

Human Factors in Urban Water System Safety: Humans and Technology

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The Urban Water Security Research Alliance (UWSRA) is a \$50 million partnership over five years between the Queensland Government, CSIRO's Water for a Healthy Country Flagship, Griffith University and The University of Queensland. The Alliance has been formed to address South East Queensland's emerging urban water issues with a focus on water security and recycling. The program will bring new research capacity to South East Queensland tailored to tackling existing and anticipated future issues to inform the implementation of the Water Strategy.

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FOREWORD

Water is fundamental to our quality of life, to economic growth and to the environment. With its booming economy and growing population, Australia's South East Queensland (SEQ) region faces increasing pressure on its water resources. These pressures are compounded by the impact of climate variability and accelerating climate change.

The Urban Water Security Research Alliance, through targeted, multidisciplinary research initiatives, has been formed to address the region's emerging urban water issues.

As the largest regionally focused urban water research program in Australia, the Alliance is focused on water security and recycling, but will align research where appropriate with other water research programs such as those of other SEQ water agencies, CSIRO's Water for a Healthy Country National Research Flagship, Water Quality Research Australia, eWater CRC and the Water Services Association of Australia (WSAA).

The Alliance is a partnership between the Queensland Government, CSIRO's Water for a Healthy Country National Research Flagship, The University of Queensland and Griffith University. It brings new research capacity to SEQ, tailored to tackling existing and anticipated future risks, assumptions and uncertainties facing water supply strategy. It is a \$50 million partnership over five years.

Alliance research is examining fundamental issues necessary to deliver the region's water needs, including:

- ensuring the reliability and safety of recycled water systems.
- advising on infrastructure and technology for the recycling of wastewater and stormwater.
- building scientific knowledge into the management of health and safety risks in the water supply system.
- increasing community confidence in the future of water supply.

This report is part of a series summarising the output from the Urban Water Security Research Alliance. All reports and additional information about the Alliance can be found at <http://www.urbanwateralliance.org.au/about.html>.



Chris Davis

Chair, Urban Water Security Research Alliance

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EXECUTIVE SUMMARY

1. The first phase of this project, completed in June 2011, was a basic overview of human factor issues in the area. Recommendations stemming from this preliminary phase were that Stage 2 should focus on interactions between humans and technology, especially in the context of changing roles, responsibilities and asset ownership in the sector. Due to funding and time constraints, the focus of the research was restricted to two operational water grid entities – bulk water distribution and advanced water treatment. These focus areas were selected because they represented the greatest disparity in operational activities, age and quality of infrastructure, and geographical extent/containment of control networks.
2. Our work focused on control room operations, especially operator interfaces and alarms. Adopting a user-focused approach, we evaluated Supervisory Control and Data Acquisition (SCADA) system interfaces and alarms. Best-practice evaluation tools were used for Human Factors auditing, including the 2007 Engineering Equipment and Material Users' Association guidelines. In addition, naturalistic observations of control room practices were conducted, as well as extensive interviews and technical discussions with operators. Human Error classification and prediction tools, including a short-form Cognitive Task Analysis, were applied to a routine control room activity at the bulk water distribution facility.
3. The recent amalgamation of water grid assets resulted in the bulk water distribution entity inheriting five geographically independent, non-integrated SCADA systems, one of which was running on a different software platform to the rest. This created compatibility and consistency issues, particularly with regard to interface design, and system functionality to a lesser extent. Alarm system performance in four of the SCADA systems was considerably below industry benchmarks for system stability, and alarm flooding was common during system upsets and incidents. Interface design did not effectively support operators in simple routine tasks, and mechanisms for activity and incident logging were inefficient or absent.
4. At the time of data collection, the bulk water distribution entity had put out a tender for the commissioning of a unitary, fully-integrated SCADA system and control room upgrade. The operational issues described above are being progressively addressed with upgraded control room facilities. The commissioning of a new, integrated, state-of-the-art SCADA system will further enhance the monitoring of the bulk water network.
5. The Advanced Water Treatment Plant represents state-of-the-art water recycling and treatment technology and provided an interesting analytical contrast. The plant was commissioned relatively recently and considerable efforts have been put into the development of a stable, rational SCADA interface and a sophisticated alarm management protocol. Operators reported a high degree of satisfaction with the control room facilities during normal operation and plant upsets, and alarm flooding was not reported to occur. However, operators reported some dissatisfaction with the remote alerting system for when the plant is not staffed, and the system fell short of the best-achievable industry benchmark because alarm documentation was not electronically integrated.
6. This project has provided an encouraging initial assessment, but it is recognised that an ongoing process is required to optimise the way in which workers interact with broader system components, especially in times of rapid change in the industry. Further task analyses, participatory designs, application of human factors expertise, and iterative testing are needed.
7. Recommendations for future research topics include processes and procedures for abnormal situations, and reviews of previous accidents and incidents using retrospective task analysis methodologies. As found in other industries that have embraced an HF-style approach, research of this nature can help to better integrate people and technologies, and improve the robustness and error tolerance of the sociotechnical system. In the long term, what is needed is for the water industry to adopt a user-centred approach and to view the human element in the system as an integral part of ensuring safety, reliability and efficiency.

1. INTRODUCTION

1.1. The Need for Human Factors Research in Drinking Water Treatment and Delivery

The human element in complex socio-technical systems has gained increasingly greater importance in the study and application of risk and safety management (Horberry, Burgess-Limerick and Steiner (2010). In recent decades, attribution of incidents and accidents to human and organisational error has been steadily increasing, which can be explained by two aspects of technological advances: 1) increases in the reliability of mechanical, electrical and information-processing components of systems; and 2) system complexity, and the often poorly-defined role of the human operator in the control loop.

Contemporary thinking in human factors and related disciplines characterises human error as a consequence, rather than a cause, of system failures (c.f. Reason, 1990). Detailed analyses of industrial accidents with human error contributions show that it is always the case that multiple safety barriers at organisational, technical and operational levels are breached before fragments of aberrant human behaviour – labelled as ‘error’ – can take place. As such, many industries now recognise the need to integrate human factors research and principles into their overall risk management schemes. In systems responsible for the provision of drinking water, this recognition is in the earliest stages, and with the exception of one recent review article (Wu *et al.*, 2009), human element risks in water treatment and delivery have received scant attention in the academic literature. This is surprising given the similarities to other high-reliability industries, several of which contributed to the early development of human factors as an academic discipline. Given the potentially serious nature of incidents and accidents involving water treatment and distribution infrastructure, including threats to public health and large-scale destruction of property, the sector should be playing more of an active role in understanding and managing human element risks.

1.2. Understanding of Human Element Risks in the Water Sector

Recognition is growing among various stakeholders that water treatment and supply systems in first-world countries like Australia are not immune to large-scale disease outbreaks. The case of *E. coli* contamination in Walkerton, Ontario is the most widely publicised and discussed example of a disease outbreak in a developed country (see Hrudey and Hrudey, 2003; 2004; Vicente and Christoffersen, 2003 and Woo and Vicente, 2003, for extensive commentary), and also an excellent demonstration of how factors across a broad range of stakeholders interact to result in a public health disaster, not just the presence of demonstrably incompetent and devious human behaviour. Nor is the water sector unsusceptible to industrial accidents, which can have equally troubling implications for public health and safety.

For example, a detailed investigation into a recent incident in South East Queensland (SEQ) implicated several instances of human error as contributory factors (Pascoe, 2009). This was one of the incidents that alerted regulators to potential shortcomings in the management of human element risks. In early 2009, 400 kL of treated drinking water was accidentally dosed with a concentrated fluoride solution in a large SEQ water treatment facility, in which fluoridation equipment had recently been installed. The treatment plant in question was offline for maintenance, but due to a combination of technical malfunctions and maintenance activities, the fluoride dosing equipment continued to function, resulting in a high concentration of fluoride in the treated water. This water was then delivered to a small residential area surrounding the treatment plant. A fluoride alarm was triggered in the early stages of the incident and was acknowledged by an on-duty operator at a different treatment plant. However, this was not acted upon because the operator knew that the plant was not operational and had been issuing a number of spurious fluoride alarms in the days prior. An operator at the affected treatment plant also recorded very high consumption of dry fluoride powder in the daily operating log, but despite the plant being offline, did not initiate an investigation into the irregularity.

