



risk



risk management

- about risk
 - risk is the possibility of suffering loss
 - risk itself is not bad, it is essential to progress
 - the challenge is to manage the amount of risk
- two parts:
 - risk assessment
 - risk control
- useful concepts:
 - for each risk: Risk Exposure
 - $RE = p(\text{unsatisfactory outcome}) \times \text{loss}(\text{unsatisfactory outcome})$**
 - for each mitigation action: Risk Reduction Leverage
 - $RRL = (RE_{\text{before}} - RE_{\text{after}}) \div \text{cost of mitigating action}$**



risk management (2)

- **RRL > 1**: good ROI, do it if you have the money
- **RRL = 1**: the reduction in risk exposure equals the cost of the mitigating action. could pay the cost to fix instead (always?)
- **0 < RRL < 1**: costs more than you save. still improves the situation, but losing \$\$
- **RRL < 0**: mitigating action actually made things worse! don't do it!



risk assessment

- **quantitative:**
 - measure risk exposure using standard cost & probability measures (probabilities are rarely independent!)
- **qualitative:**
 - develop a risk exposure matrix

| | | Likelihood of Occurrence | | |
|---------------------|------------------------|--------------------------|--------------|----------|
| | | Very likely | Possible | Unlikely |
| Undesirable outcome | (5) Loss of Life | Catastrophic | Catastrophic | Severe |
| | (4) Loss of Spacecraft | Catastrophic | Severe | Severe |
| | (3) Loss of Mission | Severe | Severe | High |
| | (2) Degraded Mission | High | Moderate | Low |
| | (1) Inconvenience | Moderate | Low | Low |



some risks and countermeasures

- personnel shortfall
 - use top talent
 - team building
 - training
- unrealistic schedule/
budget
 - multisource estimation
 - designing to cost
 - requirements scrubbing
- developing the wrong
functions
 - better requirements
analysis
- continuing
requirements changes
 - high change threshold
 - incremental
development
 - agile methods
- developing wrong UI
 - use cases
 - prototypes
- gold plating
 - cost-benefit analysis
 - proper planning



case studies



Case Study: Mars Polar Lander

Launched

3 Jan 1999

Mission

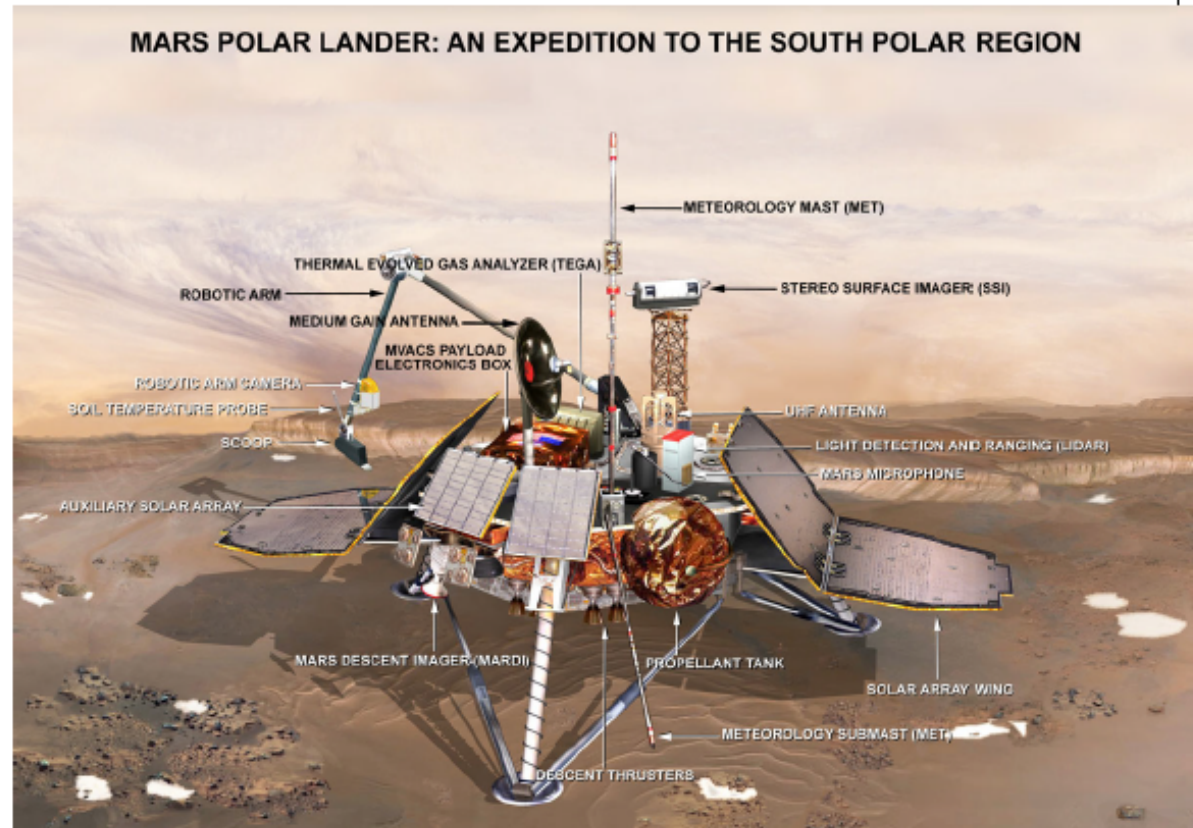
Land near South Pole
Dig for water ice with a
robotic arm

