

Combining STPA and RAM modelling to identify and evaluate potential losses in controller-based systems with complex interactions

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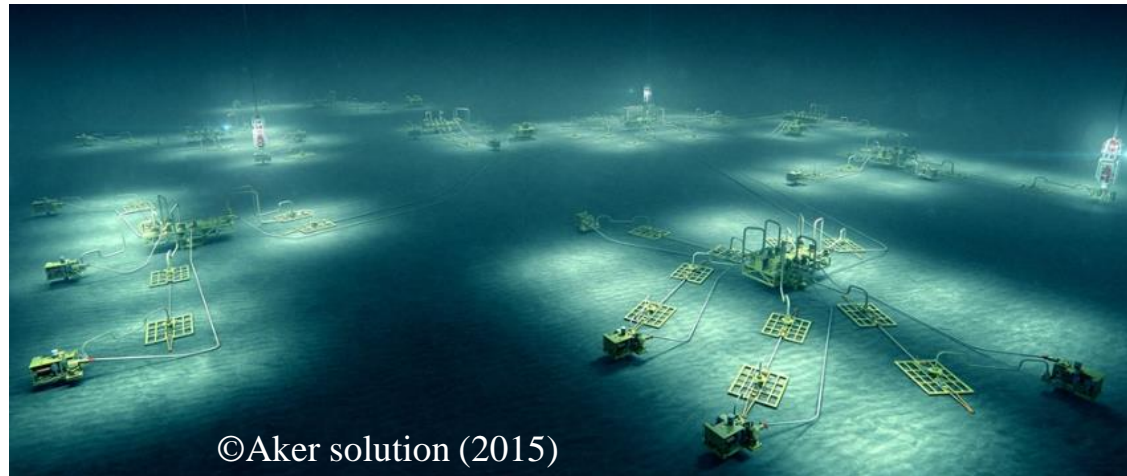
Outline of presentation

- Background
- STPA
- Proposed approach
- Illustrative case
- Discussions

PhD project in SUBPRO

Objective: Incorporating RAM analysis for innovative subsea design accounts for:

- Subsea conditions
- Early design phase
- Technology qualification



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Hazard identification: what can go wrong?

Combining STPA and RAM modelling to identify and evaluate potential losses in controller-based systems with complex interactions

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Abstract: Hazard identification methods are important tools to verify that the system is able to operate according to specifications under different operating conditions. Unfortunately, many of the traditional methods are not adequate to capture possible dysfunctional behavior of complex systems that involve highly coupled parts, non-linear interactions and software-intensive functionalities. The rather recent method named System-Theoretic Process Analysis (STPA) is one promising candidate to improve the coverage of hazard identification in complex and software-intensive system. Still, there is no guideline for utilizing STPA output to evaluate the potential of loss, which is important for basis for decision-making about system configuration and equipment selection. The focus of this article is placing on the interface between STPA and reliability, availability and maintainability (RAM) modelling. The approach named STPA-RAM modelling is proposed to translate feedback control loops into Petri-nets for discrete event simulation. The proposed approach is demonstrated with a simple case related to subsea design concept. It has been found that the new proposed approach extends the application of STPA, while also improving, and as such reducing completeness uncertainty and model uncertainty, associated with input data and information for RAM modelling.

Keyword: Reliability, Systematic approach, Complexity, Subsea system

1. INTRODUCTION

Highly coupled parts, non-linear interactions and software-intensive functionalities characterize today's engineering systems. One example could be subsea systems for Oil and Gas (O&G) production and processing. As of today, the traditional technologies for subsea control (e.g. hydraulically operated systems) have been gradually replaced by electrical/electronic/programmable electronic technologies with a higher level of autonomy, self-diagnostics, and monitoring. Such a shift in technologies gives opportunities for more cost-efficient and autonomous operation in marginal subsea fields that have special restrictions associated with accessibility [1]. Meanwhile, demonstrating how to meet reliability and availability targets through proper modelling and analysis is very important. Reliability, availability and maintainability (RAM) modelling mainly considers the combination of degradation, failure, diagnostics and maintenance of hardware. In some cases, human-related interaction errors are indirectly included, e.g. ISO/TR 12489 [2].

Subsea control systems include sensors, actuators and controller that interact with the controlled process and other connected systems, such as systems on-board an offshore platform or onshore at the receiving facilities. Loss of critical functionality is not only the result of component faults but also the improper interactions when components are brought together, i.e. the technologies interact in response to the internal and external environment. Unfortunately, identifying hazards arisen from improper interactions is beyond the scope of conventional methods, such as Failure Mode, Effects and Criticality Analysis (FMECA) and Hazard and Operability study (HAZOP) [3, 4]. FMECA focuses on the failure modes and causes of distinct components, whilst HAZOP has a more focus on the consequences of deviations related to process parameters, software functions and procedures. In an FMECA or HAZOP, components, process objects, or procedures are analyzed one by one and the interactions are analyzed pairwise. For complex and software-intensive systems, it is important to also complement with analyses that are able to identify failure modes and dysfunctional behavior beyond the physical failures. As of today, some candidate solutions have been proposed by researchers, such as Accimap [5], blended hazard identification method (BLHAZID) [6], functional resonance analysis method (FRAM) [7] and Systems-Theoretic Process Analysis (STPA) [8]. Of the mentioned methods, STPA is the

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Old approaches for hazard identification

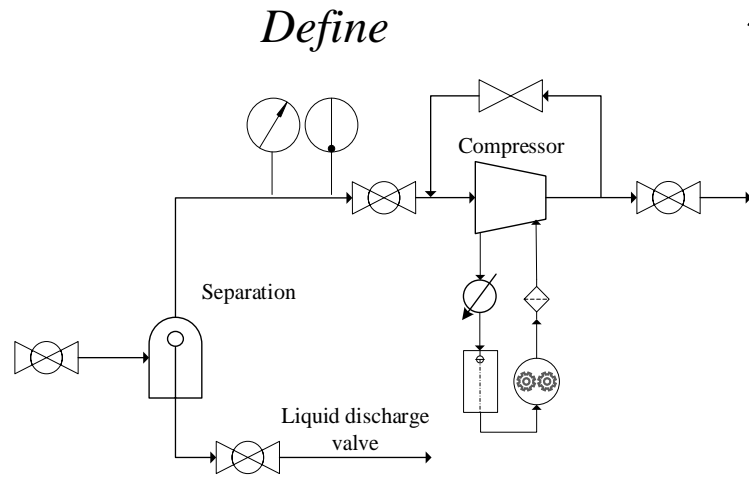
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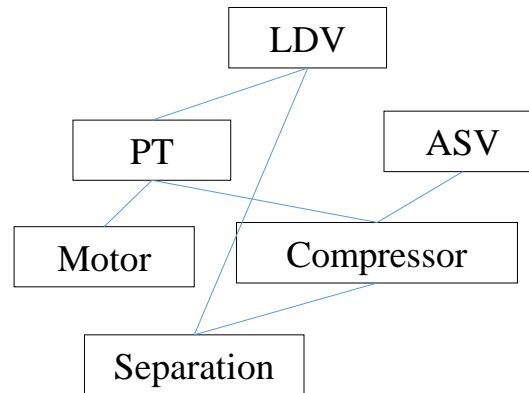
Illustrative case

