

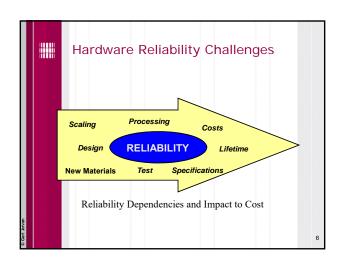
Hardware and Environment
Failures

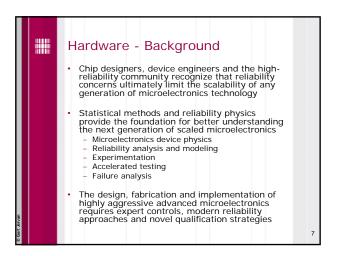
• Moving parts, high speed, low tolerance, high complexity: disks, tape drives/libraries

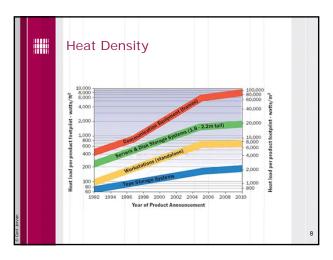
• Lowest MTBF found in fans and power supplies

• Often fans fail gradually → subtle, sporadic failures in CPU, memory, backplane

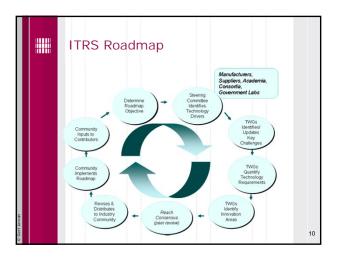
• Environment: power, cooling, dehumidifying, cables, fire, collapsing racks, ventilation, earthquakes, ...







ITRS Roadmap · ITRS predicts the main trends in the semiconductor industry spanning across 15 years into the future. The International Technology Roadmap for Semiconductors is sponsored by the five leading chip manufacturing regions in the world: Europe, Japan, Korea, Taiwan, and the United States. The objective of the ITRS is to ensure cost-effective advancements in the performance of the integrated circuit and the products that employ such devices, thereby continuing the health and success of this industry.



ITRS Roadmap

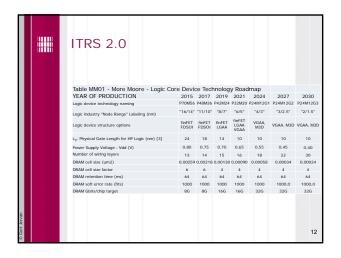
• www.itrs2.net

• ITRS 2.0: 2015

• ITRS 1.0 Editions:

- 1994, 1997, 1999, 2001, 2003, 2005, 2007, 2009, 2012, 2013

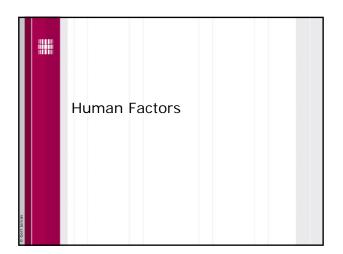
- Previously: SIA Roadmap





The problem to be solved:

How to design reliable system out of non-reliable hardware?



Human Factors

• The role of humans in safety-critical systems

• Human Reliability Analysis

• task analysis

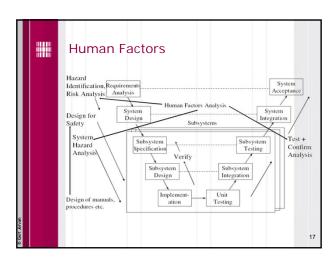
• human error identification

• human error model: Reason

• human reliability quantification

• mitigating human error

• Safe user interface design



Have we learnt since Therac-25

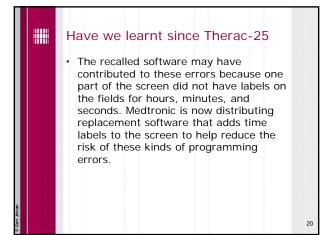
Software for Certain Medtronic Implanted Infusion Pumps Recalled

FDA Patient Safety News: Show #32, October 2004

• Medtronic is recalling certain software application cards. They're used in the company's Model 8840 N'Vision Clinician Programmers. These hand-held devices are used to program a number of implantable devices, including the SynchroMed and SychroMed EL implantable infusion pumps.