The investigation report demonstrated due recognition of the complex and multi-causal nature of the incident, which is consistent with contemporary understanding of human error (Reason, 1990; Simpson *et al.*, 2009). However, a stance the water sector should be anxious to avoid is to implicitly assume that technological components of complex systems – in particular supervisory control systems – always provide sufficient, meaningful and credible information to the operators. Clearly in the case of the incident described above, they do not. Alarms, for instance, can be particularly problematic, by being unreliable, too numerous, incorrectly prioritised, and uninformative, i.e., unaccompanied by information about what the triggers of the alarm are, and the steps the operator needs to take to rectify the situation. It is also the case that new infrastructure is not always well integrated into existing plants, which, in the case of the incident just described, was partially the result of procurement, installation and operator training decisions being made to a pressing deadline.

The corollary to the assumption that technological systems work ‘as intended’ is that redemptive actions – following a near-miss, incident or accident – are likely to be limited to reactive measures, a common candidate of which is additional training. Without proper consideration of human element risks, actions like additional training do not address deeper systemic issues (Simpson *et al.*, 2009).

1.3. Impetus for this Research Project

In 2007, an extensive period of drought saw SEQ bulk water storage fall to 17% of capacity. The state government’s response to the water supply crisis was aggressive and rapidly implemented, including the creation of a new statutory authority and business model, introduction of new large assets (advanced water recycling and desalination plants), and a combination of more stringent demand-side measures (restrictions on business and residential water use) and demand reduction incentives (water tank rebates) (Head, 2010). Around the same time, automatic fluoride dosing equipment had been installed at all major water treatment plants to meet separate state government policy commitments for dental health.

This research project had its beginnings in stakeholder responses to the rapid and sweeping changes the sector had experienced in response to extended drought conditions. In the view of some interested parties, the maxim that ‘change precedes trouble’ (Hrudey and Hrudey, 2004) rang true with the occurrence of two well-publicised incidents within a relatively short period, both of which implicated human failings in the operation of new water infrastructure.

This project was conceived in two stages, with the first stage as an exploratory exercise and fact-finding mission. Insights generated in Stage 1 determined the scope and detailed focus areas for this Stage 2 report, which focuses on control room operations in major water grid entities.

1.3.1. Stage 1 Findings

A period of pilot work (Cloete, Horberry and Head, 2011), involving analysis of recent incidents, confidential interviews with various water industry participants, and inspection of major assets, aimed to identify avenues for human error potential, and how a human factors framework could offer opportunities for improvement.

Vulnerabilities at all levels of participation in the sector were revealed. At higher levels, a pressing concern expressed by most informants was communication, both within and between water grid entities. The perception among interviewees was that this deficiency in communication stemmed from rapid organisational change, namely, the creation of new roles and shifts in responsibility for strategic and operational decision-making, which created an environment of relatively low trust and left many in the sector unsure of the limits of their authority. Closer to the coal face, concerns were expressed over the size of the SEQ Water Grid, the potential redundancy of many smaller-capacity water treatment plants, and the post-amalgamation position of considering the decommission or integration of assets, and the complexities of connecting grid assets to an integrated distributed control system, or, at the very least, facilitating communication between independent control systems.

Brief analyses of two recent incidents in the SEQ Water Grid were also conducted. A series of incidents involving cross-connections in residential dual-reticulation systems was briefly summarised, but could not be explored in detail because the incidents are the subject of a class action. The fluoride dosing incident described in section 2.2 was recast in the risk management framework used by Vicente and Christoffersen (2006) to characterise the 2000 Walkerton disaster. Several parallels between the two incidents could be drawn, most notably a range of latent influences. These ranged from pressure from the State Government for the rapid procurement and installation of fluoride dosing equipment, right down to the lack of an effective tagging system for equipment maintenance.

The corporate and government-level complexities in the sector certainly stood out as issues which require resolution. However, the agreed focus for the remainder of this project fell to the issues at the 'sharp end' of interactions between humans and technology, which could be addressed within limited time and budget constraints, and for which the team's expertise was best suited.

2. PREVIOUS LITERATURE

2.1. Review of Previous Human Element Research in the Water Industry

Prior to the pilot work conducted by our group, the only published literature dealing exclusively with human factors in water (Wu *et al.*, 2009) was based on a broad survey of disease outbreaks in affluent countries, which had been previously conducted by one of the co-authors (Hrudey and Hrudey, 2004). The 2009 paper defined human error and human reliability in very broad terms, then identified human element contributions within a catalogue of incidents involving disease outbreaks over a thirty-year period. Wu *et al.* used a human error taxonomy derived from the Reason (1990) 'swiss cheese' model, categorised system failures along one of four dimensions, and determined the total contribution of each dimension to system failure. The four dimensions were:

1. Physical system failures and extreme environmental conditions:
 - a. Equipment failure.
 - b. Disease-carrying animals and animal waste.
 - c. Extreme weather.
2. Active errors:
 - a. Mistaken belief in the security of a water system.
 - b. Failure to recognise and/or to take adequate measures on warnings.
 - c. Sanitary violations.
 - d. Failure to follow recommendations.
3. Latent errors:
 - a. Design errors:
 - i. Lack of sufficient water safety barriers.
 - ii. Existing deficiencies in system.
 - iii. Raw water not isolated from animal waste.
 - b. Maintenance errors.
 - c. Operation errors.
 - d. Insufficiently qualified staff.
 - e. Inadequately trained operators.
 - f. Communication errors.
4. Influences from consumers and third parties:
 - a. Failure to inform new residents and visitors consuming untreated surface water.
 - b. Failure to report warning signals.
 - c. Failure to appreciate the risk of disease transmission.
 - d. Lack of cooperation, interaction or communication among various parties responsible for water safety.
 - e. Failure of regulator to implement policy.

All 61 cases had contributory influences from multiple dimensions. This reinforces the notion alluded to in the example of the fluoridation incident that errors do not occur in isolation. The distribution of active and latent error contributions were approximately equal at 38% and 37% respectively, with physical system failures (22%) and influences from consumers and third parties (3%) playing a much smaller role. This article (Wu *et al.*, 2009) is the first of its kind, and is an important step in publicising the role of human factors in drinking water contamination, especially in the context of broader system factors. However, the classification of some error classes is arguably erroneous (dimension 2a and 3c, for example) and very little information is provided as to how incidents are categorised along the four dimensions, and specific details for each case are only rudimentary in form.

2.1.1. Case Study: Analysis of the Walkerton Disaster

As noted in the Stage 1 report, possibly the most serious, widely publicised and well-studied drinking water contamination incident was the *E. coli* outbreak in Walkerton Ontario in May 2000. In a town of

5,000 residents, approximately half became ill as a result of ingesting contaminated water, and seven fatalities were attributed to the event. There was a likelihood of long-term health consequences, particularly for infected children. Residents in the town of Walkerton and across the province of Ontario developed a serious mistrust of the water delivery authorities, with doubts about the future security of the water system. The total economic cost of the incident was estimated at \$64.5m CAD, which included an expensive nine-month official investigation (O'Connor, 2002). Investigation of this case revealed a unique combination of ineffective regulatory oversight, incompetent leadership, extremely poor monitoring procedures, and even deliberate concealment of adverse monitoring results (Vicente and Christofferson, 2006).

Although the gross incompetence and deception on the part of employees of the Walkerton Public Utilities Commission (WPUC) were the most obvious and salient contributions to the disaster, the O'Connor (2002) investigation made it clear that the system was already vulnerable due to the presence of numerous latent errors. The actions of individuals served only as a trigger; there were profound deficiencies in the physical treatment infrastructure, which were present from the very time it was installed and which were known to the WPUC leadership and the regulatory authority charged with oversight. The shallowness of one of the wells made it vulnerable to contamination via runoff, and additional contamination pathways were evident in local geographical features of the well site. Another well was not even equipped with a chlorinator for disinfection, which demonstrated the dire ignorance and lack of training of the WPUC leadership. This was also reflected in the lax approach to routine monitoring, which involved serious breaches of reporting requirements; monitoring was sporadic at best, and operators were encouraged to fabricate monitoring results in the official records. The systemic culture of noncompliance was extreme, chronic, and seemingly invisible to the regulator. In sum, safety defences in the Walkerton supply grid were either absent or severely crippled by a deficient organisational culture and ineffective oversight, which allowed violations by operators and senior management to inevitably progress to a water contamination incident.

2.2. Lessons from Other Comparable Domains

There are many examples of sociotechnical systems similar in size and complexity to the water sector. However, it is difficult to find examples of industries charged with the control of similar hazards (e.g., pathogens), and occupying similar organisational and operational environments. Food manufacturing is an obvious candidate for a meaningful comparison in human factors terms. There are risk management frameworks engineered specifically for food production (e.g., HACCP); however, none explicitly address the impact and control of human element risks. An extensive literature search failed to identify empirical research specifically addressing human factors issues in this industry¹. It is therefore fitting to review approaches to human factors issues in other domains.

