Fault Tolerant System Design

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What is Fault Tolerance ?

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Why use Fault Tolerance?

It is Written:
"To err is human, but to ***really*** foul up takes a computer"

- Computers are used where system failure would be catastrophic in terms of money, human lives, or ecosystem.
- Applications: Process Control, Patient Monitoring Systems, Missile guidance & Control, Air Traffic Control, Fly-by-Wire Aircraft, Transaction Processing, Stock Market

Fault-Tolerant System Design

- Different flavors, e.g.
  - General Fault Tolerance
  - Design for Testability
  - FT for safety critical applications
  - Hardware Fault Tolerance
  - Software Fault Tolerance
  - Related terms/concepts:
    - » Survivability
    - » Resilience
    - » ...

Introduction

- Designing Safety-Critical Computer Systems
  - the discussion below is directly drawn from the same-called article by William R. Dunn, IEEE Computer, Vol. 36 , Issue 11 (November 2003), Pages: 40-46.
  - to avoid visual clutter references, e.g., of figures etc. are omitted

- More and more computers are used to control safety-critical applications
  - fly-by-wire, hospital life-support systems, manufacturing robots etc.
  - coming up: steer-by-wire automotive systems, automated air- and surface-traffic control, powered prosthetics, smart Grid, etc.

Introduction

- Concern: can these systems fail and cause harm?
  - early example: Therac 25 therapeutic computer system accidents
- Concern: proposed system concepts and architectures
  - have been found to be impractical for safety critical real-life engineering applications
  - fail in practice for three primary reasons:
    - » originators or users
      - have incomplete understanding of what makes a system safe
      - fail to consider the larger system into which the system in integrated
      - ignoring single point of failure

Introduction

- Therac-25:
  - Radiation therapy machine produced by Atomic Energy of Canada Limited (AECL) and CGR of France after the Therac-6 and Therac-20.
  - Between June 1985 and January 1987 involved in six accidents involving massive overdoses of radiation, which resulted in patient deaths and serious injuries.
  - Described as worst series of radiation accidents in history of medical accelerators.
  - "*The mistakes that were made are not unique to this manufacturer but are, unfortunately, fairly common in other safety-critical systems*", [1]

- source: [1] Nancy G. Leveson and Clark S. Turner, *An Investigation of the Therac-25 Accidents*, IEEE Computer, Vol. 26, Issue 7, July 1993.

Introduction

- Defining "Safe"
  - We often think "safe" w.r.t. driving a car, flying etc.
    - » e.g. "is it safe to drive?"
    - » one thinks of a *mishap*
  - Mishap
    - » MIL-STD-882D definition: "*An unplanned event or series of events resulting in death, injury, occupational illness, damage to or loss of equipment or property, or damage to the environment*."
  - Mishap Risk
    - » MIL-STD-882D definition: "*An expression of the impact and possibility of a mishap in terms of potential mishap severity and probability of occurrence.*"
    - » Example: airline crash vs. fender-bender: less likely, but higher impact
    - » What is the important message here:
      - **Systems are never absolutely safe => thus reduce risk...**

Introduction

- Acceptable Mishap Risk
  - public establishes acceptable risk for a given mishap
  - willingness to tolerate mishap as long as it occurs infrequently
  - typical fail rates: 10^{-2} to 10^{-10} per hour
  - how do designers decide on what constitutes an acceptable risk?
    - » they don't!
    - » they rely on standards such as
      - MIL-STD-882D
      - IEC 61508, Functional safety of electrical/electronic/ programmable electronic safety-related systems.

Introduction

- Computer System
  - Application
    - » physical entity the system controls/monitors, e.g. plant, process
  - Sensor
    - » converts application's measured properties to appropriate computer input signals, e.g. accelerometer, transducer
  - Effector
    - » converts electrical signal from computer's output to a corresponding physical action that controls function, e.g. motor, valve, break, pump.
  - Operator
    - » human(s) who monitor and activate the computer system in real-time, e.g. pilot, plant operator, medical technician
  - Computer
    - » hardware and software that use sensors and effectors to control the application in real-time, e.g. single board controller, programmable logic controller, flight computers, systems on a chip.