Have we learnt since Therac-25

 The recall is prompted by reports of data entry errors that have led to serious drug overdoses, including two patient deaths. The overdoses occurred when clinicians who were programming the pump entered the wrong time duration or the wrong interval --- for example, mistakenly putting the time interval between periodic drug boluses in the "minutes" field, instead of the "hours" field.



Automation

- A driving force of automation is to compensate for human disadvantages
 - humans are unreliable components of systems requiring replacement by reliable computers
 - humans have limited capabilities in response time and capacity
- However, humans play an essential role in safety-critical decision making
 - computers are not flexible or adaptable, e.g., response in emergency situations
 - computers cannot make creative judgements or strategic decisions

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Human Error and Risk

- Automation yields
 - Increased capacity and productivity
 - Reduction in manual workload and fatigue
 - Increased safety
- But
 - Need specialised training
 - Cost of maintenance
- · Impact on human operators
 - Unclear if overall workload reduced
 - Increased complacency due to overconfidence?

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Role of Humans

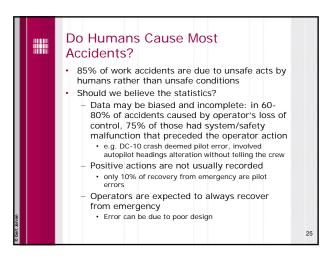
- Monitor: detecting errors
 - it may not be possible to determine if an error has occurred
 - the system may provide inadequate feedback
 - operators may become complacent
- Backup: in an emergency
 - operators may become de-skilled
 - information provided may be inadequate for intervention
 - automated systems are usually too complicated

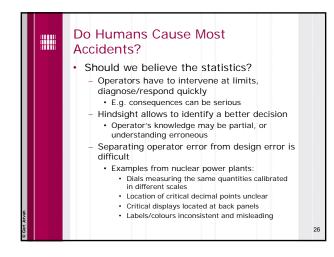


Role of Humans

- Partner: responsible for part of a task
 - humans may be assigned "hard to automate" part
 - humans may be responsible for monitoring and maintaining
 - division of responsibility may make building a mental model harder

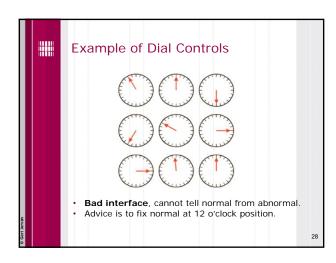
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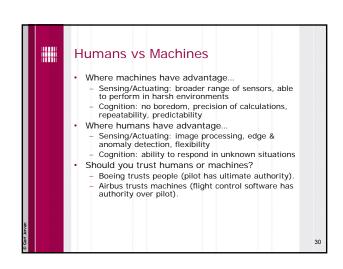
What are humans good at?

Detecting correlations and exceptions
Patterns/clusters in graphical data
Breaks in lines
Visual/sound disturbances
Detecting isolated movement
Waving
Flashing lights
Detecting differences
Sounds, alarms, etc
Lights on/off
etc.



Example of Dial Controls

Good interface: can spot abnormal position even for 5 deg change





Human Machine Interaction (HMI)

- · Hybrid discipline: psychology, engineering, ergonomics, medicine, sociology, mathematics
- Concerned with the impact of human operators and maintainers on system performance, safety and productivity
- Concerned with enhancing the efficiency, flexibility, comprehensibility and robustness of user interaction
- In the safety-critical context, the primary concern is to enhance robustness, possibly at the expense of efficiency and flexibility



Human Reliability Analysis (HRA)

- Identify potential operator errors that may lead to hazards and reduce error where risk is sufficiently high
- Four steps:
 - task analysis: characterise the actions performed to achieve particular goals
 - human error identification: identify possible erroneous actions in performing
 - human reliability quantification: estimate likelihood of error
 - mitigation of human error: identify control options

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Task Analysis

- Tasks are activities to transform some given initial state into a goal state, i.e., goal-directed
- Structured from sub-tasks and elementary actions
- Each elementary action is concerned with a manipulation to be performed upon an object in the task domain
- Procedures for
 - normal operation of the system
 - maintenance of the system
 - emergency situations
- Logical sequence of actions that the operator engages in and the detailed physical executions that the operator

