

Hazard Analysis

Design and Integration of Embedded Systems

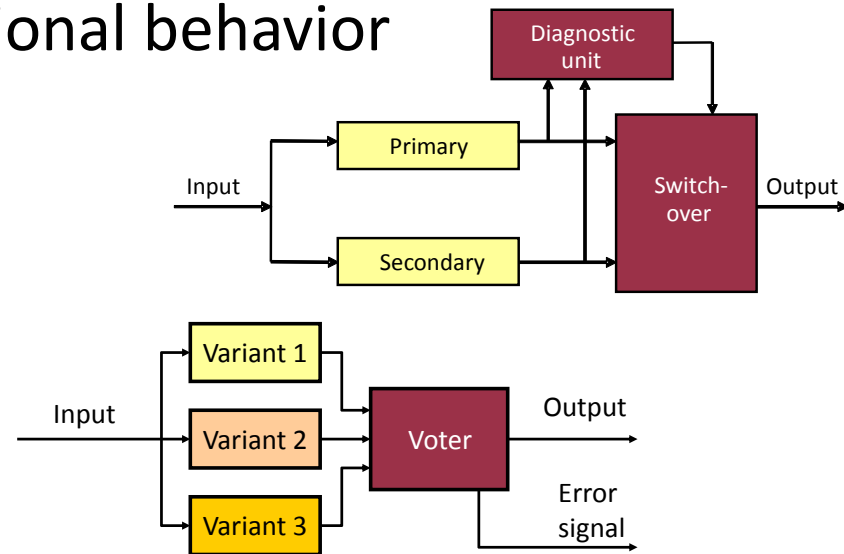
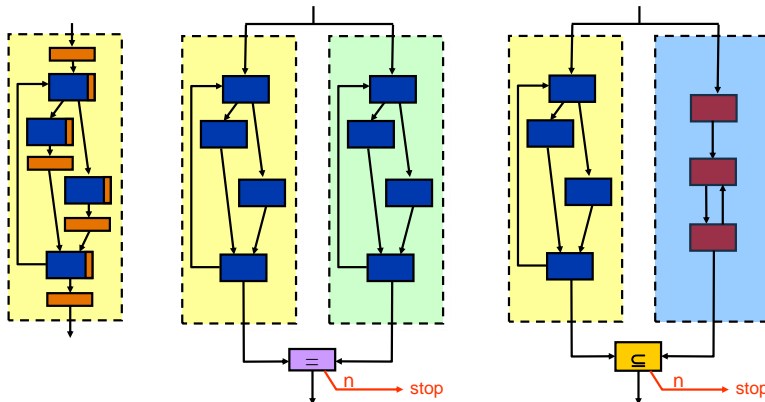
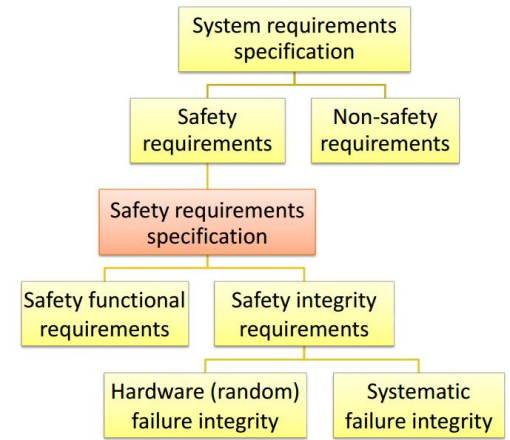
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Previous topics

- Specification in safety-critical systems
 - Safety function requirements
 - Safety integrity requirements
 - Dependability requirements
- Architecture design solutions
 - Error detection for fail-stop behavior
 - Fault tolerance for fail-operational behavior



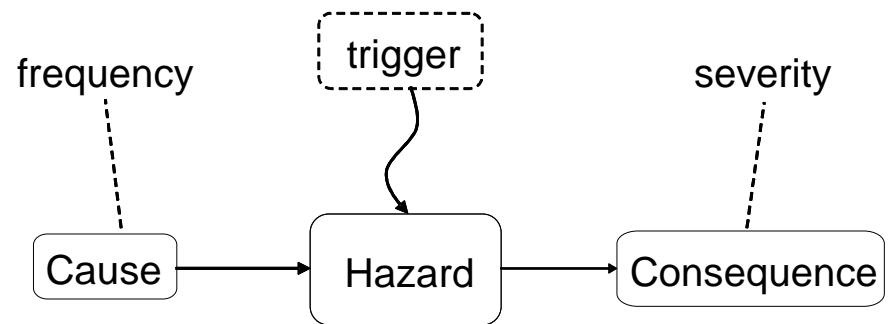
Goals of this presentation

- Focus: **Evaluation of the system architecture** to ...
 - Analyze the **causes** of potential hazards
 - Analyze the **effects** of component faults
- Learning objectives
 - Understand the role of architecture evaluation
 - Know the typical techniques for the analysis
 - Understand the method of risk estimation
 - Perform evaluation of a concrete architecture

Hazard analysis

- Goal: Analysis of the fault effects and the **evolution of hazards** (hazardous states)
 - What are the **causes** of a hazard?
 - What are the **consequences** of a component fault?
- Results:
 - Hazard catalogue
 - Categorization of hazards
 - **Frequency** of occurrence
 - **Severity** of consequences

→ **Risk matrix**



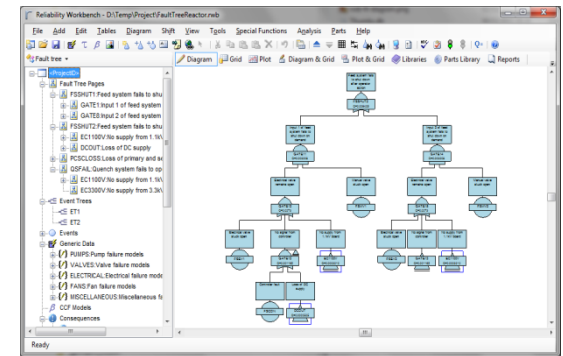
- These results form the basis for **risk reduction**

Categorization of the techniques

- On the basis of the development phase (tasks):
 - **Design phase**: Identification and analysis of hazards
 - Delivery phase: Demonstration of safety
 - Operation phase: Checking the effects of modifications
- On the basis of the analysis approach:
 - Cause-consequence view:
 - **Forward (inductive)**: Analysis of the **effects** of faults/events
 - **Backward (deductive)**: Analysis of the **causes** of hazards
 - System hierarchy view:
 - **Bottom-up**: From the components up to system level
 - **Top-down**: From the system level down to the components
- **Systematic** techniques are needed

Overview: Analysis techniques

- Informal analysis
 - Checklists
- Systematic analysis of hazard causes and fault effects with risk estimation:
 - Fault tree analysis (FTA)
 - Event tree analysis (ETA)
 - Cause-consequence analysis
 - Failure modes and effects analysis (FMEA)



Checklists



Checklists

- Basic approach
 - Collection of **experiences** about typical faults and hazards
 - Used as **guidelines** and as “rule of thumb” to avoid hazards
- Advantages
 - Known sources of hazards are included
 - Well-proven ideas and solutions can be applied
- Disadvantages
 - Completeness is hard to achieve (checklist is **incomplete**)
 - False confidence about safety
 - Applicability in **different domains** than the original domain of the checklist is questionable

Example: Checklist to examine a design

- **Completeness**
 - Complete list of functions, components, tools
- **Consistency**
 - Internal and external consistency (e.g., with standards)
 - Traceability of requirements to components
- **Realizability**
 - Resources are sufficient
 - Usability is satisfied
 - Maintainability is considered
 - Risks handled: cost, technical, environmental
- **Testability**
 - Properties are specific, measurable, unambiguous
 - Quantitative statements (if possible)

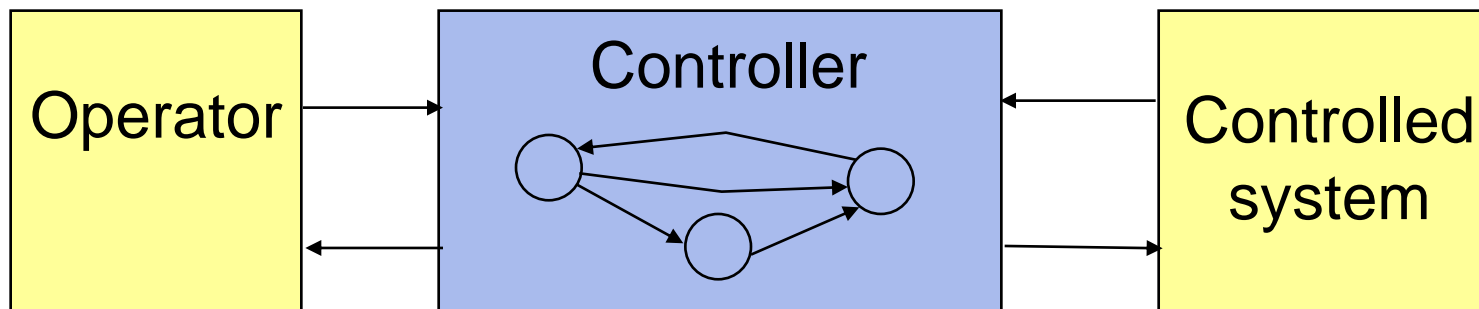
Motivations to check the specification

- Experience: Hazards are often caused by **incomplete or inconsistent specification**
 - Example: Statistics of failures detected during the software testing of the Voyager and Galileo spacecraft
 - 78% (149/192) **specification related failures**, from which
 - 23% stuck in dangerous state (without exit)
 - 16% lack of timing constraints
 - 12% lack of reaction to input event
 - 10% lack of checking input values
- Potential solutions to avoid such problems
 - Using a strict specification language
 - Applying well-proven design patterns
 - **Checking the specification**

