

# Human Robot Interaction I

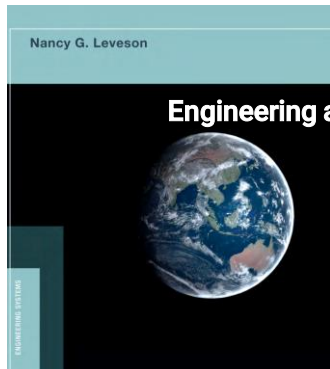
Prof. Dr. Marian Daun



## Safety Engineering



## Recommended Reading



[https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKewjezrGE36H\\_AhVFCuwKHSewCdcQFnoECAoQAQ&url=https%3A%2F%2Flibrary.oapen.org%2Fbitstream%2F20.500.12657%2F26043%2F1%2F1004042.pdf&usg=AOvVaw2IziuP7bKPZ1UGIqV1BCEy](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKewjezrGE36H_AhVFCuwKHSewCdcQFnoECAoQAQ&url=https%3A%2F%2Flibrary.oapen.org%2Fbitstream%2F20.500.12657%2F26043%2F1%2F1004042.pdf&usg=AOvVaw2IziuP7bKPZ1UGIqV1BCEy)

## Fundamentals of Safety Engineering

# Safety-Critical Software-Intensive Systems

Many systems nowadays take on safety-critical functionality. As with almost all innovations, they achieve their functionality mainly through the use of software.

## Examples:

### Automotive Electronic Stability Program

monitors speed and yaw rate and activates wheel individual brakes to ensure safe trajectory in curve while decelerating

### Airborne Traffic Collisions Avoidance Systems

detects other aircraft on collision course and advises flight crew to increase separation altitude

### Airborne Wing Control Software

adjusts flight surface parameters depending on "cargo" and fuel consumption

### Industry 4.0 manufacturing cell supply chain monitoring software

monitors the supply of raw material, work products, and intrusion of foreign objects into the manufacturing cell

# Safety – What is that?

"Safety" denotes the **absence of the potential harm during operation** for

human users

human non-users (e.g., "innocent bystanders," other stakeholders)

external systems

the system itself (sometimes... depending who you ask)

the environment (e.g., through pollution)

"Harm" could entail...

injury

**death**

destruction

Which can lead to **"risk"**, such as

- financial loss
- legal liability
- loss of reputation

Please note, that "risk" in this sense means "risk to the company making the product". Later, we will call "risk" the **"probability of something bad happening."**



## Group Discussion

# Why is there no absolute safety?



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## But...

The development process must ensure  
that during operation, the system will be  
**sufficiently safe.**



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## Group Discussion

# What does sufficiently safe mean?

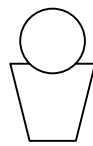


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## Difference between Safety and Security



**Safety:** System's behavior harms external entities by causing injury, death, or destruction.



System under Development



**Security:** Malicious, external entities exploit system's behavior to control or obtain assets.



System under Development



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# Safety Requirements Engineering Definitions

## **Hazard-Inducing Requirement**

A functional safety-related requirement in the sense of [Firesmith 2004], which is the origin of a hazard during operation, given the occurrence of trigger conditions from the operational context of the system.

## **Hazard-Mitigating Requirement**

A functional safety-related requirement in the sense of [Firesmith 2004], which, possibly together with other hazard-mitigating requirements, mitigates a hazard.

## **Hazard**

An **operational situation** that – given disadvantageous triggering conditions from the operational context of the system – could lead or contribute to harm to come to humans or systems.

## **Trigger Condition**

An **operational or environmental condition**, which may occur during operation such that a hazard is caused and must hence be avoided or rendered sufficiently unlikely to occur during operation for the hazard to be mitigated.

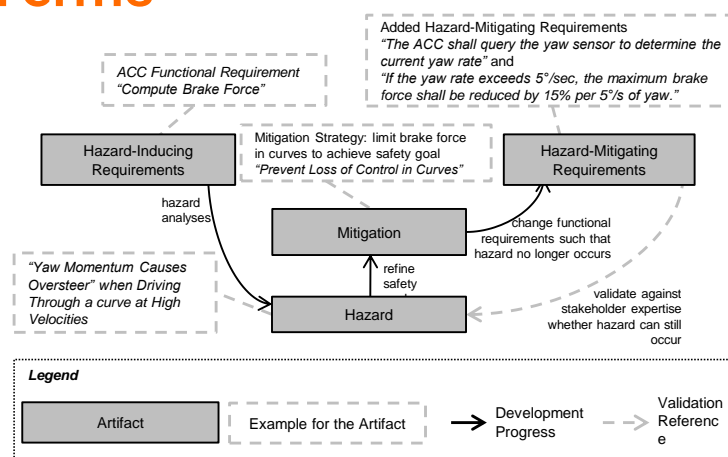
## **Safety Goal**

A statement about the system's safety or specific safety property the system possesses or shall possess.

## **Mitigation**

A **set of hazard-mitigating requirements**, which refine a safety goal into **concrete, implementable measures** that are intended to mitigate a specific hazard.

# Example of the Relationship of these Terms



# The Software Safety Development Process

## Safety Assessment

Safety Assessment is the collection of all activities carried out during development to ensure that the system is sufficiently safe.

### Safety Engineering

**Safety Engineering is the academic study of the processes underlying safety assessment during development of safety-critical systems.**

# Safety Assessment during “Early” and “Late” Stages of Development

## “Early” Stages of Development:

### “left side of the V”

Activities **before** implementation

The further up in the V, the earlier

### Purpose during Safety Assessment:

Find out which harm could occur.