Fate:

Arrived 3 Dec 1999
No signal received after
initial phase of descent

Cause:

Several candidate causes
Most likely is premature
engine shutdown due to
noise on leg sensors





What happened?

Investigation hampered by lack of data

spacecraft not designed to send telemetry during descent

This decision severely criticized by review boards

Possible causes:

Lander failed to separate from cruise stage (plausible but unlikely)

Landing site too steep (plausible)

Heatshield failed (plausible)

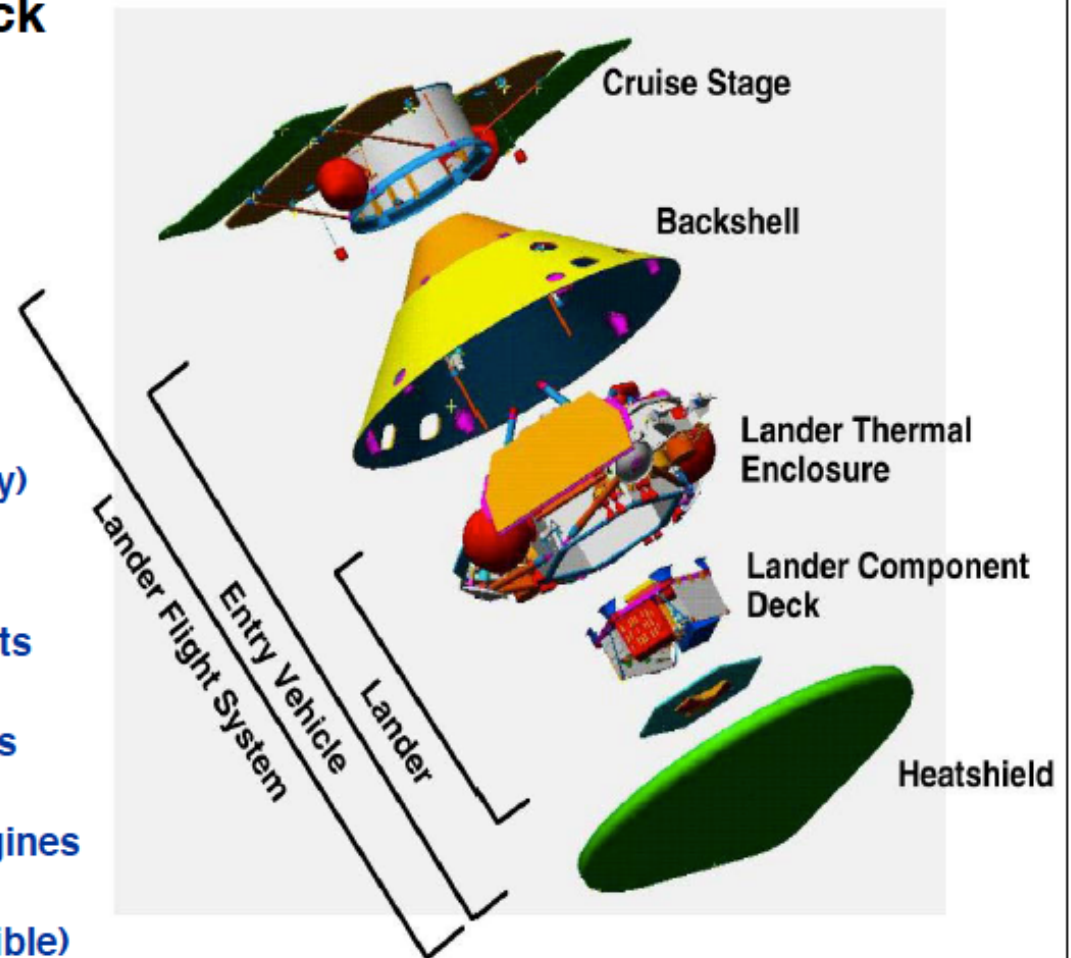
Loss of control due to dynamic effects (plausible)

