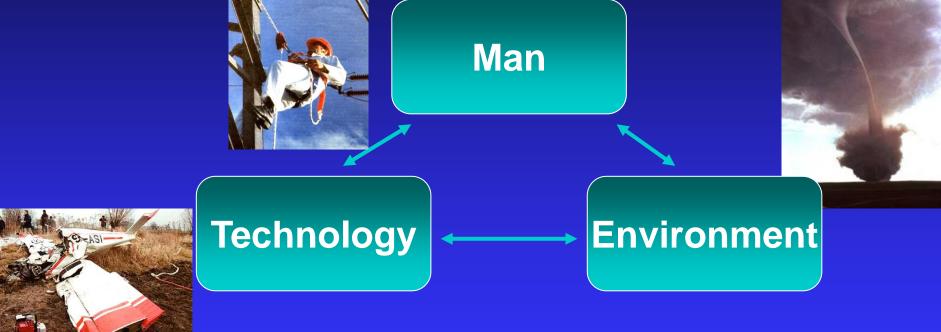


Human Reliability



Marek Matyjewski

Risk in the M-T-E system



risk measure unreliability

measure

hazard

measure

Human nature

It is in the nature of man to err - Cicero

Human error is here to stay



Human errors

Three out of four aircraft accidents result from inadequate performance of the human component in the aircraft man-machine system.

F. Hawkins – Human Factors in flight, 1993

60%÷90% of accidents are the result of human error

Catastrophes

Bhopal (1984, over 2500 fatalities)
Chernobyl (1986)

- North Sea offshore platform Piper Alpha destroyed in a fire (1988, 167 fatalities)
- Ferry capsized after leaving the Zeebrugge port (1987, 193 fatalities)
- Collision of two aircrafts at Tenerife (1977, 583 fatalities)

Three-Mile Island nuclear power plant incident (1979)

Bhopal

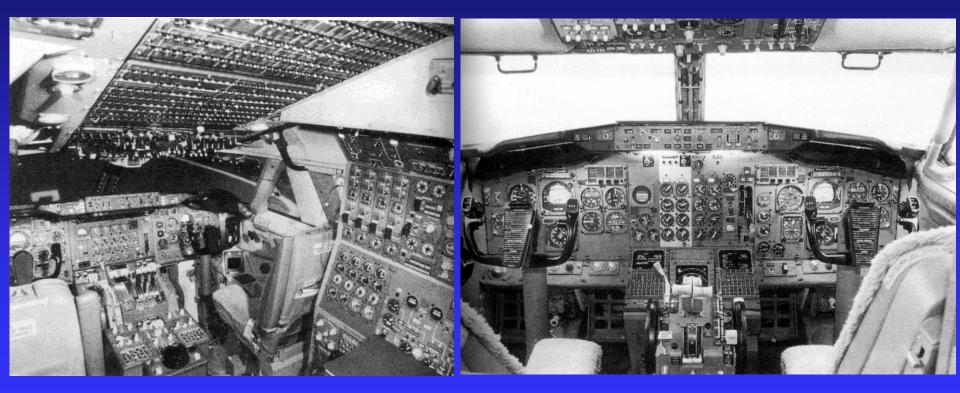


Factors facilitating occurrence of errors:

economical
sociological
psychological, emotional
physiological

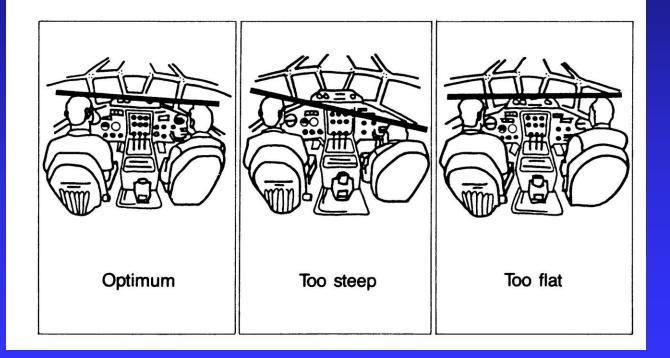


Boeing 747



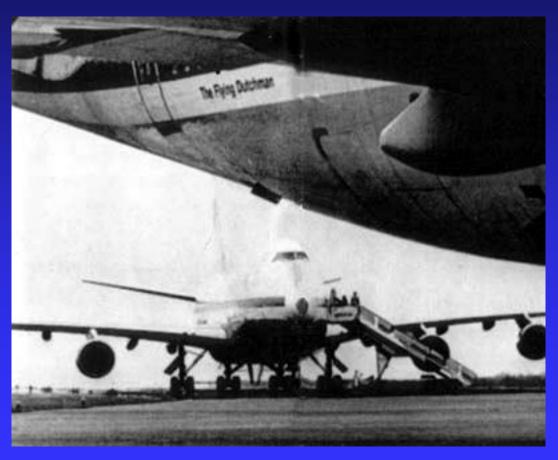
In the 1970s

The trans-cockpit authority gradient

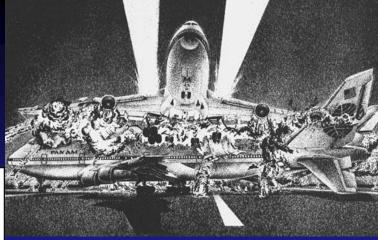


Tenerife disaster – 1977

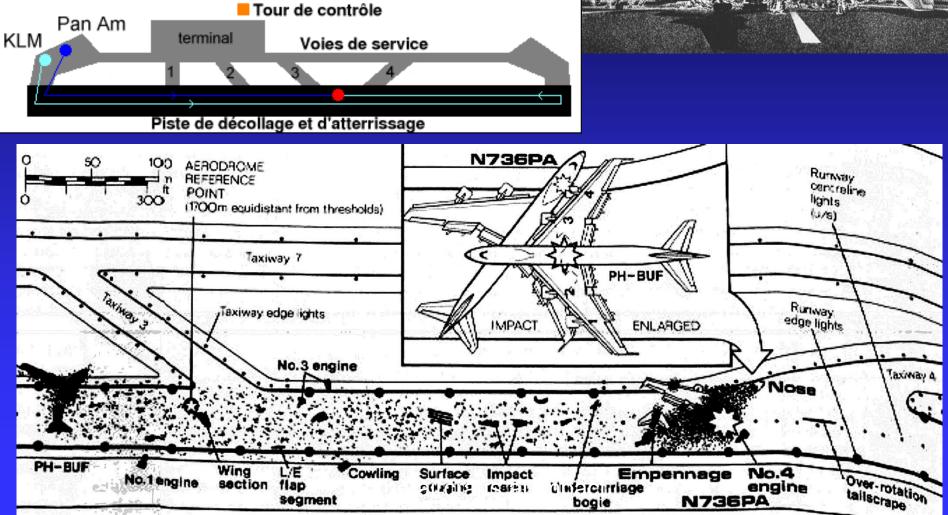




the Boeings 747



Tenerife disaster



Victims:



KLM4805:	234 passengers and 14 crew members killed Aircraft completely destroyed by fire
PA1736:	326 passengers and 9 crew members killed, 61 persons were rescued, 9 out of them died in hospital



The accident investigation

The investigators questions:

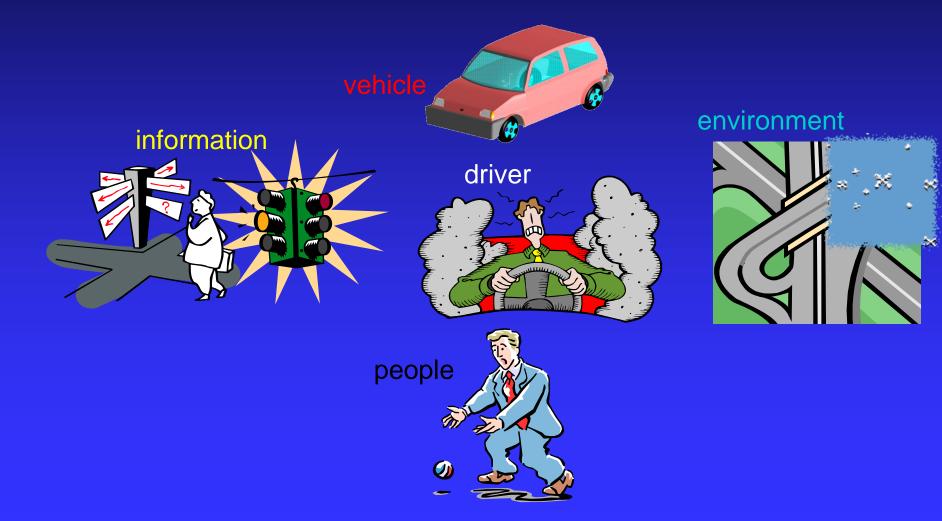
- Why had KLM Captain commenced takeoff without the control tower's clearance to do so?
- Why had PanAm Captain been instructed to vacate the runway at Taxiway 3, one that led back towards the main apron at an angle of 135 degrees from the runway, rather than the far more conveniently placed 45 degree angled Taxiway 4? And unexpected as this instruction was, why had Captain Grubbs disregarded it?
- Why did the KLM crew not grasp the significance of the PanAm aircraft's report that it had not yet cleared the runway, and would report again to the Tower when it did?



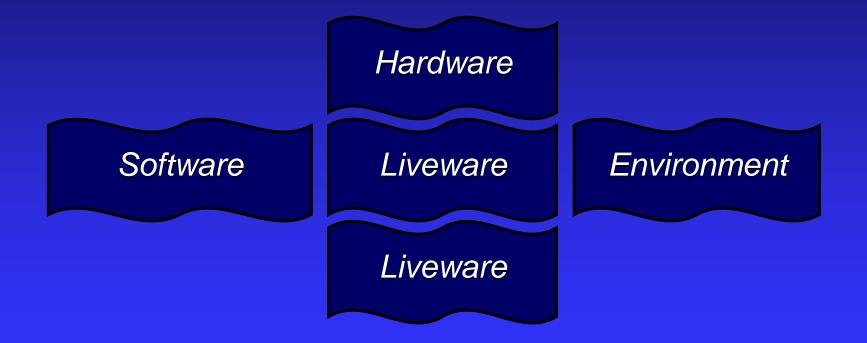
Human Factors

Fatigue, stress Overload Mind set Frustration Time pressure Authority in cockpit Passenger satisfaction

An example of M-T-E system



A conceptual model of Human Factors



The SHEL model



Human Factors is concerned with the interfaces shown in the model

Liveware in engineering terms

Physical size and shape

In the design of any workplace and most equipment, body measurements and movement play a vital role. These will vary not only between ethnic, age and sex groups, but extensive differences can be expected to occur within any particular group. Fundamental decisions must be taken at an early stage in the design process as to the human dimensions, and consequently the population percentage, which the design is going to satisfy. Data to make such decisions are available from anthropometry and biomechanics.

Fuel requirements

In order to function properly, man needs fuelling with food, water and oxygen. Deficiencies in this fuel supply can affect his performance and well-being. This type of information is available from physiology and biology.

Liveware in engineering terms

Man has been provided with a vast system for collecting information from the world about him. He has means for sensing light, sound, smell, taste, movement, touch, heat and cold. Some senses involve more directional information; some are more sensitive than others. And all are subject to degradation. Physiology and biology are the main sources of knowledge here. Once information is sensed and processed, messages are sent to the muscles and a feedback system helps to control their actions. We need to know the kind of forces which can be applied and the acceptable direction of movement of controls. Speech characteristics are vital components in the design of efficient voice communication procedures. Here we look to biomechanics and physiology for support.