Human-Task Mismatch

- · Human error is not a useful term
 - Implies possible to improve humans
- Human-Task Mismatch better term
 - Erroneous behaviour inextricably connected to the behaviour needed to complete a task
- Tasks
 - Involve problem solving, decision making
- Need adaptation, experimentation, optimisation
- Levels of cognitive control [Rasmussen's]
 - Skills-based behaviour (smooth sensory based) Rule-based behaviour (conscious problem solving)
 - Knowledge-based behaviour (goal known, planning by selection, trial and error, etc)



Experimentation versus Error

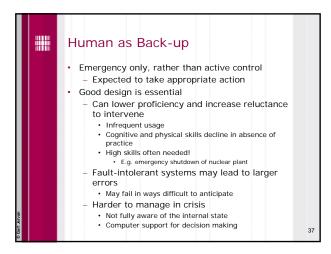
- Designer relies mostly on knowledge-based behaviour
- Operator employs all three
 - In training, from knowledge- or rule-based to skills based
 - In unfamiliar situation, use knowledge-based to develop rules-based
 - Needs to maintain knowledge-based throughout
- Experimentation
 - Test a set of hypothesis through mental reasoning
- May be unreliable
- Human error
- unsuccessful experiments, in unkind environment Design for error tolerance

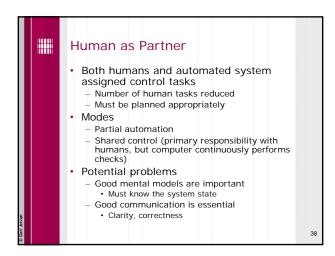


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Human as Monitor

- Monitoring, rather than active control
 - Responsible for detecting/repairing problems
- Humans perform badly.
 - Task may be impossible Cannot check in real-time if computer performs correctly
 - Operator dependent on information provided
 - Too much or too little is bad
 - Information is indirect
 - System handles most functionality
 - Failures may be silent or masked
 - E.g. autopilot disengages
 - Tasks are such that lower alertness results
 - Mechanical, lack of stimulation, can act without noticing





Accident Models

Reduce description of accident to a set of events and conditions

Used in investigations, for prediction, etc

Domino models

Social environment

Fault of a person

Unsafe act or mechanical/physical hazard

Accident

Injury

Chain-of-events

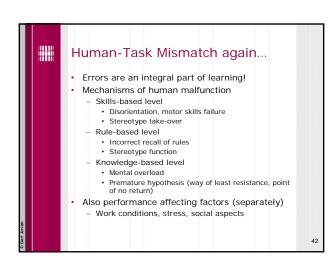
Event trees, fault trees

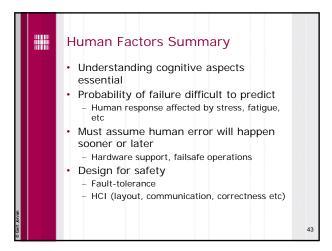
System theory

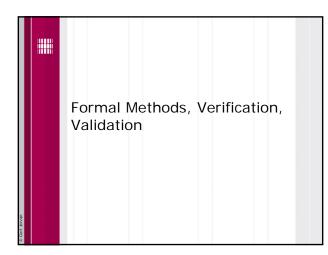
Accidents result from complex interactions



Human Error Models Cognitive, e.g. Reason's model eight primary error groups False sensation (lack of correspondence between subjective experience and reality) Attentional failures (distraction, dividing attention) Memory lapses (forgetting items) Unintended words/actions Recognition failures (wrongly observed signals) Inaccurate and blocked recall (misremembering sequences) Errors in judgement (misconceptions) Reasoning errors (false deduction) Also Norman model of slips, mistakes in planning







Verification vs. Validation

• Verification:

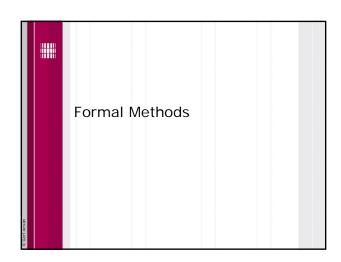
"Are we building the system right"

- The system should conform to its specification

• Validation:

"Are we building the right system"