Loss of control due to center-of-mass shift (plausible)

Premature Shutdown of Descent Engines **(most likely!)**

Parachute drapes over lander (plausible)

Backshell hits lander (plausible but unlikely)





Premature Shutdown Scenario

Cause of error

Magnetic sensor on each leg senses touchdown

Legs unfold at 1500m above surface

software accepts transient signals on touchdown sensors during unfolding

Factors

System requirement to ignore the transient signals

But the **software** requirements did not describe the effect

Engineers present at code inspection didn't understand the effect

Not caught in testing because:

Unit testing didn't include the transients

Sensors improperly wired during integration tests (no touchdown detected!)

Result of error

Engines shut down before spacecraft has landed

estimated at 40m above surface, travelling at 13 m/s

estimated impact velocity 22m/s (spacecraft would not survive this)

nominal touchdown velocity 2.4m/s



SYSTEM REQUIREMENTS

FLIGHT SOFTWARE REQUIREMENTS

3.7.2.2.4.2 Processing

- 1) The touchdown sensors shall be sampled at 100-Hz rate.
The sampling process shall be initiated prior to lander entry to keep processor demand constant.
However, the use of the touchdown sensor data shall not begin until 12 meters above the surface.
- 2) Each of the 3 touchdown sensors shall be tested automatically and independently prior to use of the touchdown sensor data in the onboard logic.
The test shall consist of two (2) sequential sensor readings showing the expected sensor status.
If a sensor appears failed, it shall not be considered in the descent engine termination decision.
- 3) Touchdown determination shall be based on two sequential reads of a single sensor indicating touchdown.

- a. The lander flight software shall cyclically check the state of each of the three touchdown sensors (one at 100 Hz during EDL).
- b. The lander flight software shall be able to cyclically check the touchdown event state with or without touchdown event generation enabled.
- c. Upon enabling touchdown event generation, the lander flight software shall attempt to detect failed sensors marking the sensor as bad when the sensor indicates "touchdown state" on two consecutive reads.
- d. The lander flight software shall generate the landing event based on two consecutive reads indicating touchdown from any one of the "good" touchdown sensors.

Adapted from the "Report of the Loss of the Mars Polar Lander and Deep Space 2 Missions -- JPL Special Review Board (Casani Report) - March 2000".
See <http://www.nasa.gov/newsinfo/marsreports.html>



Lessons?

Documentation is no substitute for real communication

Software bugs hide behind other bugs
(full regression testing essential!)