<u>Input signals</u> \rightarrow Information processing \rightarrow Output signals

While the sensing apparatus is vast, the information processing capabilities of man have severe limitations. Poor instrument and warning system design has frequently resulted from a failure properly to take into account the capabilities and limitations of the human information processing system. Many human errors find their origin in this area of information processing. The source of background knowledge here is the discipline of psychology.

Liveware in engineering terms

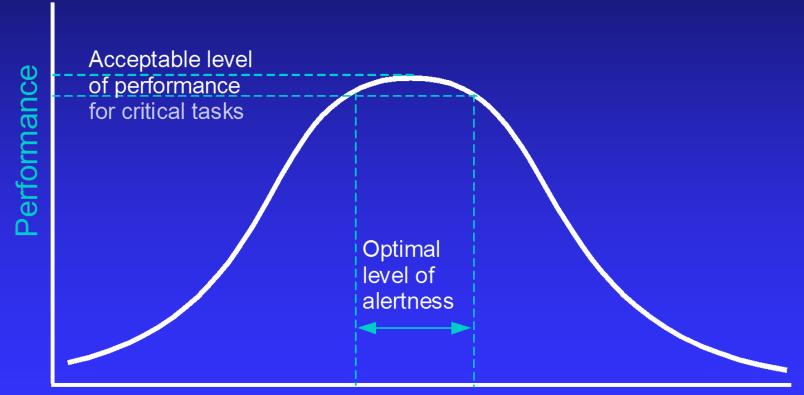
Environmental tolerances

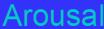
People, like equipment, are constructed to function effectively only within a rather narrow range of environmental conditions. Temperature, pressure, humidity, noise, time-of-day, light and darkness, can all be reflected in performance and sometimes also well-being. In less tolerant individuals, performance can also be affected by heights (acrophobia), enclosed spaces (claustrophobia). Physiology and biology all provide relevant information on these environmental effects.

State of a man

A man at work is in a **physical**, **physiological** and **emotional state**. A boring or a stressful working environment can also be expected to influence performance. Psychology.

A hypothetical relationship between arousal and performance (1908)





Piper Alpha





Fire of oil platform in the North Sea (1988, 167 employees killed)





Human Error

The measure of **human reliability** is the probability that a task is **performed correctly** in **specified time**.

Human Error

Human error – any member of a set of human actions or activities that exceeds some limit of acceptability, i.e. an out of tolerance action [or failure to act] where the limits of performance are defined by the system

Swain, 1989

Human Error Probability (HEP)



Quantification of human error probability

 $Q(A) = \frac{\text{Number of errors occurred}}{\text{Number of opportunities for error}}$

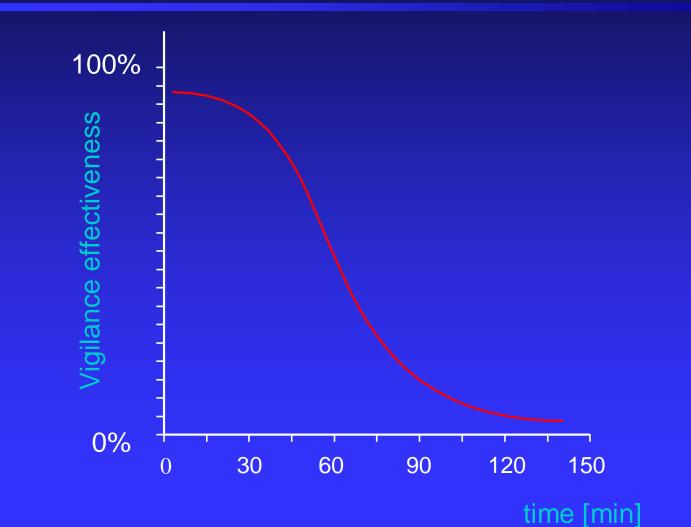


Three basic tenets with respect to human error :

- the origins of errors can be fundamentally different,
- anyone (even very well trained) can and will make errors,
- the consequences of similar errors can also be quite different.



The effect of performance decline



Error probability estimation based on statistical data

statistical data is available for $\Delta \tau$ years

The probability Q(1) of an event A occurrence in one year per one employee

$$Q(1) = \frac{W(\Delta \tau)}{N \cdot \Delta \tau} \qquad [1/year]$$

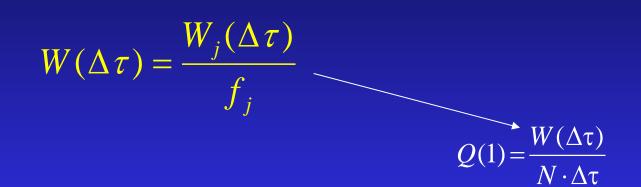
 $W(\varDelta \tau) - \text{the total number of events } A,$ that occurred in $\varDelta \tau$ years,

- $\Delta \tau$ the number of years of data collection
 - N the number of concerned workers



Events not resulting in injury





 $W_j(\Delta \tau)$ – the number of accidents that caused loss not less then c_i , $j = 1 \div 5$

 $f_{j'}$ – accident factor, the probability that occurrence of the event *A* causes a loss in category at least c_{j}

Changing the time unites

$$Q(1) = \frac{W(\Delta \tau)}{N \cdot \Delta \tau} \quad \text{[1/year]}$$

$$\downarrow$$

$$Q = \frac{Q(1)}{d \cdot m} \quad \text{[1/single realisation of an action]}$$

- *Q* the probability of the event *A* occurrence during a single execution of the specified action,
- m the number of repetitions of the action in one day of work carried out by the worker,
- *d* the average number of work days in a year.



