

Discussion on Risk in Complex Operational Settings

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Ken Ellis WANO Managing Director 23 October 2013

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(a) Product of unreliable system components (Complicated)

Risk

(b) Product of improperly aligned, or poorly integrated activities (Interactions, relations) (Complex)

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Complicated Systems

Designed based on a defined set of rules

Collection of interrelated individual components

 $Risk = \sum_{i=1}^{n} c_i p_i$

Reliable: Designed such that functioning whole is dependent on collection of parts

- MTBF
- FMEA
- SPV

Complicated: can disassemble it, put it back together and it still works



Complicated Systems (continued)



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(a) Product of unreliable system components (Complicated)

Risk

(b) Product of improperly aligned, or poorly integrated activities (Interaction, relations) (Complex)



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Complex Systems (continued)

Collection of interrelated individual Almost an organic components with process specific design rules Hetwork of Systems does NOT apply **Fundamental** understanding of wholistic No SPV system >> one persons knowledge Risk Things not Inter-relationships unclear hardwired but loosely coupled Large variability of actions that no longer have a direct link from stimulus to output **Diversity** of inputs Perception and Interdependencies perspective can vary versus dependencies widely

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Complex Systems (continued)

Normalisation of deviations (reduced safety merging)

> **Results** are path and time dependent

Technical depth (or lack thereof) of staff at given moment

Risk Tolerance / Risk Rationalisation by individual staff

> **Risk appetite of** organisation (senior managers, supervisors)

Culture feeds off historical normal

Reactive decision making is risky business



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Problem: Where is acceptable risk? (and by whom)

Answer: You only really know where the boundary is when you cross it.

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Man's ability to conceptualise, design and construct a technology often outstrips mankind's ability to operate it



Event \rightarrow Accident investigation \rightarrow Reconstruct

The event puzzle using Newtonian cause/effect \rightarrow distill down to the root cause (often human error) \rightarrow building in future defences

Has served us well over the years, and is powerful

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How to deal with complex systems:

The more exotic the system, the more exotic the problems, and the need for exotic solutions....

Some ideas to get a foothold:

- 1. Talk about risk frequently
- 2. Carry out gap analysis between expectations and behaviours in the field "you get what you inspect, not expect"
- 3. Actively solicit diverging opinion to (avoids intentional blindness)
- 4. Debate "acceptable boundaries"
- 5. Discuss antecedents for people's behaviours including the 'unofficial messages'
- 6. Never allow doubt and uncertainty to go unchallenged

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How to deal with complex systems (continued)

- 7. Demand proof it is safe to operate, not unsafe to operate
- 8. Demand Operational Decision Making (ODM) forums discuss the above when debating a new issue
- 9. Create a Nuclear Safety Culture Monitoring Panel (NSCMP) to meet quarterly to:
 - a) Discuss the above
 - b) Construct the puzzle without first knowing the final picture, ie: avoid the event instead of reacting to it