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Workflow: analytical reduction

Decompose



Bottom up approach

Analyse

Unit	Subsystem	Top Node	Sub-Functional ID	Failure Mode	Cause	Capacity Loss of Failure	Capacity Loss of Impact	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode	Failure Mode
Water supply	Storage system	S-1001	Reservoir	Leak	Crack in metal storage tank			Accumulation	Accumulation	1	1	1000-00	0.0000000000000000	0.0000000000000000	0.0000000000000000	0.0000000000000000	0.0000000000000000	0.0000000000000000	0.0000000000000000
Water supply	Pumping system	P-1001	Pump	Deposited material	30	30	2	1	1	0.35	1.2E-05	2.42200E-11	0.0020	12	0.250700706				
Water supply		P-1001	Pressure sensor	Pressure sensor failure			2	1	1	0.85	1.2E-05	5.2783E-11	0.0020	24	0.408607794				
Water supply	Heat Exchanger system	CT-1001	Heat Exchanger	Blocked	Blocked			2	1	1	0.36	1.0E-05	6.49850E-12	0.0020	24	0.227677035			
Water supply	Heat Exchanger system	CT-1001	Heat Exchanger	Dropped	Dropped			2	1	1	0.44	1.0E-05	5.95270E-12	0.0020	36	0.277094021			
Water supply	Heat Exchanger system	CT-1001	Heat Exchanger	Failure	Failure			2	1	1	0.2	1.0E-05	5.95270E-12	0.0020	36	0.122205464			
Water supply	Heat Exchanger system	P-1002	Pump	Deposited material	30	30	2	1	1	0.35	1.2E-05	0.97703E-12	0.0020	36	0.250700706				
Water supply	Heat Exchanger system	P-1002	Pressure sensor	Pressure sensor failure			2	1	1	0.85	1.2E-05	6.05840E-12	0.0020	48	0.408607794				
Water supply	Heat Exchanger system	C-1001	Control Valve	Deposited material	30	30	2	1	1	0.32	9.28E-06	5.95740E-12	0.0020	48	0.523463276				
Water supply	Heat Exchanger system		Remote start	Remote start failure			2	1	1	0.68	9.28E-06	7.74930E-12	0.0020	24	0.104059002				
Water supply	Heat Exchanger system		Heat Exchanger	Heat Exchanger failure			2	1	1	0.36	1.77E-06	2.93000E-13	0.0020	24	0.107095453				
Water supply	Heat Exchanger system		Heat Exchanger	Heat Exchanger failure			2	1	1	0.4	1.77E-06	2.93000E-13	0.0020	24	0.104330009				
Water supply	Heat Exchanger system		Heat Exchanger	Heat Exchanger failure			2	1	1	0.25	1.77E-06	5.90600E-13	0.0020	12	0.107095453				

Why new approach is needed?

Old approaches cannot properly handle:

- Software errors
- Human-related interactions
- Design errors
-

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STPA

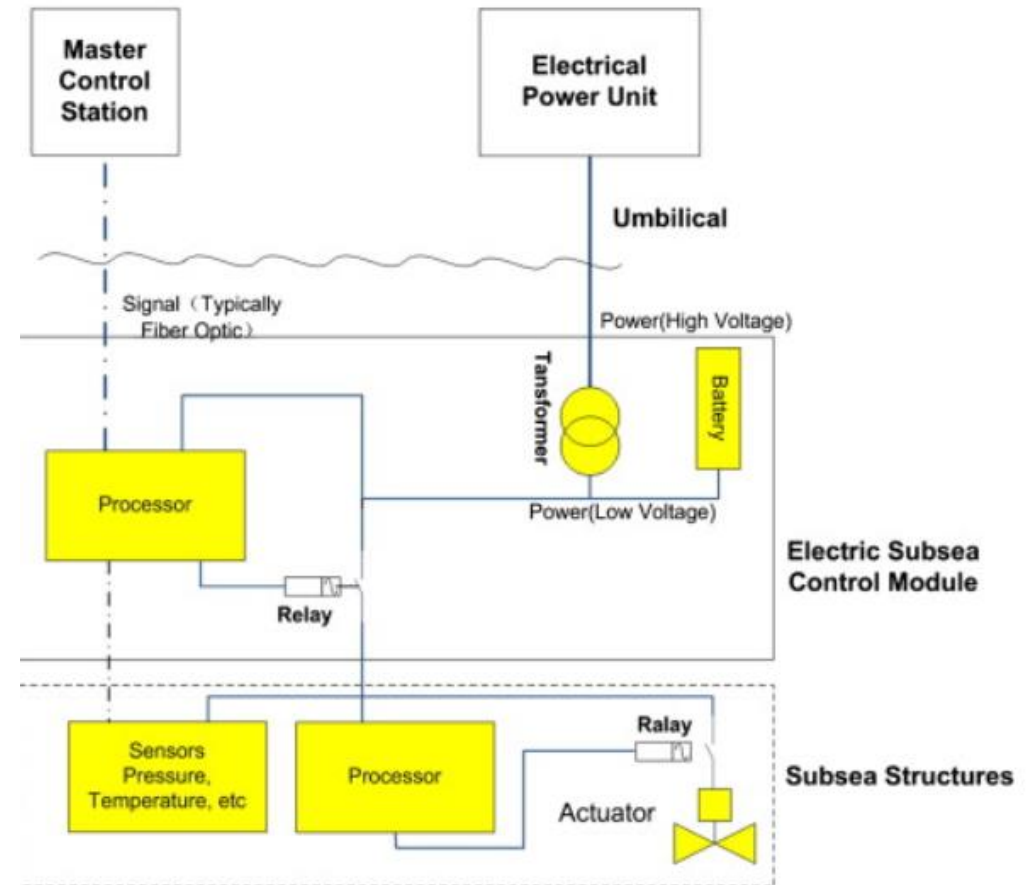
Proposed approach

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Subsea system built today:

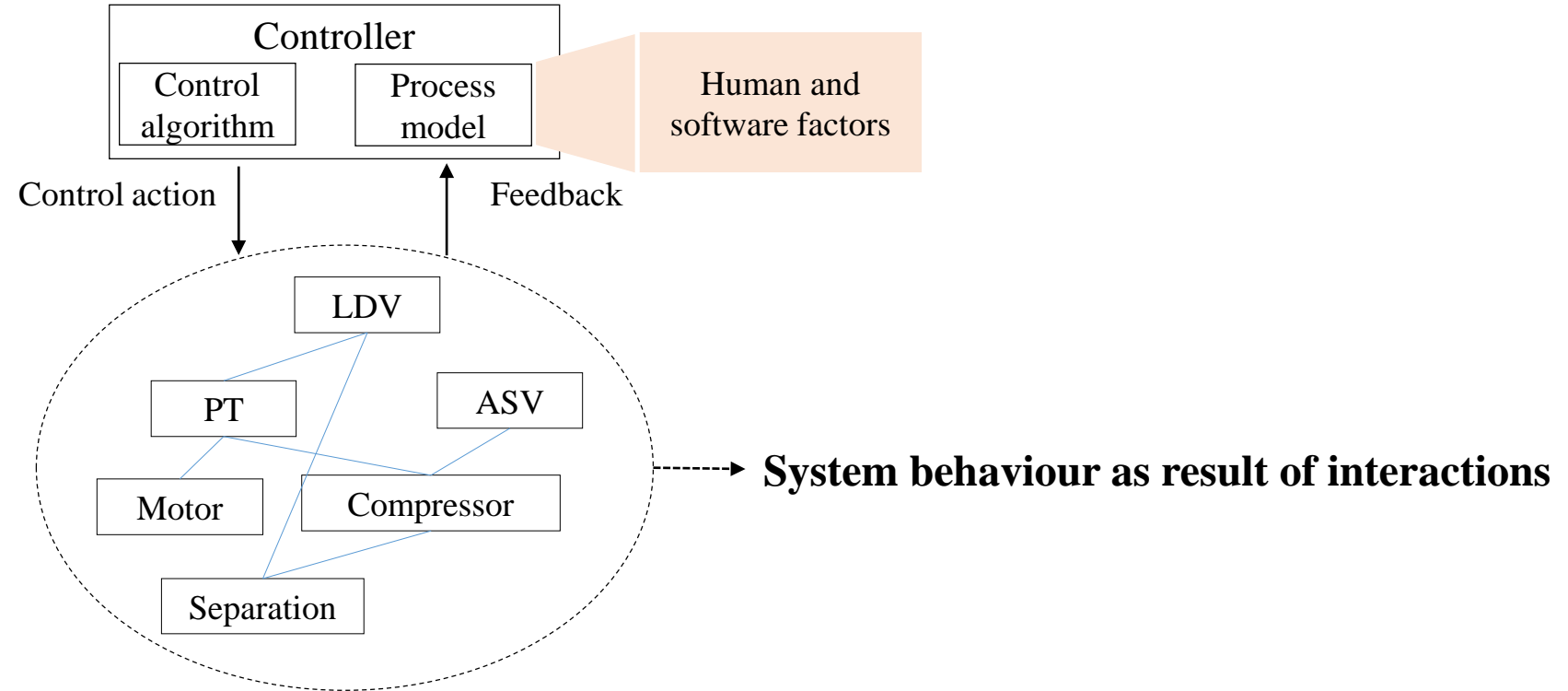
- Highly-coupled
- Software-intensive
- Higher level of autonomy



All electric control system. Ref. (Bai & Bai, 2010)

System-Theoretic Process Analysis (STPA)

System theory and control theory:



STPA features:

- Top down approach
- Assume that safety is achieved under **adequate control**
- Interactions of **all actors** for system behaviour are included

Background

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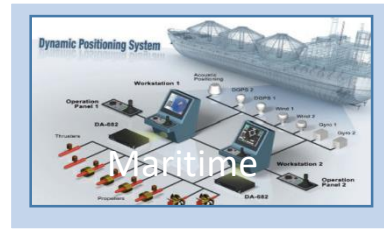
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Is STPA practicable/useful?

Lessons learnt:

- ❑ Increase **coverage** of hazards



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RECOMMENDED PRACTICE
DNV-RP-A203



Qualification of New Technology

Recommended Practice for Subsea Production System Reliability and Technical Risk Management