2.2.1. Human Factors in Process Control

Many parallels to water treatment and recycling can be found in process control studies, and control room environments have been the target of concerted research efforts. A full review is beyond the scope of this report, but a recent example in the domain of minerals processing (Li *et al.*, 2011) is worth highlighting, principally because of the considerable overlap with the present research in the methods used. These researchers demonstrated widespread shortcomings in the way control room environments accommodate operator requirements. Control strategies were typically reactive, operators mistrusted or ignored alarm systems, and generally did not utilise the technology available to them: operators often lacked the will or ability to engage in process optimisation. At the organisational level, decisions regarding operator training, task allocation and job design compounded problems at the operational level. Also, this study uncovered numerous deficiencies in the current information environment, which included poorly designed and integrated Human-Machine Interfaces and alarm systems.

¹ Examples were found of safety-focused interventions firmly rooted in the behaviourist tradition, but which ignores wider system factors and explicitly attributes accident causation to the actions of individuals.

2.3. Overview of Stage 2

Unfortunately, the January 2011 floods limited the capacity of SEQ's largest Water Grid entity (Seqwater) to contribute the human resources necessary for its participation in Stage 2. Participation was sought from the bulk water transport authority (Linkwater, referred to as BWTA hereafter), and from a newly-commissioned advanced water treatment plant (AWTP), owned by Seqwater but operated under license by Veolia Water.

The facilities were selected to represent the broadest range of technological sophistication and operational activities within the timeframe and budget available. On the one hand, the AWTP plant was commissioned and built relatively recently (2009-2010), it is highly automated and designed to run with minimal input from human operators, and it is largely self-contained with only one input and one output. At the other end of the spectrum, bulk water distribution relies on a complex network with major components 40-50 years old. It requires extensive manual operation, and there may be significant risks to public health and safety through incidents, accidents and water-borne disease. The differences in age, asset quality and public risk exposure therefore provided an interesting analytic context.

3. METHOD

A variety of human factors research methods were used. Under ideal circumstances, detailed cognitive task analyses using quantitative error rate prediction tools, appraisal and redesign of human-machine interfaces under a participatory ergonomics framework, and evaluation of new design concepts in a desktop simulation, would all have been undertaken. Constraints on budget, time and human resources of participating Water Grid entities meant that research activities were restricted to problem-specification tasks, including an appraisal of supervisory control and alarm systems using a best-practice audit tool, questionnaires and observations of work practices, and interviews with operators and management.

3.1. Scope

The agreed focus for Stage 2 found its most meaningful application in control rooms of treatment plants and other facilities, rather than in the field. Control rooms house the desktop interfaces for distributed control systems, and are where the majority of network operations in the grid are initiated and governed.

The key topics we addressed in our research activities were:

- Alarm systems
 - An operator's inappropriate response to a critical alarm was identified as a contributory factor in a recent industrial accident. A review and user-centred evaluation of alarm systems across the sector was therefore designated a priority research area.
- Elements of Human-Computer Interaction
 - Recent changes in the organisational structure and ownership of assets in the Water Grid precipitated, for some entities, a need to decommission aging or redundant plant equipment and upgrade existing facilities with newer, more sophisticated technology. The corollary to such changes is the modification, and in the case of the BWTA, a complete overhaul of supervisory control systems. By way of contrast, the newly-commissioned AWTP featured a state-of-the-art process control system, which was expected to deliver a more ergonomically sound working experience to control room operators.
- Extent of automation
 - Automation is a defining feature of modern process control systems, and if appropriately implemented, automation can remove tedious, time-consuming and error-prone tasks from the operator's workload. Rather than replacing humans, automation significantly changes the role they play in the system. If it is implemented without due consideration of human skills, abilities and limitations, it can lead to problems including mistrust, overreliance, compromises to situational awareness, and manual skill degradation. Modern process control systems are highly automated, but the bulk water transport network has a complex mixture of manual and automatic control points, which creates working conditions for control room operators which are substantively different to those of a typical process-control plant.

3.2. Tools

3.2.1. Operator Observations, Interviews and Questionnaires

A questionnaire assessing the operator's level of interaction with the SCADA system (particularly the alarm components) and perceptions of its effectiveness was adapted from the EEMUA and ASM Consortium guidelines (EEMUA, 2007). A checklist assessing the SCADA systems' conformity with ASM design requirements was adapted from similar guidelines and completed by the SCADA or Control Systems Engineer. Semi-structured interviews were held with operators and representatives

from management, including Service Delivery Managers, Network Managers and SCADA Systems Engineers.

In addition, naturalistic ‘fly-on-the-wall’ observations of operators at work in the control room environment were conducted. Non-intrusive observation coincided naturally with periods of higher operator workload, whilst in quieter periods (and with the operator’s consent) the experimenters asked questions and led discussions on human factors issues.

3.2.2. Short-form Cognitive Task Analysis using Modified HTA/SHERPA Methodology

At the water distribution facility, an Hierarchical Task Analysis (HTA) was conducted on reservoir flushing, which is a control room activity typically undertaken on multiple storage reservoirs several times a week. This task was selected for detailed analysis on the advice of management and operators. It is essential to the overarching goal of bulk water transport, because omission or incorrect execution could have potentially serious – although short-term – consequences for water supply. In addition to potential under-supply, overfilling reservoirs could lead to surrounding areas being affected by inundation, which carries implications for safety and equipment/property damage.

An HTA involves observing a task and documenting each step in a hierarchical manner. The analysis is organised according to the overall goal of the activity, and it is sequentially broken down into subgoals, individual tasks, and eventually to the level of low-level manual behaviours like key-presses (although such a high level of detail was not employed for the HTA reported in this document).

Human error prediction using the SHERPA (Systematic Human Error Rate Prediction Approach) human error taxonomy (Stanton, 2004) was undertaken at all nodes in the HTA framework. The SHERPA technique was selected for its strong theoretical grounding, efficiency and simplicity (Kirwan, 1998). It has the advantage of being a rigorously structured approach and, compared to other task analysis techniques, affords greater reliability and ease of interpretation. For the purposes of this analysis, the quantitative components of error rate prediction were not included²; instead, operators rated error likelihood on a discrete 5-point scale, with the ‘Observed’ category reserved for errors actually witnessed during the data collection activities. The error taxonomy and likelihood scale are presented in Table 1.

² Quantitative error rate prediction requires extensive periods of observation or the availability of relevant accident/incident data.

Table 1: SHERPA Error Taxonomy and Codes.

Action	Checking	Retrieval	Communication	Selection	Likelihood
A1 Operation too long/too short	C1 Check omitted	R1 Information not obtained	I1 Information not communicated	S1 Selection omitted	L1 Observed
A2 Operation mistimed	C2 Check incomplete	R2 Wrong information obtained	I2 Wrong information communicated	S2 Wrong selection made	L2 Reported as highly likely
A3 Operation in wrong direction	C3 Right check on wrong object	R3 Information retrieval incomplete	I3 Information communication incomplete		L3 Reported as likely
A4 Operation too little/much	C4 Wrong check on right object				L3 Reported as unlikely
A5 Misalign	C5 Check mistimed				L4 Reported as highly unlikely
A6 Right operation on wrong object	C6 Wrong check on wrong object				L5 Reported as impossible
A7 Wrong operation on right object					
A8 Operation omitted					
A9 Operation incomplete					
A10 Wrong operation on wrong object					

3.3. Procedure

Clearance to conduct the research was obtained from the University of Queensland Human Ethics Review Committee, in accordance with NHMRC guidelines for research with human participants. Introductory meetings were held with network and technical managers at the BWTA prior to commencing. Research activities for both Water Grid participants consisted primarily of site visits, during which the research team underwent safety inductions and were given an overview of the control network and site tour (AWTP only). Operators were then interviewed and asked to complete standardised questionnaire instruments. Extensive technical discussions were held, and demonstrations of work practices for the purposes of Cognitive Task Analysis (BWTA only) were conducted.

4. RESULTS

Similar data collection procedures were undertaken at both sites. Results from each site are presented separately, followed by a comparison of the sites' alarms systems against the 2007 EEMUA best-practice benchmarks.

4.1. Water Distribution

4.1.1. Control Room and Operator Observations

Operators were observed over five three-hour control room visits, which were conducted at various shift/roster combinations during standard business hours. The operator's duty can be summarised as ensuring efficient and safe bulk water supply to the SEQ Water Grid. This entails monitoring the system for abnormalities, performing routine transport operations, issuing instructions to third parties and other Water Grid participants, and coordinating a very active maintenance schedule. As such, duties vary considerably, especially when only one operator is on duty. Regardless of time-of-day, communication over the phone appeared to be a dominant activity, and operators were often observed manipulating the SCADA system and performing other tasks whilst talking on the phone. The unavailability of appropriate hands-free telephone headsets increased the apparent difficulty of working conditions, especially during multiple tasks.