**Design the system to avoid harm** or protect humans.

## “Late” Stages of Development:

### • “right side of the V”

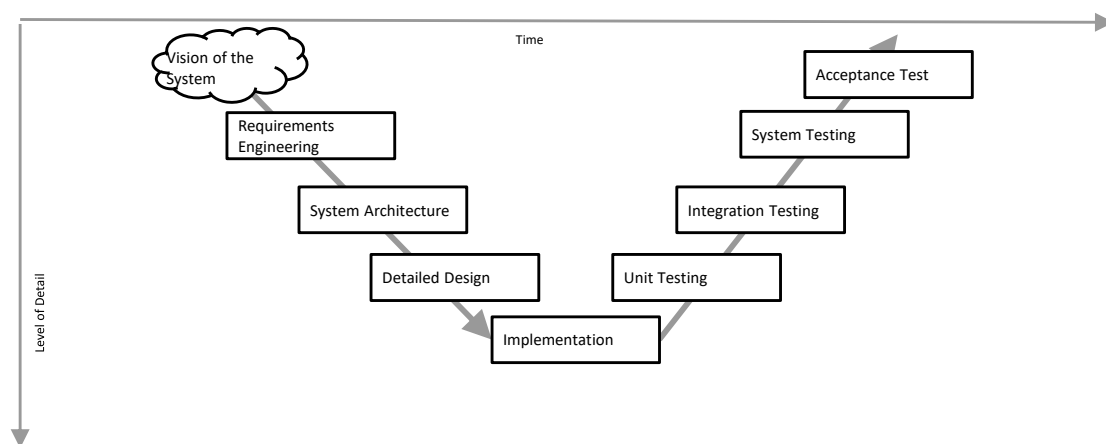
• Activities **after** implementation

• The further up in the V, the later

### Purpose during Safety Assessment:

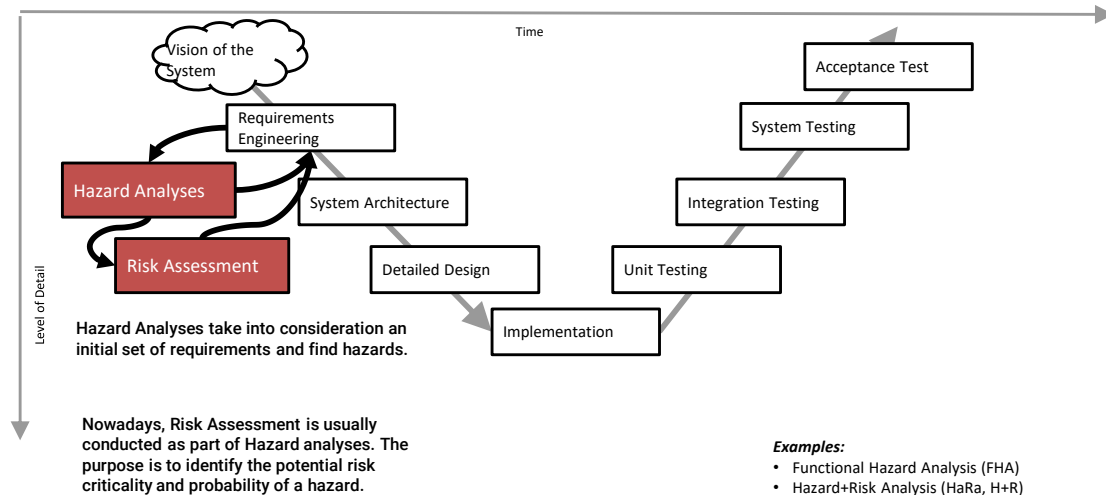
Find out **if the system was designed to avoid harm** or protect humans well enough. Fix, if necessary.

# The Software Development Process

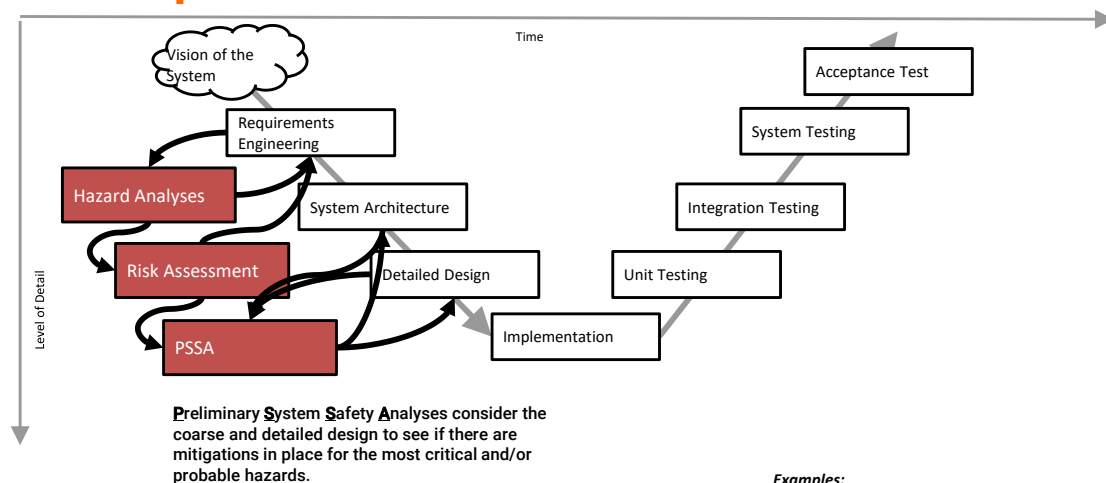




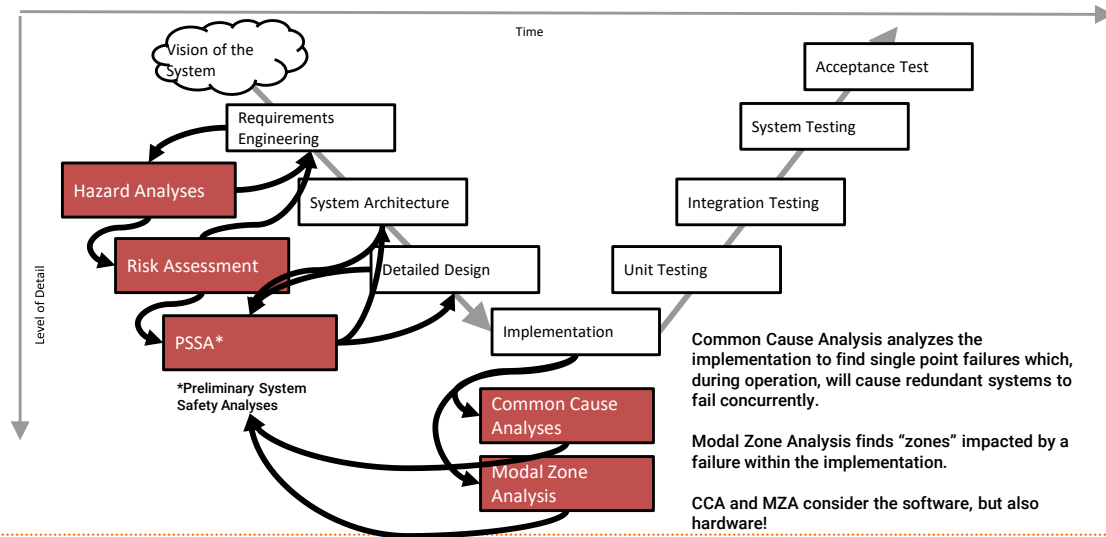
# The Software Safety Development Process



