

### Critical Systems

- System failure can lead to
  - Loss of life
  - Damage to the environment
  - Loss of much money
  
- Cost of failure > Cost of the system

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### Dependable Systems

- Availability - ready for use
- Reliability - works as it should
  
- Safety - does no damage
- Security - resists intrusion

Good things happen

Bad things don't happen

with some probability  
or with very low probability

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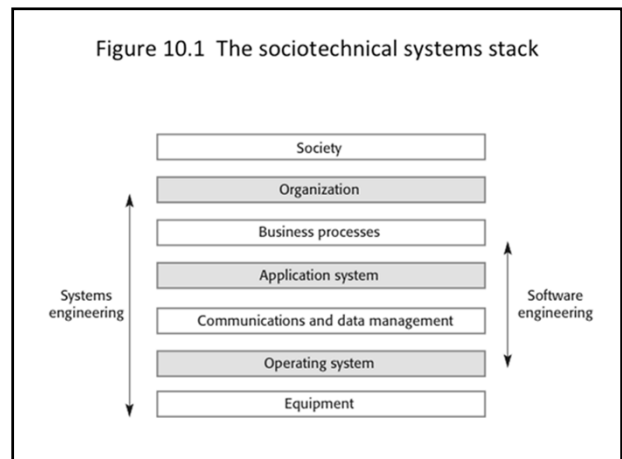
### System perspective

- People
- Software
- Hardware

}

- Environment

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### Issues

- Requirements
  - How to express dependability (measures)
  - How much is required?
- Design, Implementation
  - How to make the system dependable?
- Verification
  - How to verify dependability

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	Terminology		Specification		Design & Impl.		Verification	
<b>Avail &amp; Reliab.</b>	11.2	12.3	13	15.2				
<b>Safety</b>	11.3	12.2/5		15.1/4/5				
<b>Secure</b>	11.4	12.4	14	15.3				

Sommerville 9th edition

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### Terminology

- Fault - static: undesirable state
- Failure - dynamic: undesirable behaviour
- Hazard - situation out of control
- Accident - event(s) causing damage
- Damage - resulting loss

### Reliability metrics [12.3.1]

- AVAIL probability that system is available
- POFOD Probability Of Failure On Demand
  - irregular use: fire alarm
- ROCOF Rate of OCcurrence Of Failure
  - regular use: coffee machine
  - per time unit (week) or usage (per 1000 cups)
- MTTF Mean Time To Failure
  - long transactions (editor)
  - = 1/ROCOF

### Specify per failure!

- Planned / unplanned unavailability
- Transient / Permanent (requires service)
- Corrupting data?

### Reliability costs - be realistic!

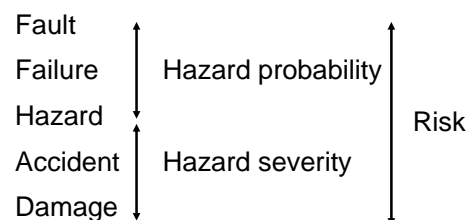
- POFOD
  - can be quite high: 1/100 - 1/1000
- AVAIL
  - 99% - 14 minutes/day
  - 99.9% - 10 minutes/week
  - 99.99% - 1 minute/week
  - 99.999% - 5 minutes/year
- Low probabilities cannot be tested!

### Reliability testing [15.2]

- Statistical testing
  - does not work for very high reliability
  - fault injection

	unknown faults	injected faults
found		
not found	?	

### Safety Terminology



## Risk-driven analysis

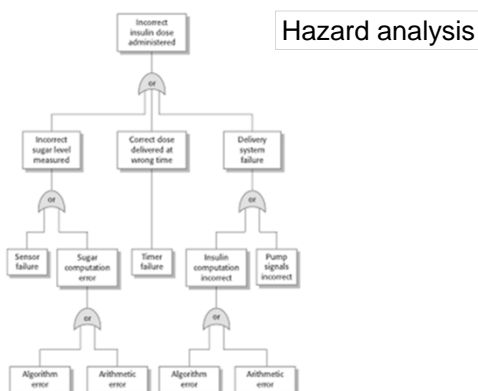
- Hazard identification
  - what are the hazards?
- Risk assessment
  - risk from this hazard is acceptable?
- Hazard analysis
  - how does the hazard occur?
- Risk reduction

Domain knowledge

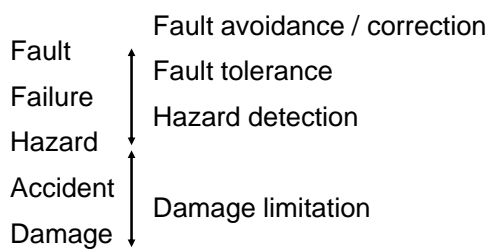
Figure 12.3 Risk classification for the insulin pump