Example Injuries sustained in team games

Fireman at Warsaw fire-brigade

PUE – trip over, fall, contact with other players

In 4 years 42 injures were recorded

$$W(\Delta \tau) = \frac{W_2(\Delta \tau)}{f_2} = \frac{42}{0,263} \approx 160 \qquad Q(1) = \frac{W(\Delta \tau)}{N \cdot \Delta \tau} = \frac{160}{825 \cdot 4} \approx 0,048 \quad [1/year]$$

Probability of **PUE** occurrence

 $Q = \frac{Q(1)}{d} = \frac{0,048}{121} = 0,00040 = 4,0 \cdot 10^{-4} \quad [1/\text{single training}]$ Probability of injury $Q_{urazu} = Q \cdot f_2 = 4,0 \cdot 10^{-4} \cdot 0,263 = 1,05 \cdot 10^{-5} \quad [1/\text{single training}]$ $Q_{urazu}(1) = Q_{urazu} \cdot d = 1,05 \cdot 10^{-5} \cdot 121 = 0,013 \quad [1/\text{year}]$



Human error classification

perception errors \rightarrow cognitive errors \rightarrow manual errors







group 1manual errors – execution of tasksperception errors – observation & identification of signals

group 2 cognitive errors (diagnostic errors and errors in decision taking) caused by information processing and combining it with knowledge, familiar rules and practiced actions

HEP classification

from THERP method

Errors of Omission

Omits entire task Omits a step in a task

Errors of Commission

Selection error: Error of sequence Time error Qualitative error

- Selects wrong control (switch, display), reads from wrong device,
- Mispositions control (includes reversal errors, improperly made connections, etc.)
- Issues wrong command or information (via voice or writing)

Cognitive behaviour classification [Rasmussen 79]:

Skill-based level

A skill-based behaviour represents a type of behaviour that requires very little or no conscious control to perform or execute an action once an intention is formed. Performance is smooth, automated, and consists of highly integrated patterns of behaviour in most skill-based control (Rasmussen, 1990).

Rule-based level

A rule-based behaviour is characterised by the use of rules and procedures to select a course of action in a familiar work situation (Rasmussen, 1990). Operators are not required to know the underlying principles of a system, to perform a rule-based control.

Knowledge-based level

A knowledge-based behaviour represents a more advanced level of reasoning. This type of control must be employed when the situation is novel and unexpected. Operators are required to know the fundamental principles and laws by which the system is governed.

Which face is happier?

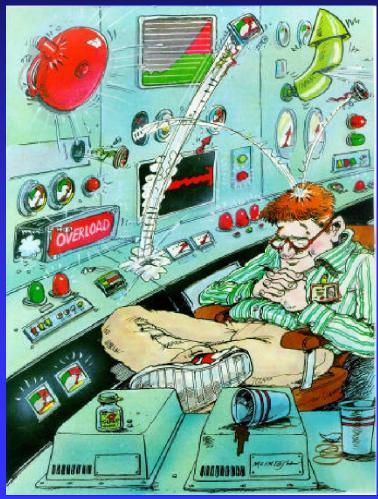




Factors influencing the human reliability

performance shaping factors

- visual illusions
- quality of instructions & documentation
- motivation
- **time**



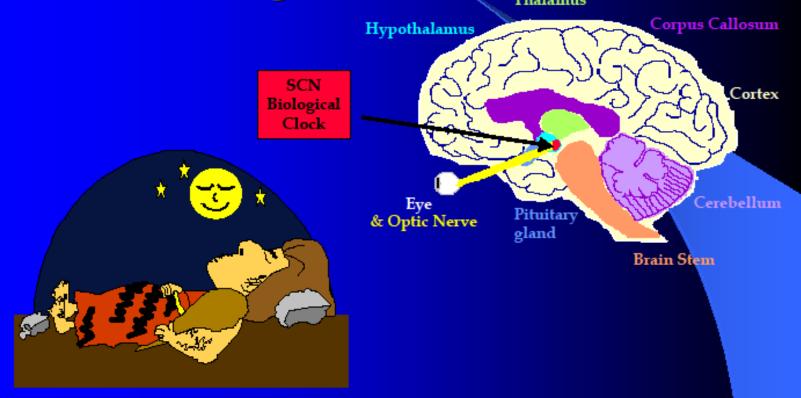
PSF Performance Shaping Factors

(Influence factors)

External	Internal
organizational features	competence
technical features	physiological and psychological factors