API RECOMMENDED PRACTICE 17N
FIRST EDITION, MARCH 2009

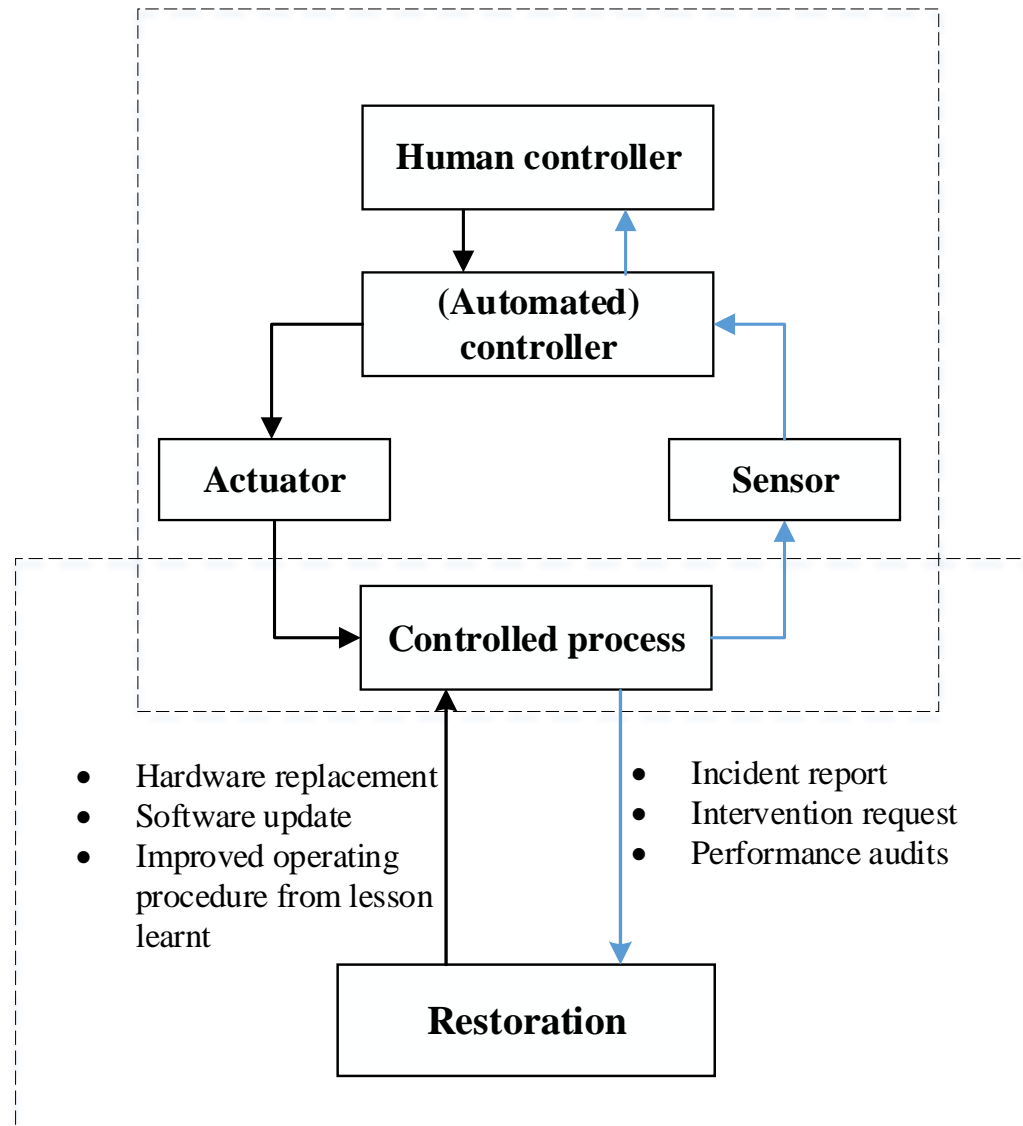


Not adopted in technology qualification:

- ❑ How to interpret STPA outputs?

Approach

Objective: utilize STPA result to improve RAM analysis



Step I: Carry out STPA

Covert into state-space modelling

Step II: Develop RAM model

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STPA

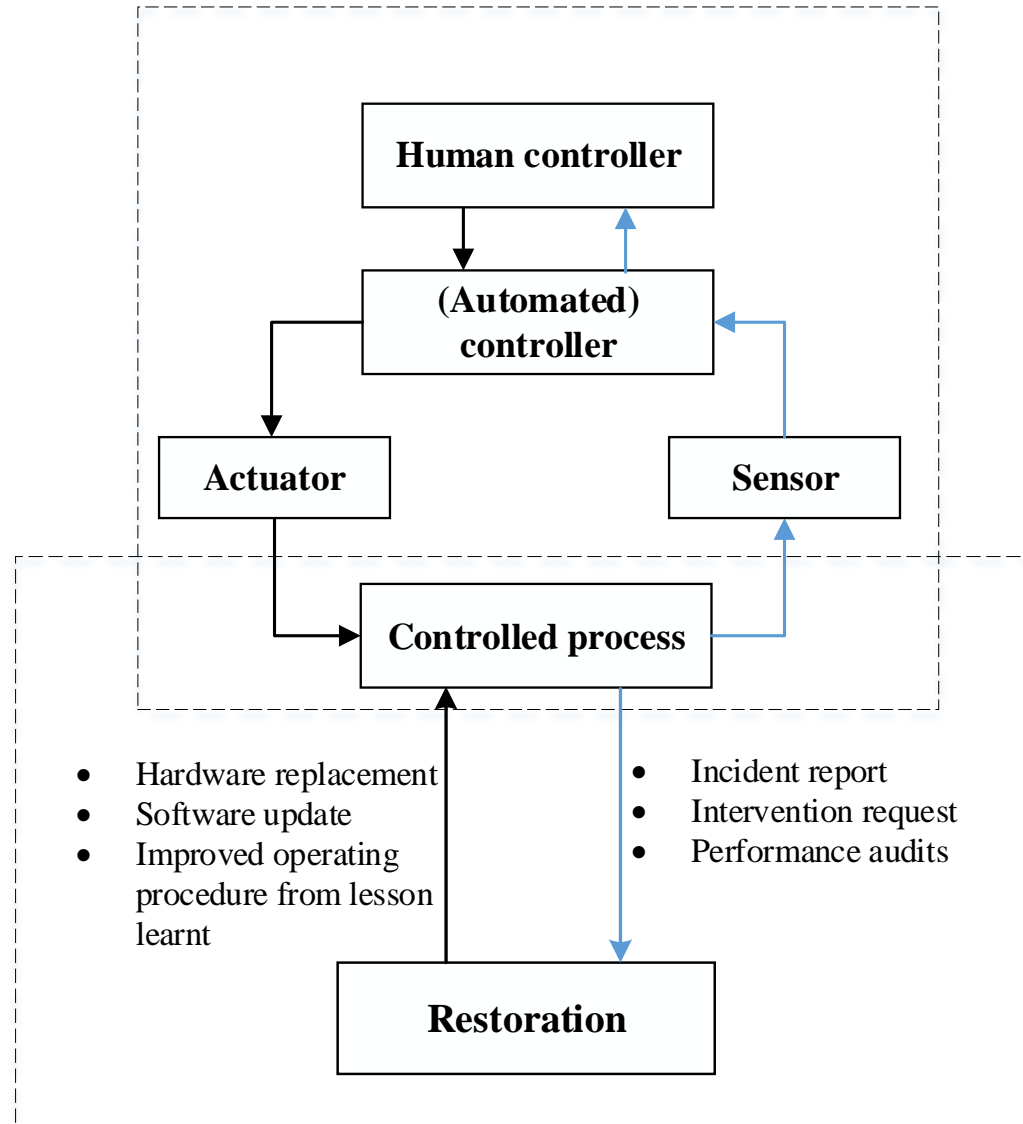
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Approach

Objective: utilize STPA result to improve RAM analysis



Step I: Carry out STPA

Selection of experiments

Step II: Develop RAM model

Background

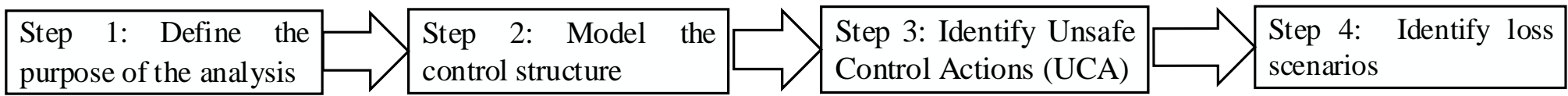
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Step I: carry out STPA



