scenarios for fire-only and fire-plus-impact in the calculation of the probability of loss of shielding (LOS).

D2.2.1 Analysis of Loss of Shielding for Transportation Casks

All transportation casks contain separate gamma and neutron shields. The neutron shields are generally composed of a low melting point polymer material that would melt and offgas very quickly when exposed to a fire. For that reason, it is given that the neutron shield is always lost in fire scenarios. The composition of the gamma shield varies between cask designs, with some designs having layers of steel and depleted uranium, others having layers of steel and lead, or and others with layers of steel. Only casks containing lead could lose their gamma shielding in a fire.

As previously discussed, the thermal analyses for the transportation casks (Ref. D4.1.65, Table 6.5) shows that the internal regions of the cask reach the 350°C range in the range of 0.59 to 1.37 hours for the long duration 1,000°C fire. The least time represents the steel- depleted uranium casks and the longest the monolithic steel. The time to reach 350°C for SLS casks is about one hour. The time to reach the lead melting temperature (327.5°C) should be somewhat less than one hour but is not specified. However, NUREG/CR-6672 (Ref. D4.1.65) indicates that lead melting in itself does not result in significant LOS but the melting must be accompanied by outer shell puncture that permits the lead to flow out of the shield configuration.

NUREG/CR-6672 (Ref. D4.1.65) states that there are four characteristic fires of interest in the transportation risk analysis: 10 minutes as the duration of a typical automobile fire; 30 minutes for a regulatory fires; 60 minutes for an experimental pool fire for fuel from one tanker truck; and 400 minutes for an experimental pool fire from one rail tank car. These typical durations suggest that a real fire is unlikely to last long enough to result in a LOS condition for transportation scenarios.

D2.2.2 Probability of LOS in Fire Scenarios

Melting of the lead shielding and loss of containment of the molten lead results in loss of shielding for SLS casks. Two mechanisms for escape of the molten lead are considered:

- Puncture of the outer shell
- Rupture lead containment due to internal pressure.

Puncture of the two-inch thick (or more) outer shell, in addition to exposure to fire, would allow molten lead to escape, resulting in LOS. The shell puncture would be an independent failure with a probability of 10^{-8} for the low speeds at which the cask would be moving (Table 6.3-4). With the additional failure of exposure to fire, the LOS probability would be even less.

Containment of the molten lead could be lost due to thermal expansion of the lead coincident with the thermal weakening of the steel. Molten lead is cast into the cavity bounded by the inner and outer shells and the bottom plate ((Ref. D4.1.50, p. 1.1-4); (Ref. D4.1.49, p. 1.2-2); (Ref. D4.1.9, p. 1.2-5); and (Ref. D4.1.47, p. 1-5)). The lead contracts as it cools and solidifies. When the cask is exposed to a fire and the lead melts, it expands to reoccupy the volume when originally cast. When heated beyond the melting point, the liquid lead could continue to expend, exerting hoop stresses upon the inner and outer shells. The shells are thick and strong, e.g. the inner and outer shell thicknesses for the MP197 are 1.25 and 2.5 inches, respectively (Ref. D4.1.47, Drawing 1093-71-4, rev. 1), and the bottom plate thickness is 6.5 inches (Ref. D4.1.47, Drawing 1093-71-2, rev. 1). Consequently, failure of the steel is considered very unlikely.

As part of the PCSA, an attempt was made to analyze hydraulic failure of the molten lead containment due to a fire. Unfortunately, the thermal and physical properties of lead necessary for this analysis could not be found. Thus, hydraulic failure cannot be conclusively disproved. For that reason, a probability of 1.0 is used for LOS by transportation casks due to fire.

D2.2.3 Bases for Screening of Loss of Shielding Pivotal Events for Aging Overpacks in Fire Scenarios

This section summarizes the rationale for screening loss of shielding pivotal events associated with heating of aging overpacks in a fire. Loss of shielding could occur if the concrete that comprises the majority of the aging overpack spalled as a result of the fire. Spalling would reduce the thickness of the concrete and, if sufficient spalling occurs, the thickness could be reduced below the level required for adequate shielding.

D2.2.3.1 Thickness of Concrete Required for Adequate Shielding

The concrete thickness needed for adequate shielding can be estimated by determining the dose outside the overpack for different concrete thicknesses and comparing that dose to the exposure limits for radiation workers. For this calculation, the exposure rate on the surface of the aging overpack prior to the fire is 40 mrem/hr (Ref. D4.1.15, Section 33.2.4.17).

The dose outside the aging overpack is primarily due to Co-60 gamma radiation, the gamma attenuation due to concrete can be estimated based on data available from the National Institute of Standards and Technology "Concrete, Ordinary." *Table 4. X-Ray Mass Attenuation Coefficients*(Ref. D4.1.40). This reference lists a value for the mass attenuation coefficient of the concrete divided by the concrete density (μ/ρ) of 0.058 cm^2/g for the gammas produced by Co-60. Multiplying this value by an approximate concrete density of 2.3 g/cm^3 (Ref. D4.1.39, Table 4.2.5) yields a value for the mass attenuation coefficient of 0.133 cm^{-1}. Based on this value, there is approximately a factor of 10 reduction in the gamma dose for each 17.2 cm (6.8 inches) of concrete.

If the outer 6.8 inches of concrete were to spall as a result of the fire, the dose at the surface of the aging overpack would increase to 400 mrem/hr. If an additional 6.8 inches of concrete were to spall, the dose on the surface would be 4 rem/hr. The original concrete thickness is 34 inches based on existing aging overpack drawings (Ref. D4.1.14). There are 27.2 inches of concrete remaining after the first 6.8 inches of spallation and 20.4 inches of concrete remaining after the second 6.8 inches of spallation.

The dose outside the aging overpack can be estimated by noting that the dose decreases as the square of the distance from the source. After 13.6 inches of concrete has spalled, the dose

20.4 inches from the surface of the aging overpack would be 1 rem/hr, and the dose 61.2 inches from the surface would be 250 mrem/hr. Therefore, even in the case of extensive concrete spalling, workers involved in fire fighting or post-fire activities could be in close proximity to the degraded aging overpack for a lengthy period of time without exceeding either the annual exposure limit of 5 rem or special exposure limits outlined in 10 CFR Part 20 (Ref. D4.2.1, Paragraph 20.1206).

D2.2.3.2 Extent of Concrete Spalling in a Fire

The current aging overpack design has a steel liner outside the concrete shielding. Consequently, spalling and removal of concrete from the surface cannot occur unless the steel liner is removed or fails catastrophically. However, because alternative aging overpack designs have been considered without a steel outer liner, the potential for substantial spallation with a bare concrete shield was assessed.

Extensive spalling of structural concrete has been observed under some conditions when the structural concrete is exposed to intense fires. The most extensive spalling has been observed in tunnel fires, such as the Channel Tunnel fire in 1996. In such cases, a significant fraction of the concrete spalled when exposed to the intense heat from the long-duration fires.

Due to the potential significance of spalling in reducing the strength of concrete support structures, spallation of concrete has been the subject of considerable study. "Limits of Spalling of Fire-Exposed Concrete" (Ref. D4.1.37) provides a good overview of the factors that control concrete spalling due to fire. Hertz indicates that that there are three types of spalling that can occur: (1) aggregate spalling, (2) explosive spalling, and (3) corner spalling. Aggregate spalling occurs with some aggregates (such as flint or sandstone) and results in superficial craters on the surface of the concrete. Corner spalling occurs only on the convex corners of beams or other structures and is caused by a localized weakening and cracking of the concrete such that the corner breaks off under its own weight. This mode of spalling is not relevant for the aging overpacks. Explosive spalling occurs when sufficient pressure builds up inside the concrete to cause pieces of concrete to be ejected from the surface. Explosive spalling is believed to account for the extensive concrete loss observed in the Channel Tunnel fire. Of the three modes of spalling, only explosive spalling could produce the loss of concrete necessary to significantly reduce the shielding capability of the aging overpack.

"Predicting the fire resistance behaviour of high strength concrete columns," (Ref. D4.1.43) notes that explosive spalling occurs when sufficient pressure builds up in the pores of the concrete to cause ejection of concrete from the surface. Buildup of such a high pressure requires three things: (1) low concrete permeability, (2) high moisture content in the concrete, and (3) rapid heating and resulting large thermal gradients. In addition, "Limits of Spalling of Fire-Exposed Concrete" (Ref. D4.1.37) notes that spallation is more pronounced in concrete structures undergoing high compressive stress, such as support columns.

Low permeability prevents gas migration and allows pressure to build. High structural strength concretes, such as those used in tunnel construction, are known to have very low permeability and are therefore more prone to spalling. In contrast, normal strength concretes do not have low permeability and spallation is not observed (Ref. D4.1.43). Because the concrete used for shielding in the aging overpacks is not counted on for structural strength and is therefore classified as normal strength concrete[2], spallation is unlikely to occur.

Moisture content is a major factor in pressure buildup because water vapor is the gas primarily responsible for high pore pressures in the concrete. The concrete in the aging overpacks is unlikely to have high moisture content because it is heated both internally by decay heat and externally by solar heat. In addition, it is likely to have been sitting in the Nevada desert for a lengthy period of time.

Thus, although the fire will produce large thermal gradients in the concrete, these gradients are unlikely to result in pressure buildup sufficient to cause extensive spallation due to the expected high permeability and low moisture content of the aging overpack concrete. This would be true regardless of whether the outer steel liner is present or not.

D2.2.3.3 Conclusion

The preceding discussion has shown that a substantial amount of concrete would have to spall during a fire to produce a hazard to workers involved in either fire fighting or post-fire activities. In addition, it was shown that spallation is very unlikely given the type of concrete to be used in the aging overpacks and the likelihood that the aging overpacks will have an outer steel liner. For these reasons, loss of aging overpack shielding in a fire is considered Beyond Category 2 and need not be analyzed further.

