Dimensions of Human Factors in Nuclear Power Safety

From
A. H. AKBAR
DIRECTOR GENERAL
CHASHMA NUCLEAR POWER GENERATING STATION (CNPGS)
PAKISTAN ATOMIC ENERGY COMMISSION
## Nuclear Power Plants in Pakistan

<table>
<thead>
<tr>
<th>Nuclear Power Plants</th>
<th>Capacity (MWe)</th>
<th>Year of Commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Operation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KANUPP</td>
<td>137</td>
<td>1972</td>
</tr>
<tr>
<td>CHASNUPP-1</td>
<td>325</td>
<td>2000</td>
</tr>
<tr>
<td>CHASNUPP-2</td>
<td>325</td>
<td>2011</td>
</tr>
<tr>
<td><strong>Under-construction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHASNUPP-3</td>
<td>340</td>
<td>2016</td>
</tr>
<tr>
<td>CHASNUPP-4</td>
<td>340</td>
<td>2017</td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Installed Capacity</td>
<td>8,800</td>
<td>by 2030</td>
</tr>
</tbody>
</table>
Location of NPPs

KANUPP

TAJIKISTAN

CHINA

AFGHANISTAN

C1/C2/C3/C4

INDIA

IRAN
<table>
<thead>
<tr>
<th>Milestone</th>
<th>C-1</th>
<th>C-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Concrete Pouring</td>
<td>Aug 01, 1993</td>
<td>Dec 28, 2005</td>
</tr>
<tr>
<td>Submission of FSAR</td>
<td>Apr 01, 1998</td>
<td>Nov 30, 2009</td>
</tr>
<tr>
<td>First Fuel Loading</td>
<td>Nov 22~28, 1999</td>
<td>Dec 22~30, 2010</td>
</tr>
<tr>
<td>First Criticality</td>
<td>May 03, 2000</td>
<td>Feb 22, 2011</td>
</tr>
<tr>
<td>Connection to Grid</td>
<td>June 13, 2000</td>
<td>Mar 14, 2011</td>
</tr>
<tr>
<td>Commercial Operation</td>
<td>Sep 15, 2000</td>
<td>May 18, 2011</td>
</tr>
</tbody>
</table>
C-1 Cycle Wise Performance

Longest Continuous Operation: 239 Days
C-2 Cycle-1 Performance
May 12, 2011 – Jan 20, 2013

Availability Factor 86.7 %
Capacity Factor 79.3 %
Longest Continuous Operation 161.7 Days
CNPGS Organization

Director General
CNPGS

- PM C-1
- PM C-2
- Dir. TS
- Dir. QA
- Dir. CHASCENT
  - Dir. Admin.
  - Dir. Finance
  - Security
Director
CHASCENT

- Manager, Simulator
- Manager, Basic Training
- Manager, Operations Training
- Manager, Maint. & Tech. Training
- Manager, PSA
Operational Safety

- Periodic Safety Review (PSR) for unit C-1
- Corporate and Plant Safety Policy
- Technical Specifications requirements
- Operating Experience Feedback
- Management oversight
- Regulatory Oversight
- Support from Reactor vendor, Designer available
- Third Party Inspections
- Self-assessment program
- IAEA Pre-OSART and OSART missions, WANO Peer Reviews / Follow-ups / TSMs at C-1
Operational Safety

- WANO-TC Pre-startup Peer Review / Follow-up and TSM for C-2 in Human Performance improvement and organization for multi-unit sites
- Corrective Action Program (CAP)
- Safety Performance Indicators Program
- Ageing Management Program
- Equipment Condition Monitoring Program
Regulatory Oversight
Pakistan Nuclear Regulatory Authority (PNRA)

- Regulations
- Operating License Conditions
- Operating License Re-Validation
- Approval of Modifications affecting safety
- Participation in selected activities
- Surveillance
- Formal Audits / inspections
- Review of Mandatory Reports
- Approval of FSAR, EPP, QAP, PSP, PSA etc.
Pakistan Atomic Energy Commission (PAEC) has always given importance to the axis of nuclear safety.

- Safety & QA Directorates at corporate Level
- Inspections in the area of nuclear safety, radiological safety, industrial safety, and physical protection
- QA audits
- Corporate Peer Review
- Safety enhancement improvements under Fukushima Response and Action Plan (FRAP C-12).
Human Factors (HF) for Nuclear Power Safety

Aims of Presentation…..

Raise awareness of need to address human factors risks related to design, maintenance and operation of safety-related systems

• We all know Human Factors have much to offer nuclear safety
• Environment where the persons works
• The equipment interface and functionality
• The design of Systems and Procedures
• The organization of work
• The reliability and capability of the personnel
Foreword

• The incidents at Three Mile Island and Chernobyl are much cited, and a recent accident at Fukushima has seemingly reinforced this concern, caused to a large extent by human errors.
• Success of the nuclear industry from safety point of view has large credit to the international exchange of experience.
• IAEA has played a crucial role in this spread of nuclear safety.
• The nuclear industry is regarded as the Gold Standard in human factors but there is a little room of complacency.
This paper addresses the human aspects of nuclear power. The purpose of this paper is to bring together established human factors approaches and effective application of these socio-technical challenges being faced in nuclear power industry.