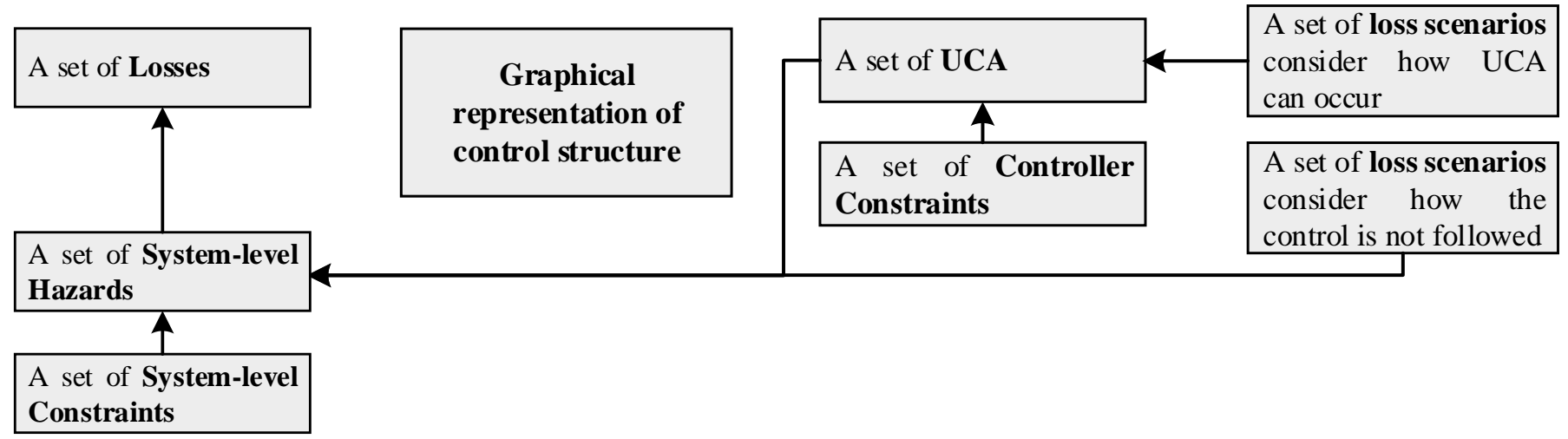
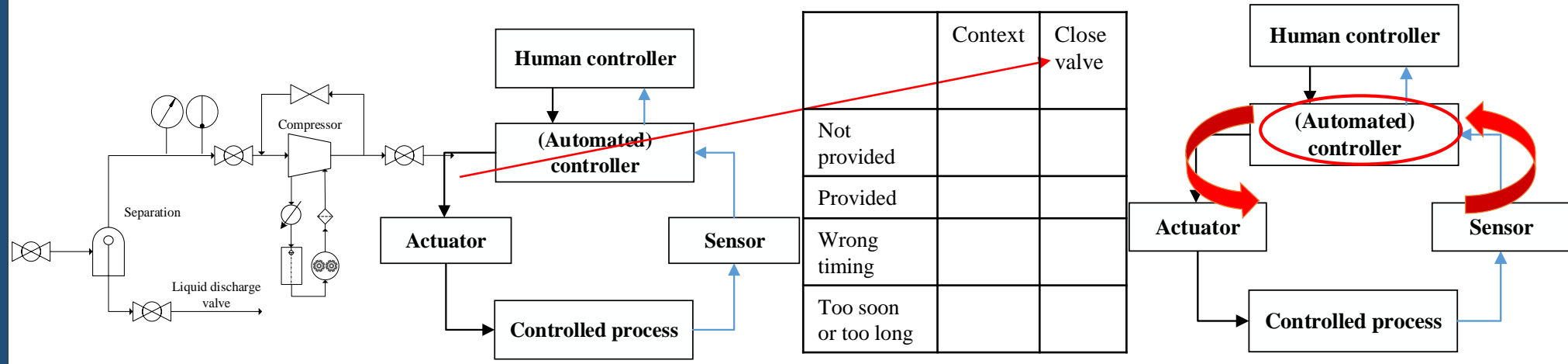
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State-space modelling of STPA output

Example control action: close shutdown valve

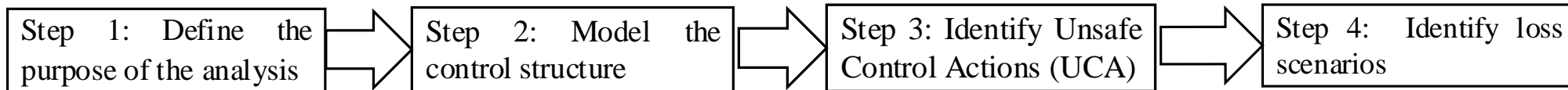
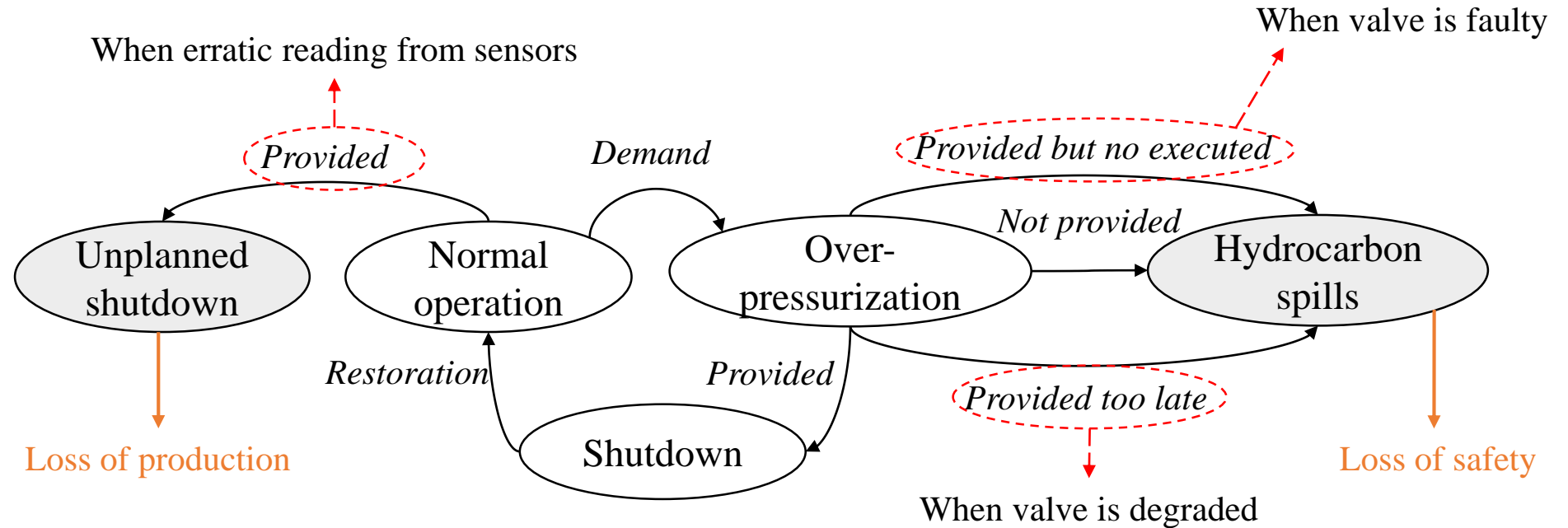
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Step II: Develop RAM model