D3 SHIELDING DEGRADATION DUE TO IMPACTS

Neutrons emitted from transportation casks are shielded by a resin surrounded by a steel layer. The neutron shielding is present in the top lid, bottom and shell. Neutron shields designed to 10 CFR Part 71 (Ref. D4.2.2) are robust against 10 CFR Part 71 hypothetical accident conditions related to impacts or drops, exhibiting factors of safety greater than 1 for Service Level D allowables. Meeting *2004 ASME Boiler and Pressure Vessel Code* Service Level D (Subsection NF) (Ref. D4.1.6) provides for twice the allowable stress intensity as normal operation but still results in an extremely low failure probability. In addition, neutron dose typically attenuates quickly with distance from the transportation cask so it is only a small fraction of the gamma dose to personnel more than two meters away. Evacuation to that distance is the way to reduce personnel dose from neutrons. For these reasons, the analysis below focuses on the principle threat to workers on the site, which is degradation of gamma shielding.

This section summarizes information on loss of shielding mechanisms that could occur in event sequences for repository waste handling operations. The information is derived from transportation cask accident risk analyses. This information provides insights and bases for estimating probabilities of passive failures that result in LOS for casks and overpacks in waste handling event sequences.

[2] For example, the compressive strength of the concrete used in the HI-STORM storage overpack (Ref. D4.1.39, Table 1.D.1) is listed as 3,300 psi or 22.75 MPa, which is well below the strength of 55 MPa usually defined as necessary for high strength concrete (Ref. D4.1.43).

The repository facilities process three categories of waste containers that provide shielding: transportation casks (truck and rail) and aging overpacks. The event sequence diagrams for operations involving processing of transportation casks and aging overpacks include the pivotal event “loss of shielding” for event sequences that are initiated by physical impact or fire. LOS due to fire was addressed previously in section D2.2 of this attachment. The following discussion focuses specifically on LOS due to drops and impacts.

The information in this section is based in large part on results of FEA performed for four generic transportation cask types for transportation accidents as reported in NUREG/CR-6672 (Ref. D4.1.65) and NUREG/CR-4829 (Ref. D4.1.32). The results of the FEA were used to estimate threshold drop heights and thermal conditions at which LOS may occur in repository event sequences, using damage severity levels keyed to the FEA results to determine the challenge needed to cause LOS. The four cask types included one steel monolith rail cask, one steel/depleted uranium truck cask, one SLS truck cask and one SLS rail cask. NUREG/CR-6672 (Ref. D4.1.65) states that the steel in any of the cask is thick enough to provide some shielding, but the depleted uranium and lead provide the primary gamma shielding for the multi-shell cask types. The referenced study performed structural and thermal analyses for both failure of containment boundaries and loss of shielding for accident scenarios involving rail cask and truck cask impacting unyielding targets at impact speeds of 30-60, 60-90, 90-120, and greater than 120 mph. The impact orientations included side (0–20 degrees), corner (20-85 degrees), and end (85–90 degrees). The referenced study also correlated the damage from impacts on real targets including soil and concrete.

The event sequences used in the transportation accident analyses included impact-only, impact plus-fire, and fire-only conditions. The results of the FEA indicate that LOS could occur in the impact-only at speeds as low as 30 mph with an unyielding target and in fire scenarios of sufficient intensity and duration. The structural analyses did not credit the energy absorption capability of impact limiters. Therefore, the results are deemed applicable to approximate the structural response of transportation and similar casks in drop scenarios.

The primary reference NUREG/CR-6672 (Ref. D4.1.65), however, does not provide a threshold below which no LOS could be assured. Therefore, information quoted in an evaluation by the Association of American Railroads (Ref. D4.1.30) was used to establish thresholds for LOS conditions based on damage categories that are correlated to plastic strain in the inner shell of a cask. That information is based on a prior transportation accident analysis known as the “Modal Study” (Ref. D4.1.32). For potential PCSA applications, FEA results for inner shell strain versus impact speed were extended to estimate the lower bound of impact speed or drop heights to establish conditions at which LOS may occur in cask-drop scenarios in repository operations.

NUREG/CR-6672 (Ref. D4.1.65) addresses two modes of LOS in accident scenarios: deformations of lid and closure geometry that permit direct streaming of radiation; and/or reductions in cask wall thickness or relocation of the depleted uranium or lead shielding. The LOS due to lid/closure distortion can be accompanied by air-borne releases if the inner shell of the cask is also breached.

The results of the FEA reported in NUREG/CR-6672 (Ref. D4.1.65) provide some definitive results that are deemed to be directly applicable to the repository event sequence analyses:

- Monolithic steel rail casks do not exhibit any LOS, but there may be some radiation streaming through gaps in closure in any of the impact scenarios. This result can be applied to both transportation casks.

- Steel/depleted uranium/steel truck cask exhibited no LOS, explained by modeling that included no gaps between forged depleted uranium segments so that no displacement of depleted uranium could occur.

- The SLS rail and truck casks exhibit LOS due to lead slumping. Lead slump occurs mostly on end-on impact with a lesser amount in corner orientation. For side-on orientation, there is no significant reduction in shielding.

Therefore, this analysis focuses on LOS for SLS casks to estimate the drop or collision conditions that could result in LOS from lead slumping. Figure D3.2-1 illustrates the effect of cask deformation and lead slumping for a SLS rail cask following an end-on impact at 120 mph onto an unyielding target from the result of the FEA reported in NUREG/CR-6672 (Ref. D4.1.65).

D3.1 DAMAGE THRESHOLDS FOR LOS

The Association of American Railroads study (Ref. D4.1.30) is used as a reference for this report. The information cited, however, was derived from an earlier transportation cask study known as the "Modal Study," (Ref. D4.1.32). The Modal Study assigned three levels of cask response characterized by the maximum effective plastic strain within the inner shell of a transport cask. The severity levels are defined as:

- S1–implies strain levels < 0.2%
- S2–implies strains between 0.2 and 2.0%
- S3–implies strain levels between 2.0 and 30%.

The amount of damage to a cask for the respective severity levels is summarized in the following:

S1:

- No permanent dimensional change
- Seal and bolts remain functional
- Little if any radiation release
- Less than 40 g axial force on lead for all orientations
- No lead slump
- Fuel basket functional; up to 3% of fuel rods may release into cask cavity
- Loads/releases within regulatory criteria.

S2:

- Small permanent dimensional changes
- Closure and seal damage; may result in release
- Limited lead slump
- Up to 10% of fuel rods release to cask cavity.

S3:

- Large distortions
- Seal leakage likely
- Lead slump likely
- 100% fuel rods release to cask cavity.

As stated above, limited lead slumping may occur at damage level S2, but is likely to occur at damage level S3. The respective strain levels associated with damage levels S2 and S3 were applied to the results from NUREG/CR-6672 (Ref. D4.1.65) to establish a threshold impact speed for the onset of LOS.

D3.2 SEVERITY OF DAMAGE VERSUS IMPACT VELOCITY

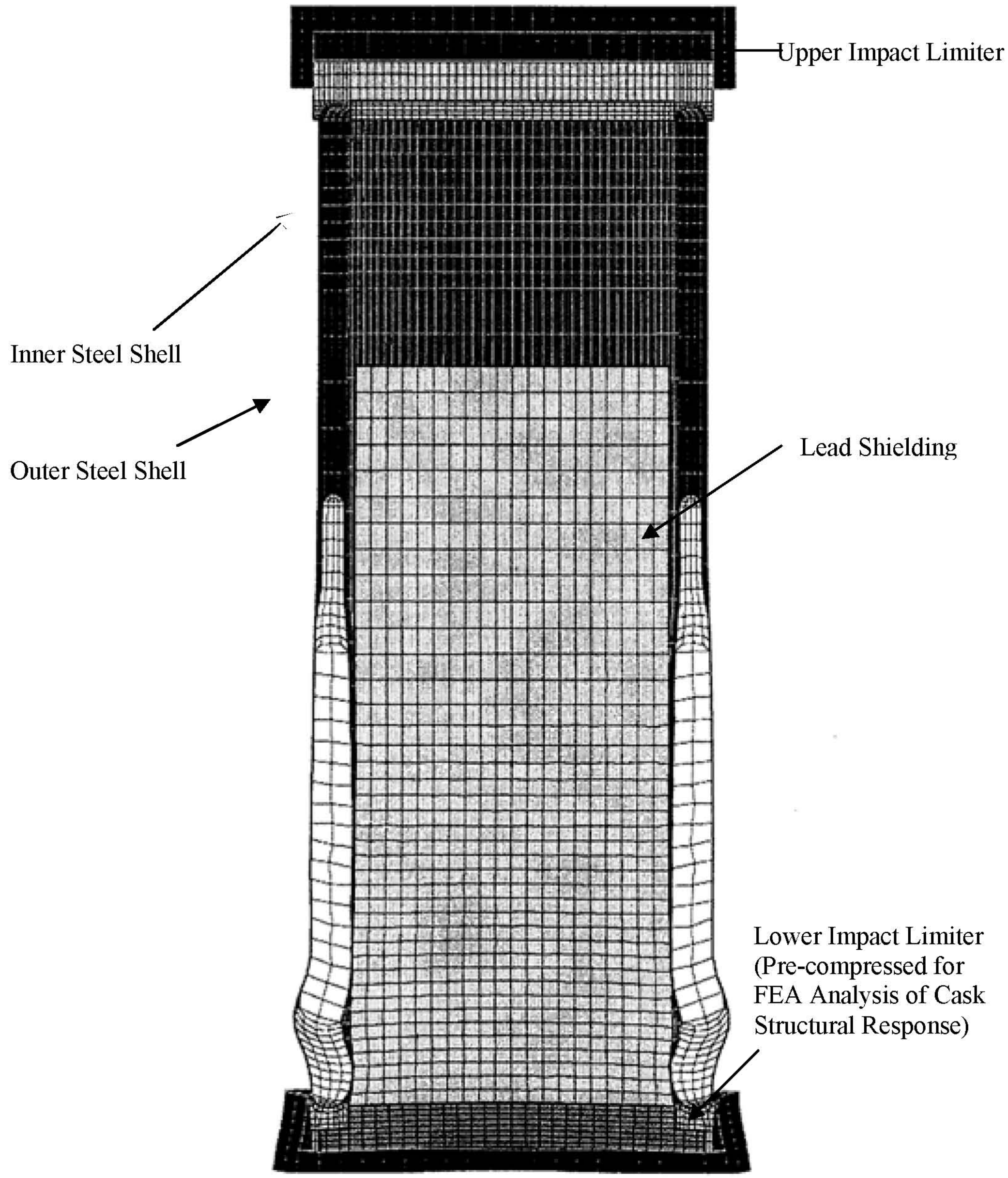
The FEA results given in Table 5.3 of NUREG/CR-6672 (Ref. D4.1.65) are summarized in Table D3.2-1. The strain in the inner shell of the SLS casks are shown in Table D3.2-1 and illustrated in Figure D3.2-1. These data were plotted (Figures D3.2-2 and D3.2-3). The data points start at the lowest speed range of 30 to 60 mph. The data were plotted as points using the lower boundary of each of the four speed ranges on the abscissa. The strain plots were extended to the origin by including the point (0, 0) with the Table D3.2-1 data.