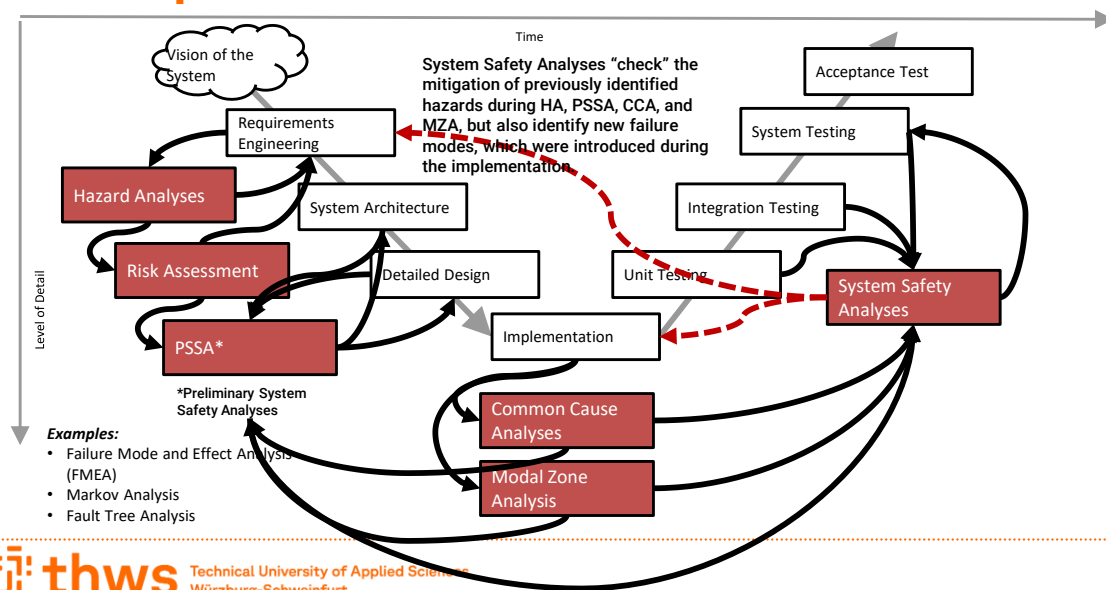
# The Software Safety Development Process



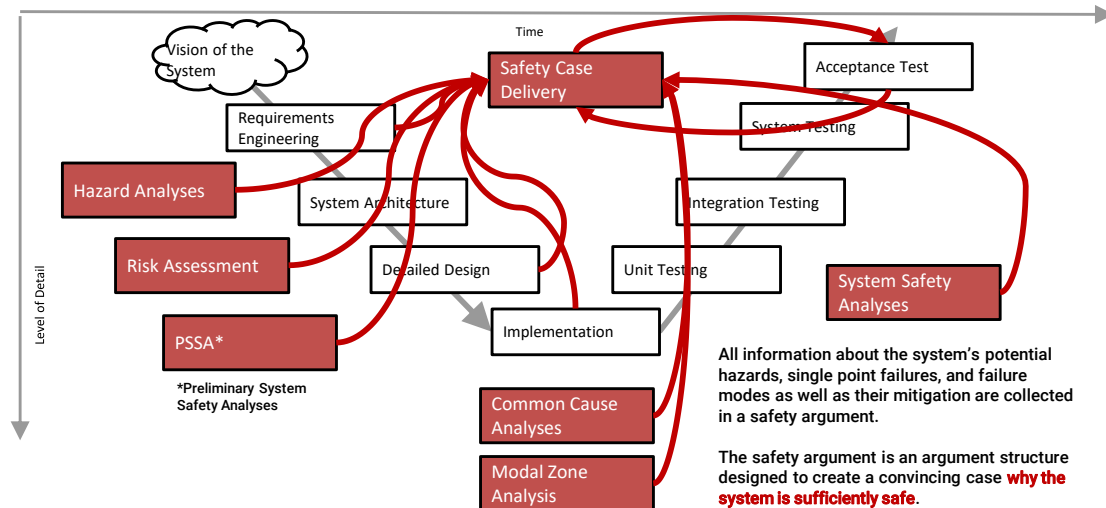
# The Software Safety Development Process



# The Software Safety Development Process



# The Software Safety Development Process



## Lifecycle of Safety Requirements

# Requirements

## Requirements Types



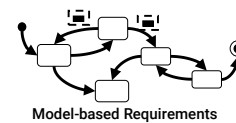
## Requirements Artifact Types

Goals

Scenarios

Solution-oriented Requirements

## Documentation Format



## Group Discussion

# What is a Safety Requirement?

## Safety Requirements

Depending on whom you ask, the term “**safety requirement**” means something different.

*Safety requirements could be...*

**Quality** (“non-functional”) requirements

- safety is a type of quality property of the system

**Goals** in goal-based requirements engineering

- see the GRL learning materials

**Solution-oriented** requirements in the **Functional** Perspective

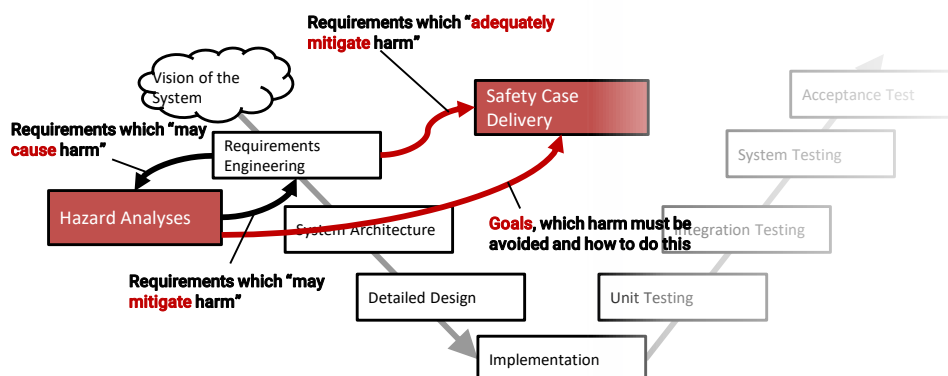
- for example, function “deploy airbag”

**Solution-oriented** requirements in the **Behavioral** Perspective

- for example, function “deploy airbag”

## The Role of Safety Requirements

It becomes even more complicated when you look at this:



## Summary

Safety Engineering is the study of processes underlying safety assessment.