Being regulatory requirement, Chashma Nuclear Power Generating Station (CNPGS) conforms to the requirement of Human Factors Engineering (HFE).
Human Factors Review Areas

**HUMAN FACTORS GOAL**
Minimize potential for human error by addressing factors that may adversely influence human performance

- Human Factors in Design
- Human Actions in Safety Analysis
- Work Organization & Job Design
- Procedures and Job Aids
- Organization Performance
- Fitness for Duty
- Performance Monitoring and Improvement
  HF in root-cause analysis
Why adopt a human factors approach to nuclear safety?

- As technology becomes more reliable, so human failure becomes the prevalent cause of nuclear incidents.
- Do we point the finger at technology not keeping up its promises or do we point the blame at human error and complacency?
- Although the approach to human factors has matured considerably, yet, pockets of over-emphasis on technology without recognizing the human contribution to risk, do still exist.
Human factor and Safety

Successive Approaches to Nuclear Power Safety
Classification of human errors

- **Attentional failures**
  - Intrusion
  - Omission
  - Reversal
  - Misordering
  - Mistiming

- **Memory failures**
  - Omitting planned items
  - Place-losing
  - Forgetting intentions

- **Rule-based mistakes**
  - Misapplication of good rule
  - Application of bad rule
  - Knowledge based
    - mistakes
    - Many variable forms

- **Routine violations**
  - Exceptional violation
  - Acts of sabotage

**Basic Error Types**

- **SLIP**
- **LAPSE**
- **MISTAKE**
- **VIOLATION**

**Unintended Action**

- **Unsafe Acts**

**Intended Action**
Human Error Chains

System Errors → Unsafe Situation → Situation Awareness → Final Error (Point of No Return) → ADVERSE EVENT

Human Errors

Catalyst Errors
Dimensions of the Human Factors

- Cultural and Organizational Factors
- Optimizing human performance
- Human factors in high demand situations
- Human factors as a part of the engineering design process (HFE)
- Human performance in Plant outages
- Outline of HFE Program at CNPGS
- Human Performance Improvement Program at CNPGS
Human Factors Profile

ORGANIZATIONAL ISSUES

- Design process
- Ergonomic assessment
- Human reliability assessment
- Safety culture

PERSONNEL ISSUES

- Selection
- Teams
- Stress
- Shift work
- Training
- Operators

DESIGN ISSUES

- Input devices
- Simulators
- Alarms
- Procedures
Safety Culture

Team working

Leadership Management commitment and support Employee involvement

Involvement

Attitudes and behaviour

Behaviour
Safety Culture – Success Factors

• Active participation of workforce and management
• Issue card reminders and checklists of behaviors that need to be observed
• Constantly reinforce and encourage behavioral change
• Measurement through surveys, questionnaires.
Optimizing Human Performance

Through:

- Procedures
- Training
- Incorporation of Human Factors in the design Process
Factors affecting human performance

**INPUTS**

**INDIVIDUAL**
Attitude, abilities, knowledge, skills, personality, etc.

**GROUP**
Structure, size, cohesiveness, culture, power, relationship, etc.

**ENVIRONMENTAL**
Task design, reward structure, organizational structure, decision support, technological support, etc.

**SYSTEM**
Exchange of information coordination, participation, consensus reaching decisional characteristics etc.

**OUTCOMES**

**TASK RELATED OUTCOMES**
Safety, efficiency, productivity, quality, etc.

**GROUP RELATED OUTCOMES**
Changes in member satisfaction, attitudes, cohesiveness, structure, etc.
Procedures and compliance

• Well known fact: people don’t respect procedures! 90% of the accidents have at least one root cause related to mistakes within procedures.

WHY?

Complex, not updated, too restrictive, do not describe the best way to do the job....

Technical accuracy and usability of procedures

Need to address normal and Emergency Procedures and assessed descriptions of EOP related practices
Training

• Training helps people acquire the skills, knowledge, and attitudes to make them competent in the safety aspects of their works and assigned tasks to diagnose plant upsets.

• Should be defined as a function of the needs found in the plant

  what, how and, why does the trainee need to learn?
  What knowledge, skills and abilities?

• Implementation of a training management

  Annual training plan, training team, assessment, use of Simulator training frequency of training, and instructors qualifications.

• Examination based on a task analysis
1. Detailed analysis of tasks

2. Specification of training requirement

3. CONDUCT TRAINING

4. Assessment of training, including:
   • Observation of actual performance
   • Observation of simulated performance
   • Oral / written examination and interview

5. Final authorization and license to practice

6. Periodical review

7. Changes in training content as required

General framework for training

Independent monitoring
Cognitive Task Load Design

• Tasks to be designed considering human limits: Interactions among multiple work members, equipment and systems.
• A specific database to analyze operator tasks.
• Available time – response to alarms

The combination of the three load factors determines the cognitive task load
A wide issue about assuring the human response to an alarm

Operators routinely ignore alarm in the plant control room

Operators facing as few as 10 alarms (say) a minute in an emergency may quickly abandon the alarm list to reduce stress. They may find a way to solve the problem without using the alarms
How to face this problem?