Table D3.2-1. Maximum Plastic Strain in Inner Shell of Sandwich Wall Casks

Cask Type	Orientation: Speed, mph	Corner Impact Strain, %	End Impact Strain, %	Side Impact Strain, %
SLS Truck	30	12	3.9	N/A
	60	29	12	16
	90	33	18	24
	120	47	27	27
SDUS Truck	30	11	1.8	6
	60	27	4.8	13
	90	43	8.3	21
	120	55	13	30
SLS Rail	30	21	1.9	5.9
	60	34	5.5	11
	90	58	13	15
	120	70	28	N/A

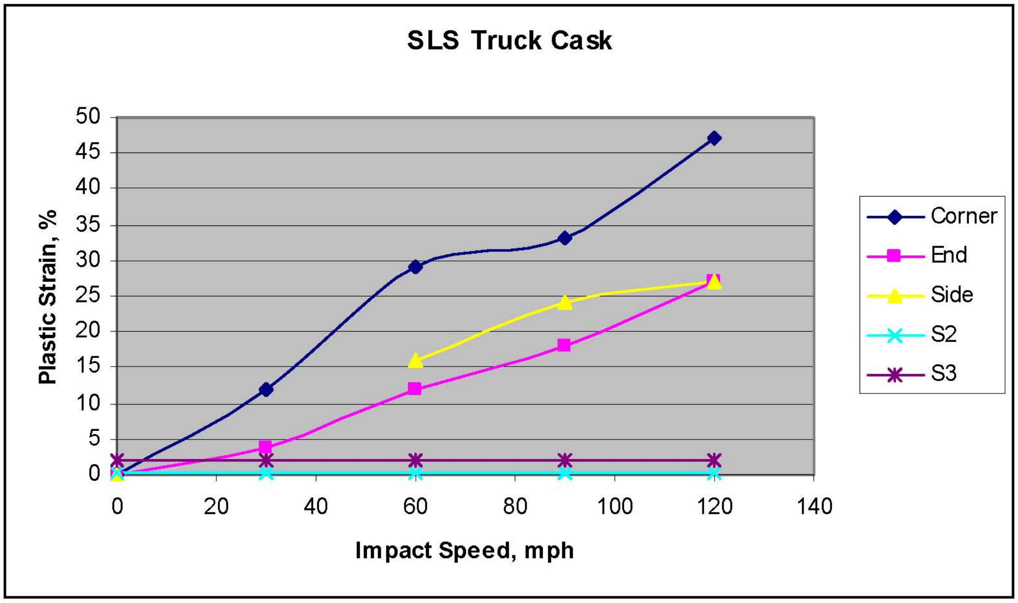
NOTE: SDUS = steel-depleted uranium-steel; SLS = steel/lead/steel.

Source: From NUREG/CR-6672 (Ref. D4.1.65, Table 5.3)



Source: From NUREG/CR-6672 (Ref. D4.1.65, Figure 5.9)

Figure D3.2-1. Illustration of Deformation and Lead Slumping for a SLS Rail Cask Following End-on Impact at 120 mph



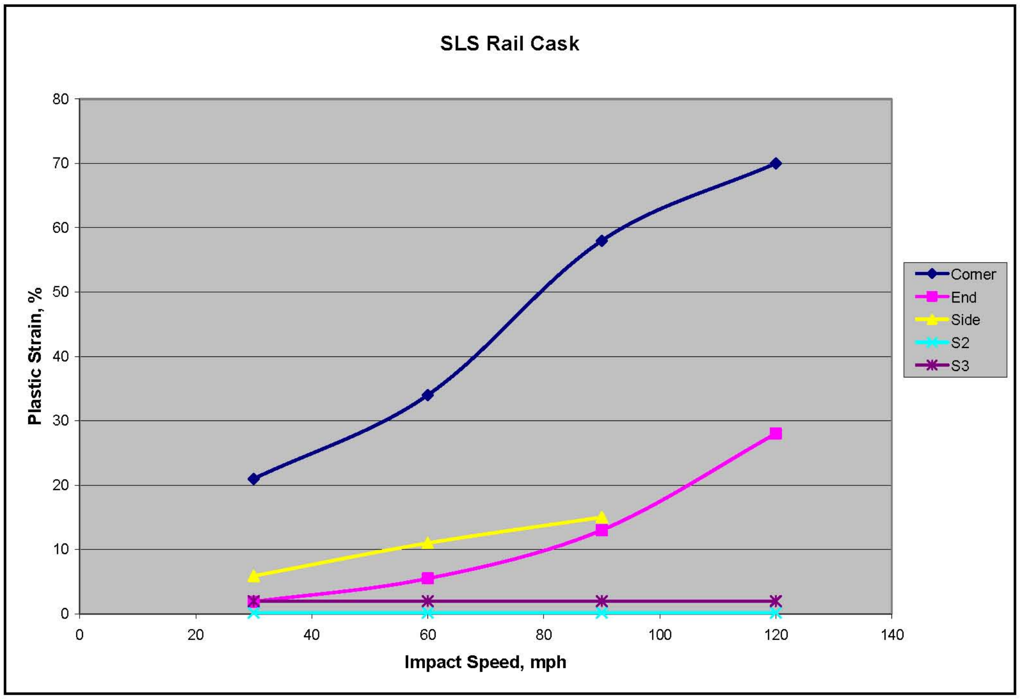
NOTE: [1] Data points for strain versus speeds greater than 30 mph taken directly from NUREG/CR-6672 (Ref. D4.1.65, Table 5.3): plots extended to origin (0,0) to determine crossover for S2 and S3 threshold strains.
[2] S2 and S3 threshold strains based on information in *A Railroad Industry Critique of the Model Study* (Ref. D4.1.30).

mph = miles per hour; SLS = steel/lead/steel.

Source: Original

Figure D3.2-2. Truck Steel/Lead/Steel Inner Shell Strain versus Impact Speed

Two horizontal lines were superimposed on Figures D3.2-2 and D3.2-3 to plot the 0.2% and 2.0% strain to represent the respective S2 and S3 thresholds for inner shell strain. The intersections of the strain curves with the respective threshold values indicate the minimum impact speed at which the respective S2 and S3 strain thresholds appear to be exceeded.



NOTE: [1] Data points for strain versus speeds greater than 30 mph taken directly from NUREG/CR-6672 (Ref. D4.1.65, Table 5.3): plots extended to origin (0,0) to determine crossover for S2 and S3 threshold strains.
[2] S2 and S3 threshold strains based on information in *A Railroad Industry Critique of the Model Study* (Ref. D4.1.30).

mph = miles per hour; SLS = steel/lead/-steel.

Source: Original

Figure D3.2-3. Rail Steel/Lead/Steel Strain versus Impact Speed

D3.3 ESTIMATE OF THRESHOLD SPEEDS FOR LOSS OF SHIELDING DUE TO IMPACTS

The plots in Figures D3.2-2 and D3.2-3, and Table D3.2-1 illustrate that the S2 threshold is exceeded for both the truck and rail SLS casks for all four speed ranges and all orientations. Since NUREG/CR-6672 (Ref. D4.1.65) does not report LOS conditions for low impact speeds, it is concluded that the S2 criterion is not a valid threshold for LOS in SLS casks. Therefore, the remainder of this analysis applies the S3 criterion (2% shell strain) as a basis for estimating LOS threshold impact speeds.

Figures D3.2-2 and D3.2-3, and Table D3.2-1 indicate that the S3 threshold is exceeded for both truck and rail SLS casks for all orientations. The intersections of the strain curves and the 2% strain line in Figures D3.2-2 and D3.2-3 illustrate the impact speed at where the S3 threshold is reached for each case. A small exception being the end drop of a SLS rail cask in the 30-60 mph range for which the shell strain of 1.9% is just below the lower bound for S3 damage. However, this margin is too small to exclude that case. Although the strains for the side drop cases exceed the threshold for lead slumping, NUREG/CR-6672 (Ref. D4.1.65) states that lead slumping does not occur in side drops. Therefore, LOS for side drops is excluded from the remainder of this report.

Using the 2% shell strain condition as the threshold for LOS in SLS casks, the following is observed:

- LOS for the truck SLS cask would occur at impact speeds of about 5 mph for corner impact and about 18 mph for end impact

- LOS for the rail SLS cask would occur at about 3 mph for corner impact and about 30 mph for end impact.

It is observed that the corner drop cases give the largest shell strain at a given impact speed but the finite element analyses indicate that the extent of lead slumping is less in corner drops than for end impacts.

Table D3.3-1 shows the drop height equivalents for impact speed onto a horizontal unyielding surface. Thus, to exceed 5 mph, for example, a drop height greater than 0.8 ft is required; to exceed 30 mph impact, a drop height greater than 30 ft is required. Using the results cited above:

- LOS for the truck SLS cask would occur at impact speeds of about 0.8 ft (5 mph) for corner impact and about 10 ft (18 mph) for end impact

- LOS for the rail SLS cask would occur at about 0.5 ft (3 mph) for corner impact and about 30 ft (30 mph) for end impact.

Such drop heights could occur in some geologic repository operations area (GROA) handling operations.