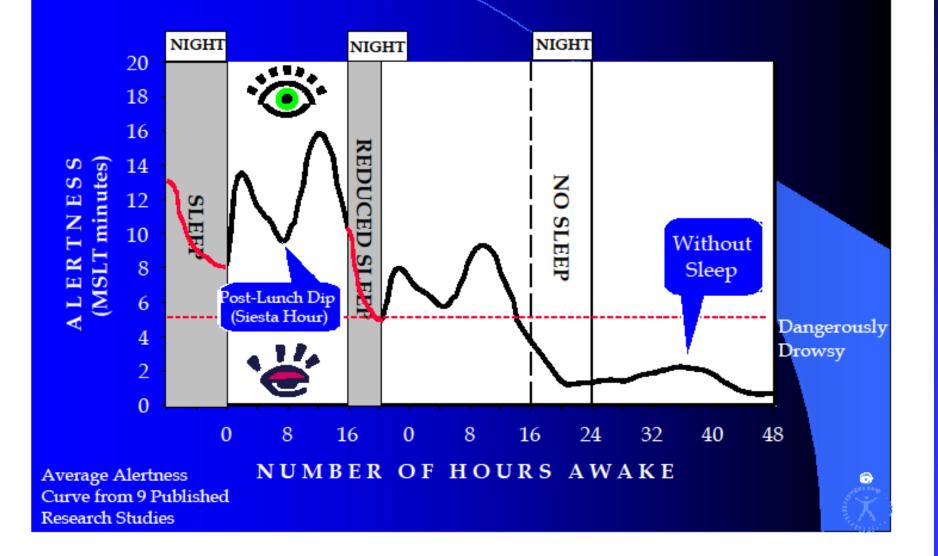


Humans were designed to SLEEP at night

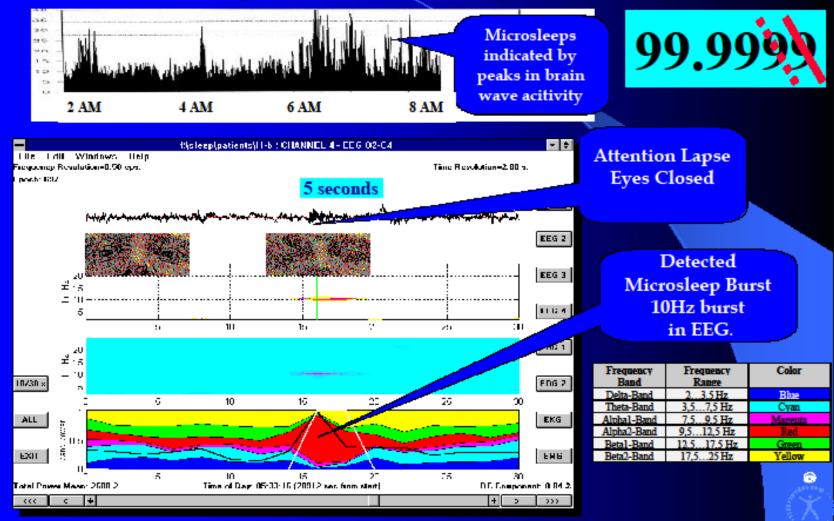


Sleep and alertness cycle is controlled by a biological clock in the brain 🙍

Daily Circadian Rhythm of Alertness



Microsleeps with Total Lapses in Attention while Driving or Monitoring Colo

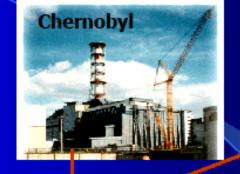


24/7 Business Costs: Night Time Accidents



2

0.1







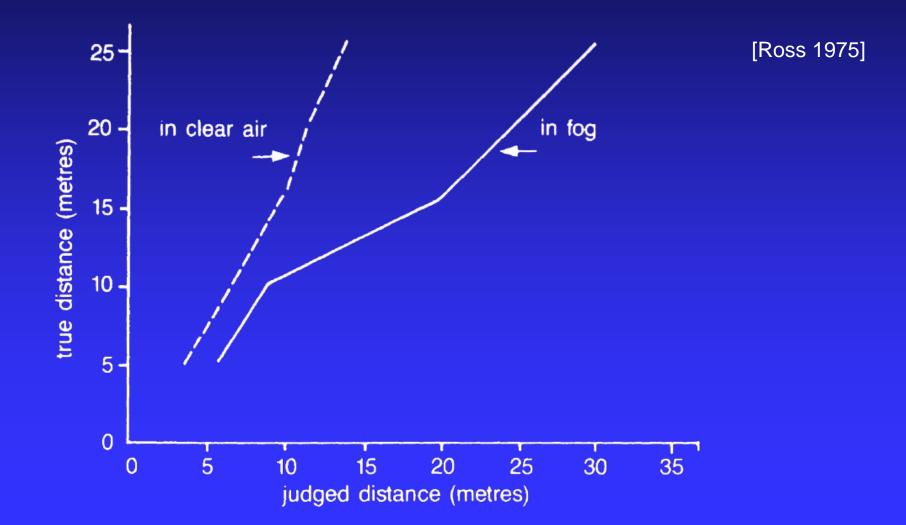
Relative Accident ¹ Rate

Exxon Valdez

24 hr Mean 4 P 8 P 12 MN 4 A 8 A 12 MD Time of Day (hrs)