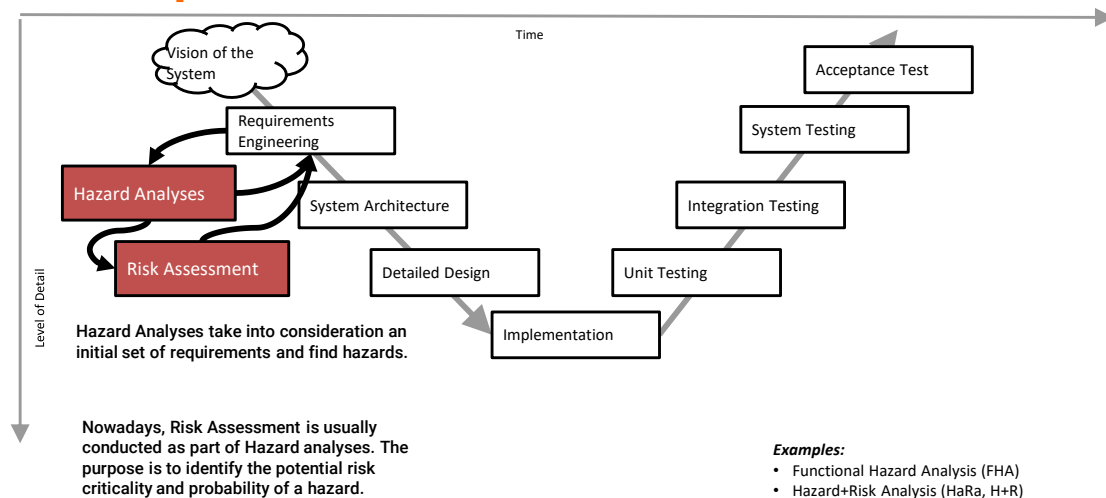
**Safety Assessment** describes the collection of **processes** that are **parallel to the regular development process**, which comprise all activities pertaining to the establishment of hazards, the design of mitigations, and the validation/verification that the mitigations are adequate.

**Identified hazards, mitigations, and analysis results** become part of a **safety argument**.

The safety argument documents that a system is sufficiently safe during operation.

## Hazard Analyses

# The Software Safety Development Process



# The Purpose of Hazard Analyses

## Hazard

An **operational situation** that – given disadvantageous triggering conditions from the operational context of the system – could lead or contribute to harm to come to humans or systems.

Hazard Analyses **consider the functionality** of the system and identify:

operational situations, in which harm could occur

(i.e., **hazards**)

the conditions, under which the hazard occurs

(i.e., the **trigger conditions**)

A principle strategy or desired property to mitigate the hazard

(i.e., the **safety goal**)

## Types of Hazard Analyses (Examples)

### *Functional Hazard Analysis* (FHA)

Common in the aviation industry and US military applications

mandated by ARP 4761, FAA, US DoD

→ common in the avionics domain

Also includes a **risk analysis** component

### *Hazard and Risk Analysis* (HaRa, H+R Analysis)

Common in the automotive industry

mandated by ISO26262

→ common in the automotive domain

Also includes a risk analysis component

Almost the same thing as FHA

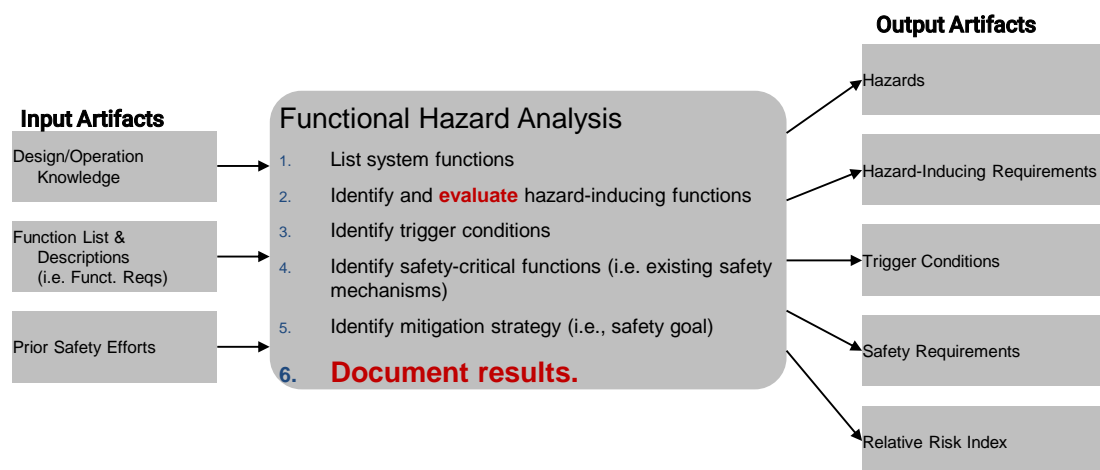
### *Hazard and Operability Studies* (HAZOP)

Predecessor to FHA and H+R

mandated by (the now superseded) UK DoD MIL Std 882e

Focuses on exceptional behavior, not so much risk

## FHA Process Overview





## FHA Input Artifacts

### Input Artifacts

Design/Operation Knowledge

Function List & Descriptions  
(i.e. Funct. Reqs)

Prior Safety Efforts

**Context of the System**  
& lots and lots of Experience

Functions within the Context,  
**Functional Solution-Oriented Requirements**,  
sometimes also Static-Structural SORs,  
& lots and lots of Experience

Prior Hazard Analyses and other kinds  
of safety-relevant analyses and documents,  
all documented in the **Context of the System**  
& lots and lots of Experience



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## FHA Process Details

### Functional Hazard Analysis

1. List system functions
2. Identify and **evaluate** hazard-inducing functions
3. Identify trigger conditions
4. Identify safety-critical functions (i.e. existing safety mechanisms)
5. Identify mitigation strategy (i.e., safety goal)
6. **Document results.**

Write them all down, one by one.

**Purpose: If you wrote them down, this means you thought about it and didn't forget.**

Apply **guidewords!**

What happens, if the function/requirement...

1. ... executes **too early?**
2. ... executes **too late?**
3. ... **fails** to execute?
4. ... **executes, but shouldn't?**
5. ... executes, but renders **wrong value?**

This about **when and why**.

You may want to look at:

- **Scenarios**
- **Behavioral SORs**
- **Conditions** in the Context



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CSC436 Unit 06: Hazard Analyses and Mitigation Strategies

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# Document Results

276 FUNCTIONAL HAZARD ANALYSIS

Wait... what about  
Risk Assessment?

System Subsystem: <sup>1</sup>		Functional Hazard Analysis						Analyst: <sup>3</sup> Date: <sup>4</sup>	
Function	Hazard No. <sup>2</sup>	Hazard	Effect	Causal Factors	IMHI	Recommended Action	FMRI	Comments	Status
<sup>5</sup>	<sup>6</sup>	<sup>7</sup>	<sup>8</sup>	<sup>9</sup>	<sup>10</sup>	<sup>11</sup>	<sup>12</sup>	<sup>13</sup>	<sup>14</sup>

Page: 1 of n

## Risk Assessment in FHA (and many other HAs)

System Subsystem: <sup>1</sup>		Functional Hazard Analysis						Analyst: <sup>3</sup> Date: <sup>4</sup>	
Function	Hazard No. <sup>2</sup>	Hazard	Effect	Causal Factors	IMHI	Recommended Action	FMRI	Comments	Status
<sup>5</sup>	<sup>6</sup>	<sup>7</sup>	<sup>8</sup>	<sup>9</sup>	<sup>10</sup>	<sup>11</sup>	<sup>12</sup>	<sup>13</sup>	<sup>14</sup>

**Initial and Final  
Mishap Risk Indices**

**This** could go wrong,...

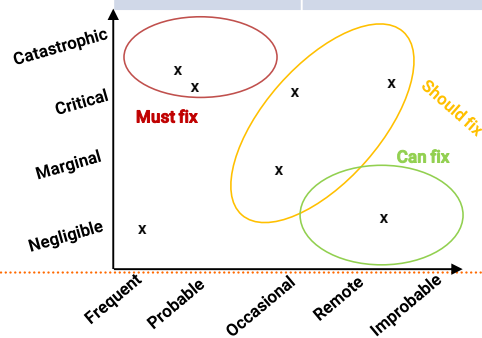
... which is approx. **this** likely,...