However, when the effect of the energy absorption by real targets is considered, much greater impact speeds are required to impose the damage equivalent to impacts on unyielding targets. NUREG/CR-6672 (Ref. D4.1.65) provides a correlation of impact speeds for real versus unyielding target, but provides only bounding values for a large number of cases as presented in Table D3.3-2. Therefore, if LOS occurs at 30 mph for an end drop of a SLS train cask on unyielding surface, a speed of greater than 150 mph is required for an impact on concrete. This impact speed would require a drop of over 500 ft. Such drop heights cannot be achieved in repository handling.

Some of the LOS cases, including corner drops of truck and rail SLS casks, appear to result in LOS for impact speeds less than 10 mph. If the corner drops are onto concrete, a speed of 2 to 3 times the threshold speed for LOS for impact on an unyielding target. This implies a threshold impact speed of 20 to 30 mph for a corner drop onto concrete. The corresponding drop height is 13 to 30 feet. Such drops could occur in event sequences for repository handling.

Table D3.3-1. Drop Height to Reach a Given Impact Speed

Impact Speed, mph	Equivalent Drop Height, ft
2	0.1
5	0.8
10	3.3
20	13.4
30	30.1
40	53.4
50	83.5
60	120.2
70	163.7
80	213.8
90	270.6
100	334.0
110	404.2
120	481.0

NOTE: ft = feet; mph = miles per hour.

Source: Original

Table D3.3-2. Impact Speeds on Real Target for Equivalent Damage for Unyielding Targets

Cask Type	Real Target type	Impact Type\Orientation w/o Impact Limiters	Impact Speed, mph			
			30	60	90	120
Rail SLS	Soil	End	>>150	>>150	>>150	>>150
		Side	72	>150	>>150	>>150
		Corner	68	133	>150	>150
	Concrete slab	End	>150	>>150	>>150	>>150
		Side	85	>150	>>150	>>150
		Corner	>>150	>>150	>>150	>>150
Truck SLS	Soil	End	>150	>>150	>>150	>>150
		Side	70	>150	>>150	>>150
		Corner	61	>150	>>150	>>150
	Concrete slab	End	123	180	>>150	>>150
		Side	35	86	135	>150
		Corner	56	123	>150	>>150

NOTE: mph = miles per hour; SLS = steel/lead/steel.

Source: Based on NUREG/CR-6672 (Ref. D4.1.65, Tables 5.10 and 5.12)

D3.4 PROBABILITY OF LOSS OF SHIELDING

NUREG/CR-6672 (Ref. D4.1.65) develops probabilities for LOS in transportation accidents. The probability of LOS uses event tree analysis with split fractions for various types of transportation accidents and frequencies based on accident rates per mile of travel for cask-bearing truck trailers or rail cars. The results of probability analyses of LOS as derived in NUREG/CR-6672 (Ref. D4.1.65) do not have any direct relevance to event sequences for waste handling operations. However, the basic approach that breaks down the overall probability of an event sequence involving LOS into conditional probabilities for occurrence of various physical conditions that lead to LOS can be adapted for PCSA.

The vulnerability to LOS for repository event sequences varies with the container type:

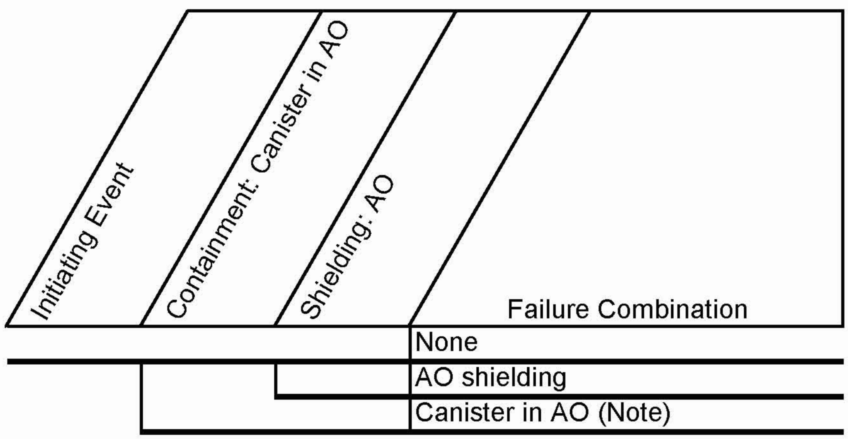
1. Concrete overpack with no containment boundary (aging overpack)

2. Sandwich type with steel containment boundary and lead in the annulus between the steel shells (transportation cask)

3. All other casks including monolithic steel casks or casks with layers of steel or steel and depleted uranium (e.g., transportation cask, STC).

Concrete Overpacks

Aging overpacks provide shielding but not containment. They are used within the GROA to transport DPCs and TAD canisters between buildings and to and from the aging pads. The event sequences that involve both are of the form shown in Figure D3.4-1 below.



Note: Implies shielding is ineffective because of radionuclide release

NOTE: AO = aging overpack.

Source: Original

Figure D3.4-1. Summary Event Tree Showing Model Logic for Canisters and Aging Overpacks

A site transporter transports aging overpacks with canisters within the GROA. The transporter is designed for a maximum speed of 2.5 mph (Ref. D4.1.18, Sections 3.2.1 and 3.2.4) and will elevate the aging overpack no more than 3 feet from the ground (equipment limit is 12 inches (Ref. D4.1.18, Section 2.2, item 9), additional two feet is allowed for potential drop off edge of aging pad). Expanding the probability of success (no breach) of a canister within an aging overpack yields:

$$p_{AO}(C) = p_{AO}(C \mid O)p_{AO}(O) + p_{AO}(C \mid \overline{O})p_{AO}(\overline{O}), \qquad \text{(Eq. D-26)}$$

where

$p_{AO}(C)$ Ť probability of canister success within an AO.

$p_{AO}(C \mid O)$ Ť probability of canister success given AO shielding does not fail.

$p_{AO}(O)$ Ť probability that AO shielding does not fail.

$p_{AO}(C \mid \overline{O})$ Ť probability of canister success given AO shielding fails.

$p_{AO}(\overline{O})$ Ť probability that AO shielding fails.

The inner and outer steel lined three foot concrete aging overpack is much more robust against impact loads than a DPC. Therefore, if the overpack fails, it is much more likely that the canister will breach. This yields: $\mathrm{p_{AO}(C \mid O) >> p_{AO}(C \mid \overline{O})}$. Furthermore, the probability of aging overpack breach is much less than probability of aging overpack success at the above drop and speed conditions. Therefore: $\mathrm{p_{AO}(O) >> p_{AO}(\overline{O})}$. The second term on the right hand side of Equation D-26 is much less than the first term and need not be considered further in this analysis.

This leaves

$$p_{AO}(C) \cong p_{AO}(C \mid O)p_{AO}(O) \qquad \text{(Eq. D-27)}$$

Note that

$p_{AO}(C) = 1 - p_{AO}(\overline{C})$ and $\qquad p_{AO}(O) = 1 - p_{AO}(\overline{O})$ and

$$p_{AO}(C \mid O) = 1 - p_{AO}(\overline{C} \mid O) \qquad \text{(Eq. D-28)}$$

Substituting Equations D-28 into D-27 and rearranging yields:

$$\mathrm{p_{AO}(\overline{O}) \cong 1 - \frac{1 - p_{AO}(\overline{C})}{1 - p_{AO}(\overline{C} \mid O)}} \qquad \text{(Eq. D-29)}$$

LLNL has developed a mean probability of failure for a canister within an aging overpack, $p_{AO}(\overline{C})$, for a 3-foot drop onto a rigid surface with an initial velocity of 2.5 mph (Ref. D4.1.27).

This analysis uses a conservative value of 1E-05 relative to the 1E-08 value in the referenced LLNL report. The probability of canister failure given the aging overpack does not fail, $p_{AO}(\overline{C} \mid O)$, must be less than the overall probability of canister failure within an aging overpack, $p_{AO}(\overline{C})$. It is, therefore, reasonable to use a range of values of 1E-06 to 1E-05 for this, both of which are conservative relative to the value in the reference. The LLNL (Ref. D4.1.27) value, itself, has a conservative element in that it analyzes impact onto a rigid surface. The more realistic concrete surface would have a lower canister failure probability. Using the average between 1E-06 and 1E-05 of 5E-06 for $p_{AO}(\overline{C} \mid O)$ and also substituting the aforementioned value for $p_{AO}(\overline{C})$ into Equation D-29, there obtains:

$$p_{AO}(\overline{O}) \cong 1 - \frac{1 - p_{AO}(\overline{C})}{1 - p_{AO}(\overline{C} \mid O)} = 1 - \frac{1 - 10^{-5}}{1 - 5 \times 10^{-6}} = 5 \times 10^{-6} \qquad \text{(Eq. D-30)}$$

Steel/Lead/Steel Sandwich-Type Casks

For these sandwich-type casks, the probability of LOS due to lead slumping can be estimated from results of transportation cask studies that can be coupled to event sequence probability analysis and insights from the passive failure analyses. Since the speed of transport of transportation casks to, and within, the processing facilities is limited to a few mph, it is judged that LOS of SLS casks (and the other types) may be screened out from collision scenarios. However, LOS for SLS casks due to drops cannot be ruled out, if SLS casks are processed in the repository.

For SLS casks, the probability of LOS is derived from the probability that the drop height or impact speed exceeds the threshold at which lead shielding may slump. For all cask types, the probability of LOS is derived from the probability that the drop height or impact speed exceeds the threshold at which cask closure and/or seals fail in such a way to permit to permit direct streaming. A simplified conservative approach to estimating the probability of LOS due to lead slumping resulting from a drop of an SLS cask is summarized in the next section.

The PCSA considers drop and collision event sequences of transportation casks. Should a canister rupture occur, the analysis conservatively models the shielding as also lost. In such event sequences the probability of loss of shielding is taken to be 1.0 given canister rupture. This applies to all types of casks.

Event sequences also include LOS without canister rupture. That is, the drop or collision was not severe enough to cause a rupture but a LOS is possible in some casks. Such an event sequence can not occur in the steel/depleted uranium truck casks. The loss of shielding associated with streaming through the head of steel monolith rail casks is due to structural failure of the casks. The probability of this is estimated by taking the breach/rupture probability of a steel monolith transportation cask at the weakest location and applying it as a head rupture probability.