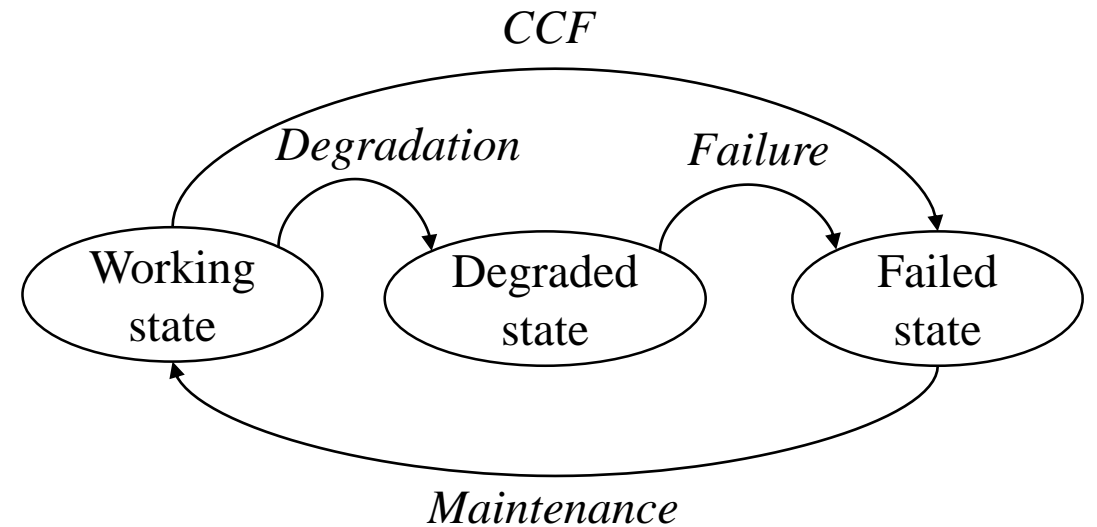
How can system fails:

- Failure modes
- Common cause failure
- Degradation
- ...

How can system recover:

- Inspection
- Maintenance
- ...

State transitions for valve:



Background

STPA

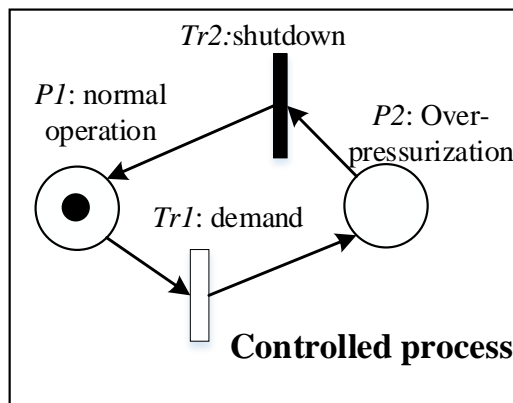
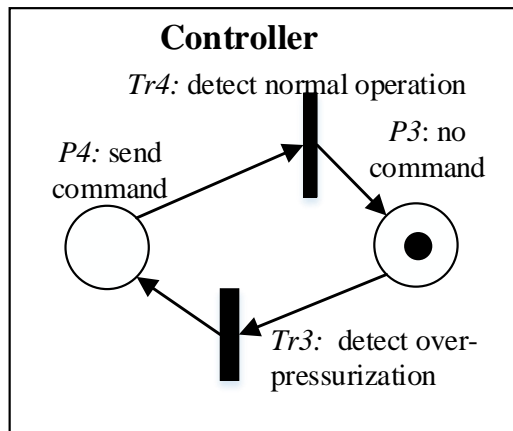
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Petri-nets with Predicates

Safe control scenario:



Transition	Predicate	Assertion
<i>Tr1</i>		normal_state=false
<i>Tr2</i>	reset ==true	normal_state=true
<i>Tr3</i>	normal_state== false	reset =true
<i>Tr4</i>	normal_state ==true	reset =false

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Petri-nets with Predicates

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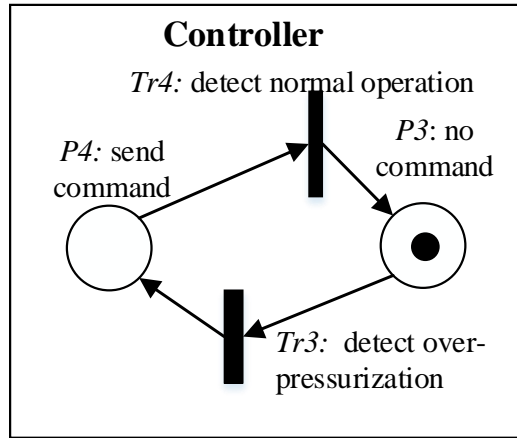
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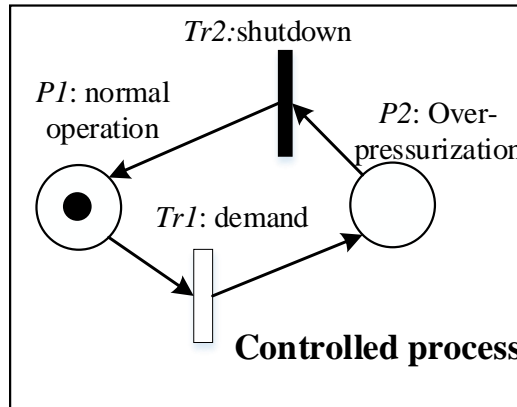
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Safe control scenario:



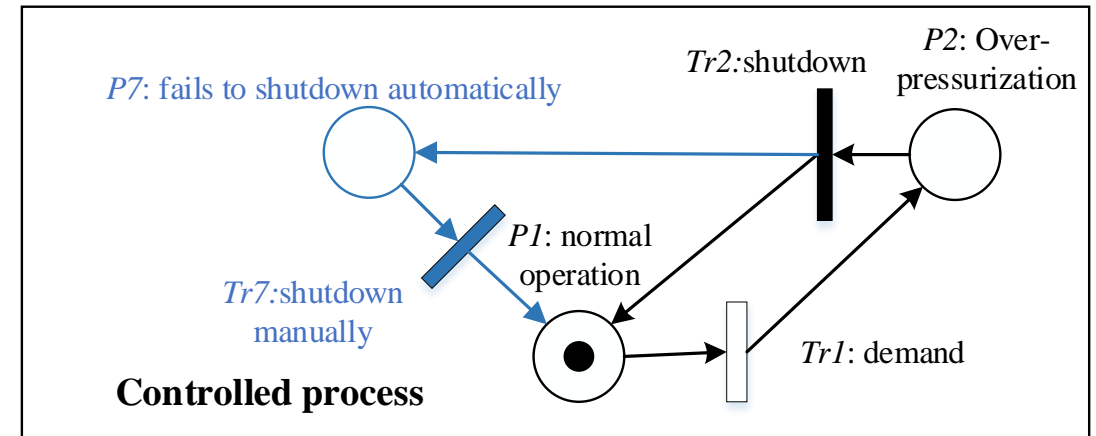
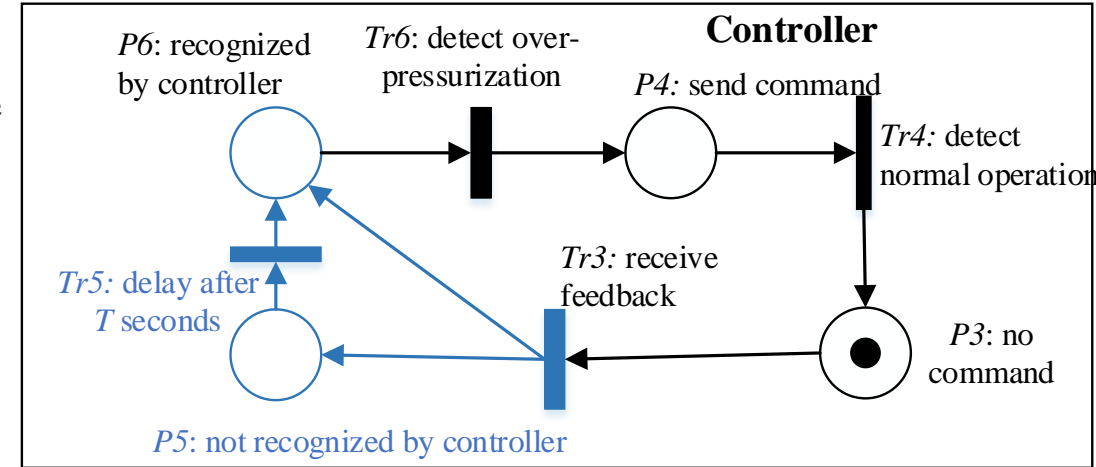
Controller sends the command **too late** (after T seconds)



Controlled process is **not successful activated**



Safe control scenario+ two loss scenarios:



Petri-nets with Predicates

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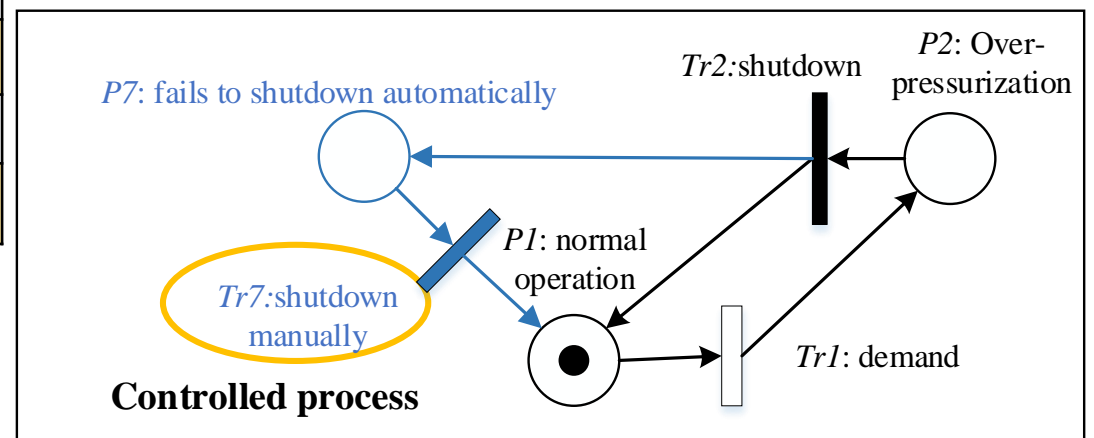
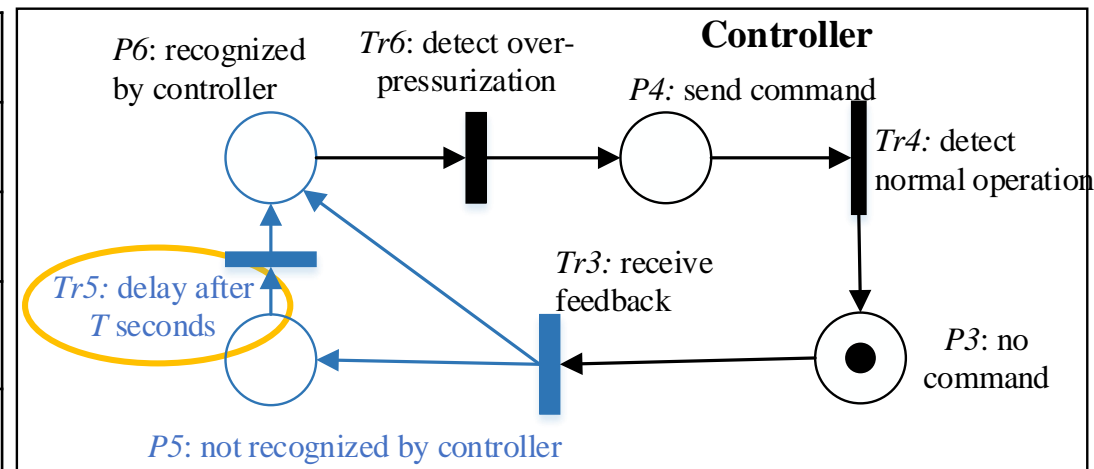
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Transition	Predicate	Assertion	Delay of transition
Tr1		normal_state=false	stochastic delay, λ
Tr2	reset =true	normal_state =true	X seconds
Tr3	normal_state =false		0
Tr4	normal_state =true	reset =false	0
Tr5			T seconds
Tr6		reset =true	0
Tr7		$\lambda = \lambda \times (1 + \alpha)$	0

Safe control scenario+ two loss scenarios:



Subsea Gate box (SGB)