Maintaining the operator log also stood out as a major component of the task-load, although it was not treated with the same priority as other duties. Operators frequently took notes by hand, which were later transcribed into the operator log. Distraction and interference by other personnel was frequently observed. Extensive documentation is stored in the control room, and site engineers and maintenance personnel made frequent use of the large wall-mounted screens (located directly in front of the operator consoles) for GIS-related activities. Figure 1 shows the BWTA control room.



Figure 1: The control room at the BWTA central office, showing two operator consoles with four monitors each, and two large wall-mounted LED screens.

4.1.2. Operator Experience Questionnaires and Interviews

From a workforce of seven operators, we interviewed four and obtained the consent of three to complete our questionnaire instruments. Unfortunately, the particularly small sample size did not allow us to quantitatively analyse questionnaire data, but did provide some insights that were consistent with observations and interviews. The segment of the questionnaire dealing with perceptions of the alarm system had been used previously in a survey spanning the chemical and power industries (Bransby and Jenkinson, 1998). In section 5.3 of this report, these findings are contrasted with responses of individual operators from both of the facilities we visited.

Responses to some questionnaire items were quite variable, which indicates that individuals may develop a unique operating style. This was reflected in some observations, particularly the idiosyncratic ways in which operators arrange their screens and manage the operator log. Operators were fairly consistent in their assessment of the alarm system, but again differed in their preferences for the way information in the SCADA system is displayed and manipulated.

4.1.2.1. Operator Log

Operators also reported numerous problems with the operator log; primarily that it was maintained in an Excel spreadsheet, which was burgeoning in size and processed on an ageing laptop. One operator claimed that the volume of log entries required and delays due to inadequate computing power accounted for up to 50% of their time in the control room, and this was confirmed with other operators in subsequent discussions. Given that the most trivial situations require multiple log entries, such as a cleaner or tradesperson requiring access to a secure facility, this is an issue of considerable concern. Operators also stated that they were uncertain as to what the operator log information was used for, which left them uncertain as to what information and level of detail to include. They were unanimous in their desire for improvements to information logging, and argued that this functionality would be best implemented at the level of discrete operations within the system, for instance, if a valve is opened or pump disabled, the system would log the date and time of the operation, which operator initiated it, and a brief description of why the operation was undertaken, e.g., isolation, maintenance, routine operation, etc. Information logging on-the-fly has the potential to improve the quality and reliability of the data collected, but would need to be designed with considerable input from users to ensure that it would not introduce a new set of usability issues.

4.1.2.2. Alarms

Two lines of alarm information are displayed at the bottom of each screen. A dedicated alarm screen is accessible by clicking, but most operators reported that they did not allocate an entire screen to this function full-time. Alarms are categorised according to priority, but alarm priority is not clearly distinguished in the system, and neither priority is signalled by an auditory alarm. Figure 2 shows a screen-shot of the alarm list. Note that the use of red text on a dark blue background is quite difficult to read.

assessing various aspects of display and alarm design and general control room ergonomics. Compliance was rated on only 13 of the 40 items by both respondents. Both SCADA platforms demonstrated relatively poor compliance with EEMUA best-practice guidelines, however, this finding takes second stage to the fact that different SCADA platforms are used in the same control room. Major deviations are detailed in Table 2.

Table 2: Deviations from EEMUA (2007) Best-Practice Guidelines.

Best-Practice Violation	Comments
Lack of integration of SCADA systems, use of different platforms and no integration to ArcGIS system.	The ArcGIS system contains highly detailed information concerning the type and locality of network components, such as manually-operated and automatic valves. Properly integrated to the SCADA system, it could serve as the basis for an ecologically valid way of depicting the distribution network, which would confer several benefits.
Lack of consistency in the use of colour, graphic design elements and schematics between the different SCADA software platforms.	In some instances, colours are used to convey diametrically opposite meanings (e.g., on/off). This is a plainly unacceptable situation.
No spatially/geographically organised network overview screen and no protocols to constrain the way in which operators organise the screens.	Operators do not always organise their displays in an efficient way. Organisation according to the geographical distribution of the network, potentially utilising the GIS system, is recommended.
No dedicated screens for intranet, email and ad-hoc tasks.	The lack of a dedicated non-SCADA terminal means that operators need to use screens which should be dedicated to system monitoring and network activities.
No dedicated screen for alarm lists.	Best practice recommends that active alarms are displayed schematically on SCADA interfaces. However, with a large and complex network, an alarm list is generally the only way that all active alarms can be depicted simultaneously. A dedicated alarm screen should be provided, as long as functionality to navigate directly from the alarm list to the relevant screen is included.
No auditory alarms, with unacknowledged alarms progressing to SCADA phone alert after three minutes.	Recommendations are that category 1 alarms (requiring immediate operator action) have an auditory signal.
No one-click integration of alarms to relevant screens/schematics, and no online alarm documentation.	Click-to-navigate functionality reduces the operators' reliance on memory and saves time navigating to the appropriate screen to deal with the problem. The lack of this functionality is particularly problematic if the operators' mental model of the network is inconsistent with the SCADA system. Alarm documentation including detailed information on fault diagnosis and step-by-step instructions for remedying the situation should be available at a mouse-click.
Alarm flooding during incidents is common.	Alarm flooding defeats the purpose of alarms, which is to support operators in fault detection and diagnosis. Alarm flooding has been implicated in several major industrial catastrophes, including Three-Mile Island.

The above list presents a preliminary audit of the operating environment, and more detailed observations and task analysis would be required to determine the suitability of changes made simply to satisfy best-practice criteria. Controlling water distribution differs significantly to the more geographically constrained but equally complex process control environments for which these guidelines were developed. What may be considered desirable and appropriate for process control operations may not be suitable for distribution applications, and the outcome of a comprehensive user-centred design (as proposed in Section 6.3.1) should take precedence over published guidelines. Figure 3 illustrates the marked differences between the two SCADA platforms; the upper panel shows an alarm list and overview screen for the Brisbane leg of the distribution network under the Logica software platform, and the lower panel shows a regional network leg under the Citect platform. A number of discrepancies between the two systems are immediately apparent in these images, most notably the use of colour. In the Logica System, a pump icon with a filled red circle indicates that the pump is out of service whilst in the Citect system, that condition is designated by the pump icon shaded green, with red used to designate a pump which is running. This particular use of colour contravenes an incredibly strong and pervasive colour stereotype (green=go, red=stop).

4.1.4. Cognitive Task Analysis – Reservoir Flush

Flushes are routinely conducted to maintain water quality and reduce sediment build-up in bulk water storage facilities. To give an example of the cognitive processes involved in a real task, a senior operator was observed demonstrating (but not actually performing) a routine 4 ML reservoir flush on a large temporary storage reservoir. He was asked to verbalise major steps of the process. With verbalisation and occasional interruption for questioning by the researchers, the initiation of this procedure took approximately six minutes. The operator claimed that it would ordinarily take about one to three minutes. After a draft hierarchical process was drawn up, the operator and researchers devised a comprehensive list of potential errors that could be made at each discrete step (Figure 4), and the operator determined the likelihood of each. These likelihood ratings were confirmed with another operator who was not present at the time of the flush demonstration. The errors, corresponding SHERPA error codes, likelihood ratings, steps to recovery and proposed remedies are presented in Table 3.