Introduction

- Hazard Analysis
  - Hazard
    - » MIL-STD-882D definition: "*Any real or potential condition that can cause injury, illness, or death to personnel; damage to or loss of a system, equipment or property; or damage to the environment*."
  - examples: loss of flight control, nuclear core cooling, presence of toxic materials or natural gas

Introduction

- System design
  - identify hazards of application components
  - next, determine how operator, sensor, computer and effectors can fail and cause mishaps
    - » use failure-modes analysis to discover all possible failure sources in each component, i.e. operator, sensor, computer and effector
    - » includes random hardware failure, manufacturing defects, program faults, environmental stresses, design errors, maintenance mistakes
  - now the design can begin

Introduction

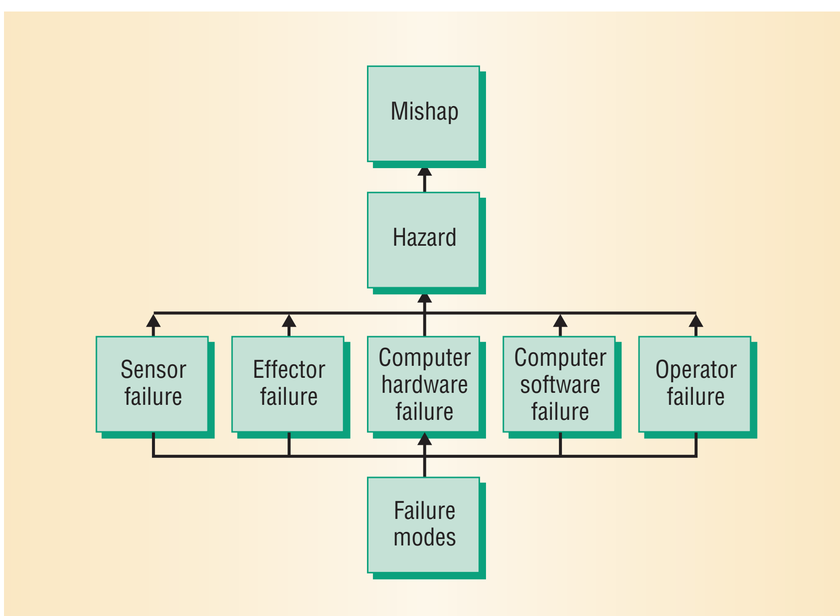

Figure 1. Mishap causes. System designers identify the application's attendant hazards to determine how system-component failures can result in mishaps.