Example: Checklist for state machine design

Completeness and consistency:

- State definition
- Inputs (trigger events)
- Outputs
- Relation of inputs (triggers) and outputs
- State transitions
- Human-machine interface



Example: Checklist for state machine design

■ State definition

■ Inputs / outputs

- Safe initial state

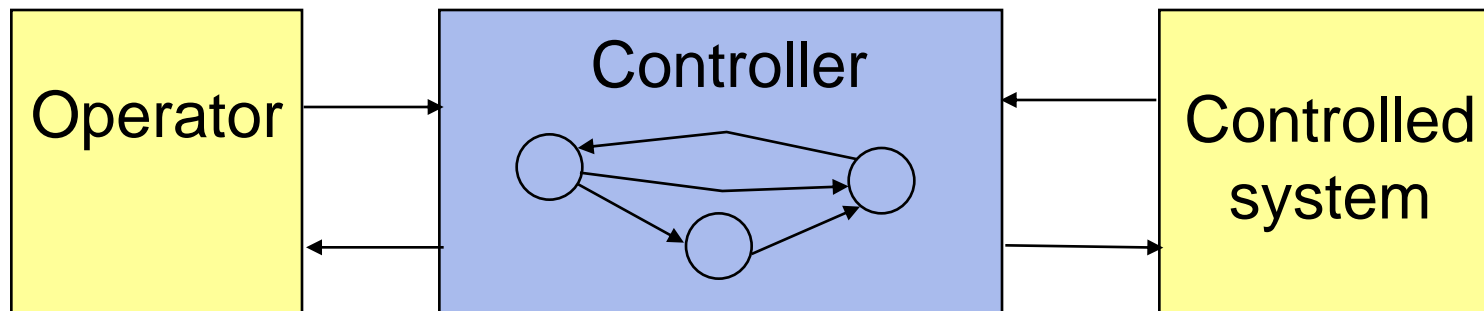
■ Output

- Actualization of the internal model: if input events are missing then timeout and transition to “invalid” state is required; output is not allowed in this state

■ Relation

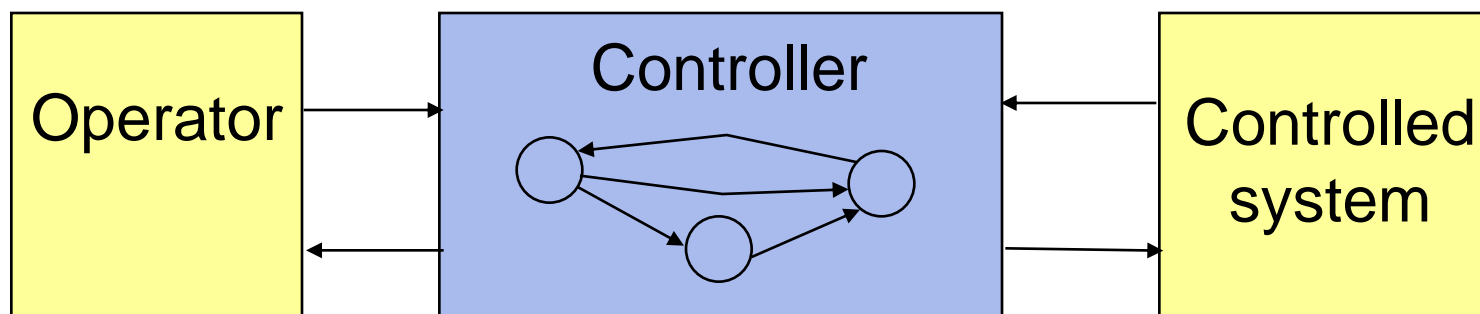
■ State transitions

■ Human-machine interface



Example: Checklist for state machine design

- State definition
- **Inputs (trigger events)**
- Output
 - Reaction to each potential input event
- Relation
 - Deterministic reactions
 - Input checking (value, timing)
- State t
 - Handling of invalid inputs
- Human
 - Limited rate of interrupts (to avoid overload)



Example: Checklist for state machine design

- State definition
- Inputs (trigger events)

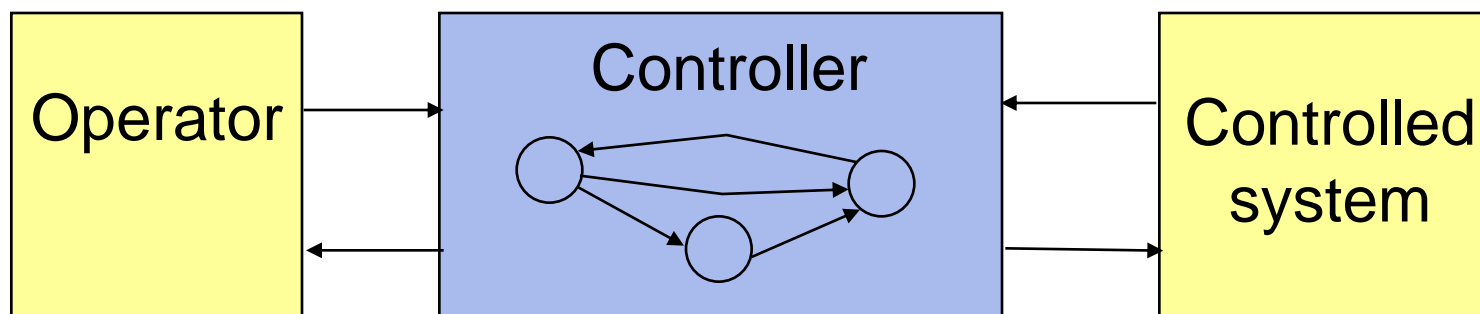
■ Outputs

■ Relationship

- Acceptance checking on the output
- There are no unused outputs
- Compliance with the limitations of the environment

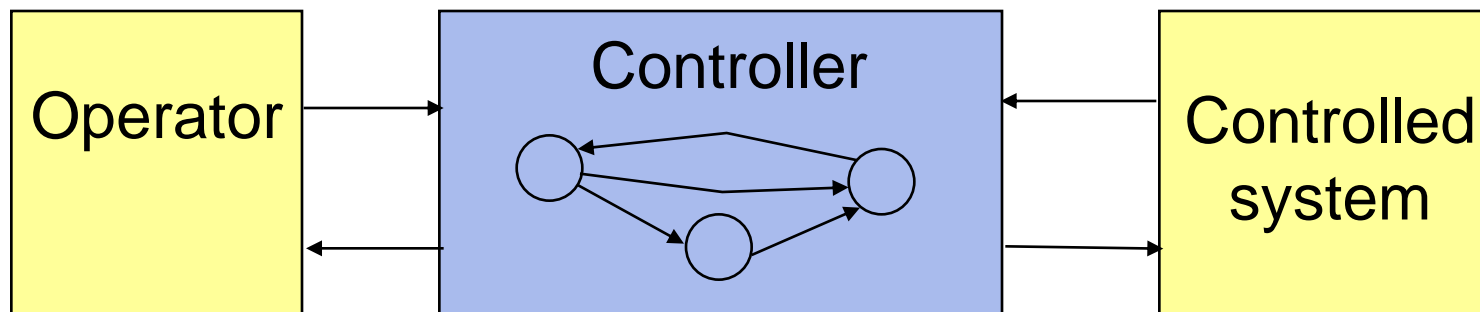
■ State t

■ Human



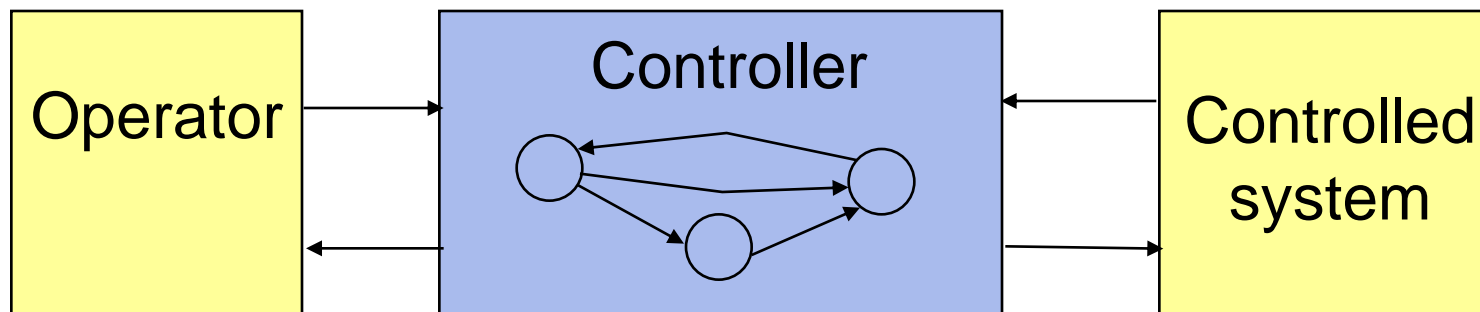
Example: Checklist for state machine design