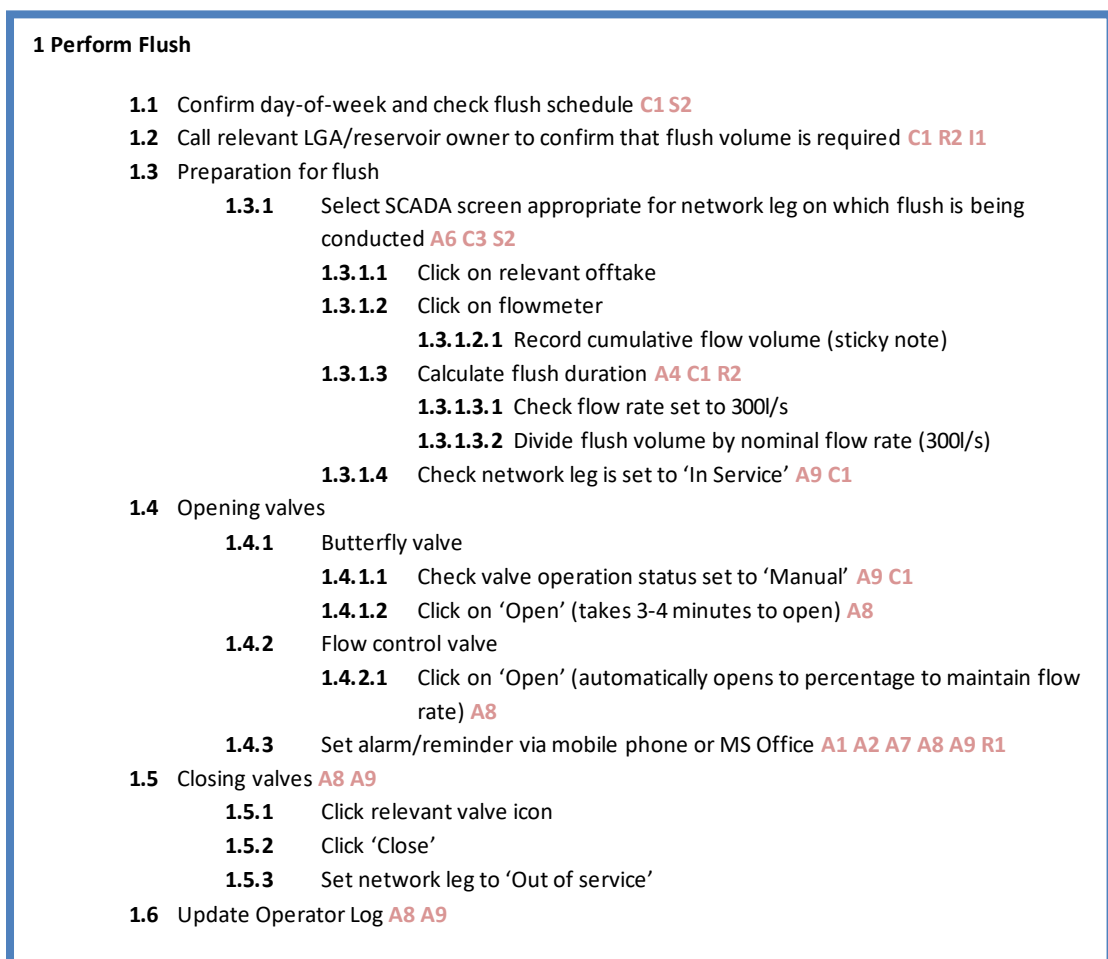


Figure 4: Hierarchical task analysis of a simulated reservoir flush. Avenues for human error are indicated with the SHERPA taxonomic codes in red text.

Table 3: Potential Errors in the Flush Task, with Corresponding SHERPA Taxonomic Codes.

Errors	Classification				
	Action	Checking	Retrieval	Communication	Selection
Day-of-week wrong		C1 Check omitted			S2 Wrong selection made
Do not obtain or misunderstand LGA/reservoir owner request		C1 Check omitted	R2 Wrong info obtained	I1 Info not communicated	
Incorrect network leg selected	A6 Right op on wrong object	C3 Right check on wrong object			S2 Wrong selection made
Flush time calculated incorrectly	A4 Op too little/much	C1 Check omitted	R2 Wrong info obtained		
Failure to check flow set point at 300l/s		C1 Check omitted			
Failure to check/set network leg status	A9 Op incomplete	C1 Check omitted			
Failure to check Manual operation status	A9 Op incomplete	C1 Check omitted			
Failure to open valve	A8 Op omitted				
Failure to open valve	A8 Op omitted				
Failure to set outlook/mobile phone alarm	A8 Op omitted				
Incorrect time set on outlook/mobile phone alarm	A7 Wrong op on right object; A2 Op mistimed				
Failure to detect/respond to mobile phone alarm	A9 Op incomplete		R1 Info not obtained		
Failure to close valves	A8 Op omitted; A9 Op incomplete				
Failure to check/set network leg status	A9 Op incomplete	C1 Check omitted			
Failure to update operator log	A8 Op omitted; A9 Op incomplete			I1 Info not communicated	

Errors	Risk Assessment			Remedy
	Likelihood	Consequence	Recovery	Fix
Day-of-week wrong	L4 Reported as highly unlikely	Minor; Inability to complete remainder of task	Should be corrected with phone call to LGA/res owner	Integrate programmable flush scheduling into SCADA
Do not obtain or misunderstand LGA/reservoir owner request	L3 Reported as unlikely	Potential Oversupply or undersupply	Undersupply rectified within ~4 hours if notification received; minor oversupply results in changes to future scheduled flushes	Improve instrumentation at customer assets and integrate into SCADA
Incorrect network leg selected	L3 Reported as unlikely	Undersupply to intended reservoir; oversupply to other parts of network		Incorporate geographical schematic and prompt operator for confirmation
Flush time calculated incorrectly	L1 Observed	Potential Over-supply or under-supply		Change set-point to flush volume instead of flow rate
Failure to check flow set-point at 300l/s	L2 Reported as likely			
Failure to check/set network leg status	L2 Reported as likely	Unintended operations	-	Automate timing of valve operations according to flush volume set-point
Failure to check Manual operation status	L4 Reported as impossible	Inability to complete remainder of task	-	
Failure to open valve	L4 Reported as impossible		-	
Failure to open valve	L4 Reported as impossible		-	
Failure to set outlook/mobile phone alarm	L2 Reported as likely		Over-supply	
Incorrect time set on outlook/mobile phone alarm	L2 Reported as likely			
Failure to detect/respond to mobile phone alarm	L2 Reported as highly likely			
Failure to close valves	L3 Reported as likely			
Failure to check/set network leg status	L2 Reported as likely	Unintended operations	-	
Failure to update operator log	L2 Reported as highly likely	Potential financial and legal/statutory implications	-	

4.1.4.1. Cognitive Issues

The most outstanding omission in the system was the lack of functionality to control the timing and/or volume of water movement through the network off-takes. These parameters have to be calculated and monitored by the operators according to the demands of the customer reservoirs. The crucial system set-point was not attached to the variable directly under control (flush volume); instead, it was attached to a variable of a higher control order (flow rate). This is similar to asking a driver to reach the speed limit by monitoring and controlling their acceleration for an unspecified period of time, rather than simply monitoring their velocity. Targeting variables at an inappropriate control order necessitates additional mental calculations (or heuristics, both of which can be grossly inaccurate) and introduces the need for additional monitoring – in this case timing, which was not supported by the system, thus further necessitating the introduction of external devices with their own potential human factors issues.

Further to the issue of inappropriate targeting, error can be introduced at several steps of the flush process:

1. The operators determine complete flush volume on readings from a cumulative flow meter which can be reset at any time; and
2. Flushes are performed at prescribed intervals, which may correspond to extremely busy periods. This issue pertains to a flush being initiated and an incident or high-workload situation subsequently developing; a flush would not be performed strictly to schedule if such a situation was already underway³.

4.1.4.2. Human Error Potential

The procedure demonstrated by the operators represents a creative work-around which has developed because basic functionality for the flush task is not built into the system. Throughout the task analysis process, the operator who assisted us came across as very optimistic with respect to the likelihood of human error. From an outsider's perspective, however, it seems at least logically possible that the operators could commit fundamental errors, such as selecting the wrong reservoir at the very outset. The operator did, however, mention that forgetting to close the valves during reservoir flushes is easy during busy periods, and reported that it occurs with an appreciable frequency – approximately 2-3 times a month. Because the majority of storage reservoirs and balance tanks are kept well below capacity, the consequences of overfilling from an ill-timed flush operation are generally not severe, but if the reservoirs are at or near capacity, overfilling can occur.

4.1.4.3. Proposed Solution

A general solution to the potential problems identified would be to automate some aspects of the task. To address the problem of control order, flush volume should be used as a set-point (rather than flow rate), and the timing of the valve operations should be automated. The flush process should be combined with a confirmation/validation process that geographically depicts the part of the network or particular asset targeted by the action, which would reduce the likelihood of operators inadvertently performing actions on wrong parts of the network. The potential effectiveness of the first part of this solution was corroborated in discussions with the operators, who indicated a strong willingness for routine operations like flushes to be managed by the system. However, because two fundamental parameters tend to fluctuate – supply capacity and local demand – the operators were not in favour of full automation.

4.1.5. Summary

The control system for water distribution is inefficient and struggling to support the operators in their duties. In the context of recent organisational changes, this is not surprising. Short-term gains could be

³ Assuming adequate communication between the control room and customer regarding supply levels.

made by addressing problems in a piecemeal fashion, but the only way to ensure a robust solution would be a thorough evaluation and overhaul of instrumentation, networking process control, alarm rationalisation, interface design and appropriate allocation of system functions to automation. Fortunately, both management and operators are well aware of the system limitations and steps are being taken to procure a new and more stable system.

