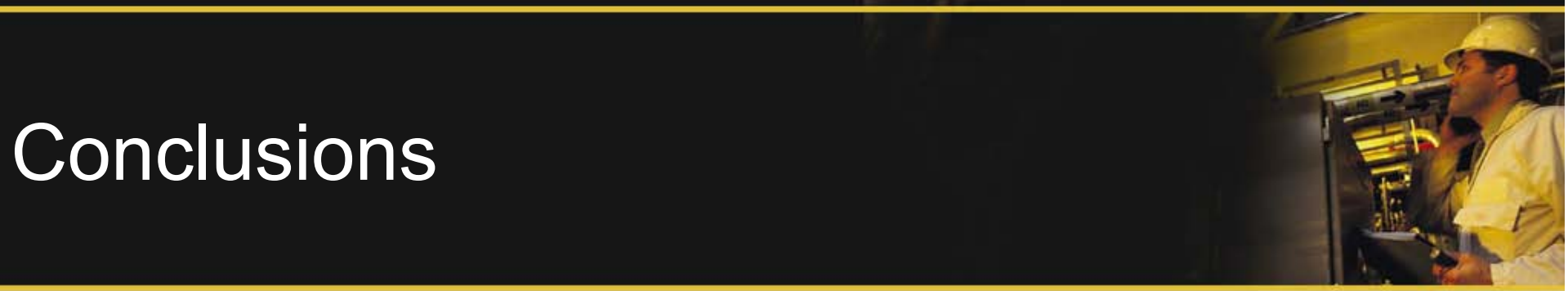


- Model direct dependence, including cognitive dependencies
- Apply HPLVs as appropriate
- Consider impact on risk target
- If risk sensitive:
  - If single personnel consider centralising / adding personnel
  - If new plant, consider design change to improve human-system reliance balance
  - Work on ‘optimising factors’, countering ‘mechanisms’
  - Deem ‘non-credible’ go to peer review
  - Use  $10^{-6}$  if long timescale
  - Make As Low As Reasonably Practicable (ALARP) case
  - Re-design task



# Conclusions

- Two of the four companies make regular use for HPLVs – most of the time they don't matter; but occasionally they help assessors see 'the wood for the trees', and they know they have to dig deeper
- In new plant, the ideal would be to have a better balance between technology and human, such that there was less need to resort to HPLVs. However, outage PSAs etc. may remain a different story
- As ever, the numbers are less important than the search for vulnerabilities and the attempts to defend against them, and maintaining transparency throughout this process. HPLVs are 'blunt' but clear.



## Closing statements (from the Workshop)



- Balance between human and hardware reliability
- HPLVs covering 'residual' (epistemic) uncertainty
- Regulator – no expectation for licensees to use HPLVs – but can see that direct dependence will not capture everything, and you can get excessively optimistic cutsets – there is a case for using HPLVs – though not as a substitute of direct dependence modelling

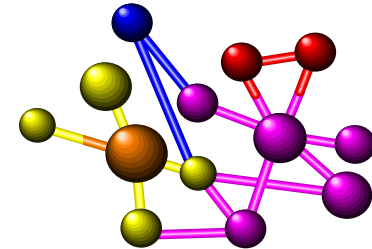
Questions?



# INDIRECT DEPENDENCE

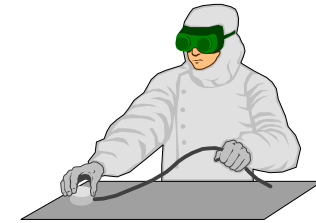
- Equivalent of CMF or Beta factors
- Allowing for unforeseen dependencies – interactions less understood
- Incident & accident experience tells us we are not so reliable
- Accounting for (partially) errors of commission
- Limits of human performance
- Limits of prediction

***Epistemic Uncertainty***



# HPLV Issues

- DIRECT DEPENDENCE
- Clear mechanism of dependence
- Swain/HSE factors apply – same people, task, timeframe, etc.
- Use of THERP adjustment factors, conditional probabilities, judgement, etc.



# Multiple perspectives