... but if we do **this**...

... It might only be **this** likely.

### Assessing Risk:

Severity	Probability
1: Catastrophic	A: Frequent
2: Critical	B: Probable
3: Marginal	C: Occasional
4: Negligible	D: Remote
	E: Improbable



## FHA Output Artifacts

### Output Artifacts

Hazards

Hazard-Inducing Requirements

Trigger Conditions

Safety Requirements

Relative Risk Index

276 FUNCTIONAL HAZARD ANALYSIS

System Subsystem		Functional Hazard Analysis					Analyst Date		Comments		Status
Function	Hazard No.	Hazard	Effect	Causal Factors	IMHI	Recommended Action	FMRI				
5	6	7	8	9	10	11	12		13		14

Page 1 of n

## Hazard Mitigation Strategies

## So.... We have the Safety Goals... Now what?

Hazard Analyses are but **the first step in the safety development process**.

Now, we need to find mitigations to implement the safety goals.

### **Mitigation**

A **set of hazard-mitigating requirements**, which refine a safety goal into **concrete, implementable measures** that are intended to mitigate a specific hazard.

## Mitigations

A mitigation must exist **for each hazard**.

Mitigations subsume requirements that establish safety. These are called **hazard-mitigating requirements**.

But, there is rarely a 1:1 correspondence...

**One-to-One:** One hazard-mitigating requirement exists for one hazard.

**One-to-Many:** One hazard-mitigating requirements exists for multiple hazards.

**Many-to-One:** A number of hazard-mitigating requirements exist to mitigate one hazard.

**Many-to-Many:** A number of hazard-mitigating requirements exist to mitigate multiple hazards.

## Mitigation Strategies

### Hazard Prevention.

A hazard is mitigated by **preventing** the hazard's **trigger conditions** from occurring during operation.

### Hazard Reduction.

A hazard is mitigated by reducing the **likelihood** of the **hazard to occur**, e.g., by reducing the likelihood of the trigger conditions to occur.

## Mitigation Strategies

### Accident Prevention.

If a hazard cannot be prevented or sufficiently reduced, a mitigation can prevent the occurrence of a harmful accident due to a hazard.

### Damage Control.

If a hazard can neither be prevented, nor sufficiently reduced, nor can an accident be prevented, a mitigation can aim to **protect** human users from injury, protect external systems from damage, **or reduce the severity of such harm**.

This could be achieved, for example, by means of **additional functionality** intended specifically for damage reduction.

## Summary

Hazard Analyses identify

- Hazards

- Trigger Conditions

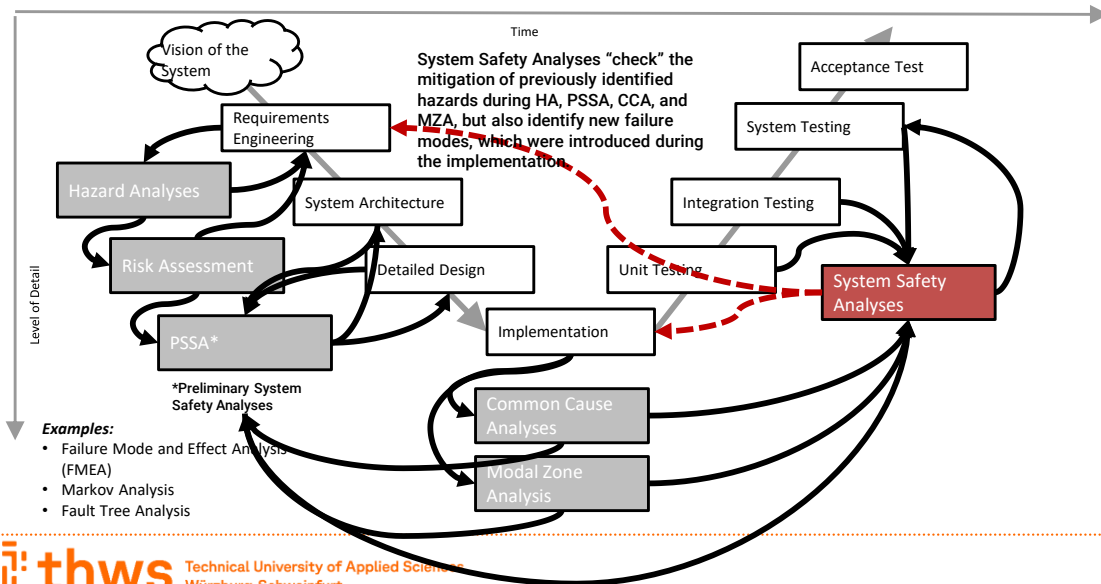
- Safety Goals

Take into account functional requirements → **hazard-inducing requirements**

Aim: find mitigation strategies and **hazard-mitigating requirements** for the most hazards with **highest severity and probability**

## Failure Mode and Effects Analysis

# The Software Safety Development Process



# The Purpose of Safety Analyses

Safety Analyses consider the **implemented functionality** of the system and identify:

possible failures, which could lead to harm (i.e., **hazards**)

the conditions, under which the failures occur (i.e., the **trigger conditions**)

the state the system and the context is in when a failure occurs (i.e., the **failure mode**)

the local and systemic impact of the failures (i.e., the **effects**)

a principle strategy or desired property to mitigate the hazard (i.e., the **safety goal**)