Fixed cost + fixed schedule = increased risk



Case Study: Mars Climate Orbiter

Launched

11 Dec 1998

Mission

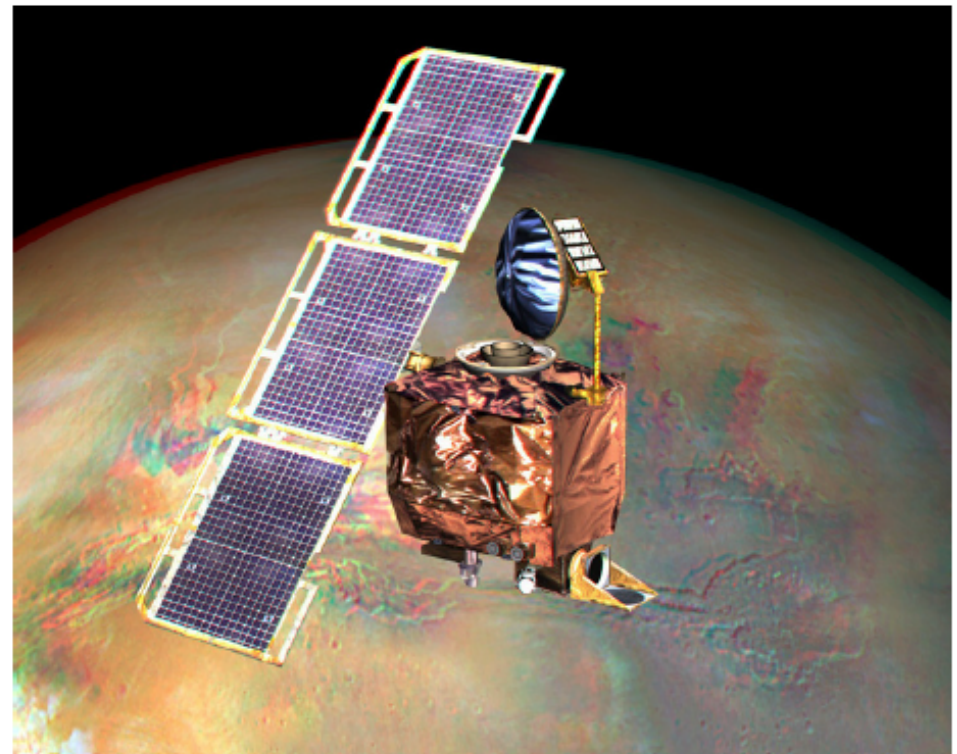
interplanetary weather satellite
communications relay for Mars Polar
Lander

Fate:

Arrived 23 Sept 1999
No signal received after initial orbit
insertion

Cause:

Faulty navigation data caused by failure
to convert imperial to metric units





MCO Events

Locus of error

Ground software file called “Small Forces” gives thruster performance data
data used to process telemetry from the spacecraft

Angular Momentum Desaturation (AMD) maneuver effects underestimated
(by factor of 4.45)

Cause of error

Small Forces Data given in Pounds-seconds (lbf-s)
The specification called for Newton-seconds (N-s)

Result of error

As spacecraft approaches orbit insertion, trajectory is corrected
Aimed for periapse of 226km on first orbit

Estimates were adjusted as the spacecraft approached orbit insertion:

1 week prior: first periapse estimated at 150-170km

1 hour prior: this was down to 110km

Minimum periapse considered survivable is 85km

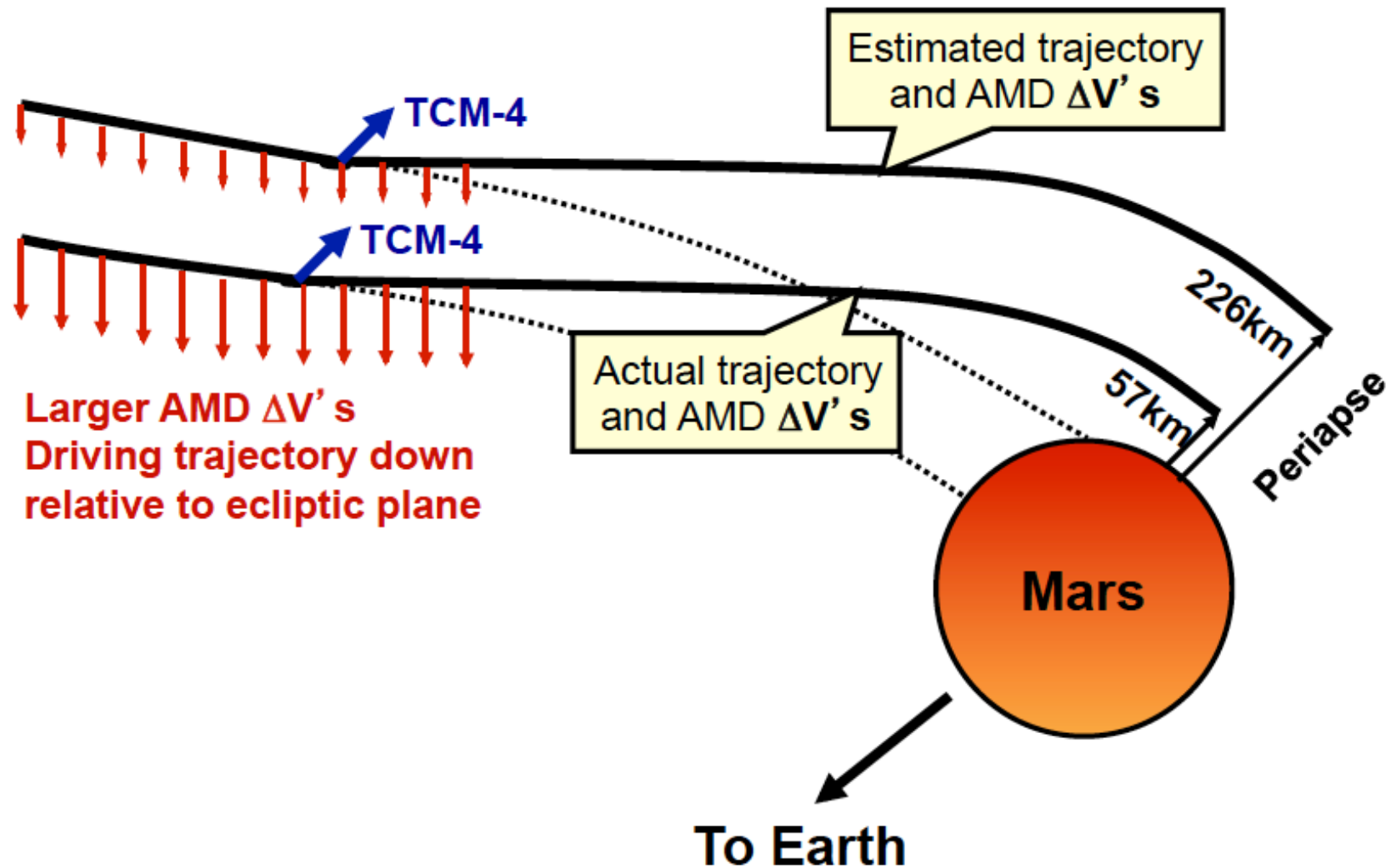
MCO entered Mars occultation 49 seconds earlier than predicted

Signal was never regained after the predicted 21 minute occultation

Subsequent analysis estimates first periapse of 57km



MCO Navigation Error





Contributing Factors

For 4 months, AMD data not used (file format errors)

Navigators calculated data by hand
File format fixed by April 1999
Anomalies in the computed trajectory became apparent almost immediately

Limited ability to investigate:

Thrust effects measured along line of sight using doppler shift
AMD thrusts are mainly perpendicular to line of sight

Poor communication

Navigation team not involved in key design decisions
Navigation team did not report the anomalies in the issue tracking system

Inadequate staffing

Operations team monitoring 3 missions simultaneously (MGS, MCO and MPL)

Operations Navigation team unfamiliar with spacecraft

Different team from development & test
Did not fully understand significance of the anomalies
Surprised that AMD was performed 10-14 times more than expected