4.2. Advanced Water Treatment

The advanced water treatment plant visited by the team is relatively new infrastructure in the Water Grid. It uses cutting edge water treatment technology to recycle treated wastewater, which is sold to industrial users and residential sections of the Water Grid with dual-reticulation systems. The plant uses a process of sedimentation, microfiltration, reverse osmosis and advanced oxidation, and is capable of producing 70 Ml of water in a 24-hour period. Current production averages 20-23 Ml per day.

4.2.1. Control Room and Operator Observations

Operators in the control room (and to a more limited extent, on site) were observed in their duties over a six-hour site visit. Observations were conducted in between more rigorously scheduled data collection activities. The staff recruitment model differed significantly to that employed at the water distribution facility. The plant is only staffed between 6:00am and 2:30pm, after which it runs automatically with an operator on call. Operators had various professional backgrounds, including trades (primarily mechanical) and postgraduate degree qualifications in water management and environmental science. The majority of control operators spent less than 25% of their time at the SCADA terminals, and performed extensive site maintenance activities as well as supervisory control.

During our visit, the pace in the control room seemed relaxed. Apart from a lead operator who staffed the control room on a full-time basis (subject to a rolling roster), operators engaged themselves between control room and site maintenance duties on an as-needed basis. A view of the primary operator console at the control room is shown in Figure 5.

4.2.2. Operator Experience Questionnaires and Interviews

Again, the limited number of operators on duty (and indeed employed on site) meant that quantitative analysis of our questionnaire instruments was not possible. Given the more limited time and opportunities for observation on this site, responses on these instruments, in conjunction with operator interviews, provided the bulk of the qualitative data presented below.



Figure 5: The primary operator console at the AWTP control room. This console is 75-90% attended during shift hours.

4.2.2.1. Alarms

The alarm system stood out immediately as more sophisticated and functional than the one examined at the water distribution facility. This was not particularly surprising given that the plant is new and quite constrained in size. However, the use of advanced water treatment technologies (microfiltration, reverse osmosis, UV disinfection) and the higher degree of automation mean that the control network is not necessarily less complex. In the interview process, the operators did report that more improvements were required, but stated that the functionality of the current system was a vast improvement over the first few years following the establishment of the plant.

Grouping of correlated alarms was in place to prevent alarm flooding and operators reported that it worked well. However, an unintended consequence of alarm groupings was the occasional situation in which fault diagnosis was impeded, as parts of the process control logic and corresponding interface are highly detailed and sequential. Operators suggested that improvements to drill-down functionality, and one-click localisation of alarms to the relevant SCADA screen, would solve these problems.

A recent introduction to the system, universally appreciated by the operators, was the ability to shelve nuisance alarms on the basis of a number of criteria, including priority, type and physical location.

4.2.2.2. Opportunities for operator feedback

It was reported that getting changes made to the system was overly restrictive. Also, some decisions pursued by control system administrators (see below in Section 4.2.2.3) had unintended consequences on operator workload.

4.2.2.3. Information Support

Operators generally felt that the system met their information support needs. Criticism of the SCADA displays and navigation hierarchy was minor and piecemeal. However, operators claimed that some aspects of general system function, particularly those pertaining to network security, required extensive work-arounds which significantly increased the time required to perform simple routine tasks. The most outstanding example was the removal of Microsoft office from SCADA terminals, which the operators use for daily reporting. Previously, operators would dump trending information directly into Excel and produce a report in approximately 15 minutes, but the introduction of strict network security protocols meant that a complicated data transfer procedure had to be followed, which often took over two hours.

4.2.2.4. Automation

The plant was designed to run unstaffed, and does run outside of the eight hours staff are onsite, with one operator on call (i.e., with access to alarms via mobile phone). Significant improvements to overall water supply system security in the last few years have created conditions of low demand for recycled water, which means that the plant's full capacity for automation has not yet been realised. Abnormal events during automatic running are dealt with in a conservative fashion, with thresholds for automatic shutdown set relatively low.

4.2.3. Analysis: Compliance with Best Practice

The system demonstrated better compliance to 2007 EEMUA best practice guidelines than the system analysed at the bulk water distribution facility. A senior operator/maintainer completed the SCADA design checklist and rated 21 of the 40 items as compliant. Minor departures included the following items in Table 4.

Table 4: Departures from 2007 EEMUA Best-Practice Guidelines.

Best-Practice Departure	Comments
Use of colour not restricted to alarm functions.	Colour is used to designate functional properties in schematics, such as operational status. Recommendations are that displays are primarily monochrome, with the excellent alerting properties of colour assigned to alarm functions only.
No one-click integration of alarms to relevant screens/schematics.	Click-to-navigate functionality reduces the operators' reliance on memory and saves time navigating to the appropriate screen to deal with the problem. The lack of this functionality is particularly problematic if the operators' mental model of the network is inconsistent with the SCADA system. Alarm documentation including detailed information on fault diagnosis and step-by-step instructions for remedying the situation should be available at a mouse click.
Rectangles used in overview screen to designate functionally different plant components.	Major system components should be differentiated symbolically. This was a major omission in an otherwise good human-machine interface.

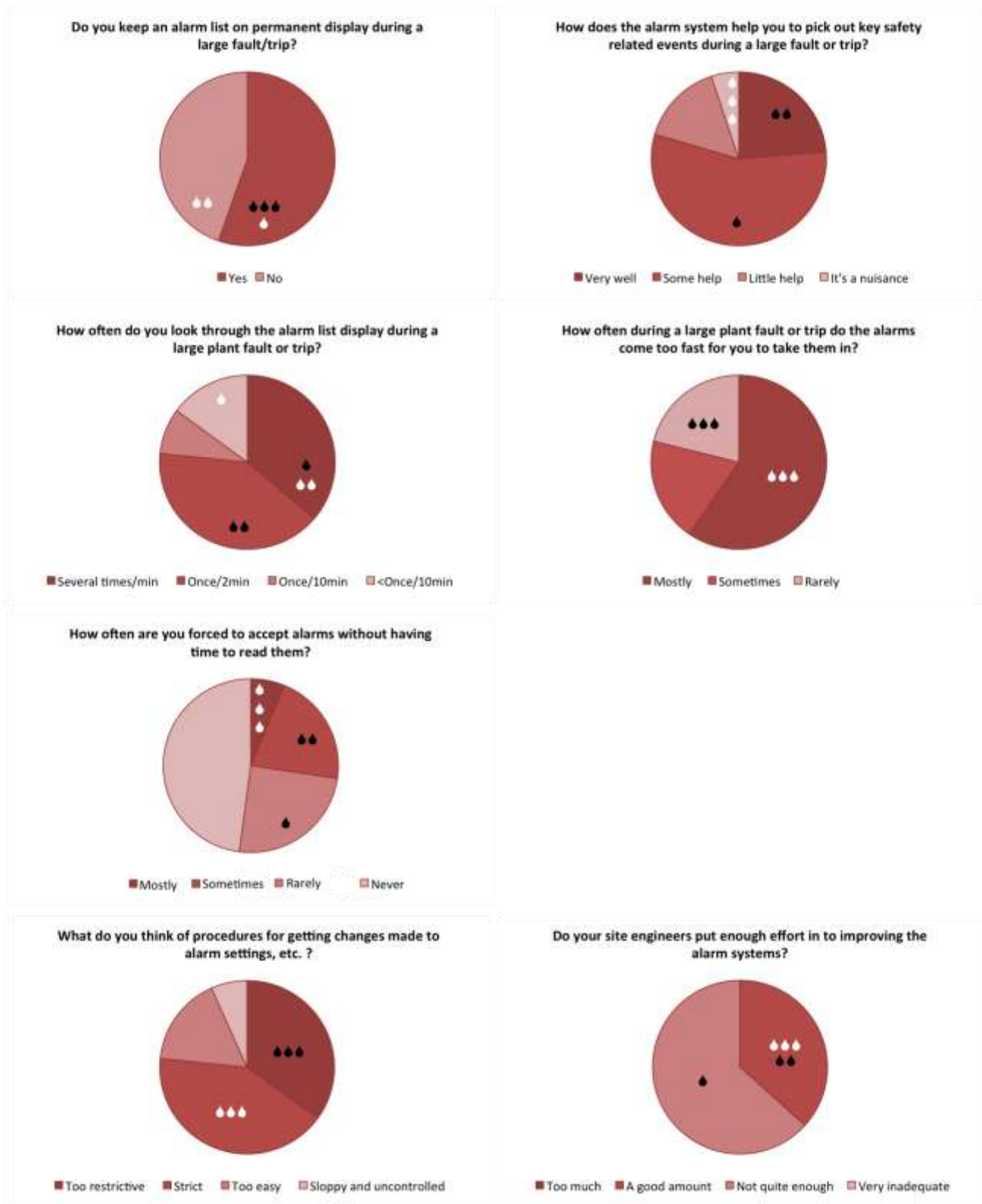
4.3. Comparison Between Sites: Alarm System Benchmark and Classification