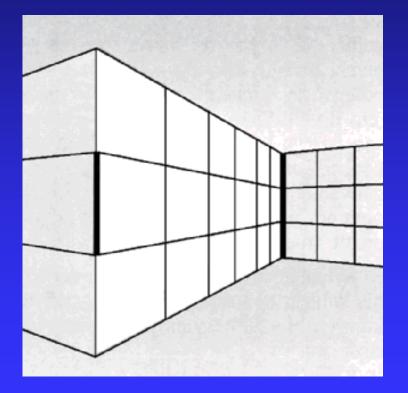
Influence of fog on distance estimation



http://erikjohanssonphoto.com

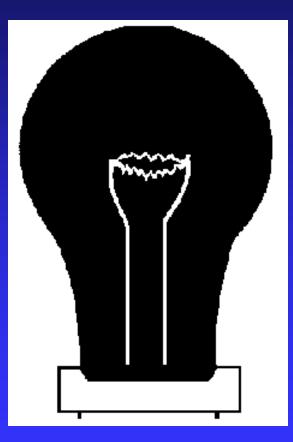


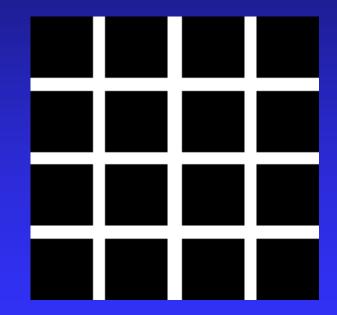
Visual illusions





Visual illusions



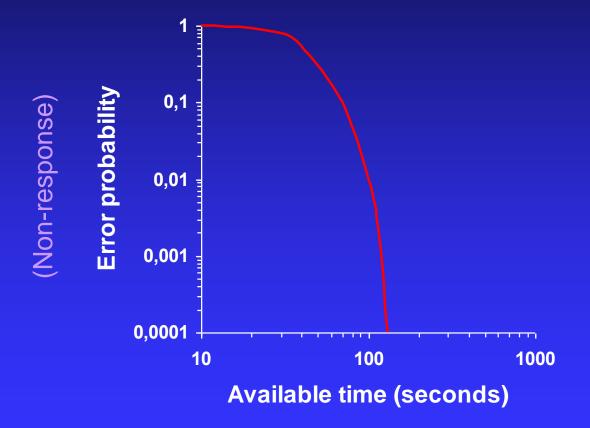


Perception depends on context

EDCBA

651622

TRC Time Reliability Correlation

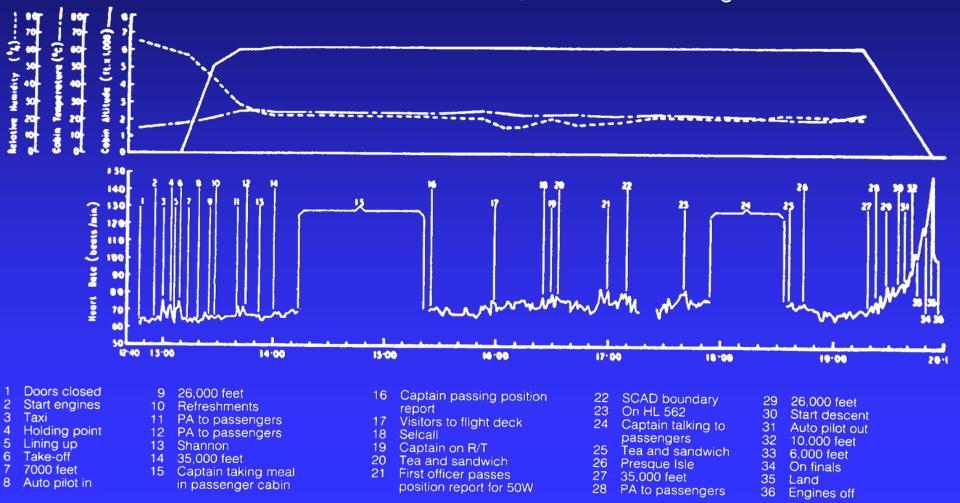






Stress

Heart rate of North Atlantic Captain taking off London, landing New York



Classification of Human Reliability Models

- decomposition methods (THERP),
- expert estimation methods (APJ, PC),
- □ Time dependent methods (HCR).

Sources of data for estimating error probabilities:

- expert methods,
- statistical methods,
- data base methods.





THERP method

(Technique for Human Error Rate Prediction)

- Data base containing HEPs (Human Error Probabilities)
- Performance Shaping Factors
- Event tree method
- Handling of dependencies between errors
- Handling of error correction (recovery)

Classification of steps for human reliability analysis

		Level of	fanalysis
	Step	error identification	error quantification
1)	plant visit	Х	
2)	review information from fault tree analyst	Х	
3)	talk-through	Х	
4)	task analysis	Х	Х
5)	develop HRA event trees		Х
6)	assign human error probabilities (HEPs)		Х
7)	estimate the relative effects of performance		Х
	shaping factors (PSFs)		
8)	assess dependence		Х
9)	determine success and failure probabilities		Х
10)	determine the effects of recovery factors		Х
11)	perform a sensitivity analysis, if warranted		
12)	supply information to the fault tree analyst		

Three-Mile Island (1979)

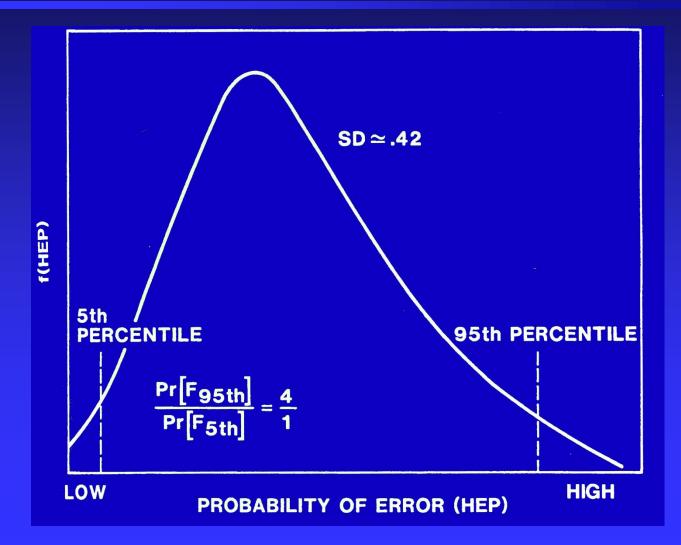


Operator Action Tree

Explanation of symbols A – capital letter probability of an error, a – minuscule (lowercase) letter probability of a success, A + a = 1**b**|**A** – probability for **b** on condition that error **A** has occurred, **b**|**a** – probability for **b** on condition that success **a** has occurred. **Event tree** P(S) = a(b|a)Α а P(F) = 1 - a(b|a) = a(B|a) + A(b|A) + A(B|A)bla Bla ЫΑ BA

PARALI

Log-normal distribution



Error Factor

uncertainty bands

HEP is 0,003 (0,001 to 0,01)

EF = 3 - Error Factor

so HEP is 0,003 (EF = 3)

 $\text{EF} = \sqrt{\frac{Q_u}{Q_l}} = \sqrt{\frac{0,01}{0,001}} = \sqrt{10} \approx 3,$

Example

A = 0,01	B a = 0,001	EF = 3
B A = 0,05		EF = 5

a = 0,99 (0,97 to 0,997) A = 0,01 (0,003 to 0,03) b|a = 0,999 (0,997 to 0,9997) B|a = 0,001 (0,0003 to 0,003) b|A = 0,95 (0,75 to 0,99) B|A = 0,05 (0,01 to 0,25) P(F) = 1 - a(b|a)

HEP nominal values P(F) = 1 - 0.99(0.999) = 1 - 0.989 = 0.011

Lower uncertainty band P(F) = 1 - 0.997(0.9997) = 1 - 0.9967 = 0.0033

Upper uncertainty band P(F) = 1 - 0.97(0.997) = 1 - 0.967 = 0.033

Total HEP is:

0,011 (0,0033 to 0,033)

Table 20-7 Estimated probabilities of errors of omission per item of instruction when use of written procedures is specified* (from Table 15-3)

Item**	Omission of item:	HEP	ĒF
	When procedures with checkoff provisions are correctly used :		
(1)	Short list, ≤10 items	.001	3
(2)	Long list, >10 items	.003	3
	When procedures without checkoff provisions are used, or when checkoff provisions are incorrectly used ^{††} :		
(3)	Short list, <10 items	.003	3
(4)	Long list, >10 items	.01	3
(5)	When written procedures are avail~ able and should be used but are not used	.05	5

The estimates for each item (or perceptual unit) presume zero dependence among the items (or units) and must be modified by using the dependence model when a nonzero level of dependence is assumed.