Identified hazard	H a z a r d probability	Accident severity	Estimated risk	Acceptability
1. Insulin overdose computation	Medium	High	High	Intolerable
2. Insulin underdose computation	Medium	Low	Low	Acceptable
3. Failure of hardware monitoring system	Medium	Medium	Low	ALARP
4. Power failure	High	Low	Low	Acceptable
5. Machine incorrectly fitted	High	High	High	Intolerable
6. Machine breaks in patient	Low	High	Medium	ALARP
7. Machine causes infection	Medium	Medium	Medium	ALARP
8. Electrical interference	Low	High	Medium	ALARP
9. Allergic reaction	Low	Low	Low	Acceptable

Figure 12.4 An example of a fault tree

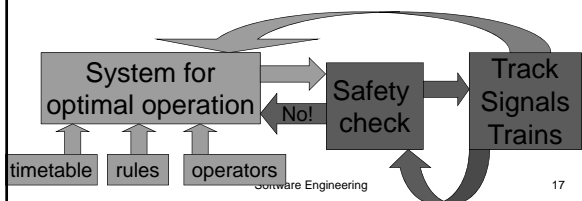


## Risk reduction

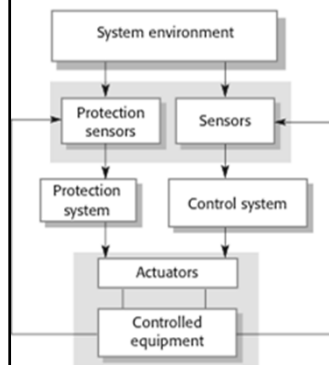


## Design principles

- Minimize the critical part
  - cost increases much with size and safety
- Example (railway operation)



## Protection system architecture



### Fault tolerance

- Fault ~~→~~ Failure
- Hardware faults
  - works ... fails
- Software faults
  - present from the start
- Human error

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### Human error [10.5.1]

- Humans *will* make errors
  - the system needs barriers

The diagram illustrates a sequence of events: 'System failure' leads to a series of 'Barriers' (represented by grey blocks with holes). An arrow points from the system failure through the barriers to an 'Active failure (Human error)'. The barriers represent safety mechanisms that prevent a system failure from becoming a human error.

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### Human error

- The human made the error because ...
  - lack of information
  - information overload Technology
  - badly designed user interface
  - "official" routines are not practical
  - pressure to take "shortcuts" Organisation
  - inadequate training / practice

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### Fault tolerance

- Detect fault
- Avoid failure
  - go into **safe state**
  - less functionality
  - railway example: all signals red
  - traffic light example: blinking yellow
- Make sure fault is noticed

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### Safe state design

- Example: railway track indicator lamp
  - Lamp on = track is free
  - Lamp off = train detected
- Why?
  - What if the lamp fails ...

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### Safety devices

- Simple
- Preferably in hardware
- Preferably autonomous
  - depend on gravity, not electricity
- Example (Therac-25)
  - Software: 2 modes.
  - Strong beam requires filter in place

The diagram shows a 'beam' passing through a 'patient' area. A 'filter' is positioned to block the beam. Text indicates that in a 'strong beam' mode, the filter must be in place. The diagram shows the filter in place, blocking the beam from reaching the patient.

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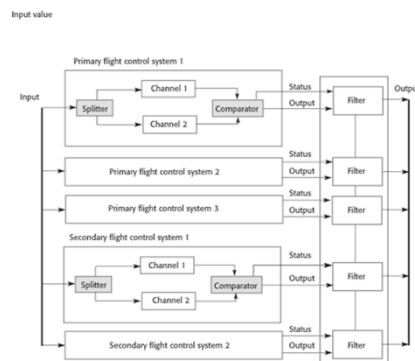
## Fault tolerance techniques

- Redundancy (spare components)
  - best for hardware
  - for safety, availability
- Diversity (*different* components)
  - design errors (SW, HW)
  - different hardware, supplier, software
  - simpler secondary system
- Monitoring

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Figure 13.5 Airbus flight control system architecture



## Software diversity

- N-version programming
- Diversity in
  - design method
  - programming language
  - tools
- Problem: specification errors
  - formal specification + verification

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## Fault avoidance

- Formal development
- Dependable programming [13.4]
  - Hiding, ADT, OOP
  - Name all constants
  - Check inputs, array bounds
  - Exception handling
  - Timeouts, restarts, rollbacks

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- Minimize error-prone constructs
  - pointers - pointer arithmetic
    - impossible to verify too
  - dynamic memory management
    - stack overflow (recursion)
  - floating point numbers
    - beware of integer overflow too
  - aliasing, inheritance (name - object)
  - parallelism, interrupts

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## Fault detection and correction

- Cannot test "shall not" requirements
- Formal verification [15.1]
  - Model checking
  - Correctness proofs
- Safety cases [15.5]
  - Structured argument: "this cannot happen"
  - Producing the argument reveals: "it can happen" = fault detection

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## Process [13.2, 15.4]

- Standardized process
  - Precise specification
    - Assign Safety Integrity Level (SIL)
  - Safety reviews (hazard monitoring)
  - Diverse verification (inspection, model checking, test, proof)
  - Version management
- Quality culture (process is accepted)

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## Process

- Documentation
  - Auditable
- Independent safety regulator
  - process is dependable
    - do we have the right process
  - process is followed
    - are we doing the process right

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