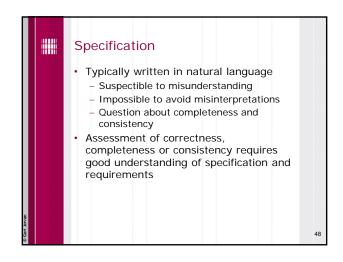
- The system should do what the user really requires

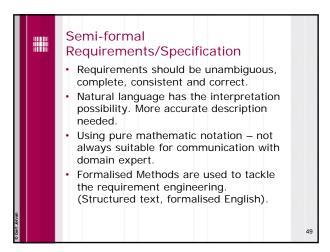


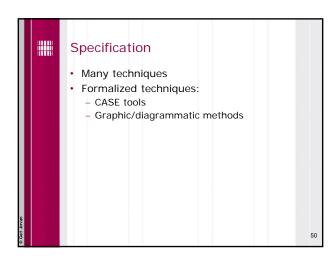
Introduction

• Formal methods – use of mathematical techniques in the specification, design and analysis of hardware and software

• Many of the problems associated with the development of safety-critical systems are related to deficiencies in specification







Formal Methods

• Based on formal languages

- Very precise rules

• System (formal) specification languages

- Can only assist!

- Main advantage: automated tests

• Requirements → spec → design

• Possibility to prove

Method Selection Criteria

• Good expressiveness
• Core of the language will seldom or never be modified after its initial development, it is important that the notation fulfils this criterion.
• Established/accepted to use with Safety Critical Systems
• Possibility of defining subset/coding rules to allow efficient automatic processing by tools.
• Support for modular specifications – basic support is expected to be needed.
• Temporal expressiveness
• Tool availability

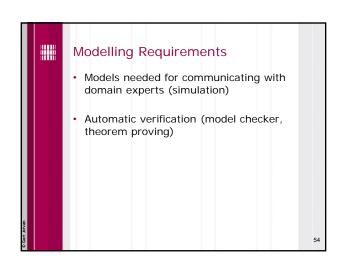
Formal Specification Languages

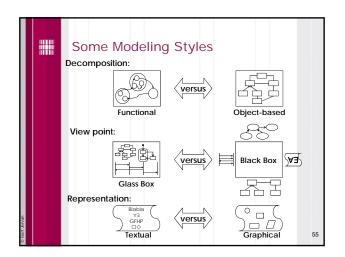
• These languages involve the explicit specification of a state model - system's desired behaviour with abstract mathematical objects as sets, relations and functions.

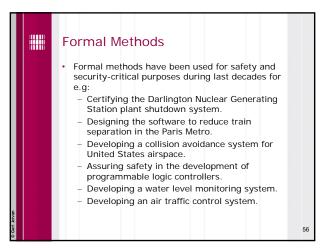
- VDM (Vienna Development Method ISO standardised).

- Z-language

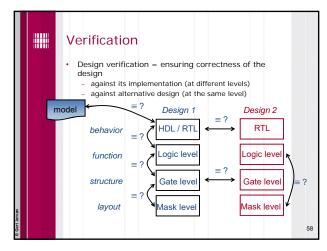
- B-Method







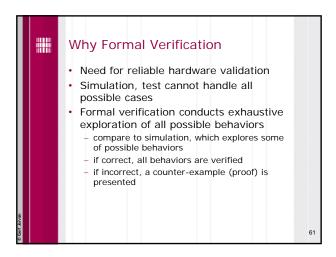


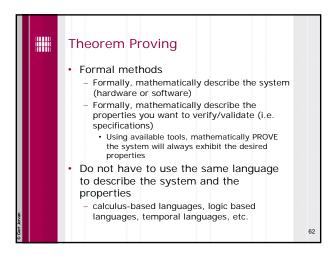


Verification Methods

Deductive verification
Model checking
Equivalence checking
Simulation - performed on the model
Emulation, prototyping – product + environment
Testing - performed on the actual product (manufacturing test)

Formal Verification · Deductive reasoning (theorem proving) uses axioms, rules to prove system correctness no guarantee that it will terminate - difficult, time consuming: for critical applications only Model checking automatic technique to prove correctness of concurrent systems: digital circuits, communication protocols, etc. Equivalence checking - check if two circuits are equivalent OK for combinational circuits, unsolved 60 for sequential





Model Checking

• Algorithmic method of verifying correctness of (finite state) concurrent systems against temporal logic specifications

- A practical approach to formal verification

• Basic idea

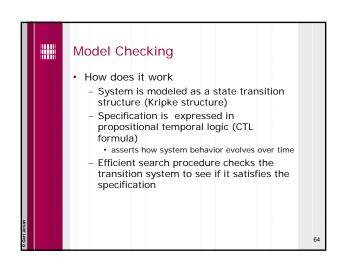
- System is described in a formal model

• derived from high level design (HDL, C), circuit structure, etc.