- State definition
 - The effects of outputs are checked through processing the induced inputs
 - Stability of the control loop is guaranteed
- Inputs (triggers)
- Outputs
- Relation of inputs (triggers) and outputs
- State transitions
- Human-machine interface



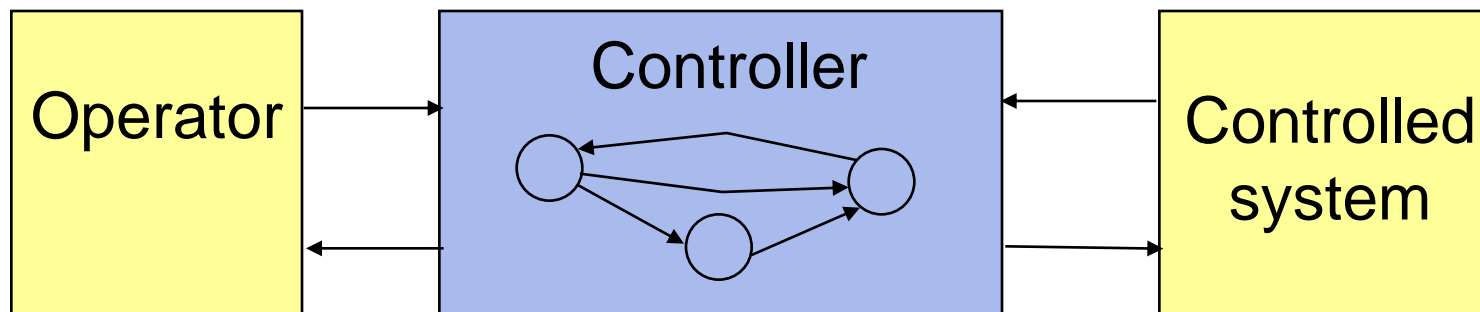
Example: Checklist for state machine design

- State
 - Each state is reachable (static reachability)
- Input
 - Transitions are reversible (reverse path exists)
- Output
 - Multiple transitions from dangerous state to safe state
 - Confirmed transitions from safe state to dangerous state
- Relationship
- **State transitions**
- Human-machine interface

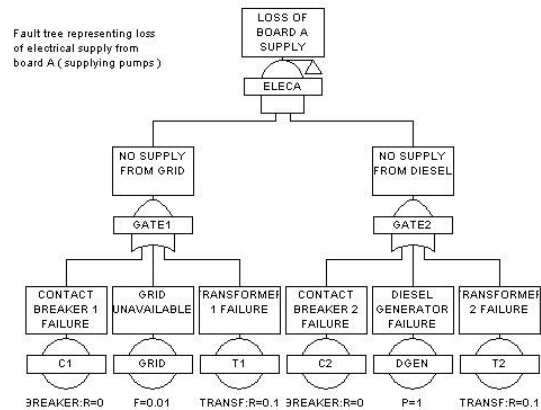


Example: Checklist for state machine design

- State definition
- Input Well-specified outputs towards the operator:
 - Ordering of events (with priorities)
- Output
 - Limited frequency of updates
 - Obsolete outputs are removed (timeliness is considered)
- Relationships
- State transitions
- Human-machine interface



Fault tree analysis



Fault tree analysis

Analysis of the **causes** of **system level hazards**

- **Top-down** analysis
- Identifying the component level **combinations** of faults/events that may lead to system level hazard

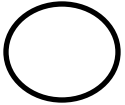
Construction of the fault tree

1. Identification of the foreseen **system level hazard**: on the basis of environment risks, standards, etc.
2. Identification of **intermediate events (pseudo-events)**: Boolean (AND, OR) combinations of lower level events that may cause upper level events
3. Identification of **primary (basic) events**: no further refinement is needed/possible

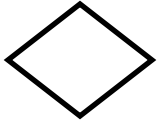
Set of elements in a fault tree



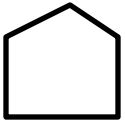
Top level or intermediate event



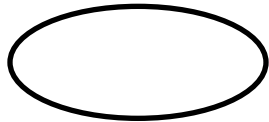
Primary (basic) event



Event without further analysis



Normal event (i.e., not a fault)