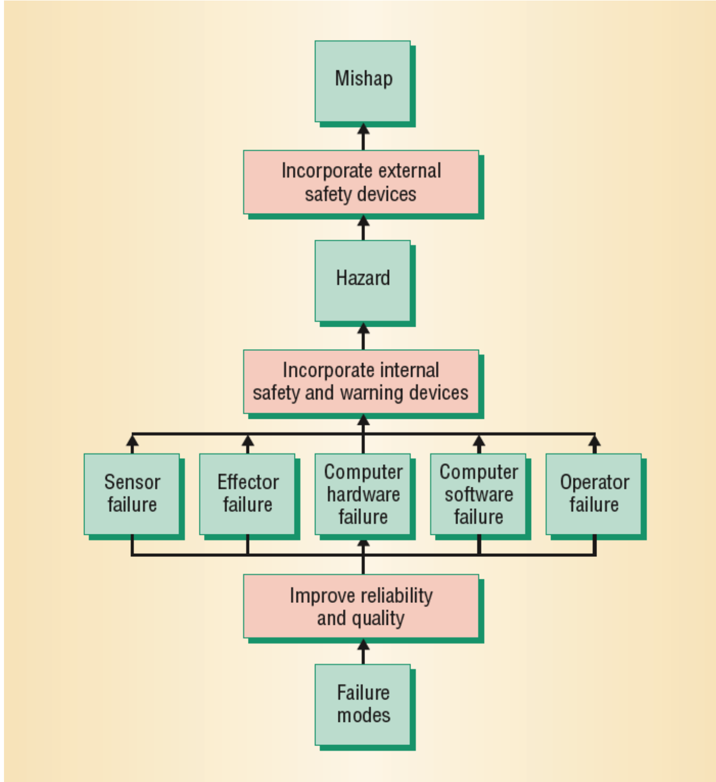

Figure 2. Risk mitigation measures. Designers can modify a system to reduce its inherent risk by improving component reliability and quality and by incorporating internal or external safety and warning devices.

Introduction: Example

- Example: computer system used for electrically heating water
  - Application
    - steel tank containing water
  - Effector
    - computer-controlled electric heating elements
  - Sensor
    - temperature sensor measures water temp and transmits to computer
  - Computer
    - software in the computer maintains water temp at 120F by controlling heating element
      - ON if water temperature is below target
      - OFF otherwise

Introduction Example

- Example cont.
  - Hazard
    - » e.g. water could overheat
  - Mishap
    - » e.g. overheated water could cause tank to explode
    - » e.g. person opens faucet and gets scald by overheated water or steam
  - Failures that could create this hazard
    - » temperature sensor malfunction signaling "low temperature"
    - » heater unit may fail and remain on permanently
    - » computer interface hardware might fail permanently signaling an "ON" state to the heater
    - » computer software fault, possibly in unrelated routine, might change the set point to 320F
    - » operator might program an incorrect set point

Introduction

- Failures that could create this hazard, (cont.)
  - » maintenance error, e.g. repair person installs wrong temperature sensor.
  - » environmental condition, e.g. overly warm application location causes chips to fail
  - » design failure that results in using the wrong sensor for the selected operating temperature.

- This water heating system (as it stands) has unacceptable risk of mishap!

Introduction

- Mishap Risk Mitigation
  - Options:
    - 1) improve component reliability and quality
      - seeks to lower probability of component failure
      - which in turn reduces probability of mishap
    - 2) incorporate internal safety and warning devices
      - e.g. thermocouple device turns off gas to home heater when pilot goes out
    - 3) incorporate external safety devices
      - range from simple physical containment to computer-based safety-instrumented systems
  - Designers should apply all of these options
    - ensure distributed, **non-single-point-of-failure** implementation

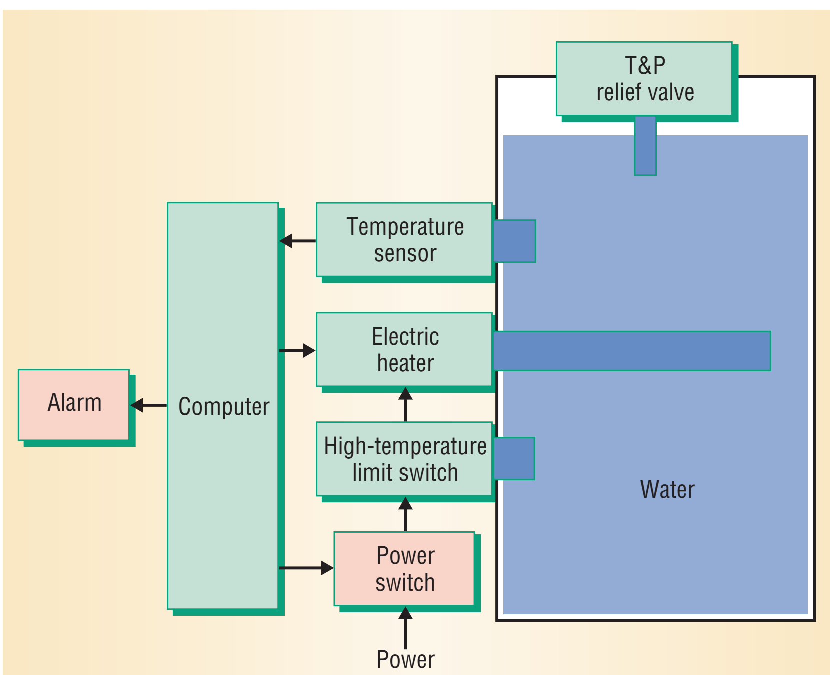

Figure 3. Applying risk-mitigation measures. The addition of safety devices such as a high-temperature limit switch and a temperature-and-pressure (T&P) relief valve has reduced the computer-controlled water heating system's operational risk.