The term "item" for this column is the usual designator for tabled entries and does \underline{not} refer to an item of instruction in a procedure.

Correct use of checkoff provisions is assumed for items in which written entries such as numerical values are required of the user.

^{††}Table 20-6 lists the estimated probabilities of incorrect use of checkoff provisions and of nonuse of available written procedures.

¹If the task is judged to be "second nature," use the lower uncertainty bound for .05, i.e., use .01 (EF = 5).

Errors of omission

**

oral instruction items not written down

Errors in recalling instructions

	Number of oral instruction items	item "N		Pr[F] to all items of recal importa	s, order I <mark>not</mark>	Pr[F] to all item of reca importa	ns, order III is
Item			(a)	(b)		(c)
		HEP	EF	HEP	EF	HEP	EF
Oral instru	uctions are deta	ailed:					
(1)	1	0,001	3	0,001	3	0,001	3
(2)	2	0,003	3	0,004	3	0,006	3
(3)	3	0,01	3	0,02	5	0,03	5
(4)	4	0,03	5	0,04	5	0,1	5
(5)	5	0,1	5	0,2	5	0,4	5
Oral instru	uctions are ger	eral:					
(6)	1	0,001	3	0,001	3	0,001	3
(7)	2	0,006	3	0,007	3	0,01	3
(8)	3	0,02	5	0,03	5	0,06	5
(9)	4	0,06	5	0,09	5	0,2	5
(10)	5	0,2	5	0,3	5	0,7	5

Errors
of Commission

Table 20-10 Estimated HEPs for errors of commission in reading and recording quantitative information from unannunciated displays (from Table 11-3)

Item	Display or Task	HEP*	EF
(1)	Analog meter	.003	3
(2)	Digital readout (< 4 digits)	.001	3
(3)	Chart recorder	.006	3
(4)	Printing recorder with large number of parameters	.05	5
(5)	Graphs	.01	3
(6)	Values from indicator lamps that are used as quanti- tative displays	.001	3
(7)	Recognize that an instrument being read is jammed, if there are no indicators to alert the user	. 1	5
	Recording task: Number of digits or letters** to be recorded		
(8)	≼ 3	Negligible	-
(9)	> 3	.001 (per symbol)	3
(10)	Simple arithmetic calcula- tions with or without calculators	.01	3
(11)	Detect out-of-range arithmetic calculations	.05	5

Multiply HEPs by 10 for reading quantitative values under a high level of stress if the design violates a strong populational stereotype; e.g., a horizontal analog meter in which values increase from right to left.

In this case, "letters" refer to those that convey no meaning. Groups of letters such as MOV do convey meaning, and the recording HEP is considered to be negligible.

**

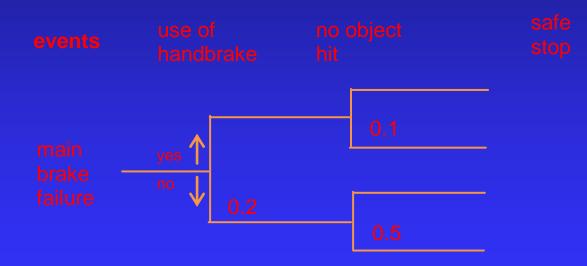
Modifications of base probabilities



	Stres level	Experienced operator	Unexperienced Operator
(1)	Very small	x2	x2
	Optimal		
(2)	Step by step	x1	x1
(3)	dynamic	x1	x2
	Relatively high		
(4)	Step by step	x2	x4
(5)	dynamic	x5	x10
	Very high		
(6)	Step by step	x5	x10
(7)	dynamic	.25 (EF = 5)	.50 (EF = 5)
		Real HEP <u>not</u> modificati	

Problem

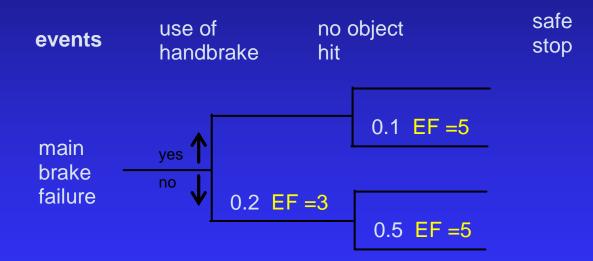
The main (foot-operated) brake on a car has failed while the car is in motion. The driver should bring the vehicle to a safe stop using the handbrake. He can also steer to avoid hitting large objects.



Calculate the probability of success, i.e. safe stop.

Problem

Calculate the probability of success, i.e. safe stop.



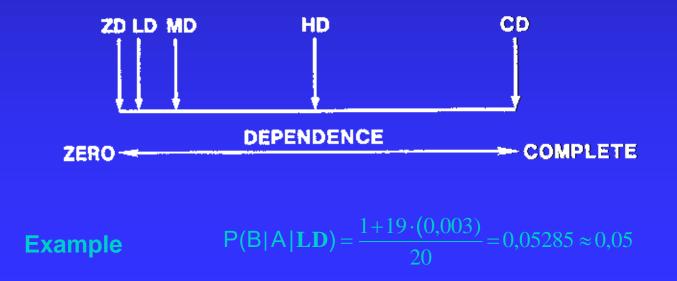
Error Factor (EF) values are also shown in the event tree. Calculate the success probability for the worst case, when the upper failure probabilities Q_{μ} occur.