Conditional event

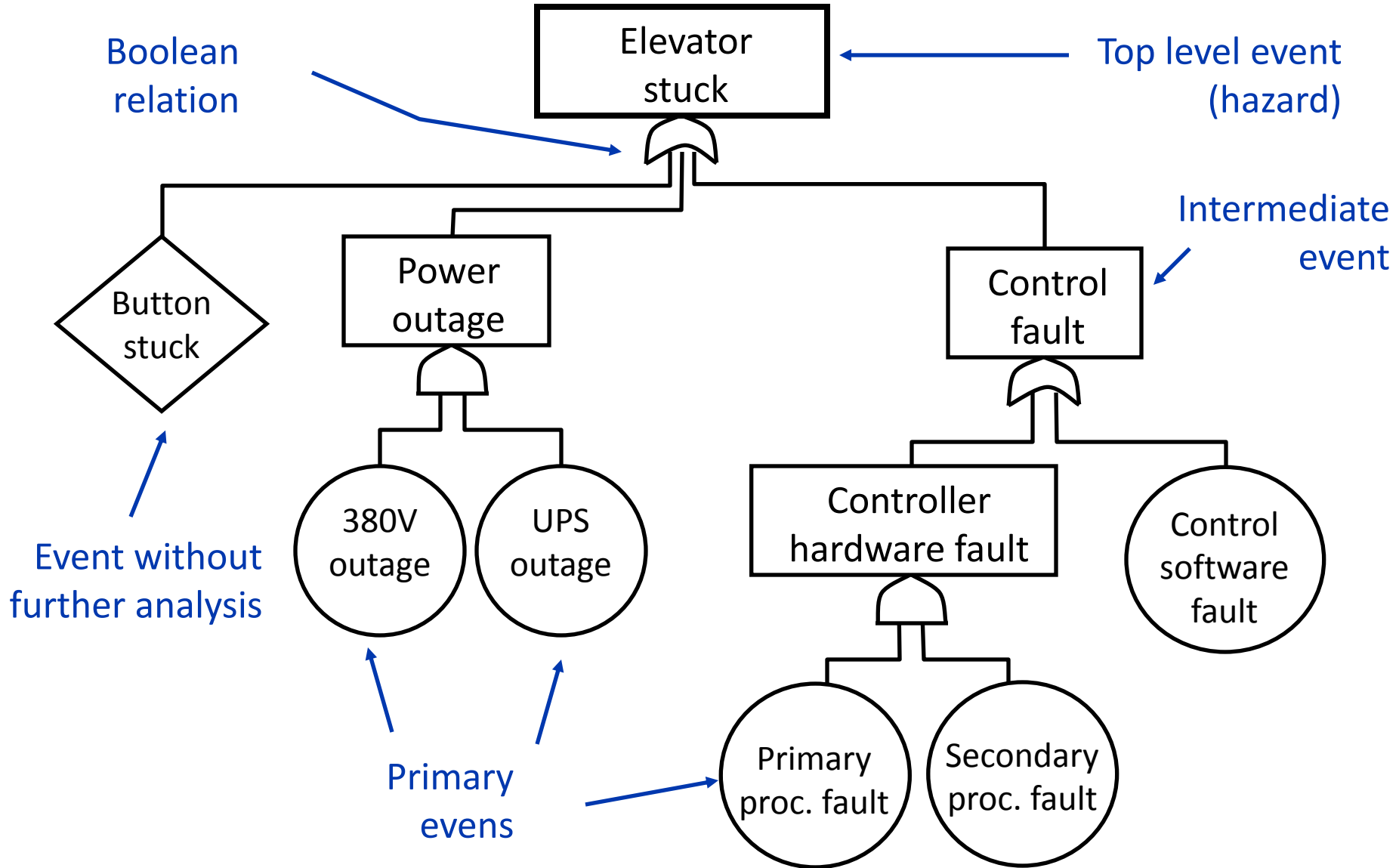


AND combination of events

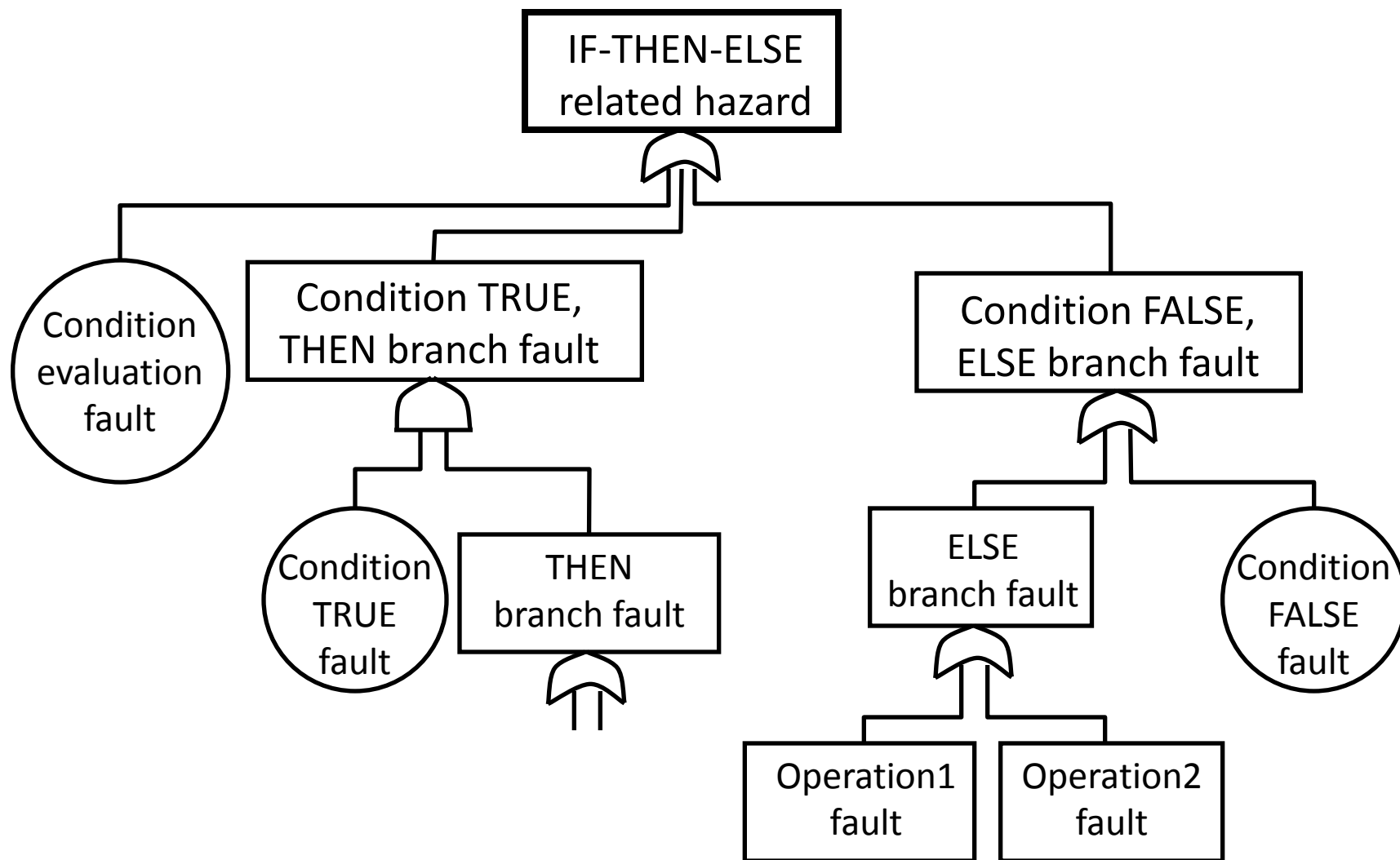


OR combination of events

Fault tree example: Elevator



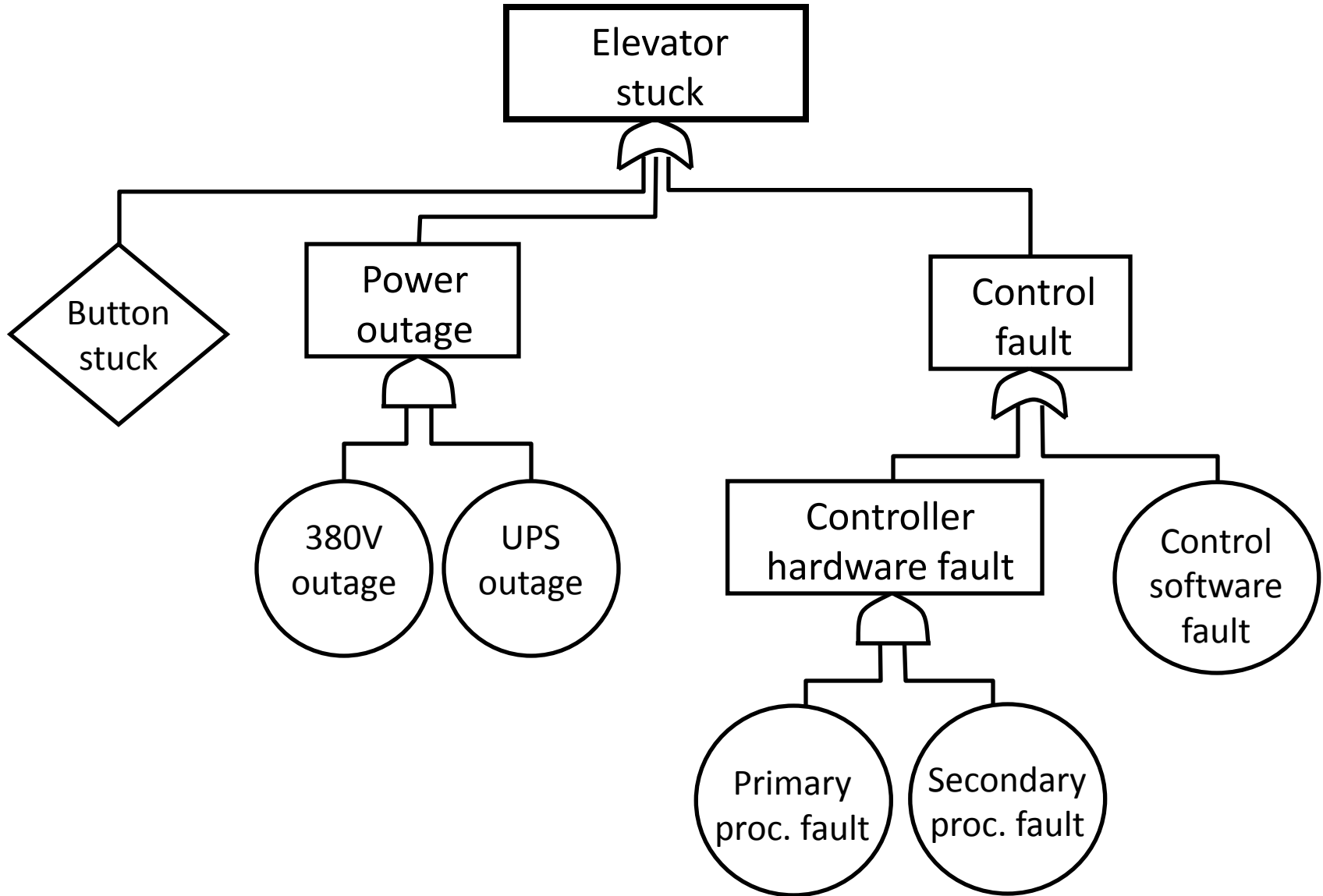
Fault tree example: Software analysis



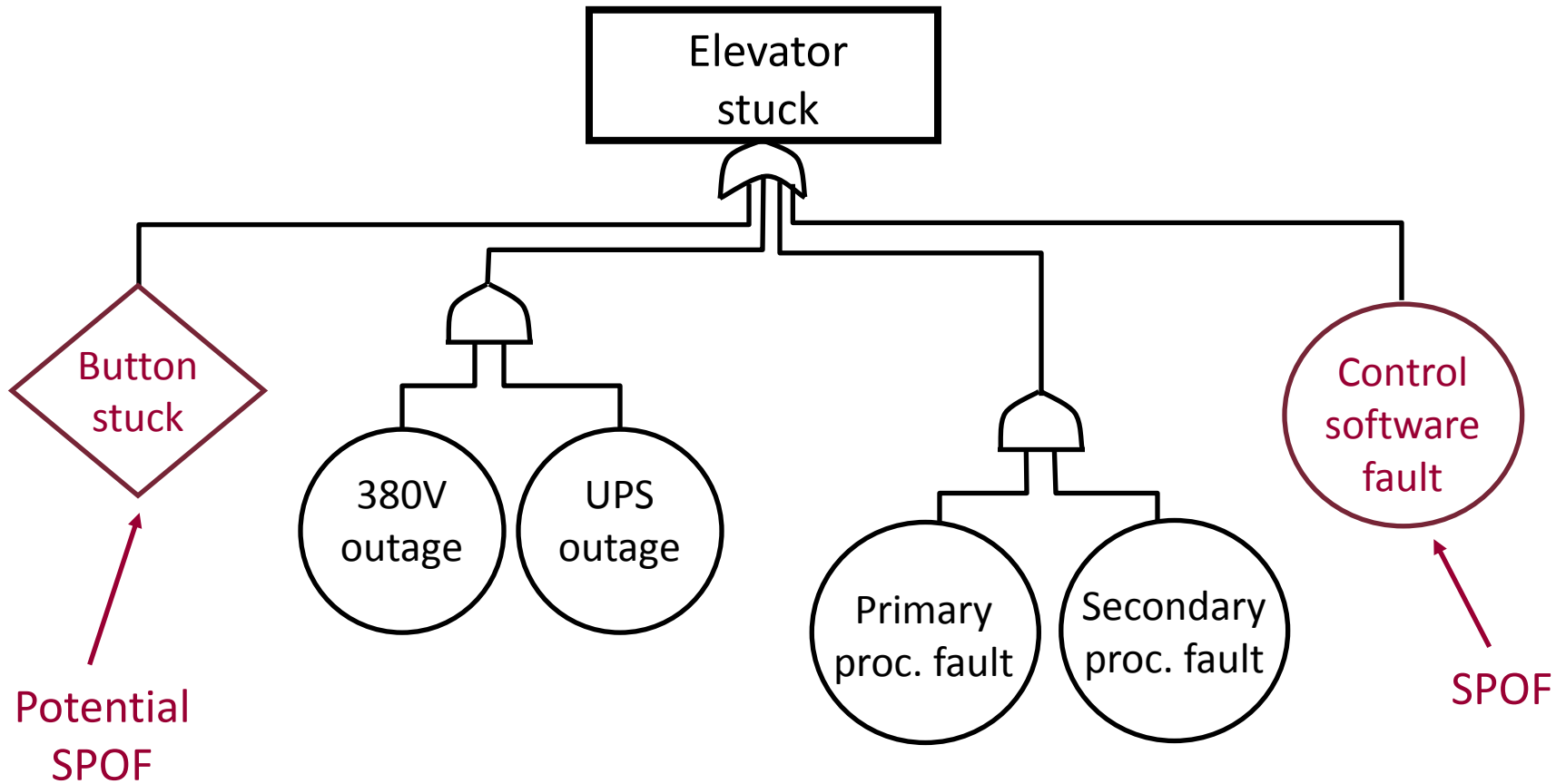
Qualitative analysis of the fault tree

- Fault tree **reduction**: Resolving intermediate events/pseudo-events using primary events
→ **disjunctive normal form** (OR on the top of the tree)
- **Cut** of the fault tree:
AND combination of primary events
- **Minimal cut set**: No further reduction is possible
 - There is no cut that is a subset of another
- Outputs of the analysis of the reduced fault tree:
 - **Single point of failure** (SPOF)
 - Events that appear in several cuts

Original fault tree of the elevator example