Introduction

- Additional Safety Devices

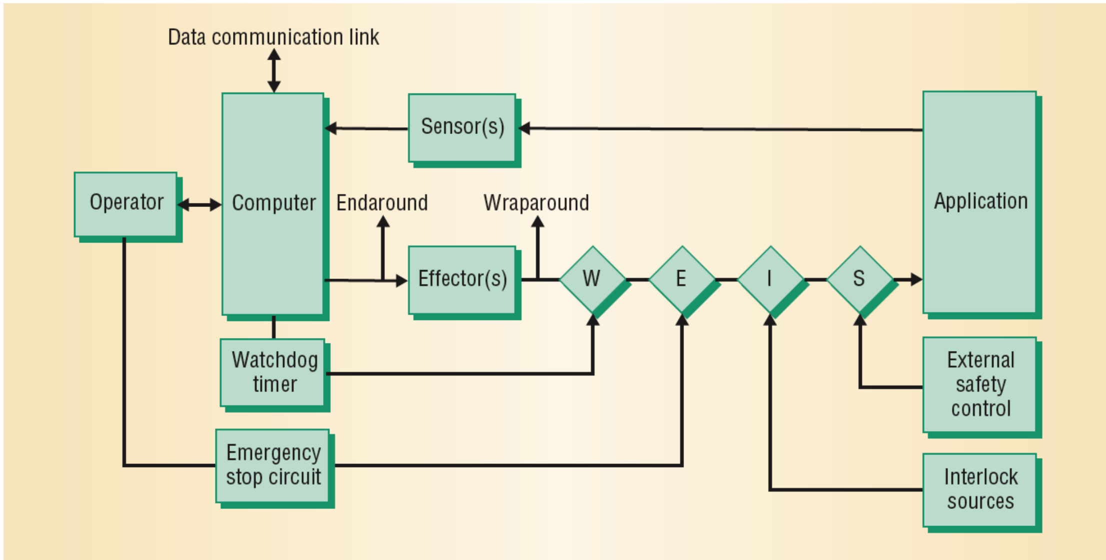

Figure 4. Risk mitigation methods. Designers have added several risk-mitigation devices to this system, including a watchdog timer, emergency stop circuit, and interlocks that inhibit effector actions unless specific external conditions are satisfied.

Introduction

- Fail-Operate Systems
  - Fail-Safe System
    - » after failure is detected, systems enters a safe state, by modifying effector outputs, e.g. shut system down.
  - Fail-Operate System
    - » many computer systems cannot just be shut down
    - » e.g. fly-by-wire aircraft control system
    - » system must continue safe operation even after one or more components have failed
    - » tolerating faults is the goal of fault-tolerant system design
    - » strongly relies on the principle of redundancy

Introduction

- Fail-Operate System
  - » principle of redundancy is simple in concept, but hard to implement
  - » all critical system components must be replicated
    - i.e. computers, sensors, effectors, operators, power source, interconnect.
    - ... not to mention the issue of homogeneous vs inhomogeneous redundancy (identical vs dissimilar)
  - » redundancy management needs to be incorporated into hardware, software, operator components
    - detect failure
    - isolate failed component
    - reconfigure components
    - we will address reconfiguration and masking extensively later in the course
  - » system cost and complexity increase fast