Collisions of casks will occur at less than 5 mph. Drops can occur as high as 30 feet. Drops may be at any orientation: side, bottom, and end. A conservative approach to estimation of the probability of SLS LOS is to use the information associated with end drops, which can cause bulging of the steel containment that allows the lead to collect towards one end. Although the corner impact can cause greater strain in the steel containment, it does not cause the spreading that increases collection of the lead at one end. All surfaces in the repository upon which a transportation cask can be dropped (concrete or soil) are concrete or softer. Therefore, the concrete related drop height vs. LOS information may be accurately used.

An impact of at least 123 mph against a real surface such as concrete or soil is required in order to cause the same damage as an impact of 30 mph against an unyielding surface (Table D3.3-2). The vast majority of casks are to be delivered to the repository by rail. The maximum strain due to an end impact of 30 mph against an unyielding surface, or 123 mph against a real surface, is about 3.9% for a truck cask (greater than the 1.9% strain for a rail cask) (Table D3.2-1). Noting in Figure D3.2-3 that the amount of strain is roughly linear with the impact velocity, a velocity of 63 mph is estimated to correspond to the strain of 2% indicative of S3 damage and lead slumping. A 63 mph collision, equivalent to a 133-foot drop, is the threshold for causing enough damage to indicate potential loss of shielding due to lead slumping.

In order to develop fragility over height, the available information described herein indicates that an estimate of a median threshold for a failure drop height is 133 feet. This would yield 2% strain. A coefficient variation (the ratio of standard deviation to the median) is 0.1. This is an estimate derived from the distribution of capacity associated with the tensile strength elongation data described in Section D1.1. The probability of LOS due to lead slumping resulting from a 15-foot vertical drop would be less than 1×10^{-8}, given the drop event. For a 30-foot drop resulting from a 2-blocking event, the computed failure probability based on the 133-foot median drop height is also less than 1×10^{-8}. LOS due to lead slumping applies only to those casks using lead for shielding but the PCSA applied this analysis to all casks. A conservative value of 1×10^{-5} is used to be consistent with the probabilities based on the LLNL (Ref. D4.1.27) results.

Results are shown in Table D3.4-1.

Table D3.4-1. Probabilities of Degradation or Loss of Shielding

Description	Probability	Note
Sealed transportation cask and shielded transfer casks shielding degradation after structural challenge	1×10^{-5}	Section D3.4
Aging overpack shielding loss after structural challenge	5×10^{-6}	Section D3.4
CTM shielding loss after structural challenge	0	Structural challenge sufficiently mild to leave the shielding function intact[a]
WPTT shielding loss after structural challenge	0	Structural challenge sufficiently mild to leave the shielding function intact[a]
TEV shielding loss (shield end)	0	Structural challenge sufficiently mild to leave the shielding function intact[a]
Shielding loss by fire for waste forms in transportation casks or shielded transfer casks	1	Lead shielding could potentially expand and degrade. This probability is conservatively applied to transportation casks and STCs that do not use lead for shielding
Shielding loss by fire of aging overpacks, CTM shield bell, and WPTT shielding	0	Type of concrete used for aging overpacks is not sensitive to spallation; uranium used in CTM shield bell and WPTT shielding does not lose its shielding function as a result of fire

NOTE: [a]In the event sequence diagrams of the PCSA, the shielding function for the CTM, WPTT and TEV is queried for the challenges that do not lead to a radioactive release. Such challenges, which were not sufficiently severe to cause a breach of containment of the waste form container, are also deemed mild enough to leave the shielding function of the CTM, WPTT and TEV intact.
CTM = canister transfer machine; STC = shielded transfer cask; TEV = transport and emplacement vehicle; WPTT = waste package transfer trolley.

Source: Original

All Other Cask Types

For all other cask types, the results of the transportation cask study indicate that the only mechanism for LOS is streaming via closure failures and closure geometry changes. Therefore, the probability of LOS can be equated to the probability of rupture/breach of such casks.

D4 REFERENCES

D4.1 DESIGN INPUTS

The PCSA is based on a snapshot of the design. The reference design documents are appropriately documented as design inputs in this section. Since the safety analysis is based on a snapshot of the design, referencing subsequent revisions to the design documents (as described in EG-PRO-3DP-G04B-00037, *Calculations and Analyses* (Ref. 2.1.1, Section 3.2.2.F)) that implement PCSA requirements flowing from the safety analysis would not be appropriate for the purpose of this document. There are no superseded or cancelled documents associated with the modifications that led to the issuance of this revision. Cancelled or superseded documents associated with the portions of this document for which the snapshot has not yet been updated are designated herein with a dagger (†).

The inputs in this Section noted with an asterisk (*) indicate that they fall into one of the designated categories described in Section 4.1, relative to suitability for intended use.

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D4.2 DESIGN CONSTRAINTS

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ATTACHMENT E
HUMAN RELIABILITY ANALYSIS

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ACRONYMS AND ABBREVIATIONS

Acronyms

ASME	American Society of Mechanical Engineers
ATHEANA	A Technique for Human Event Analysis
CCCF	Central Control Center Facility
CRCF	Canister Receipt and Closure Facility
CREAM	Cognitive Reliability and Error Analysis Method
EFC	error forcing context
EOC	error of commission
EOO	error of omission
EPRI	Electric Power Research Institute
ESD	event sequence diagram
HAZOP	hazard and operability
HCR	Human Cognitive Reliability
HEART	Human Error Assessment and Reduction Technique
HEP	human error probability
HFE	human failure event
HRA	human reliability analysis
HVAC	heating, ventilation, and air conditioning
IHF	Initial Handling Facility
ISFSI	independent spent fuel storage installation
MLD	master logic diagram
NARA	Nuclear Action Reliability Assessment
NPP	nuclear power plant
NRC	U.S. Nuclear Regulatory Commission
PCSA	preclosure safety analysis
PIC	person in charge
PLC	programmable logic controller
PRA	probabilistic risk assessment
PSF	performance-shaping factor
SNF	spent nuclear fuel
SSCs	structures, systems, and components
TEV	transport and emplacement vehicle
THERP	Technique for Human Error Rate Prediction
TRC	Time-Reliability Correlation
YMP	Yucca Mountain Project

ACRONYMS AND ABBREVIATIONS (Continued)

Abbreviations

ft	foot
in.	inch
m	meter
mrem	millirem

E1 INTRODUCTION

This document describes the work scope, definitions, terms, methods, and analysis for the human reliability analysis (HRA) task of the Yucca Mountain Project (YMP) preclosure safety analysis (PCSA) reliability assessment.

The HRA task identifies, models, and quantifies human failure events (HFEs) postulated in the PCSA to assess the impact of human actions on event sequences modeled in the PCSA. The HFEs evaluated and quantified by this task are identified during the following activities:

- Initiating event identification and grouping
- Event sequence development and categorization
- System analysis
- Sequence quantification and uncertainty analysis.

The HRA task ensures that the HFEs identified by the other tasks (e.g., hazard and operability (HAZOP) evaluation, event sequence diagram (ESD) development, event tree analysis, and fault tree analysis) are quantified with HRA techniques. The ESD finding is that the human-induced initiating events dominate the HRA. No post-initiator human actions have been credited in this analysis. The HRA task also ensures that modeled HFEs are appropriately incorporated into the PCSA and provides appropriate human error probabilities (HEPs) for all modeled HFEs. It is important to note that YMP operations differ from those of traditional nuclear power plants (NPPs), and the HRA analysis reflects these differences; Appendix E.IV of this analysis provides further discussion on these differences and how they influenced the choice of methodology.

E1.1 SUMMARY

The HRA was carried out using a nine-step process that is derived from A Technique for Human Event Analysis (ATHEANA) (Ref. E8.1.14):

1. Define the scope of the analysis.

2. Describe the base case progression of actions and responses that constitute successful completion of the operations being evaluated (base case scenarios).

3. Identify and define HFEs of concern.

4. Perform preliminary (screening) analysis and identify HFEs requiring detailed analysis.

5. Identify potential vulnerabilities for the HFEs requiring detailed analysis.

6. Search for HFE scenarios (i.e., scenarios of concern).

7. Quantify probabilities of HFEs.

8. Incorporate HFEs into the PCSA.

9. Evaluate HRA/PCSA results and iterate with design.

After the scope was defined, the activities within the subsurface operations scope were identified and base case scenarios were defined that described in detail the normal operations for each activity. Once the operations were defined and the base cases were documented, HFEs were identified through an iterative process whereby the human reliability analysts, in conjunction other PCSA analysts and Engineering and Operations personnel, met and discussed the design and operations in order to appropriately model the human interface. This process consisted of the HAZOP evaluation, master logic diagram (MLD) and event sequence development, fault tree and event tree modeling, and it culminated in the preliminary analysis and incorporation of HFEs into the model. The iteration with the event sequence and system reliability analysis also identified HFEs of potential concern. HFEs identified include both errors of omission (EOOs) and errors of commission (EOCs).

Included in this process was an extensive information collection process where the human reliability analysts interviewed subject matter experts to identify potential vulnerabilities and HFE scenarios.

The result of this identification process was a list of HFEs and a description of each HFE scenario, including system and equipment conditions and any resident or triggered human factor concerns (e.g., performance-shaping factors (PSFs)). This combination of conditions and human factor concerns then became the error forcing context (EFC) for a specific HFE. Additions and refinements to these initial EFCs were made during the preliminary and detailed analyses.

A preliminary, or screening-type, analysis was then performed to preserve HRA resources so that detailed analyses can be focused on only the most risk-significant HFEs. The preliminary analysis included verification of the validity of HFEs included in the initial PCSA model, assignment of a conservative screening value (mean value) to each HFE, and verification of preliminary values. The actual quantification of preliminary values was a six-step process that is described in detail in Appendix E.III of this analysis. Once the preliminary values were assigned, the PCSA model was quantified (initial quantification), and HFEs were identified for detailed analysis if: (1) the HFE was a risk-driver for a dominant sequence, and (2) using the preliminary values, that event sequence was above Category 1 or Category 2 according to the 10 CFR Part 63 (Ref. E8.2.1) performance objectives. The remaining HFEs retained their preliminary values. While most of the activities associated with preliminary analysis were tedious and time-consuming, extra care was taken to perform these tasks conscientiously since the results of the initial quantification were used to identify which HFEs require detailed analysis. For this analysis, preliminary values proved to be sufficient to demonstrate compliance with the performance objectives of 10 CFR 63.111 (Ref. E8.2.1); therefore, no detailed analyses were required for this HRA.