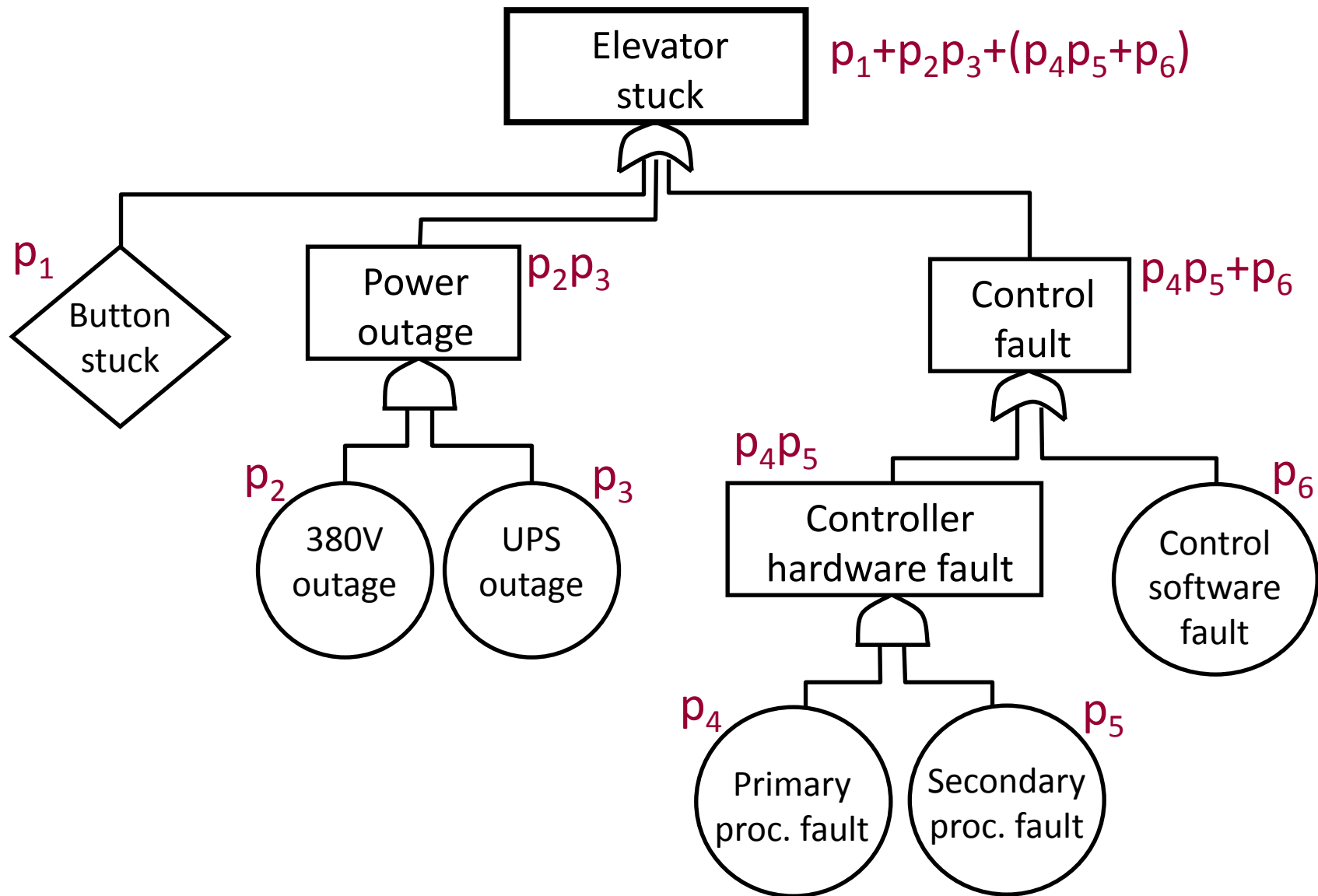
Reduced fault tree of the elevator example



Quantitative analysis of the fault tree

- Basis: **Probabilities** of the primary events
 - Component level data, experience, or estimation
- Result: Probability of the **system level hazard**
 - Computing probability on the basis of the probabilities of the primary events, depending on their combinations
 - AND gate: **Product** (if the events are independent)
 - Exact calculation: $P\{A \text{ and } B\} = P\{A\} \cdot P\{B | A\}$
 - OR gate: **Sum** (worst case estimation)
 - Exact: $P\{A \text{ or } B\} = P\{A\} + P\{B\} - P\{A \text{ and } B\} \leq P\{A\} + P\{B\}$
 - Probability as time function can also be used in computations
- Typical problems:
 - Correlated faults (not independent)
 - Representation of event sequences