Inadequate Testing

Software Interface Spec not used during unit test of small forces software
End-to-end test of ground software was never completed
Ground software considered less critical

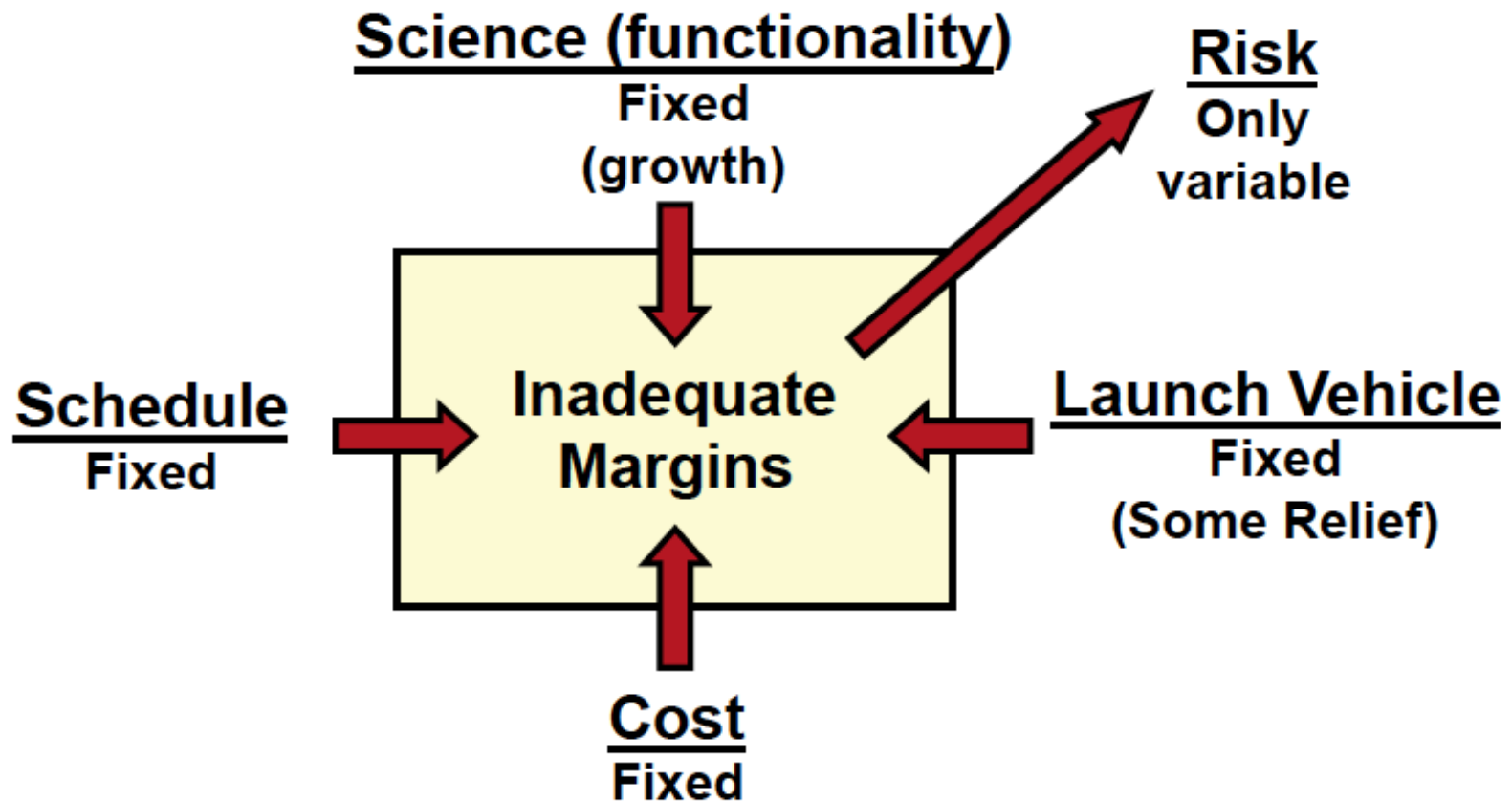
Inadequate Reviews

Key personnel missing from critical design reviews

Inadquate margins...