## Subtypes of FMEA (Examples)

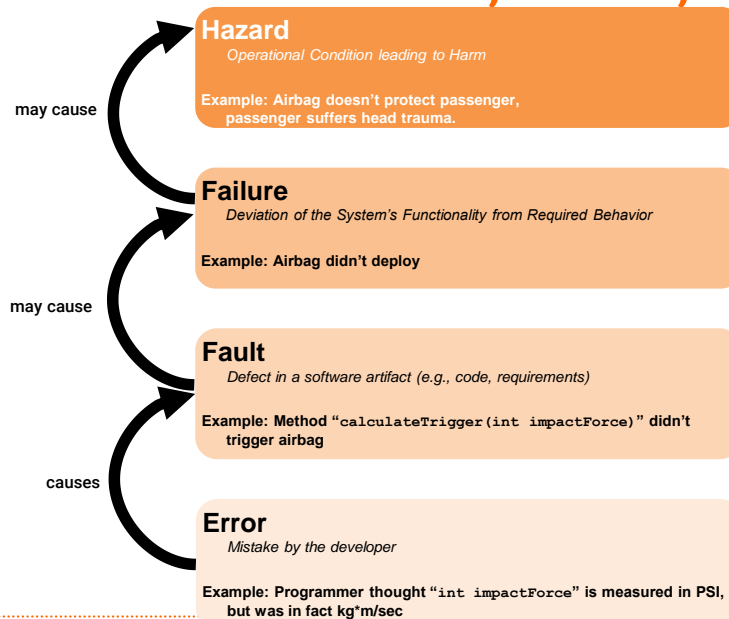
### *Failure Mode and Effects Analysis* (FMEA)

Common in the automotive, aviation, and US military applications  
mandated by ARP 4761, ISO26262, and international agencies  
Also includes a **risk analysis** component

### *Failure Mode, Effects, and Criticality Analysis* (FMECA)

Also includes a risk analysis component  
Sometimes also includes a **reliability analysis** component

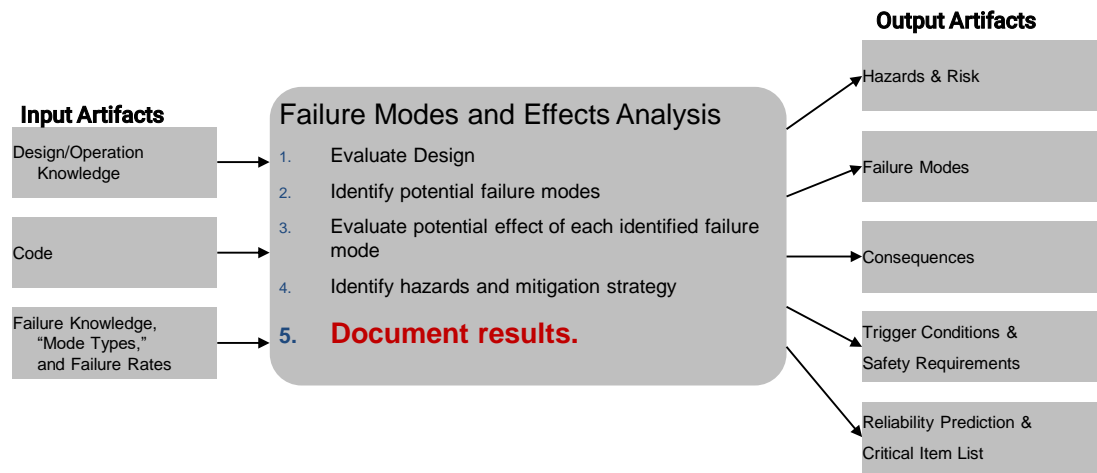
## Causal Chain of Errors, Faults, and Failures



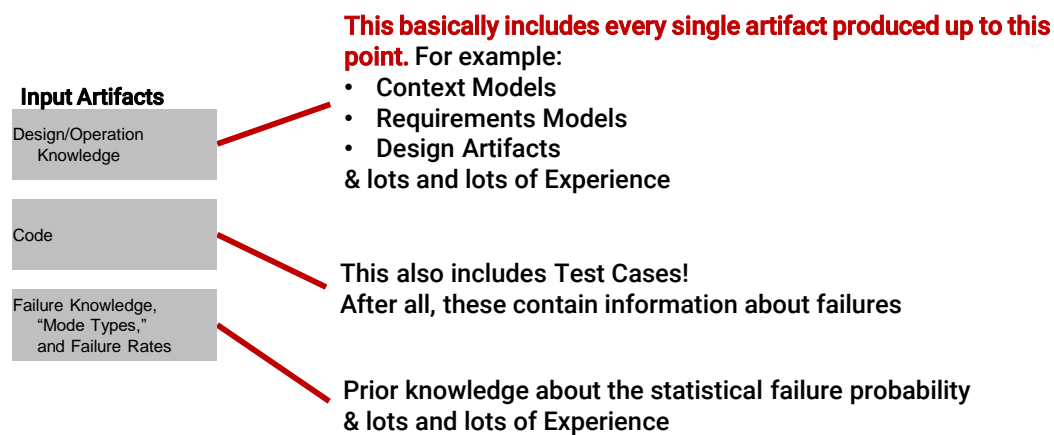
based on [Spillner & Linz, 2005]



# FMEA Process Overview



# FMEA Input Artifacts



## FMEA Process Details

### Failure Modes and Effects Analysis

1. Evaluate Design
2. Identify potential failure modes
3. Evaluate potential effect of each identified failure mode
4. Identify hazards and mitigation strategy
5. **Document results.**

### Think about:

- System purpose
- System's components
- Intended interactions
- **Possible exceptions and alternatives**

### Apply guidewords!

What happens, if the function/component...

1. ... executes **too early**?
2. ... executes **too late**?
3. ... **fails** to execute?
4. ... **executes, but shouldn't**?
5. ... executes, but renders **wrong value**?

This largely **overlaps with software quality assurance**:

- What is the **failure**?
- What will happen to the component?
- What will happen to the system?
- What will happen to a human user or external system?
- What is the **fault**?
- What could be the **error** made by a human?

## Document Results

250 FAILURE MODE AND EFFECTS ANALYSIS

Trace to a Hazard from FHA!  
If you found a new one here, add it to an FHA document.

Risk Assessment Index  
Just like in Hazard Analyses

What happens to the function?

What happens to the rest of the system?