Fault tree of the elevator with probabilities



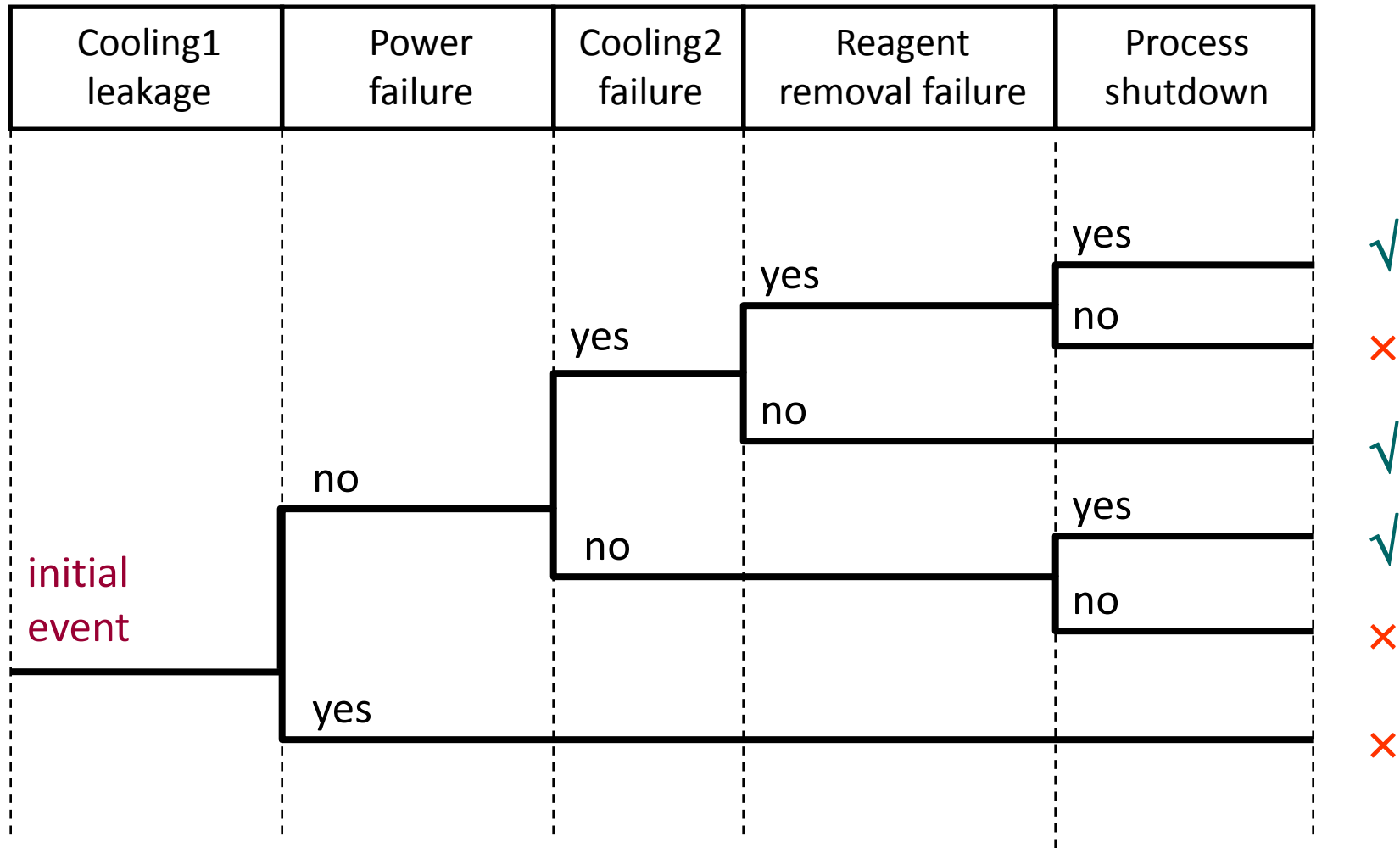
Event tree analysis

Fire Starts	Fire Detected	Fire Alarm Starts	Sprinkler System Starts	Consequence	Result	
			B9: Q=2.7208e-5	<i>Minimum Damage</i> W-1:R-3.02121e-17:	Seq-Q-3.02121e-17	
		B6: Q=2.7208e-5	B10: Q=0.000973	<i>Damage No Loss of Life</i> W-2:R-2.22070e-12:	Seq-Q-1.11030e-12	
	B2: Q=2.7208e-5		B11: Q=2.7208e-5	<i>Limited Damage / Wet People</i> W-7:R-7.77267e-12:	Seq-Q-1.11030e-12	
		B6: Q=0.989973	B12: Q=0.000973	<i>Major Damage and Loss of Life</i> W-90:R-0.134998:	Seq-Q-4.00090e-8	
B1: Q=0.0015						
		B3: Q=0.999973	B6: Q=0.999973	B16: Q=0.000973	<i>Major Damage and Loss of Life</i> W-90:R-0.134998:	Seq-Q-0.00149988

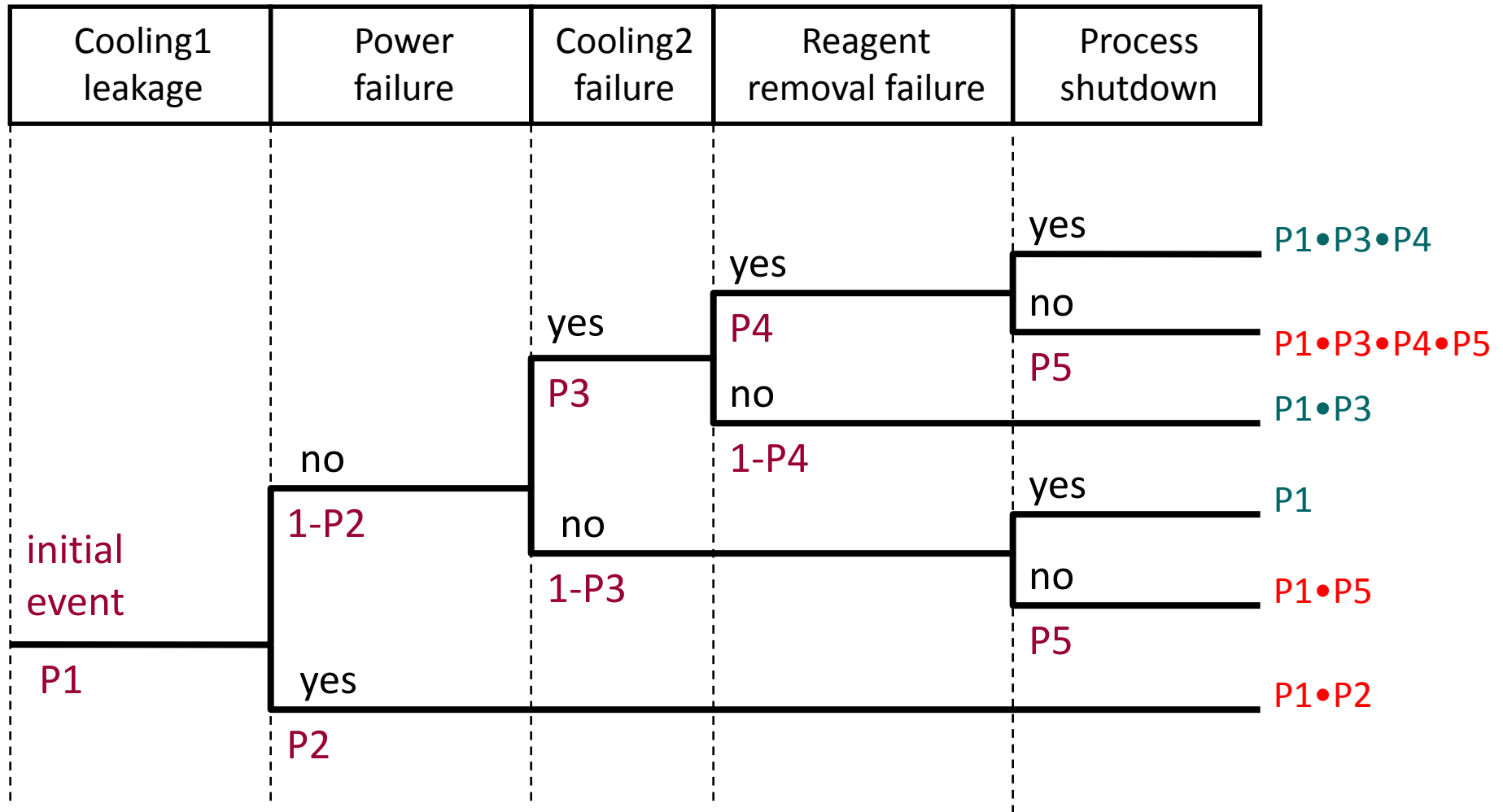
Event tree analysis

- Forward (inductive) analysis:
Investigates the **effects** of an initial event (trigger)
 - **Initial event:** Component level fault/event
 - Related events: Faults/events of other components
 - Ordering: Causality, timing
 - Branches: Depend on the occurrence of events
- Investigation of **hazard occurrence „scenarios“**
 - Path **probabilities** (on the basis of branch probabilities)
- Advantages: Investigation of **event sequences**
 - Example: Checking protection systems (protection levels)
- Limits: Complexity, multiplicity of events