$$\mathsf{EF} = \sqrt{\frac{Q_u}{Q_l}}$$

$$Q = \frac{Q_u}{\mathrm{EF}}$$

Dependencies between errors

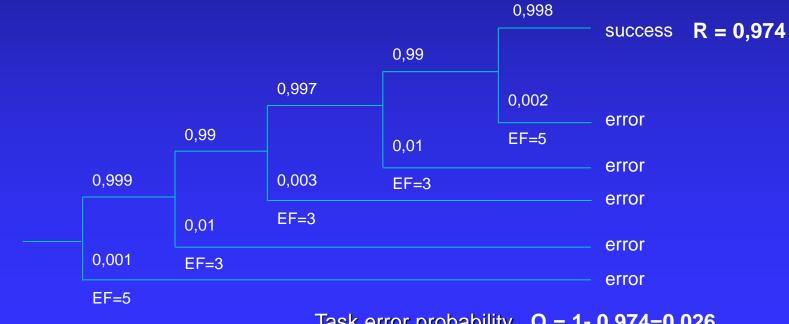
ZD – zero dependence	$P(B A \mathbf{HD}) = \frac{1+B}{2}$
LD – low dependence	2
MD – moderate dependence	$P(B A \mathbf{MD}) = \frac{1+6\cdotB}{7}$
HD – high dependence	$P(B A \mathbf{L}\mathbf{D}) = \frac{1+19\cdotB}{20}$
CD – complete dependence	20





work on a machine tool

	•	determines		reads and sets depth	
action		parameters		•	process
Event number	1	2	3	4	5

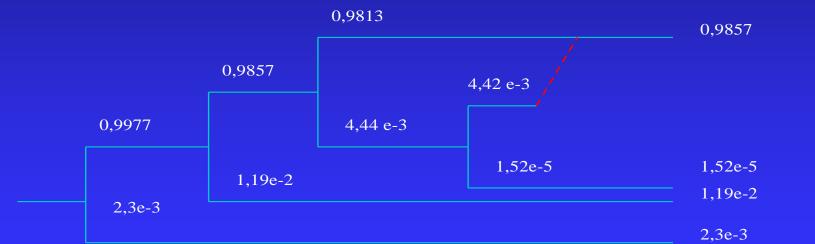


Task error probability **Q** = **1**-**0,974**=**0,026**



Error correction

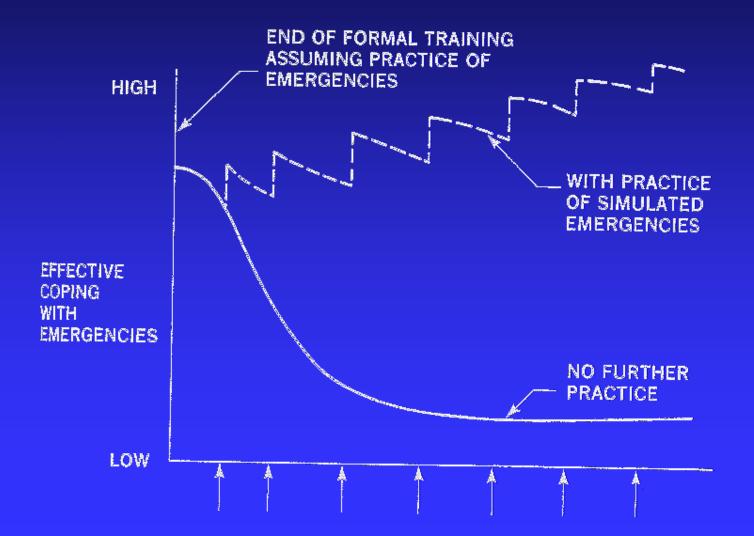
ACTION	Operator	Operator	Operator	Operator
	checks	diagnoses	takes	re-checks
	plant	fault	remedial	plant
	conditions		action	condition
Event	1	2	3	Λ
No.	1		5	4



Failure probability \approx **0,014** Error correction probability = **0,00442** Failure probability diminishes by **24%**

1,42e-2

The influence of training

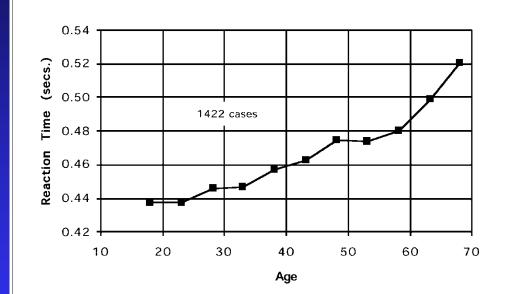


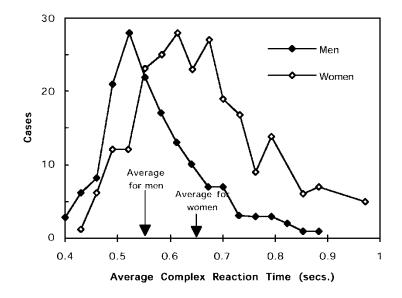


Human reaction time



The reaction time





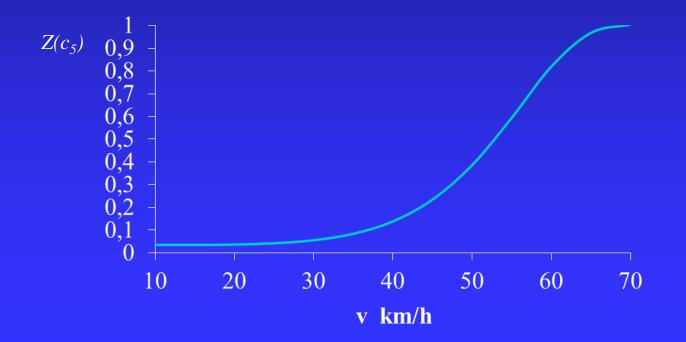
The influence of speed on the stopping distance



driver reaction time **1s** car deceleration = **7m/s²**

The influence of speed on the stopping distance

car 1 in the distance of **10,9** meters decelerates by **19.7 km/h** car 1 passes the stopping line of car 2 with the speed over **40 km/h**



HCR Method (Human Cognitive Reliability)