Converging evidence from the research methods was used to evaluate alarm system performance against the EEMUA (2007) benchmarks. System performance is classified according to a number of dimensions, with outcomes categorised along a five-point scale (overloaded, reactive, stable, robust and predictive). The guidelines clearly state that the final category could probably not be achieved with current technology, so a classification of ‘robust’ could be considered in line with best practice. Like many qualitative, discrete approaches to assessment, there are instances in which criteria are met for some aspects but not others. Thinking of the performance benchmark as a continuum therefore makes the task of assessment considerably easier. The benchmark classification document is too large to be included in the body of this report, but can be accessed at <https://www.dropbox.com/sh/eqjgmvd9e2euk5/YX2QjENJla>. Blue arrows designate the BWTA placements on the performance continuum, green arrows the AWTP. The BWTA alarm system can be characterised largely as reactive, which means that considerable improvements are required. The AWTP system, on the other hand, meets the criteria for a stable system, but a few key omissions prevent it from achieving the best possible ranking.

4.4. Comparison to Other Industries

Portions of the operator experience questionnaire were developed for a cross-industry survey of alarm systems in the chemical and power generation industries (Bransby and Jenkinson, 1998). This study was commissioned by the United Kingdom Health and Safety Executive, and represents the first and largest of its kind. Ninety-six control room operators across thirteen sites participated. Response distributions from this survey are depicted in the pie charts in Figure 6. We could not recruit a sufficient number of operators to perform a formal statistical comparison to these data (because sufficient numbers do not exist), but for the purposes of qualitative comparison, the responses of individual operators from the two sites we visited are superimposed.

This exercise suggests that the operators’ perceptions of the alarm systems, whilst variable, do not differ dramatically to those in the other industries. There were a few notable exceptions, however, mostly in how the distribution operators felt the alarm systems supported their activities during incidents and network upsets. They were unanimous in their declaration of the system as a nuisance, with one operator stating that the alarm list was not referred to at all under these conditions. Given that the systems investigated in the previous survey represent the technology and management practices of 15 years ago, this is cause for some concern.



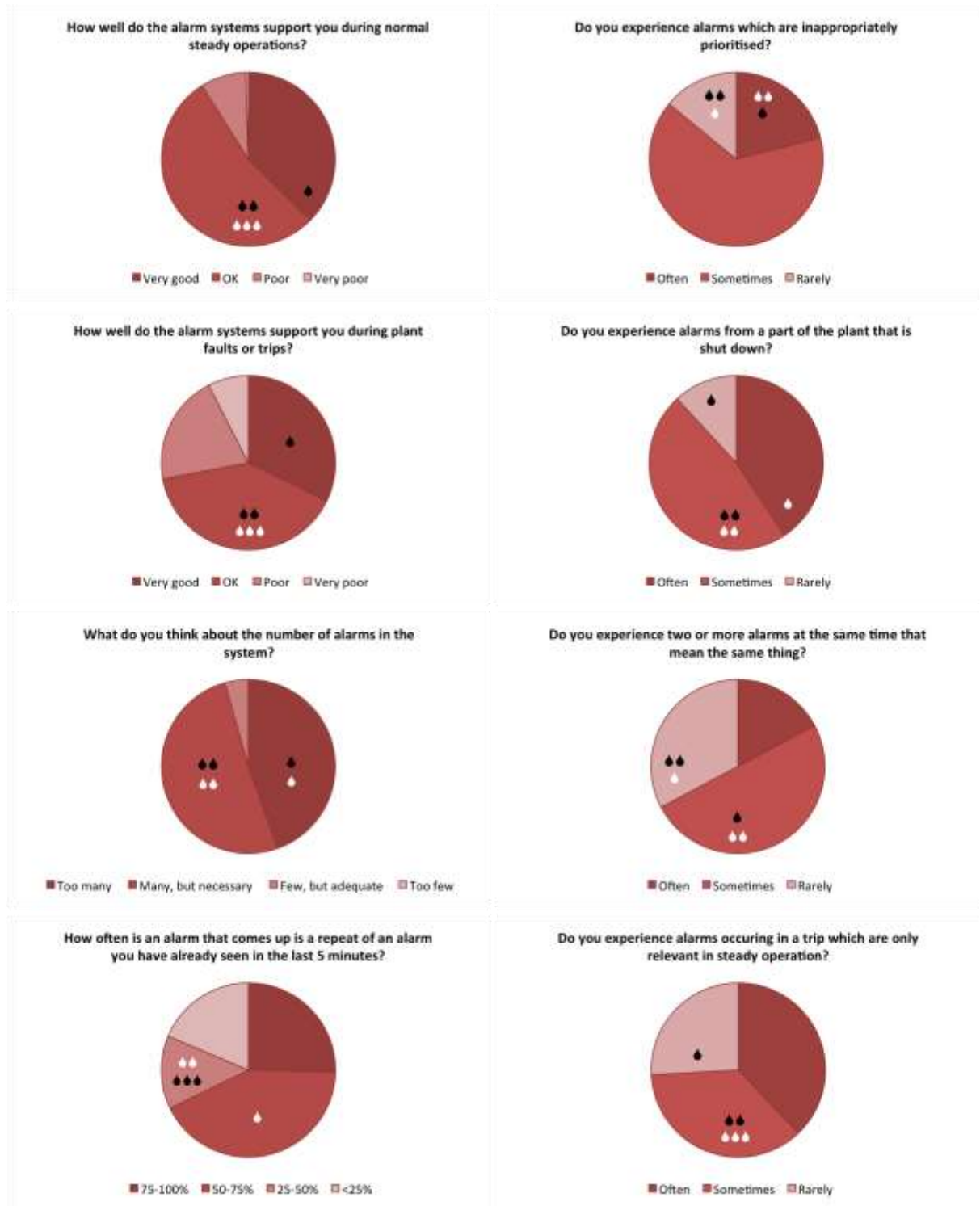


Figure 6: Findings of this report against previous survey in chemical and power industries (Bransby and Jenkinson, 1998). Pie charts depict previous survey results, white drops represent responses of distribution operators, black drops advanced water treatment operators.

5. DISCUSSION

The research described in this report has shown that applying a human factors-style approach can find system potential deficiencies and offer user-centred design solutions to help ensure a safe, productive and reliable water system. A recap of the main findings is presented below, followed by conclusions, recommendations and avenues for further research.

5.1. Summary of Main Results

The key findings are that there is considerable room for improvement in human factors issues such as alarm handling and interface design, although there were important differences between the two sites in terms of the sociotechnical reach of operations, the nature and complexity of the operators' roles, and – importantly – the necessity and urgency of change.

At the BWTA control room, many avenues for improving system stability and reducing operator workload were found. The BWTA control room does not operate along traditional process control lines, and at times the operators' role can be more readily likened to military command-and-control, e.g., detailed task preparation for major network maintenance, working out isolation strategies and coordinating workers in the field. The complex monitoring and communication role of the operator in this context requires extensive support from the supervisory control system, and this was found to be inadequate in several ways. Alarm flooding was common, operator interfaces suffered from a lack of consistency and integration, and tasks were not appropriately delegated to human operators and system automation – for example, up to 50% of the operators' time was spent manually maintaining an inefficient and potentially highly disordered log. In no small part, the problems identified at the BWTA control room are problems of inheritance owing to the recent changes in the sector, and efforts are underway to improve both technical and human aspects of the system.

The AWTP control room, on the other hand, represents state-of-the-art process control. Being newly-commissioned, it represented a considerably better integrated process control system. A sophisticated and highly consistent alarm management philosophy was in place, alarm flooding did not occur, and operators' criticism of the SCADA system was only minor. However, the system fell short of the highest standards of industry best practice in regard to the lack of click-to-navigate functionality for alarms and the lack of online alarm documentation.

Similar applied research studies in other technical domains have found similar issues. Operator evaluations of alarm systems did not differ substantially to user-centred evaluations in the chemical and power industries, although the extent to which the BWTA alarm system did not assist operators during abnormal situations stood out as a potentially serious problem. There are other industries in which the acquisition of new assets and implementation of new technologies proceeds in a way that does not adequately consider the human element. Research using a very similar human factors toolkit showed that control rooms in the minerals processing industry (Li *et al.*, 2011) have a similar pattern of poor human-technology integration.