Event tree example: Reactor cooling



Event tree example: Reactor cooling

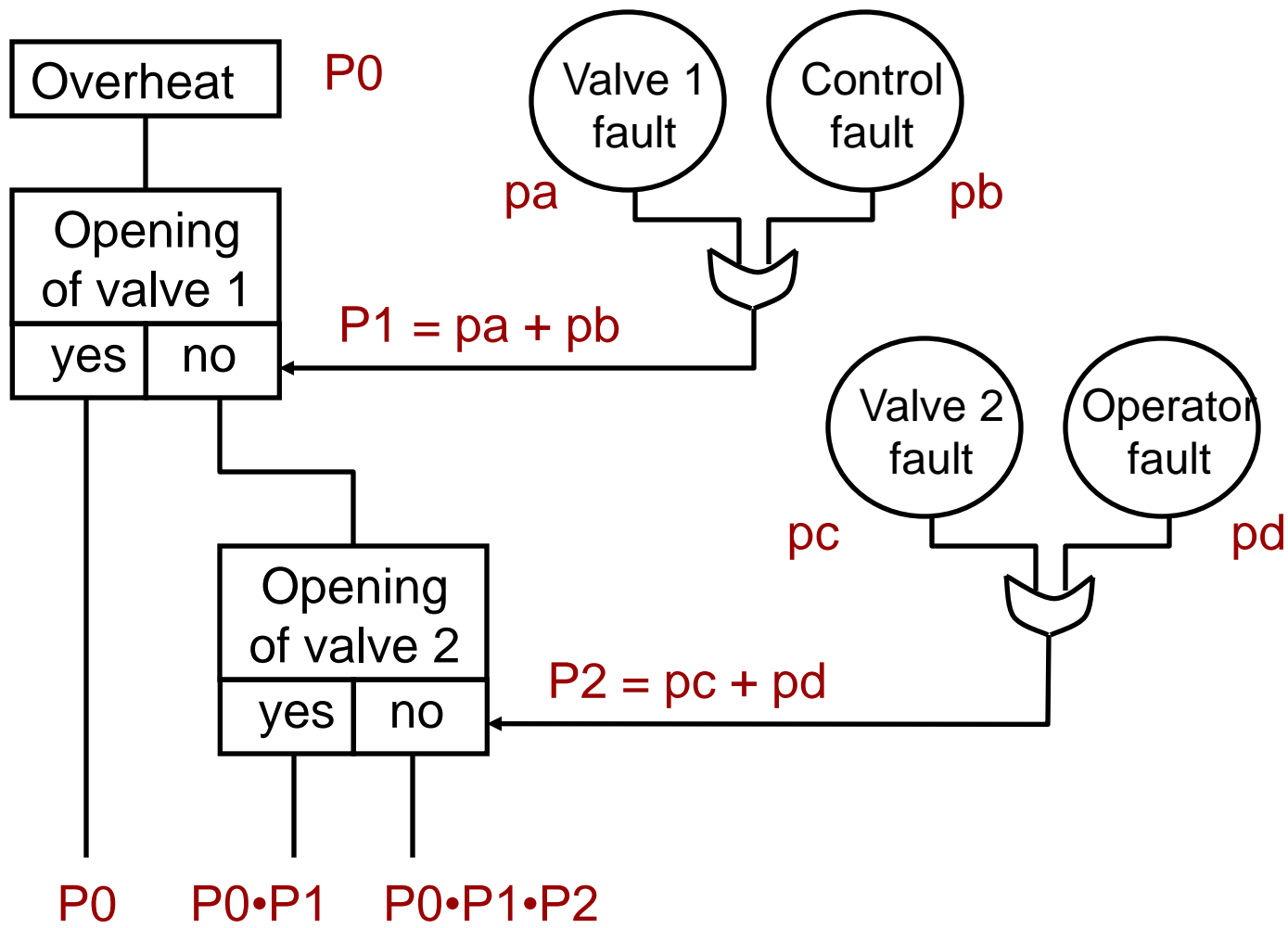


Cause-consequence analysis

4. Cause-consequence analysis

- Integration of an **event tree** with **fault trees**
 - Event tree: **Event sequences** (scenarios)
 - Attached fault trees: Analysis of the **causes** of the specific occurrence of an event in the event tree
- Advantages:
 - **Event sequences** (forward analysis) and analysis of **causal relations** (backward analysis) together
- Drawbacks:
 - Separate diagram for each initial event
 - Complexity of diagrams

Cause-consequence analysis example



Failure modes and effects analysis

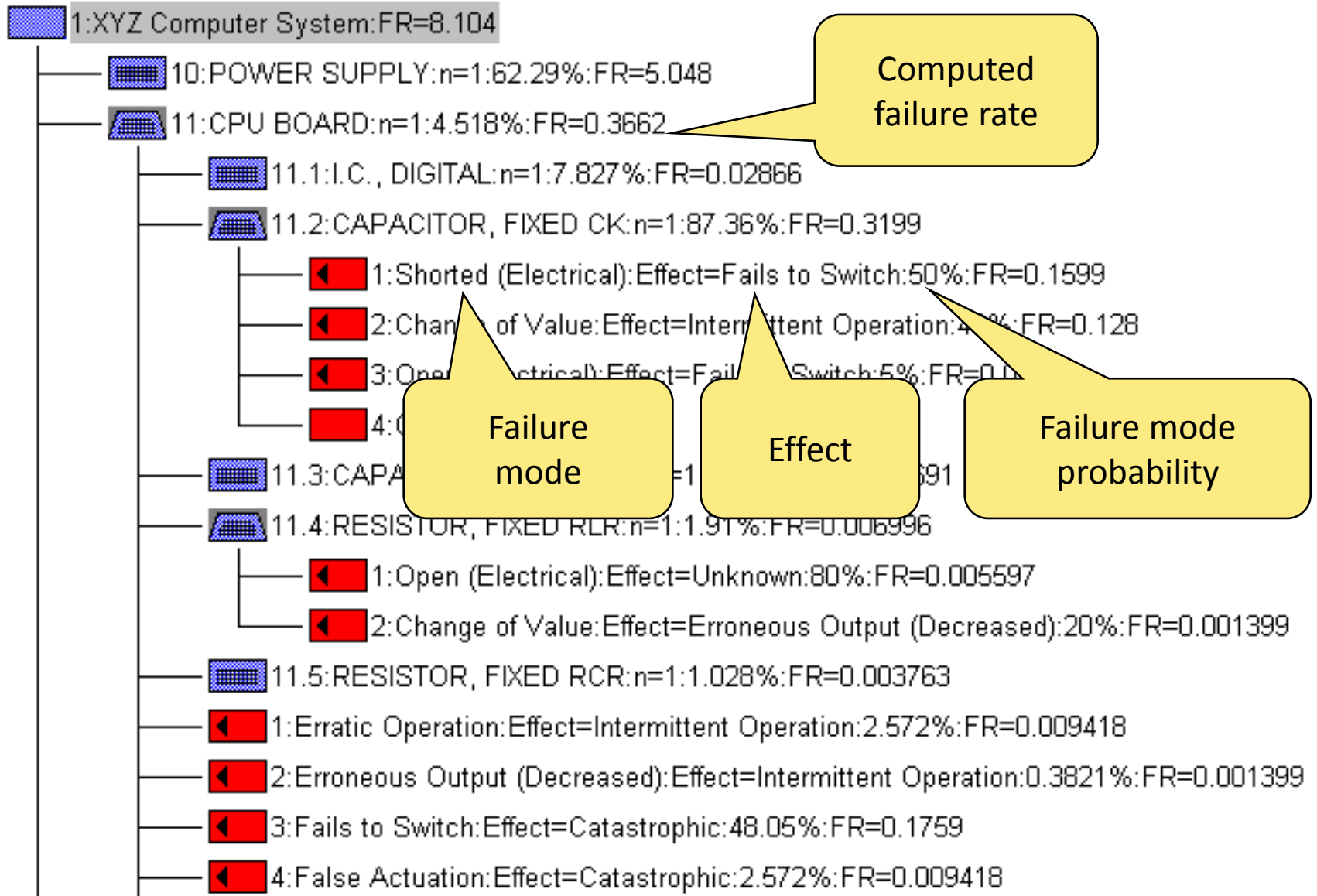
Item and (% chance of failure)	Failure mode		Effect of failure mode		Criticality of effect by severity type x 10 ⁶			
	Description	Chance	Description	Chance	V.Hi	High	Med	Low
Main stack (0.2%)	Corruption	15%	Data loss	24%	180	495	2700	1225
	Overflow	60%	System crash	66%				
	Underflow	25%	Shutdown	90%				
			System crash	10%				
			Warning	98%		300		
Total					180	795	2700	1225

5. Failure modes and effects analysis (FMEA)

- Systematic investigation of component **failure modes** and their **effects**
- Advantages:
 - Known faults of components are included
 - Criticalities of effects can also be estimated (FMECA)