Implementation of an alarm philosophy

Notify operators of events required
more focus attention

Help to prioritize response

Guide operator towards most
appropriate response
How to Incorporate HF in the Design Process?

• We cannot change the Human Condition but we can change the conditions in which humans work.

• To take human factors into account as part of the engineering design requires the design of:
  — Equipment,
  — Operations,
  — Procedures,
  — Work environments.

such that they are compatible with the capabilities, limitations and needs of the workers, and respected in all engineering design decisions.
Procedures to Reduce Human Errors within a Plant / Project

1. Identification of Errors Causes
   - Task analysis
   - Action error analysis
   - Performance goals of HFE
2. Design solution to address the Error Causes
Task Analysis

- Identification of the list of human operations performed and their relation to the system tasks
- Specification of the systems’ manning level i.e. what personnel is needed and how its members be selected
- Identification of training needs
- Evaluation of control room instrumentation
- Writing of operating and maintenance procedures
- The aim is to maximize the overall system capabilities in performing plant operation
Action Error Analysis

- Cognitive support model
- Review of plant safety in case the operator acts wrongly or does not act at all
- Check of the operators workload in case of demands occurring simultaneously or in fast sequence
- Review if the operator is able to relate alarm and the cause clearly
Performance Goals of HFE

- Identify if there could be factors that affect the task performance
- Stress, work procedures, quality of work environment....
- System is designed to, at least, at best, tolerate and prevent human error or at worst, to recovered from human error
- Synchronized cycle time, flexibility, punctuality, cost effectiveness, and quality.
- Regulatory requirement – credibility, auditability, reliability and validity
Design solution to address the error causes

Designing to reduce Human Error Precursors

- Automation
- Maintainability and Operability
- System Control and Monitoring
- System Operations and Layout
- Work Environment
Human-Machine Interface (HSI)

It includes alarms, Information Systems and Control Systems

→ Rectification of programming errors and erroneous operator inputs.

→ Operators are properly trained, software is tested and programming changes are strictly controlled.

→ Labeling and color coding reduce human errors.

→ Alarms need to be designed to be noticed but not overload the workers.

→ Design for operability, maintainability, flexibility of HSI be given a top priority.
Collection of Human Factor Data

The need for qualitative information

- By in-depth Event Notification Reports (ENRs) by plant personnel
- By on-site investigation of significant abnormal events carried out by experienced human factor experts
- By the use of simulators
Approaches to Human Performance in Plant Outages

Kindly click to this hyperlink
# *HFE Program Review Model Elements at CNPGS*

<table>
<thead>
<tr>
<th>Planning and Analysis</th>
<th>Design</th>
<th>Verification and Validation</th>
<th>Implementation and Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HFE Program Management</td>
<td>Human-System Interface Design</td>
<td></td>
<td>Design Implementation</td>
</tr>
<tr>
<td>Operating Experience Review</td>
<td>Procedure Development</td>
<td>Human Factors Verification and Validation</td>
<td>Human Performance Monitoring</td>
</tr>
<tr>
<td>Functional Requirements Analysis and Function</td>
<td>Training Program Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing and Qualification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Reliability Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* - Incorporated in FSAR of Unit-2
- Using PSA input in HFE
How to incorporate HF in the design process?

- Applicable Standards and Regulatory requirement i.e.
  - NUREG-0800 (Standard review plan)
  - NUREG-0711 (HFE program review model)
  - NUREG-0700 (Human-system design review guidelines)
Discipline: Organization and management of Multi-Unit site and establishment of an overall Human Performance Program (HUP) at CNPGS.

Recommendations:
• May be centralized responsibility / de-centralized responsibility / area oriented / function oriented.
• Fundamental function to be assured by respective organizational elements with single point responsibility and without any overlap in responsibilities.
• Regarding Human Performance, a high respected nuclear professional with strong supervisory and project management skills to be selected to lead the effort for complete success, the HUP to be seen with reference to examples of two different US utilities to facilitate HUP development.
Self-Assessment Program

Self Assessment Program (CNPGS)

- Focused SA (Issue Driven)
  - Continuous SA
  - Periodic SA
- Work Group SA
- Independent Internal Self Assessment
  - Annual SA
  - Comprehensive SA (5-Yearly)
- Independent External Assessment
  - By WANO, IAEA, IPR, etc.
A final thought

- Human behaviour can be predicted with reasonable accuracy.
- Correctly integrating HFIs into incident/event investigating process will reap rewards.
- Separating error, mistake and violation represents a high valuable first step.
- Managing human failure requires a high degree of corporate honesty:
  - What behaviour is really rewarded?
  - Are we willing to look at organizational factors, especially when see rule breaking?
  - Are we willing to make the investments that are likely to prevent reoccurrence?
  - Are we willing to strive for objectivity and pragmatism?
A final thought

- Too soon to think about it: still a long way to go with Human Factors.
- Chashma Nuclear Power Station continues to measure success, identify new problems and form new initiatives. We plan to continue improving our score in collaboration with IAEA, WANO and PNRA (Regulatory body) regulations.