Failure Mode and Effects Analysis										
System: (1)			Subsystem: (2)				Mode/Process: (3)			
Item	Failure Mode	Failure Rate	Causal Factors	Immediate Effect	System Effect	Method of Detection	Current Controls	Hazard	Risk	Recommendation
(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)

Figure 13.8 Example FMEA worksheet

SEVERITY PROBABILITY				
	Catastrophic (1)	Critical (2)	Marginal (3)	Negligible (4)
Frequent (A)	High	High	Serious	Medium
Probable (B)	High	High	Serious	Medium
Occasional (C)	High	Serious	Medium	Low
Remote (D)	Serious	Medium	Medium	Low
Improbable (E)	Medium	Medium	Medium	Low
Eliminated (F)	Eliminated			

## FMEA Output Artifacts

### Output Artifacts

Hazards & Risk

Failure Modes

Consequences

Trigger Conditions &  
Safety Requirements

Reliability Prediction &  
Critical Item List

Failure Mode and Effects Analysis										
System: (1)		Subsystem: (2)			Mode/Phase: (3)					
Item	Failure Mode	Failure Rate	Causal Factors	Immediate Effect	System Effect	Method of Detection	Current Controls	Hazard	Risk	Recomm Action
(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)

## Summary

Safety Analyses identify

- Safety critical deviations, which could lead to harm

- The failure modes, in which these deviations occur

- Trigger Conditions

- Safety Goals

Take into account implemented functionality → **code**

Aim: find mitigation strategies and **hazard-mitigating requirements** for the failures with **highest severity and probability** which lead to hazards

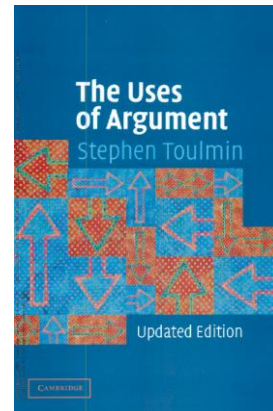
## Safety Argumentation

## Recommended Reading



This unit is mainly based on the work by  
**Prof. Dr. Tim Kelly**  
 University of York, <https://www-users.cs.york.ac.uk/tpk/>

Which in turn is based on  
 The Uses of Argument by Stephen Toulmin  
 Cambridge University Press, 1958



You may also want to look at:  
 A remarkably well-done tutorial on GSN: <http://modeling-languages.com/goal-structuring-notation-introduction/>  
 The GSN Standard Website:  
<http://www.goalstructuringnotation.info/>

## The Purpose of Safety Argumentation

The purpose of safety argumentation is to establish, maintain, and provide a **defensible argument about the system's safety**.

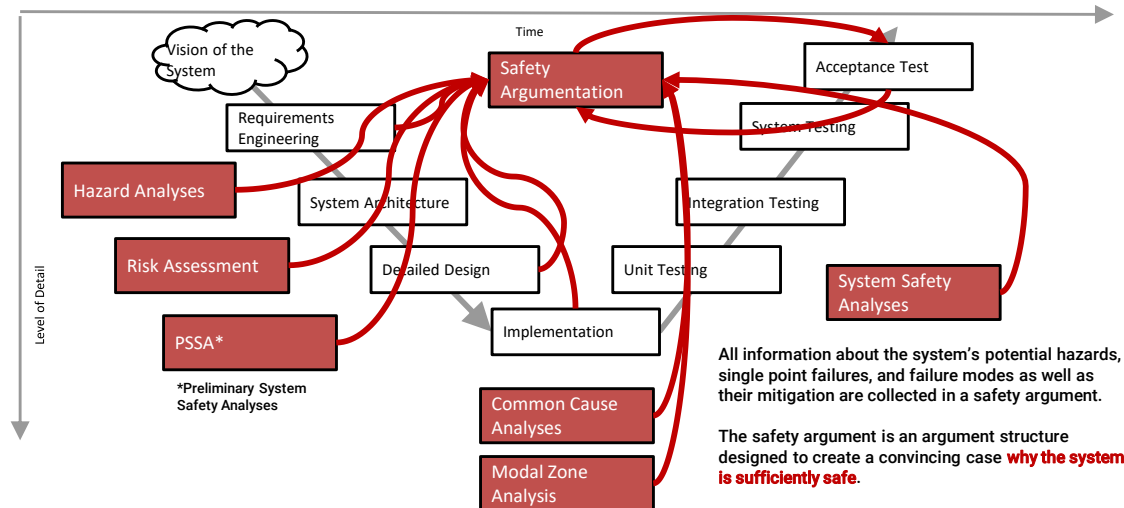
[Bishop et al. 2004], [Kelly 2007], [Tenbergen et al, 2015]

A safety argument is...

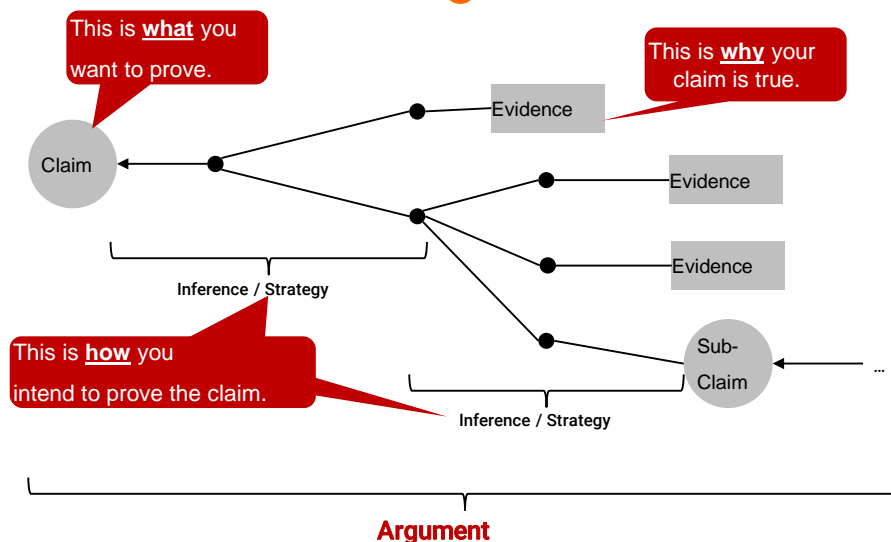
- ... established **throughout** development. You can't just "add on safety."
- ... maintained by systematically gathering **evidence about a safety claim**.
- ... provided to some type of authority for the **purpose of repudiation of liability or certification**.

A safety argument is not something you have. It's something you do.

# The Software Safety Development Process



# Structure of an Argument



## Building a Strong Safety Argument

The strength, defensibility, and irrefutability of a safety argument depends on three things:

*How strong is your **inference**?*

What do you have to argue?

How do you argue?

*How strong is your **evidence**?*

What type of evidence do you have?

How objective is the evidence?

How subjective is the evidence?

*How **confident** are you in your safety case?*

What did you do to be sure that your safety claims are accurate?

## Building an Argumentation Strategy (Inference)

*What do you have to argue? How do you argue?*

1. Start with the top level claim: "The system **is** safe."

Notice, that it does not say "must be"!

2. Argue by means of identified hazards:  
What hazards were identified? What were their IMRIs?  
What mitigations were conceived for the hazards? What are their FMRIs?

3. Provide evidence:  
Hazard Analyses worksheet  
Hazard-Mitigating Requirements  
Validation Results / other analyses

4. Argue by means of identified failure modes.  
What failures were identified? What are their effects?  
How are these effects hazardous? What are their IMRIs?  
What mitigations were conceived for the hazards?  
What are their FMRIs?