- The desired behavior is expressed as a set of properties

• expressed as temporal logic specification

- The specification is checked against the model



Model Checking

• Characteristics

- searches the entire solution space

- always terminates with YES or NO

- relatively easy, can be done by experienced designers

- widely used in industry

- can be automated

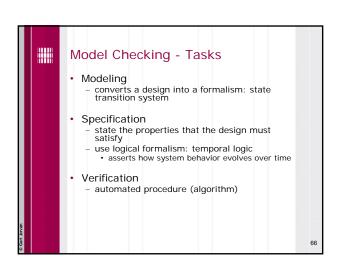
• Challenges

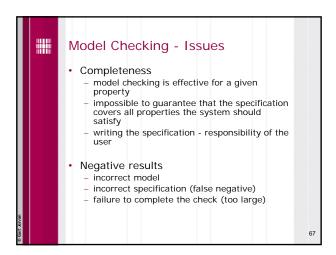
- state space explosion – use symbolic methods, BDDs

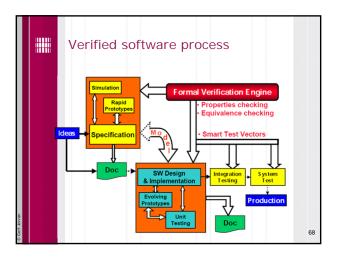
• History

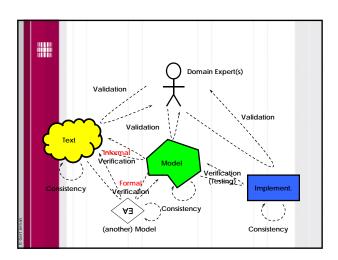
- Clark, Emerson [1981] USA

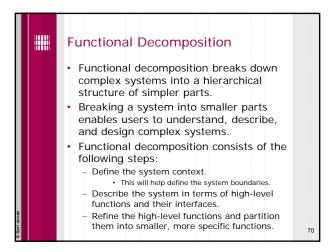
- Quielle, Sifakis [1980's] France

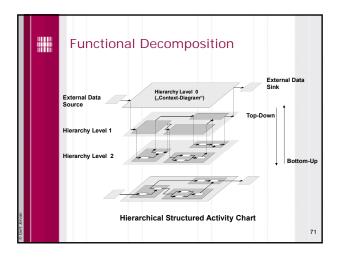


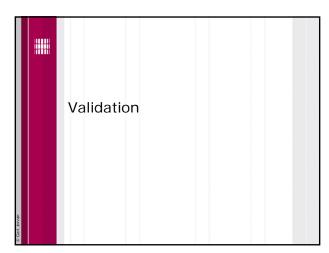


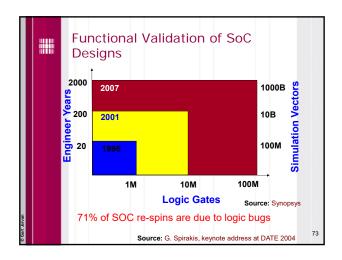


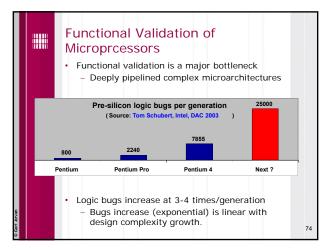


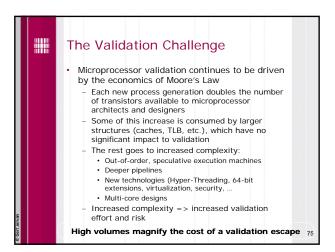


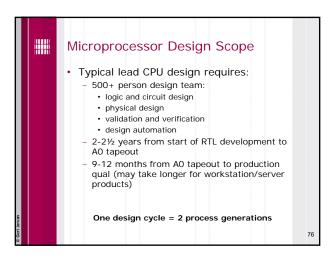


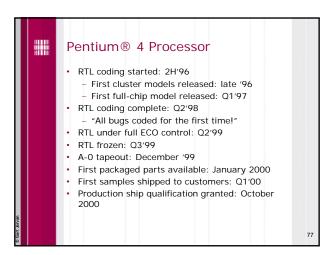


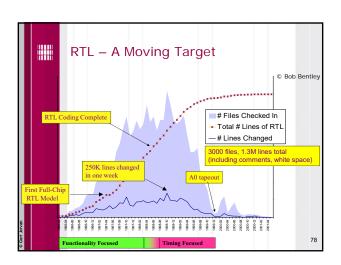


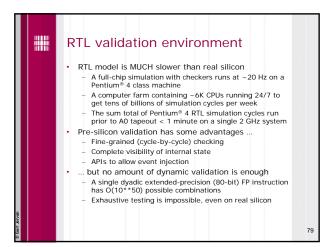


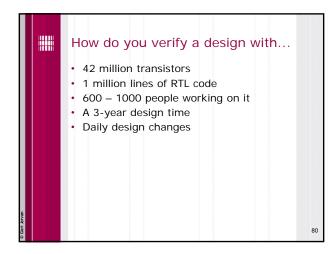












How do you verify a design which has bugs like this??

• The FMUL instruction, when the rounding mode is set to "round up", incorrectly sets the sticky bit when the source operands are:

src1[67:0] = X*2i+15 + 1*2i

src2[67:0] = Y*2j+15 + 1*2j

where i+j = 54 and {X,Y} are integers

And the answer is...

Hire 70+ validation engineers
Buy several thousand compute servers
Write 12,000 validation tests
Run up to 1 billion simulation cycles per day for 200 days
Check 2,750,000 manually-defined properties
Find, diagnose, track, and resolve 7,855 bugs
Apply formal verification with 10,000 proofs to the instruction decoder and FP units
This found that obscure FMUL bug!

Pentium 4 Validation - Staffing

10 people in initial "nucleus" from previous project