For the preliminary analysis, HFEs were modeled at a high level in order to reduce dependencies that arise from modeling detailed actions. Uncertainties were accounted for by assigning a lognormal distribution and applying an error factor of 3, 5, or 10 to the distribution, depending on the mean value of the final HEP.

To aid the reader in linking the HRA with other parts of the PCSA, Section E6.0.1 provides an overview of the subsurface operations and provides a map that links this analysis back to the MLD, the ESD, and the HAZOP evaluation.

E2 SCOPE AND BOUNDARY CONDITIONS

E2.1 SCOPE

The scope of the HRA is established in order to focus the analysis on the issues pertinent to the goals of the overall PCSA. Thus, the scope is as follows:

1. HFEs are only considered if they contribute to a scenario that has the potential to result in a release of radioactivity, a criticality event, or a radiation exposure to workers.

2. Pursuant to the above, the following types of HFEs are excluded:

   A. HFEs resulting in standard industrial injuries (e.g., falls)

   B. HFEs resulting in the release of hazardous nonradioactive materials, regardless of amount

   C. HFEs resulting solely in delays to or losses of process availability, capacity, or efficiency.

3. The identification of HFEs is restricted to those areas of the facility that handle waste forms and only during the times that waste forms are being handled (e.g., HFEs are not identified for the surface transportation of an unloaded transport and emplacement vehicle (TEV) when there is no loaded TEV on the surface tracks).

4. The exception to #3 is that system-level HFEs are considered for support systems when those HFEs could result in a loss of a safety function related to the occurrence or consequences associated with the events specified in #1.

5. Recovery post-initiator actions (as defined in Section E5.1.1.1) are not credited in the analysis; therefore, HFEs associated with them are not considered.

6. In accordance with Section 4.3.10.1 (boundary conditions of the PCSA), initiating events associated with conditions introduced in structures, systems, and components (SSCs) before they reach the site are not, by definition of 10 CFR 63.2 (Ref. E8.2.1), within the scope of the PCSA nor, by extension, within the scope of the HRA.

E2.2 BOUNDARY CONDITIONS

Unless specifically stated otherwise, the following general conditions and limitations are applied throughout the HRA task. The first two conditions always apply. The remaining conditions apply unless the HRA analyst determines that they are inappropriate. This judgment is made for each individual action considered:

- Only HFEs made in the performance of assigned tasks are considered. Malevolent behavior (i.e., deliberate acts of sabotage and the like) are not considered in this task.

- Facility personnel act in a manner they believe to be in the best interests of operation and safety. Any intentional deviation from standard operating procedures is made because employees believe their actions to be more efficient or because they believe the action as stated in the procedure to be unnecessary.

- Since the YMP is currently in the design phase, facility-specific information and operating experience is generally not available. Instead, similar operations involving similar hazards and equipment are reviewed to establish surrogate operating experience to use in the qualitative analysis. Examples of reviewed information would include spent nuclear fuel (SNF) handling at reactor sites having independent spent fuel storage installations (ISFSIs), chemical munitions handling at U.S. Army chemical demilitarization facilities, and any other facilities whose primary function includes handling and disposal of very large containers of extremely hazardous material. Equipment design and operational characteristics at the geologic repository operations area facilities, once they are built and operating (including crew structures, training, and interactions), are adequately represented by these currently operating facilities.

- YMP is initially operating under normal conditions and is designed to the highest quality human factors specifications. The level of operator stress is optimal unless otherwise noted in the analysis.

- In performing the operations, the operator does not need to wear protective clothing unless the operation is similar to those performed in other comparable facilities where protective clothing is required.

- The tasks are performed by qualified personnel, such as operators, maintenance workers, or technicians. All personnel are certified in accordance with the training and certification program stipulated in the license. They are experienced and have functioned in their present positions for a sufficient amount of time to be proficient.

- The environment inside each YMP facility is not adverse. The levels of illumination and sound and the provisions for physical comfort are optimal. Judgment is required to determine what constitutes optimal environmental conditions. The analyst makes this determination and documents, as part of the assessment of performance influencing factors, when there is a belief that the action is likely to take place in a suboptimal environment. Regarding outdoor operations on site, similar judgments must be made regarding optimal weather and rail conditions. YMP personnel are required to stop work if conditions are perceived to be unsafe.

- Personnel involved with the facility operations are expected to have the proper training commensurate with nuclear industry standards. As appropriate, this training is followed by a period of observation until the operator is proficient.

- While all personnel are trained to procedures, and procedures exist for all work required, the direct presence and use of procedures (including checklists) during operation is generally restricted to actions performed in the control room. Workers performing skill-of-craft operations do not carry written procedures on their person while performing their activities.

These factors are evaluated qualitatively for each situation being analyzed.

E3 METHODOLOGY

E3.1 METHODOLOGY BASES

The HRA task is performed in a manner that implements the intent of the high-level requirements for HRA in the American Society of Mechanical Engineers (ASME) RA-S-2002 *Standard for Probabilistic Risk Assessment for Nuclear Power Plant Applications* (Ref. E8.1.2) and incorporates the guidance provided by the U.S. Nuclear Regulatory Commission (NRC) in *Preclosure Safety Analysis – Human Reliability Analysis*. HLWRS-ISG-04 (Ref. E8.1.15).

E3.2 GENERAL APPROACH

The HRA consists of several steps, that follow the intent of RA-S-2002 (Ref. E8.1.2) and the process guidance provided in *Technical Basis and Implementation Guidelines for a Technique for Human Event Analysis (ATHEANA)*, NUREG-1624 (Ref. E8.1.14). Detailed descriptions of each HRA step are provided in the following subsections to summarize the processes used by the analysts. The step descriptions are based on the ATHEANA documentation, with some passages taken essentially verbatim and others paraphrased to adapt the material based on NPPs to the YMP facilities. Additional information is available in the ATHEANA documentation (Ref. E8.1.14). Further discussion on information collection and use of expert judgment in this process can be found in Section E4.

HFE probabilities produced in this analysis are mean values. The HEPs are modeled as a lognormal distribution, where the error factors are defined based on the method presented in Section E3.4.

E3.2.1 Step 1: Define the Scope of the Analysis

The objective of the YMP HRA is to provide a comprehensive quantitative assessment of the HFEs that can contribute to the facility's event sequences resulting in radiological release, criticality, or direct exposure. Any aspects of the work that provide a basis for bounding the analysis are identified in this step. In the case of the YMP, the scope is bounded by the design state of the facilities and equipment.

E3.2.2 Step 2: Describe Base Case Scenarios

In this step, the base case scenarios are defined and characterized for the operations being evaluated. In general, there is one base case scenario for each operation included in the model. The base case scenario:

- Represents the most realistic description of expected facility, equipment, and operator behavior for the selected operation.
- Provides a basis from which to identify and define deviations from such expectations (Step 6).

In the ideal situation (which is seldom achieved), the base case scenario:

- Has a consensus operator model[1]
- Is well-defined operationally
- Has well-defined physics
- Is well-documented in public or proprietary references
- Is realistic.

Since operators and "as built, as operated" information are not currently available for YMP, this information is sought from comparable facilities with comparable operations. Documented reference analyses (e.g., engineering analyses) can assist in defining the scenario from the standpoint of physics and operations. The reference analyses may need to be modified to be more realistic. Expert judgment, engineering documents and applicable industry experience are the keys to defining realistic base case scenarios for YMP operations; Section E4 provides greater detail on how information was collected and the role of subject matter experts in this process.

E3.2.3 Step 3: Identify and Define HFEs of Concern

Possible HFEs and/or unsafe actions (i.e., actions inappropriately taken, or actions not taken when needed) that result in a degraded state are generally identified and defined in this step. After HFEs are identified they must be classified to support subsequent steps in the process. The classification process is described further in Section E5.1.1. The analyses performed in later steps (i.e., Steps 4 through 7) may identify the need to define an HFE or unsafe action not previously identified in Step 3.

Human errors were identified based upon the three temporal parts generally analyzed by probabilistic risk assessment (PRA) and are categorized as follows:

- Pre-initiator HFEs
- Human-induced initiator HFEs

[1]ATHEANA NUREG-1624 (Ref. E8.1.14, Section 9.3.1) defines a consensus operator model in the following manner: "Operators develop mental models of plant responses to various PRA initiating events through training and experience. If a scenario is well defined and consistently understood among all operators (i.e., there is a consensus among the operators), then there is a consensus operator model."

- Post-initiator HFEs[2]:
  - Non-recovery
  - Recovery.

Each of these types of HFEs is defined in Section E5.1.1.1; identification of the HFEs for each temporal phase is described in the following sections.

The result of this identification process is a list of HFEs and a description of each HFE scenario, including system and equipment conditions and any resident or triggered human factor concerns (e.g., PSFs). This combination of conditions and human factor concerns then becomes the EFC for a specific HFE. Additions to and refinements of these initial EFCs are made during the preliminary and detailed analyses.

E3.2.3.1 Identifying Pre-initiator HFEs

Pre-initiators are identified by the system analysts when modeling fault trees, while performing the system analysis task. Special attention is paid to the possibility that an error can be repeated in similar redundant components or trains, leading to a human common-cause failure.

E3.2.3.2 Identifying Human-Induced Initiator HFEs

Human-induced initiator HFEs are identified through an iterative process whereby the human reliability analysts, in conjunction with other PCSA analysts and engineering and operations personnel, meet and discuss the design and operations of the facility and SSCs in order to appropriately model the human interface. This iterative process begins with the HAZOP evaluation and MLD development, described and documented in *Subsurface Operations Event Sequence Development Analysis* (Ref. E8.1.6), followed by a second iteration during the initial fault tree and event tree modeling, and ending with a third iteration through the preliminary analysis and incorporation of HFEs into the model. Included in this process is an extensive information collection process where industry data was reviewed (Section E4.1) and subject matter experts were interviewed (Section E4.2) to identify potential vulnerabilities and HFE scenarios. HFEs identified include both EOOs and EOCs.