5.2. Future Research

Our research activities were subject to time and funding limitations, and many other facets of risk management in the water sector deserve empirical attention. Principal among them are the inter- and intra-organisational communication issues uncovered in Stage 1. Whilst not strictly within the remit of a human factors approach (at least not from the user-centred perspective adopted in Stage 2), these problems resonate strongly with aspects of risk management and accident prevention frameworks proposed by the likes of Rasmussen (1997), Reason (1990) and Hollnagel (2004). At the time of writing, amalgamation of the Water Grid entities had been put forward as a priority by the newly-elected State Government. The consequential effects of this amalgamation will provide fertile ground for research into government influence and organisational issues.

Opportunities for observation and data collection in this project were limited to routine control room operations. This was owing to the extreme logistical difficulty of gaining access to control room facilities during incidents and emergencies, not to mention the risks and attached ethical considerations. Exploration of human factors issues surrounding abnormal situations would probably have to assume a retrospective approach, and there is no shortage of examples where this approach has been successfully applied in other industries, notably in mining (Horberry and Cooke, 2010). A review of documented emergency management procedures could be undertaken relatively easily, and the procedures could be tested in desktop simulations (Fuller *et al*, 2012). It is easy to argue, however, that the lack of any real emergency seriously limits the validity of such simulation approaches, particularly when the control room is geographically separated from the location of the emergency (as it is with water distribution).

5.3. Conclusions and Recommendations

Work presented in this report is an encouraging start to a fuller understanding the role of the human operator in the water sector, which should lead to improvements in efficiency and stability of system function. To achieve the best possible outcomes, broader applications of the same approach are still required. This section will outline a prescriptive approach to user-centred design and evaluation. This should be seen as part of an ongoing and iterative process, which should be clearly situated within a broader risk management framework.

As discussed in the opening sections of this report, modern approaches to safety and risk management view the user as a dynamic, integral part of a sociotechnical system, rather than limiting the focus simply to improvements in technological sophistication and reliability. Improper understanding of user interactions leaves ‘human error’ as an encompassing stop-rule in investigations when things go wrong and, quite inevitably, little progress toward system improvement can be made. This stands in contrast to a clear consideration of the needs and abilities of users, and the inclusion of them in design and procurement decisions, which is the recommended course of action for addressing human factors issues in complex industrial systems.

5.3.1. Human-Centred Design

The philosophy of user-centred design is neatly encapsulated in the following statement by usability pioneer Donald Norman:

“ . . . user-centred design emphasises that the purpose of the system is to serve the user, not to use a specific technology, not to be an elegant piece of programming. The needs of the users should dominate the design of the interface, and the needs of the interface should dominate the design of the rest of the system.” (Norman 1986).

Our discussions with control room operators and observations of work practices revealed several departures from this ideal, and one of the key messages emerging from this research is that operator expertise is an underutilised resource. The following section outlines the principles of user-centred design prescribed in ISO 13407:1999, which is a set of process guidelines to help optimise human-computer interactions.

1. Active involvement of users and a clear understanding of user and task requirements.
 - a) Approaches including cognitive task analysis (see Section 5.1.4) ensure that the user’s activities and potential for errors are systematically understood. Findings from task analysis exercises should be directly linked to development processes. An example from the present research was the finding that the SCADA system did not adequately support a routine activity (reservoir flush), forcing operators to derive error-prone (if creative) work-arounds.

- b) Involving operators in higher-level decision-making processes is also empowering, and gives them a sense of value, responsibility and ownership. Findings from Stage 1 of this project indicated that consultation with operators regarding procurement of fluoridation equipment was clearly lacking. Had a more mature approach been used, one of the latent conditions leading to the North Pine fluoridation incident would probably have been eliminated.
2. Appropriate allocation of function between users and technology.
- a) Allocation of function is one of the more difficult aspects of this approach, and has been labelled (somewhat mischievously) a 'black art' (Sheridan, 2000). Nonetheless, even a relatively brief interview process can reveal inefficiencies which can be remedied quite simply through automation, as we discovered in talking to distribution operators about the excessive time demands and vagaries of maintaining the operator log.
3. Multi-disciplinary design.
- a) Commissioning of a software interface for a complex sociotechnical system frequently requires expertise from a wide range of domains, including:
 - i. Most importantly, the end user;
 - ii. Management, including those with financial responsibility for the commission;
 - iii. Application domain specialists (e.g., process control engineers, chemists, microbiologists);
 - iv. IT personnel (e.g., systems analyst/engineer, programmer);
 - v. User interface/interaction designer;
 - vi. Human factors and human-computer interaction specialist; and
 - vii. Technical documentation authors and trainers.

In a wide range of work contexts, the gap between end-users and new technology is widening, which introduces problems which did not exist before the technology was introduced (Vicente, 2005). It is only through the application of human-centred methods that technology and humans can be appropriately integrated in a work system. The key message emerging from this project is that the water sector has not embraced a risk management framework which shows adequate consideration of the dynamic interactions between infrastructure and equipment, workers, management, regulators, government and consumers. Doing so will ultimately reduce the likelihood of adverse events and ensure the security of water grid operations into the future.

APPENDIX

System Overview

South East Queensland (SEQ) is a major Australian population centre. Brisbane City and the regional centres of Moreton Bay, Gold Coast, Sunshine Coast and Ipswich have a combined population of approximately 2.5 million people, and SEQ is expected to reach over 4 million by 2031 (Queensland Government, 2011). Water supply to South East Queensland is managed by three government-owned companies. Seqwater holds responsibility for catchment management, treatment storage and production (recycling and desalination), Linkwater manages bulk water transport, and the Water Grid Manager is responsible for oversight and strategic direction. The focus of this investigation is the operational side of the water grid – treatment and distribution.

Treatment, Storage and Recycling

South East Queensland's drinking water is sourced from 12 storage and flood mitigation dams with a combined capacity of 2.22 million megalitres. Recycled water is produced at three advanced water treatment facilities with a combined production capacity of 232ML/day, and currently distributed to industrial and agricultural customers. A desalination plant with a capacity of 133ML/day produces water which is supplied to residential customers in the southern legs of the SEQ water grid.

Conventional water treatment processes (Coagulation-Flocculation-Sedimentation-Filtration-Disinfection) take place at the majority of South East Queensland's 46 water treatment facilities. Depending on the risks associated with source water, some plants use additional advanced treatment processes including UV oxidation and activated carbon filtration. The largest water treatment facility is located at Mt Crosby, approximately 25km from the Brisbane CBD. This is the only treatment plant which is staffed 24 hours a day and serves as a control hub for other major treatment plants in the grid. Site operations are monitored through a networked SCADA system running on a Ci-tect software platform.

Bulk Water Transport

Linkwater's transport infrastructure includes 28 balance tanks and reservoirs, 22 pump stations, six water quality treatment facilities and 535km of transport pipelines. Network operations are centrally managed through a control room consisting of five independent SCADA platforms, which control different geographical sections of the network. Infrastructure localities are stored in a GIS system which is not integrated into the SCADA networks. The 24/7 central control room is generally staffed by two operators during daylight hours and one operator at night. Control room facilities are regularly used by network engineers and management personnel. The organisation of the SCADA platforms is a consequence of relatively recent asset amalgamation (previously, local government authorities had the responsibility for water grid operations within their geographically-defined boundaries). At the time of writing, Linkwater had put out a tender for the design and installation of an integrated SCADA network.

The final stage of water supply to the majority of SEQ customers is through gravity-fed storage reservoirs and balance tanks. Consumption from a typical urban storage reservoir is approximately 1-2ML per day. Reservoir levels are monitored by the organisation, and flushes (level top-ups) are conducted on a routine basis, usually three times a week. Most pumping and transport operations are undertaken at off-peak electricity tariff periods, between 11pm and 6am.

The extensive infrastructure network has a very active maintenance schedule. Maintenance operations often require entire sections of the network to be isolated, which involves the coordinated activity of control room operators, who determine an appropriate isolation strategy to ensure water supply to the affected network area; together with fitters, electricians and other field personnel who act under the direction of the control room, manually opening/closing valves, bringing equipment on/off line, etc.

These major responsibilities are undertaken almost exclusively from the control room, which acts as a communication hub and low-level 'command-and-control' facility for operational aspects of the organisation. This distinguishes the control room somewhat from others in process control domains, in that tasks tend to be discrete and monitoring occurs over a much longer time scale. It is only when emergencies and incidents require multi-organisation coordination that the control responsibilities are shared with an incident room. Seven operators with various trade and technical backgrounds are employed.

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