40 new hires in 1997
20 new hires in 1998

P4 Validation Environment

• Hardware

- IBM RS/6000 workstations (0.5-0.6Hz full processor model)

- Pentium III Linux systems (3-5Hz full processor model)

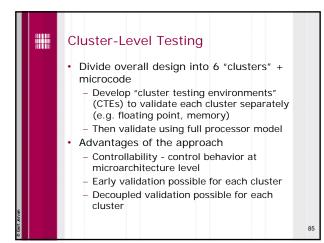
- Computing pool of "several thousand" systems

• Simulation statistics

- About 1 million lines of code in SRTL model

- 5-6 billion clock cycles simulated / week

- 200 billion total clock cycles simulated overall



Other Validation Features

• Extensive validation of power-reduction logic

• Code coverage and code inspections a major part of methodology

• Formal verification used for Floating Point & Instruction Decode Logic

Power Reduction Validation

• Power consumption was a big concern for Pentium 4

• Need to stay within the cost-effective thermal envelope for desktop systems at 1.5+ GHz

• Extensive clock gating in every part of the design

• Mounted a focused effort to validate that:

• Committed features were implemented as per plan

• Functional correctness was maintained in the face of clock gating

• Changes to the design did not impact power savings

• ~12 person years of effort, 5 heads at peak

• Fully functional on A-step silicon, measured savings of ~20W achieved for typical workloads

Formal Verification in P4
Validation

Based on model checking
Given a finite-state concurrent system
Express specifications as temporal logic formulas
Use symbolic algorithms to check whether model holds
Constructed database 10,000 "proofs"
Over 100 bugs found
20 were "high quality" bugs not likely to be found by simulation
Example errors: FADD, FMUL

Validation Results

• 5809 bugs identified by simulation

- 3411 bugs found by cluster-level testing

- 2398 found using full-chip model

• 1554 bugs found by code inspection

• 492 bugs found by formal verification

• Largest sources of bugs: memory cluster (25%)