E3.2.3.3 Identifying Non-recovery Post-initiator HFEs

Non-recovery post-initiator HFEs are identified by examining the human contribution to pivotal events in the event tree analysis. The event sequence analysts, with support from the human reliability analysts, identify HFEs that represent the operator's failure to perform the proper action to mitigate the initiating event and/or the unavailability of automatic mitigation functions as called for in the emergency operating procedures or in accordance with their emergency response training. This identification includes all actions required, whether in a control room or locally. Post-initiator EOCs and EOOs are also considered. It should be emphasized that this section presents the methodology that is used to identify non-recovery post-initiator events. However, as shown in Section E6, none of these types of errors have been identified for the

[2]Terminology common to NPPs refer to non-recovery post-initiator events as Type C events and recovery events as Type CR events.

subsurface operations event sequence and categorization analysis. During the qualitative evaluation, non-recovery post-initiator events were considered and ruled out because it was unnecessary to credit non-recovery actions to demonstrate compliance with the performance objectives stated in 10 CFR 63.111 (Ref. E8.2.1).

E3.2.3.4 Identifying Recovery Post-initiator HFEs

Recovery actions are of limited relevance to YMP operations and, for conservatism, were not credited in this analysis. Recovery post-initiator HFEs are outside the scope of this analysis (Section E2.1).

E3.2.4 Step 4: Perform Preliminary Analysis and Identify HFEs for Detailed Analysis

The preliminary analysis is a type of screening analysis used to identify HFEs of concern. A screening analysis is commonly performed in HRA to conserve resources and focus the effort on the subsequent detailed analysis of those HFEs that are involved in the important event sequences. Preliminary values are assigned for the probabilities of HFEs based upon predetermined characteristics of each HFE. This analysis involves the following steps:

- Verification of the validity of HFEs included in the initial PCSA model
- Assignment of conservative preliminary values to all HFEs included in the initial PCSA model
- Verification of assigned preliminary probabilities to all HFEs in the PCSA
- Quantification of the initial PCSA model using preliminary values (i.e., the "initial quantification")
- Identification of HFEs for detailed analysis.

The human reliability analyst performs the first three of these steps with the assistance of the PCSA quantification task leader, who also performs the last two steps. While most of the activities associated with this preliminary analysis are tedious and time-consuming, it is important to perform these tasks conscientiously since the results of the initial quantification are used to identify those HFEs requiring detailed analysis.

Analysts must strike a balance between conservatism and too much conservatism. Using too conservative a value for an HEP can overemphasize the importance of an HFE in the sequence quantification, perhaps masking a significant component failure event. By contrast, using a less conservative preliminary HEP may lead to inappropriately screening out a potentially significant event sequence. Instead of the usual screening process used in PRA, where relatively high screening values of 1.0 or 0.1 for an HEP are often inserted in initial fault tree and event sequence quantification, the PCSA applies an intermediate process where conservative preliminary values are assigned based on the context and failure modes of the HFE. Appendix E.III of this analysis provides specific details on guidelines for preliminary quantification.

Depending on the results obtained with the preliminary quantification, the event sequence and human reliability analysts may conclude that the preliminary results are sufficient for event sequence quantification and that a detailed analysis would not provide a better basis for event sequence categorization or more insights into the human factors issue for a particular waste handling operation. The preliminary quantification process is based on a characterization of each human action with respect to complexity and operational context using a judgment-based approach consisting of the following subtasks:

1. Complete the "lead-in" initial conditions required for quantification.

2. Identify the key or driving factors of the scenario context.

3. Generalize the context by matching it with generic, contextually anchored rankings or ratings.

4. Discuss and justify the judgments made in subtask 3.

5. Refine HFEs, associated contexts, and assigned HEPs.

6. Determine final preliminary HEPs for each HFE and associated context. These HEPs are then entered into the PRA logic structure to see which HFEs call for more detailed evaluation. HFEs are identified for a detailed analysis if (1) the HFE is a risk-driver for a given sequence, and (2) using the preliminary values, that sequence falls in a category (i.e., a Category 1 or Category 2) such that it does not meet 10 CFR 63.111 performance objectives (Ref. E8.2.1).

Appendix E.III of this analysis defines and provides technical bases for the HEP preliminary values recommended to be used in the YMP PRA for different categories of HFEs, depending on the general HFE characteristics. Section E4.2 provides a list of experts used in this process.

E3.2.5 Step 5: Identify Potential Vulnerabilities

This information collection step defines the context for Step 6 in which scenarios that deviate from the base case are identified. In particular, analysts search for potential vulnerabilities in the operators' knowledge and information base for the initiating event or base case scenario(s) under study that might result in the HFEs and/or unsafe actions identified in Step 4. Potential traps[3] inherent in the ways operators may respond to the initiating event or base case scenario are identified through the following:

- Investigation of potential vulnerabilities in operator expectations for the scenario

- Understanding of the base case scenario time line and any inherent difficulties associated with the required response

[3] A "trap" is a human failure that is encouraged or enabled by the existence of a specific vulnerability. That is, vulnerabilities influence operators to fall into particular traps.

- Identification of operator action tendencies and informal rules
- Evaluation of formal rules and operating procedures expected to be used in the scenario.

The knowledge and information base is taken in the context of the specific HFE being evaluated. It includes not only the internal state of knowledge of the operator (i.e., what the operator inherently knows), but also the state of the information provided (e.g., available instrumentation, plant equipment status). Section E4 provides a description of the information types that comprise this knowledge base.

E3.2.6 Step 6: Search for HFE Scenarios

In this step, the analyst must identify deviations from the base case scenario that are likely to result in risk-significant unsafe action(s). These deviations are referred to as HFE scenarios. In serious accidents, these HFE scenarios are usually combinations of various types of unexpected conditions (which form the EFC).

The principal method for identifying HFE scenarios is a HAZOP evaluation-like search scheme, coupled with a means for relating scenario characteristics with error mechanisms for each stage in the information processing model (Ref. E8.1.1). The result of such a search is a description of the HFE scenarios, including system and equipment conditions, along with any resident or triggered human factor concerns (e.g., PSFs). Again, this combination of conditions and human factor concerns then becomes the EFC for a specific HFE. As defined by the ATHEANA document (Ref. E8.1.14), an EFC is the situation that arises when particular combinations of PSFs and plant conditions create an environment in which unsafe actions are more likely to occur. (Additions and refinements to this initial EFC are likely in later steps of the process.)

E3.2.7 Step 7: Quantify Probabilities of HFEs

As shown in Section E6, no HFEs requiring detailed analysis have been identified for subsurface operations event sequence and categorization analysis. Therefore, only a general summary of the methodology associated with detailed quantification is presented in this section.

Detailed HRA quantification is performed for those HFEs that appear in dominant cut sets for event sequences that do not comply with the 10 CFR 63.111 performance objectives (Ref. E8.2.1) after initial fault tree or event sequence quantification. The goal of the detailed analysis is to determine whether or not the preliminary HFE quantification is too conservative such that event sequences can be brought into compliance by a more realistic HRA. However, the detailed analysis may result in a requirement for additional design features or specification of a procedural control (Step 9, Section E3.2.9) that reduces the likelihood of a given HFE in order to achieve compliance with 10 CFR 63.111 (Ref. E8.2.1). The qualitative analysis in steps 3, 5, and 6 sets the stage for the detailed quantification by providing the accident progression(s) for a given HFE and its context. Specifically, the qualitative analysis provides a list of unsafe actions, along with their context, characteristics, and classification (i.e., EOO or EOC). For each unsafe action, the following steps are performed:

1. Qualitative analysis (e.g., identification of PSFs, definitions of important characteristics of the given unsafe action, assessment of dependencies)

2. Selection of a quantification model

3. Quantification

4. Verification that HFE probabilities are appropriately updated in the PCSA database.

There are four HRA methods that have been selected for this quantification:

1. Cognitive Reliability and Error Analysis Method (CREAM) (Basic and Extended) (Ref. E8.1.12)[4]

2. Human Error Assessment and Reduction Technique (HEART) (Ref. E8.1.19) and Nuclear Action Reliability Assessment (NARA) (Ref. E8.1.7)

3. Technique for Human Error Rate Prediction (THERP) (with some modifications) (Ref. E8.1.18).

When an applicable failure mode cannot be reasonably found in one of the above methods, then the following HRA method is used:

4. ATHEANA's expert elicitation approach (Ref. E8.1.14).

Appendix E.IV of this analysis provides a discussion why these specific methods were selected for quantification, as well as a discussion of why some methods, deemed appropriate for HRA of NPPs, are not suitable for application in the PCSA. This discussion summarizes the main differences between NPPs and repository operations with respect to contexts and failure modes that affect potential HFEs. It also gives some background about when a given method is applicable based on the focus and characteristic of the method.

E3.2.8 Step 8: Incorporate HFEs into PCSA

After HFEs are identified, defined, and quantified, they must be incorporated into the PCSA. Section 10.3 of NUREG-1624 (Ref. E8.1.14) provides an overview of the state-of-the-art method for performing this step in PRAs. This process is done in conjunction with the PCSA analysts. Appendix E.I of this analysis provides the recommended approach for incorporation of human errors in the YMP PCSA, and Appendix E.V of this analysis provides the recommended naming conventions for HFEs incorporated in the fault tree models.

HFEs are incorporated, in the form of basic events, into the fault trees that support the initiating event and pivotal events of event trees. The HEP that is entered in a basic event is modeled as a lognormal distribution, whose mean value is the nominal value of the HEP, to which an error factor is assigned (Section E3.4) to reflect the uncertainty in the probability estimate. In many

[4]Extended CREAM (Ref. E8.1.12) creates a link between CREAM and HEART (Ref. E8.1.19), and enhances the ability of CREAM to quantify skill-based HFEs.

cases, the equipment failures and the associated HFEs are calculated as part of an integrated HRA. The resulting probability of both equipment and human failures is then placed in the fault tree as a single basic event.