5. Provide evidence:  
FMEA worksheet  
Hazard-Mitigating Requirements  
Implemented Changes in Code  
Validation Results / other analyses

**Repeat until:**

- All hazards are "argued"
- All analyses demanded by safety standards are complete
- Until you are **confident**
- Until the certification authority is satisfied

## Evidence in your Safety Argument

*There are several **types of evidence**, produced by different analyses.  
Different types of evidence have a **different argumentative strengths**.*

Type of Evidence	Source	Strength
Facts	Prior knowledge, human experience & wisdom	Objective, if provable
Assumptions	Prior knowledge, human experience & wisdom	Subjective, must be proven!
Sub-Claims	Arise from the engineering process and must be refined during continuous engineering	Depends on further refinement
Deterministic	Formal proofs (using mathematical means), formal analyses (e.g., Markov analyses)	Very objective
Probabilistic	Some form of quantitative statistical reasoning	Depends on the reasoning methodology and input data.
Qualitative	Compliance with rules that have an indirect link to the desired safety goal Opinions of "experts"	Subjective

## Confidence in your Safety Argument

*How certain are you in the adequacy of your safety claim?  
Confidence depends on two things:*

Types and strength of evidence

An argumentation that you are confident in your safety case

*But how?*

**Make a confidence case!**

Just like the argument on safety, a confidence case argues about the confidence in the argument about safety.



# Safety Cases and Confidence Cases

## Safety Argument Artifacts

The safety argument hence consists of two complimentary artifacts:

### Safety Case:

Argument structure containing claims and evidence about safety properties

### Confidence Case:

Argument structure containing claims and evidence about adequacy of evidence in the safety case

**safety argument := safety case + confidence case**

## Goal Structuring Notation (GSN)

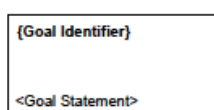
To document safety and confidence cases, Kelly's Goal Structuring Notation has been widely adopted:

UK Ministry of Defence  
 US Department of Defense  
 US Federal Aviation Administration  
 US National Transportation Safety Board  
 US Food and Drug Administration  
 US Federal Energy Regulatory Commission

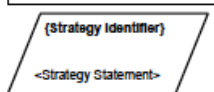
don't require, but **strongly recommend** safety arguments to be GSN-based.

They also each have a set of **standards**, which describe how to argue safety and what must be done during development.

## GSN Notation



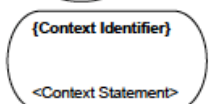
A **goal**, rendered as a rectangle, presents a claim forming part of the argument.



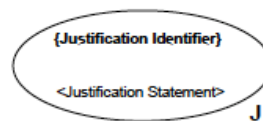
A **strategy**, rendered as a parallelogram, describes the nature of the inference that exists between a *goal* and its supporting goal(s).



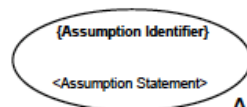
A **solution**, rendered as a circle, presents a reference to an evidence item or items.



A **context**, rendered as shown left, presents a contextual artefact. This can be a reference to contextual information, or a statement.



A **justification**, rendered as an oval with the letter 'J' at the bottom-right, presents a statement of rationale.

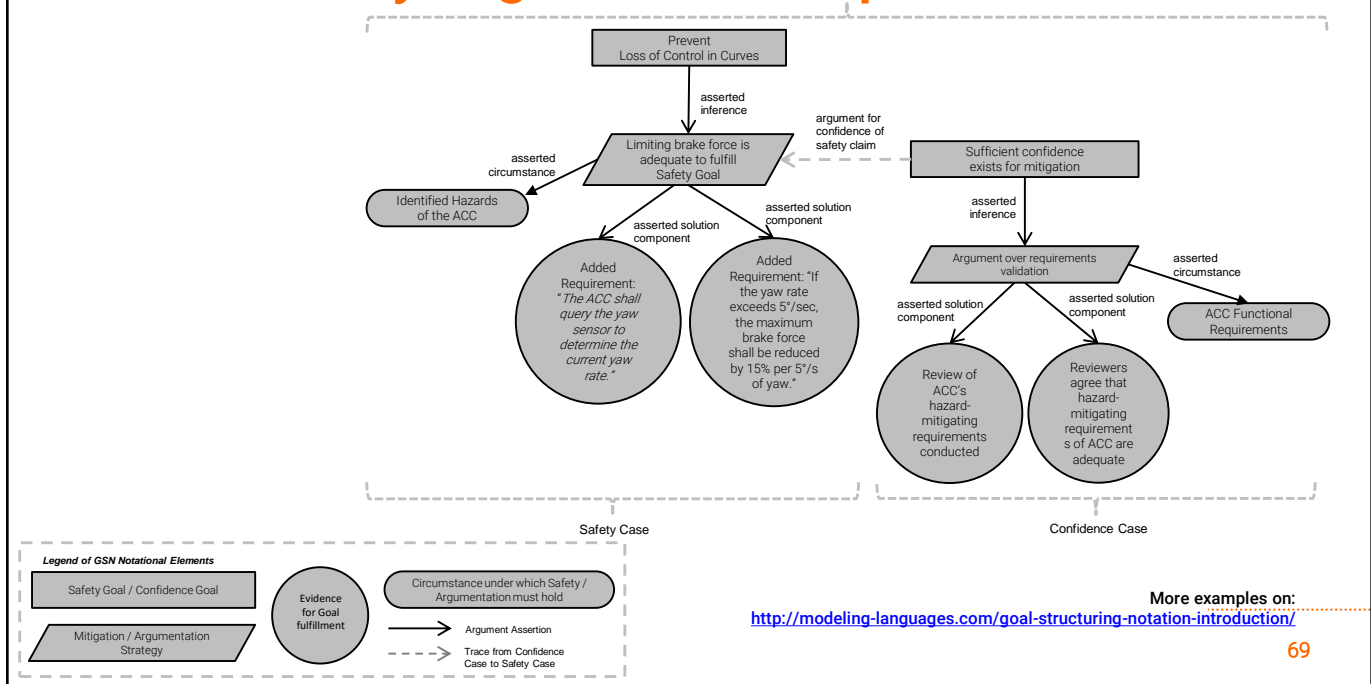


An **assumption**, rendered as an oval with the letter 'A' at the bottom-right, presents an intentionally unsubstantiated statement.



**Undeveloped entity**, rendered as a hollow diamond applied to the centre of an element, indicates that a line of argument has not been developed. It can apply to goals (as below) and strategies.

# GSN Safety Argument Example



## Summary

Safety Argumentation is concerned with establishing, maintaining, and providing a **defensible argument about the system's safety**

We use a typical argument structure consisting of claims, inferences, and evidence.

**We prefer quantitative and objective evidence!**

**Document** all your claims!

Then build a **safety case and a confidence case**. Together, these make up your safety argument.

The safety argument will be scrutinized by a **(certification) authority** or a court of law (in case of liability questions). Don't panic.