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Lecture 1: Why Does Software Fail?

→ Some background

♦ What is Software Engineering?

- ♦ What causes system failures?
- ♦ The role of good engineering practice

→ Are software failures like hardware failures?

Shuttle flight STS51-L (Challenger) ♦ Ariane-5 flight 501

→ Some conclusions

& e.g. Reliable software has very little to do with writing good programs ♥ e.g. Humans make mistakes, but good engineering practice catches them!

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Failures and Catastrophes

→ System Components often fail

♦ Parts wear out

♥ Wires and joints come loose

Scosmic rays scramble your circuits!

- Scomponents get used for things they weren't designed for
- besigns don't work the way they should

\rightarrow Point failures typically don't lead to catastrophe

♦ backup systems

- ♦ fault tolerant designs
- ♦ redundancy
- \checkmark certification using safety factors (eq 2x)

\rightarrow Good Engineering Practice prevents accidents

- ♦ failure analysis
- ♥ reliability estimation
- & checks and balances

But how does this work in *Software* Engineering???

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Defining Software Engineering

→ "Engineering...

🗞 ...creates cost-effective solutions to practical problems by applying scientific knowledge to building things in the service of humankind'

→ Software Engineering:

the "things" contain software (??)

\rightarrow BUT:

♦ pure software is useless!

- > ...software exists only as part of a system
- ♦ software is invisible, intangible, abstract
- there are no physical laws underlying software behaviour
- there are no physical constraints on software complexity
- ♦ software never wears out
 - > ...traditional reliability measures don't apply
- ♦ software can be replicated perfectly
 - > ...no manufacturing variability

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Shuttle Flight 51-L (Challenger) → Contracts for shuttle awarded 1972: **& Rockwell - Orbiter** 🗞 Martin Marietta - external tank **& Morton Thiokol - Solid Rocket Boosters** (SRBs) ♦ Rocketdyne - Orbiter Main engines → 3 NASA centers provide management: ♦ JSC - Manage the orbiter & Marshall - Manage engines, tank and SRBs ♦ KSC - Assembly, checkout and launch

→ 4 orbiters were built:

- ♦ flights began in '81;
- ♦ declared operational July '92 after STS-4
- ♦ 24 flights over 57 months up to Dec 1995



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Rogers' report findings

- \rightarrow Lack of trend analysis
- → Management Structure:
 - & safety, reliability and QA placed under the organizations they were to check
 - ${}^{\&}$ organizational responsibility for safety was not adequately integrated with decisionmaking
 - ♦ No safety representative at the meetings on 27 Jan.
- → Problem reporting and tracking

\rightarrow Complacency:

- ♦ Escalating risk accepted
- \checkmark Perception that less safety reliability and QA activity needed once Shuttle missions became routine
- → Program Pressures were a factor
 - ♦ Pressure on NASA to build up to 24 missions per year
 - > Shortened training schedules, lack of spare parts, and dilution of human resources.
 - > Customer commitments may have obscured engineering concerns
 - **Seduction of skilled personnel**

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Why did this failure occur?

- → Why was Platform Alignment still active after launch?
 - **SRI Software reused from Ariane-4** ♦ 40 sec delay introduced in case of a
 - hold between -9s and -5s > Saves having to reset everything
 - > Feature used once in 1989
- \rightarrow Why was there no exception
 - ♦ An attempt to reduce processor workload to below 80%
 - > Analysis for Ariane-4 indicated overflow was not physically possible > Ariane-5 had a different trajectory
- → Why wasn't the design modified for Ariane-5?
 - **%** Not considered wise to change software that worked well on Ariane-4
- \rightarrow Why did the SRIs shut down?
 - & Assumed faults are random hardware failures, hence should switch to backup

- \rightarrow Why was the error not caught in unit testina?
 - ♦ No trajectory data for Ariane-5 was provided in the requirements for SRIs
- → Why was the error not caught in integration testing?
 - ✤ Full integration testing considered too difficult/expensive
 - ♦ SRIs were considered to be fully certified
 - ✤ Integration testing used simulations of the SRIs
- → Why was the error not caught by inspection?
 - S The implementation assumptions weren't documented
- → Why did the OBC use diagnostic data as flight data?
 - ✤ They assumed this couldn't happen???

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Summary

- \rightarrow Failures can usually be traced to a single root cause
- → System of testing and validation designed to catch such problems
 - $\boldsymbol{\boldsymbol{\forall}}$ Catastrophes occur when this system fails
- → In most cases, it takes a failure of both engineering practice and of management
- → Reliable software depends not on writing flawless programs but on how good we are at:
 - $\textcircled{} \begin{tabular}{ll} & & \\ & &$
 - ♦ Management (of Resources and Risk)
 - $\boldsymbol{\boldsymbol{\forall}} \boldsymbol{\boldsymbol{\forall}} \boldsymbol{\boldsymbol{\mathsf{Verification}}}$ and $\boldsymbol{\boldsymbol{\mathsf{Validation}}}$
 - $\boldsymbol{\boldsymbol{\forall}} \boldsymbol{\boldsymbol{\forall}} \boldsymbol{\boldsymbol{\mathsf{Risk}}}$ Identification and tracking
 - $\boldsymbol{\boldsymbol{\forall}}$ Questioning assumptions

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