E3.2.9 Step 9: Evaluation of HRA/PCSA Results and Iteration with Design

This last step in HRA is performed each time the PCSA is quantified. The primary results are the HFEs in dominant cut sets and the associated qualitative inputs to such HFEs. Potential "fixes" to the design or operational environment can be supported by these results.

Because the YMP design and operations were still evolving during the course of this analysis, they could be changed in response to this analysis. This iteration is particularly necessary when an event sequence is noncompliant with the performance objectives of 10 CFR 63.111 (Ref. E8.2.1) because the probability of a given HFE dominates the probability of the event sequence. In those cases, a design feature or procedural safety control could be added to reduce the probability or to completely eliminate the HFE. In such cases, the modification is analyzed for potential new HFEs, and the applicable HFEs are requantified, along with the event sequences.

E3.3 DEPENDENCY

Dependency between human actions is defined to exist when the outcome of a particular human action is related to the outcome of a prior human action or actions. According to THERP (Ref. E8.1.18), the joint probability of human error for a set of dependent human actions is higher than if they were independent.

The possibility of dependencies between human actions and defined HFEs is recognized throughout the HRA task. The concern with respect to dependencies is that the joint probabilities separately assigned to a set of dependent HFEs treated as independent actions can result in a lower event sequence frequency than would result if dependencies among the HFEs were appropriately recognized and treated. This situation is especially important in the HRA activities leading up to and including preliminary analysis where an inappropriately low HEP might lead to an inappropriate screening out of a potentially significant cut set or event sequence. If dependence were properly identified and treated, the resulting HEP might then appear in dominant cut sets and, therefore, be identified for detailed analysis.

E3.3.1 Capturing Dependency

Dependencies between defined HFEs can exist for two reasons:

- Due to the characteristics of the event sequence in which the HFEs are modeled
- Due to the modeling style, especially the degree of decomposition, in HFE definition.

In the first case, dependencies are unavoidable due to the inherent characteristics of the initiator type or event sequence. In the second case, dependencies can be avoided by redefining dependent HFEs into a single HFE. In either case, dependencies can be treated by using a structured method for adjusting probabilities to account for dependencies. However, some HRA quantification methods (e.g., ATHEANA (Ref. E8.1.14)) account for certain types of dependencies within their formulation by combining dependent events as part of the normal process of addressing the accident scenario as a whole. These methods do not require additional treatment.

All event sequences that contain multiple HFEs are examined for possible dependencies. If practical, HFEs that are completely dependent may be redefined and modeled as a single event.

For the preliminary analysis, HFEs are modeled at a high level where several subtasks are combined into a single task so that explicit consideration of dependencies between subtasks is eliminated. For a detailed assessment, where the various actions that constitute an HFE are explicitly quantified, dependencies are explicitly addressed using the formulae in Table E3.3-1 from THERP (Ref. E8.1.18), where N is the independently derived HEP. The THERP dependency model was selected for its formalism and reproducibility. The model itself is not dependent on what the source of the baseline (i.e., independent) HEP is; it can be obtained from any existing model or from expert elicitation. None of the other "objective" quantification approaches used (i.e., HEART (Ref. E8.1.19)/NARA (Ref. E8.1.7) or CREAM (Basic and Extended) (Ref. E8.1.12)) has its own dependency model, and NARA (Ref. E8.1.7) specifically endorses the use of the THERP (Ref. E8.1.18) approach.

Table E3.3-1. Formulae for Addressing HFE Dependencies

Level of Dependence	Zero	Low	Medium	High	Complete
Conditional probability	N	$\frac{1+19N}{20}$	$\frac{1+6N}{7}$	$\frac{1+N}{2}$	1.0

Source: Modified from Ref. E8.1.18, Table 20-17, p. 20-33

E3.3.2 Sources of Dependency

The determination of the level of dependence between HFEs is left to the judgment of the HRA analyst. Certain factors typically are recognized as indicators of dependency. Examples of such factors are:

- Common time constraints for task performance
- Common cues or indicators for task performance
- Common diagnosis of situation
- Common facility function or system operation involved in task performance
- Common procedure steps for task performance
- Common personnel and location for task performance
- Common PSFs.

In addition, any human-induced failures of equipment that can directly or indirectly cause other equipment to fail through equipment dependencies are also identified as human dependencies.

E3.4 UNCERTAINTY

As with the values of failure probabilities used for active and passive components used in other parts of the PCSA, it is important that HFE quantification accounts for uncertainty. The HRA quantification, therefore, provides a mean HEP and an expression of the uncertainty. There are a number of ways to approach this task, as each of the HRA methods discussed in Section E3.2.7.2 provides recommendations on uncertainty parameters or bounds for HEPs. These recommendations run from the specific to the general and are often inconsistent. After a review of various recommendations, the HRA team has determined that to use any of them in their specific applications is both impractical and questionable. Rather, it was decided to develop a simple set of generic error factors developed through the use of the judgment by the HRA team, based on a holistic overview of the various recommendations presented in the following sources:

- Section 6 of NARA (Ref. E8.1.7)
- HEART (Ref. E8.1.19)
- Chapter 9 of CREAM (Ref. E8.1.12)
- Chapter 20 of THERP (Ref. E8.1.18).

Although ATHEANA (Ref. E8.1.14) does not provide specific recommendations regarding uncertainty estimation, it stresses that it is important to consider uncertainty in HRAs and that one way to approach it is through the use of expert judgment. To this extent, it can be said that the approach follows the guidance established in ATHEANA.

After review and due consideration of the uncertainty recommendations, the HRA team determined that for the purposes of this study it would be both reasonable and acceptable to establish a generic set of uncertainty parameters based on the calculated (total) HEP for any given HFE. The HRA team reached a consensus on the following error factor values to be applied to a lognormal distribution based on the mean HEP, as shown in Table E3.4-1. For each HEP range, the error factor reflects the HRA team's degree of confidence in the probability estimate.

Table E3.4-1. Lognormal Error Factor Values

Calculated Mean HEP	Lognormal Error Factor
≥ 0.05	3
>0.0005–<0.05	5
≤0.0005	10

NOTE: HEP = human error probability.

Source: Original

The same error factors are applied to both preliminary values and results of detailed HRAs. Therefore, after the HRA team has decided on an appropriate mean value, the corresponding generic error factor is assigned unless there is a basis from the detailed analysis to do otherwise.

E3.5 DOCUMENTATION OF RESULTS

The following information is included in the documentation of the results for the YMP PCSA HRA:

- General discussion of the overall set of PSFs (e.g., error-producing conditions, common performance condition) on human performance that are applicable to or especially important for the YMP PCSA and how they apply to the operations of the facility in question.

- A list of all HFEs (by basic event name and category, along with a brief description of the HFE) included in the PCSA model, with their final assigned HFE probabilities.
- Identification of preliminary values used for these HFEs.
- Identification of all expected pertinent procedures or, if no procedures are expected to exist, alternative evidence that supports the identification and quantification of HFEs and recoveries or substantiates the likelihood of human actions (e.g., normal operating practices, formal training).
- References to sources of input information (e.g., thermal-hydraulic calculations) used in detailed quantification.
- Results of qualitative and preliminary analysis.

The following information is generally included in the documentation of the results for the YMP PCSA HRA, but it is not applicable to the subsurface operations HRA:

- Identification of the HFEs analyzed in detail.
- A more detailed description of each HFE analyzed in detail.
- For each HFE analyzed in detail, identification of the quantification method, associated input parameters (e.g., PSFs), and any approximations or required procedural controls used to determine probabilities for that HFE.
- Results of detailed quantitative analysis.

E4 INFORMATION COLLECTION AND USE OF EXPERT JUDGMENT

This section addresses how and what information was collected to support the HRA analysis and how expert judgment was used in the identification and quantification of HFEs.

E4.1 FACILITY FAMILIARIZATION AND INFORMATION COLLECTION

E4.1.1 General Information Sources

As with all of the tasks in the PCSA, facility information is required to support the HRA steps. In addition to the information that is gathered to support the other modeling tasks (e.g., initiating events, systems), the analysts obtain specific additional information that is needed to support the HRA task.

Since the YMP is in the design phase, there are limits on facility-specific information available to support the HRA. Sources utilized in this analysis include the following:

- Design drawings and design studies
- Concept of operations documents
- Engineering calculations
- Discussions of event sequences with knowledgeable individuals
- Event trees and supporting documentation
- Fault trees and supporting documentation.

Information from similar facilities is used, including NPPs (particularly those with ISFSIs), chemical agent disposal facilities, and any other facilities whose primary function includes handling and disposal of very large containers of hazardous material. This was conducted primarily for ISFSI activities at NPPs. The use of this information in place of YMP plant-specific information is pursuant to the third analytical boundary condition specified in Section E2.2. Following are sources of information from ISFSI that are applied to support the YMP PCSA:

- Interviews with plant operators, operations personnel, and/or other ISFSI knowledgeable personnel.

- Pertinent ISFSI procedures (e.g., operating procedures, test and maintenance procedures).

- Plant walk-downs (e.g., at locations where operations similar to those at repository may be performed) and operations reviews.

- Studies, including PRAs and HRAs, conducted at these facilities that would substitute for the previously mentioned sources.

This information was acquired from two sources. First, information was obtained by the HRA team from outside sources specifically for use on the YMP, such as from NPPs, industry organizations, and governmental sources. Some of this information may have been obtained directly by the HRA team or may have been provided to the HRA team by members of the Licensing and Nuclear Safety, Engineering, or Operations departments who had obtained the information as a part of their regular duties on the YMP (Section E4.2.2). Second, information was obtained by the HRA team directly from internal sources, including members of the aforementioned departments who had past experience and information on ISFSIs from prior employment and projects before joining the YMP (Section E4.2.1).

Initially, information is gathered to support the identification of pre-initiator, human-induced initiator, and non-recovery post-initiator HFEs. This information is needed to:

- Identify test and maintenance activities performed for equipment included in the PCSA model

- Determine the frequency of test and maintenance activities

- Identify the procedures used to perform test and maintenance activities