Failure to manage risk



Adapted from MPIAT - Mars Program Independent Assessment Team Summary Report, NASA JPL, March 14, 2000.

See <http://www.nasa.gov/newsinfo/marsreports.html>



THE RISKS DIGEST

forum on risks to the public in computers &
related systems

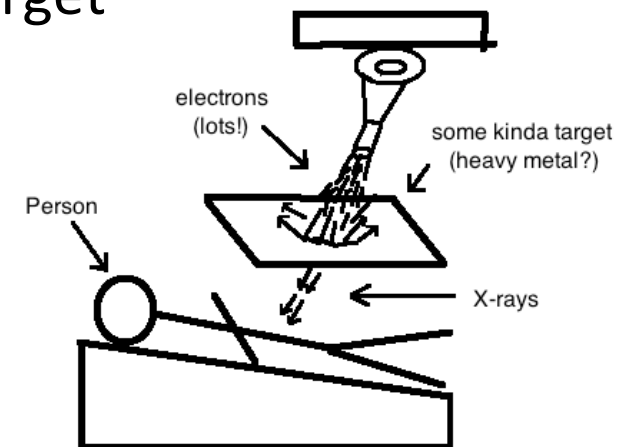
been around since 1985

<http://catless.ncl.ac.uk/Risks/>



down-to-earth examples (2)

- therac-25 from AECL, 1985-87
 - <http://catless.ncl.ac.uk/Risks/3.11.html#subj1>
 - <http://en.wikipedia.org/wiki/Therac-25>
- radiation therapy machine
 - two modes:
 - low dose, short period, electron-beam
 - megavolt x-ray therapy, collides high-dose, high-energy electron beam with target
- problem: could be made to operate w/o target in place!





down-to-earth examples (3)

- a less tragic example...
- in 1995 an “*abandoned oil tank phone harasses ma woman for 6 months*”

<http://catless.ncl.ac.uk/Risks/17.34.html#subj3.1>

- old oil tank (???) rigged to call the oil company every 90 minutes when low
- configured with wrong number of poor unsuspecting woman
- pick up phone, say “*hello?*”, no answer
- why did it take phone co. six months to trace? c’mon, really?



- if it doesn't behave how you expect it's not safe
- if your teams don't coordinate neither will their software (is this Conway again?)
- with software, everything is connected to everything else – every subsystem is critical



lessons? (2)

- full communication is only possible among peers; subordinates are too routinely rewarded for telling pleasant lies rather than the truth
 - do you agree?
- Not a good idea to have the IV&V team and R&D team reporting to the same person
 - why not?



Principles of Risk Management

Source: Adapted from SEI Continuous Risk Management Guidebook

Global Perspective

View software in context of a larger system

For any opportunity, identify both:

Potential value

Potential impact of adverse results

Forward Looking View

Anticipate possible outcomes

Identify uncertainty

Manage resources accordingly

Open Communications

Free-flowing information at all project levels

Value the individual voice

Unique knowledge and insights

Integrated Management

Project management is risk management!

Continuous Process

Continually identify and manage risks

Maintain constant vigilance

Shared Product Vision

Everybody understands the mission

Common purpose

Collective responsibility

Shared ownership

Focus on results

Teamwork

Work cooperatively to achieve the common goal

Pool talent, skills and knowledge



Continuous Risk Management

Source: Adapted from SEI Continuous Risk Management Guidebook

Identify:

Search for and locate risks before they become problems

Systematic techniques to discover risks

Analyse:

Transform risk data into decision-making information

For each risk, evaluate:

Impact

Probability

Timeframe

Classify and Prioritise Risks

Plan

Choose risk mitigation actions

Track

Monitor risk indicators

Reassess risks

Control

Correct for deviations from the risk mitigation plans

Communicate

Share information on current and emerging risks





Identifying Risks: Fault Tree Analysis

Source: Adapted from Leveson, "Safeware", p321