Introduction

- Evaluating Safety-Critical Computer Systems
  - Failure Modes and Effects Analysis (FMEA)
    - » for each component consider how it can fail, then determine the effects each failure has on the system
    - » goal is to identify single point of failure
  - Fault-Tree Analysis (FTA)
    - » identify mishap and identify all components that can cause a mishap and all the safety devices that can mitigate it.
  - Risk Analysis (RA)
    - » quantitative measure yielding numerical probabilities of mishap
    - » need failure probabilities of components

Introduction

- Reliability Modeling
  - considering all components, redundant and non-redundant, determine the probability that the system will (reliability) or will not (unreliability) operate correctly (one hour typical)

- Design Strategy
  - use fault tree to evaluate overall probability of failure
  - can consult probabilities of fault tree to identify where to apply mitigation
  - need to re-design sections that contribute heavily to unreliability
  - continue this process until desired reliability is achieved

Finding a Compromise

How much fault-tolerance is needed for a system or application?

High cost vs. customer dissatisfaction/loss of market shares

Systems operate just below the threshold of pain

Top Five Challenges

- Ram Chillarege (1995) writes:

  The top 5 challenges, which ultimately drive the exploitation of fault-tolerant technology are:

  1) Shipping a product on schedule
  2) Reducing Unavailability
  3) Non-disruptive Change Management
  4) Human Fault Tolerance
  5) Distributed Systems

  Article source: Lecture Notes In Computer Science; Vol. 774, 1999

  - the points made in the article still hold

Shipping Product on Schedule

- extreme pressure to reduce product cycle
- competitive market
  - introduce products faster
- FT adds cost in Hardware, Design, Verification
  - increase development cycle
- compressed schedule can result in greater # of errors
  - errors escape into field

Reducing Unavailability

- Outage and their Impacts:
  - software & procedural issues (operator errors)
  - hardware & environmental problems

- Years ago: Hardware problems dominant
- Improvements in manufacturing & technology
- Improvements in software not significant
  - software problems now dominate outages
  - Software Bugs:
    - » total failure < 10%
    - » partial failure 20% - 40% (requires some response)
    - » rest: Annoyance, update later, update via maintenance

Reducing Unavailability cont.

Down-Time (largest outage part)

- upgrades - maintenance - reconfiguration	planned outage
- act of technology/nature - commonly the target of FT design	unscheduled outage

Some commercial applications
- 24 x 7 operations
- reduce outage from all sources

Non-Disruptive Change Management

- Maintenance on Software
  - most software is not designed to be maintained
  - non-disruptive
- One Solution: hot standby

- The Problem of First Failure Data Capture (FFDC)
  - trap, trace, log adequate information
  - FFDC mostly poor
  - error propagation makes it harder to find root cause of problem
  - problems in re-creating

Human Fault Tolerance

- Human Comprehension of task =
  - non-defect oriented problem
  - no code change required

- Design System to tolerate human error

Distributed Systems

- Now consider Distributed Systems
- We need to start "all over again"

Fault-Tolerance & Ultra Reliable Systems

- Fly-by-Wire, Airbus 320
  - computer controls all actuators
  - no control rods, cables in the middle
  - 5 central flight control computers
  - different systems used (Thomson CSF=> 68010, SFENA=> 80186)
  - software for both hardware written by different software houses
  - all error checking & debugging performed separately
  - computer allows pilot to fly craft up to certain limits
  - beyond: computer takes over

Airbus A320/A330/A340 Electrical flight Controls: A Family of Fault-Tolerant systems, D. Briere, and P. Traverse, FTCS-23, pp.616-623, 1993.

Fault-Tolerance & Ultra Reliable Systems

* Many aircraft use active control
    F16
    forward swept wing X-29
      could not fly without computers
      moving control surfaces
* Burden of proof that fly-by-wire system
  is safe for civil flight has shifted to training
  environments and simulation.

Fault-Tolerance & Ultra Reliable Systems

- Many aircraft use active control, e.g.,
  - e.g., F16, forward swept wing X-29 could not fly without computers moving control surfaces
- Burden of proof that fly-by-wire system is safe for civil flight has shifted to training environments and simulation.
  - e.g., Boeing 777