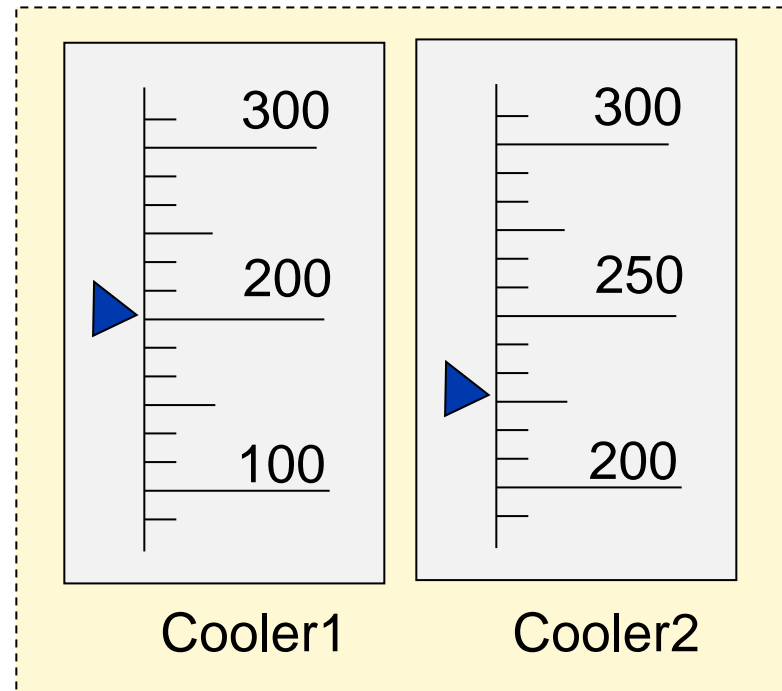
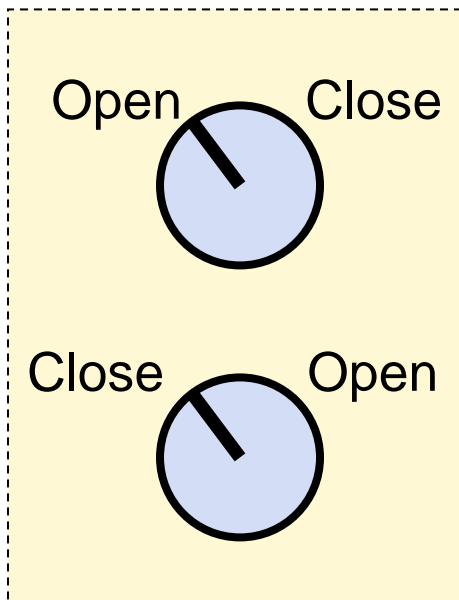
Component	Failure mode	Ratio	Effect
D1 diode	open circuit	65%	- over-heating
	short circuit	35%	- damaged product
...

Example: Analysis of a computer system

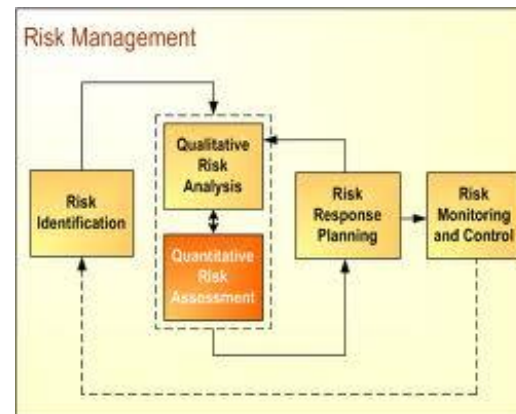
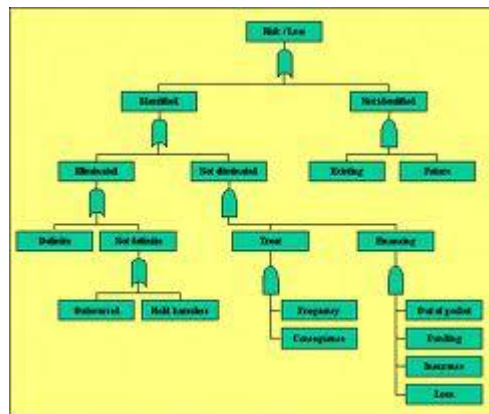


Analysis of operator faults

- Qualitative techniques:
 - Operation – hazards – effects – causes – mitigations
 - Analysis of physical and mental demands
 - Fault causes ← **human-machine interface** problems



Risk reduction techniques



Catalogue of hazards

- Categorization of hazards on the basis of hazard analysis (e.g., MIL-STD-822b, NASA):
 - **Frequency of occurrence** of hazards:
Frequent, probable, occasional, remote, improbable, incredible
 - **Severity level** of hazard consequences:
Catastrophic, critical, marginal, insignificant→ Identification of **risks**
- Output of the categorization:
 - **Risk matrix**
 - **Protection level**: Identifies the risks to be handled

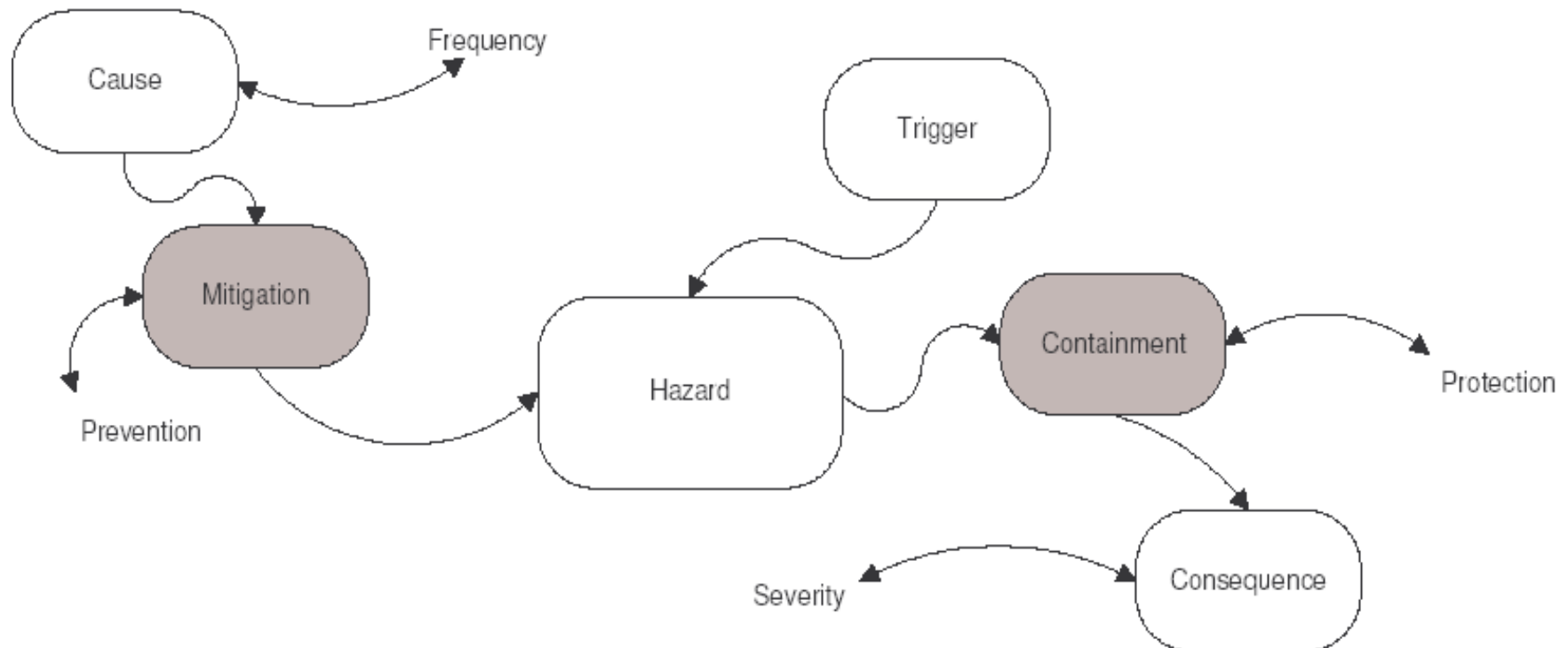
Example: Risk matrix (railway control systems)

	Frequency of Occurrence of a Hazardous Event	RISK LEVELS			
Daily to monthly	FREQUENT (FRE)	Undesirable (UND)	Intolerable (INT)	Intolerable (INT)	Intolerable (INT)
Monthly to yearly	PROBABLE (PRO)	Tolerable (TOL)	Undesirable (UND)	Intolerable (INT)	Intolerable (INT)
Between once a year and once per 10 years	OCCASIONAL (OCC)	Tolerable (TOL)	Undesirable (UND)	Undesirable (UND)	Intolerable (INT)
Between once per 10 years and once per 100 years	REMOTE (REM)	Negligible (NEG)	Tolerable (TOL)	Undesirable (UND)	Undesirable (UND)
Less than once per 100 years	IMPROBABLE (IMP)	Negligible (NEG)	Negligible (NEG)	Tolerable (TOL)	Tolerable (TOL)
	INCREDIBLE (INC)	Negligible (NEG)	Negligible (NEG)	Negligible (NEG)	Negligible (NEG)
		INSIGNIFICANT (INS)	MARGINAL (MAR)	CRITICAL (CRI)	CATASTROPHIC (CAT)
		Severity Levels of Hazard Consequence			

Basic idea for risk reduction

Intervening into the evolution of hazard consequences:

- **Mitigation** or **prevention** of causes
- **Containment** or **protection** of consequences



Summary

■ Hazard analysis

- Checklists
- Fault tree analysis
- Event tree analysis
- Cause-consequence analysis
- Failure modes and effects analysis (FMEA)

■ Risk matrix

- Frequency of hazard occurrence
- Severity level of hazard consequences
- Basic idea for risk reduction