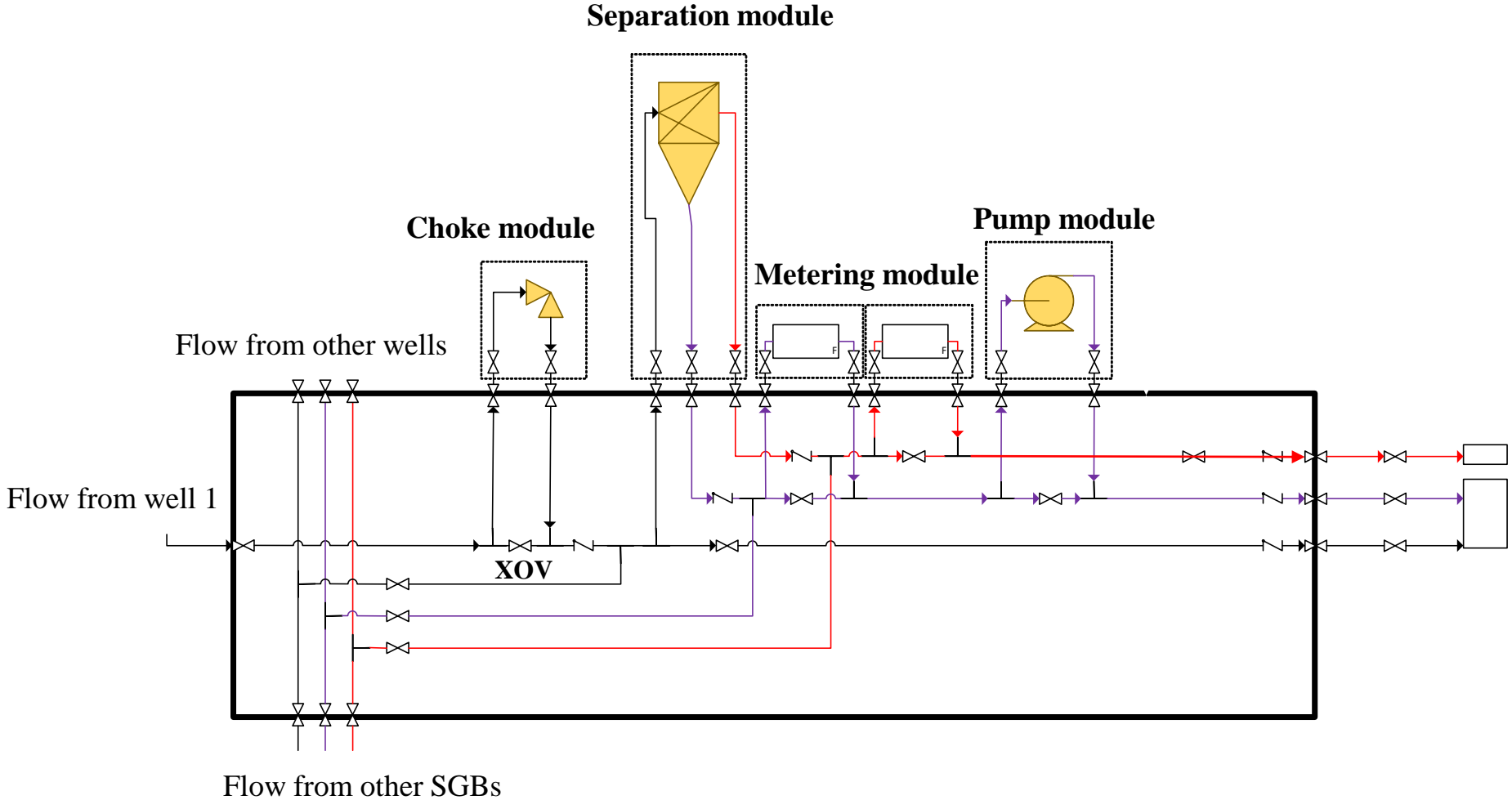
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Ref. (Mariana, 2017)

Normal processing (SGB-NP)

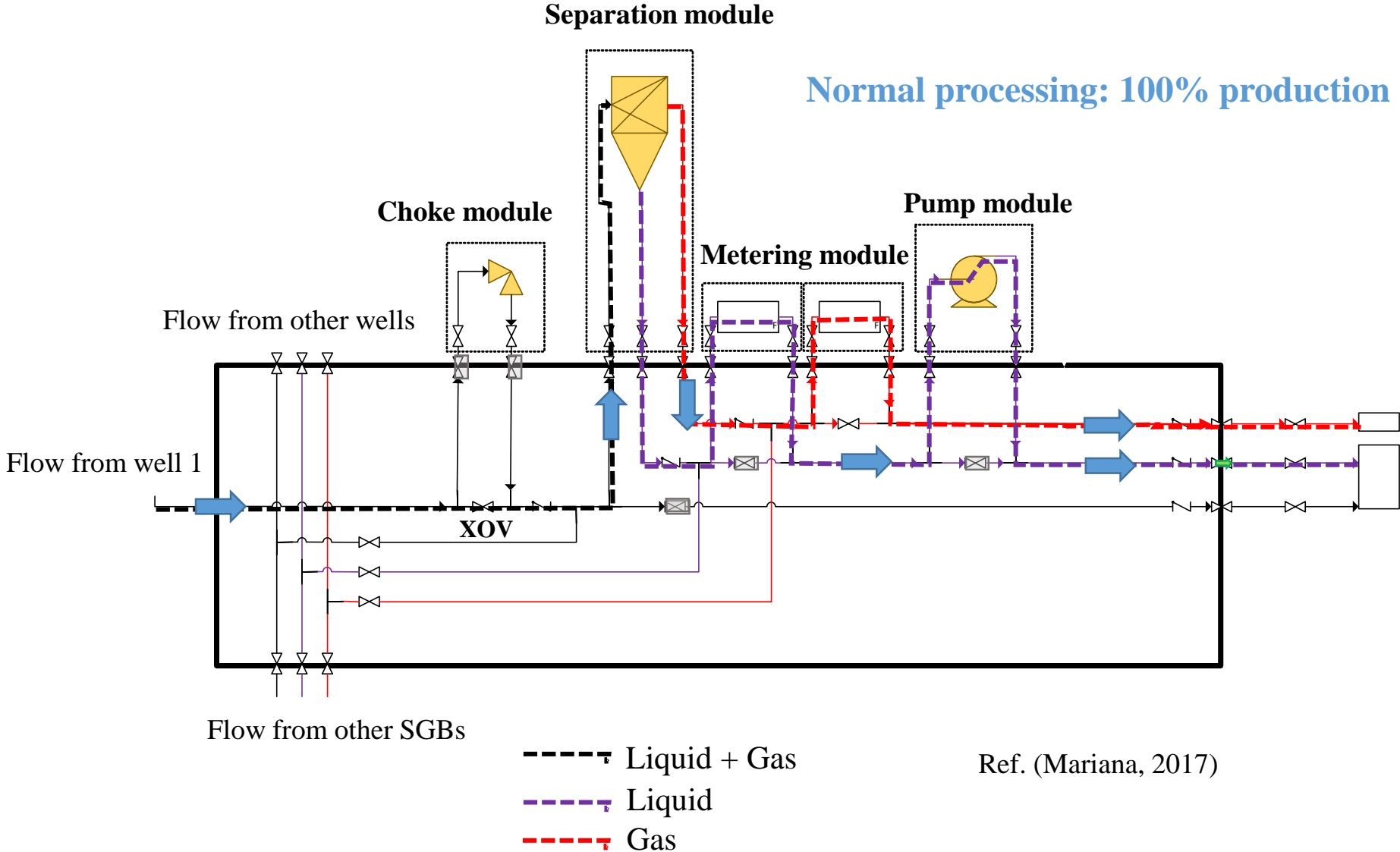
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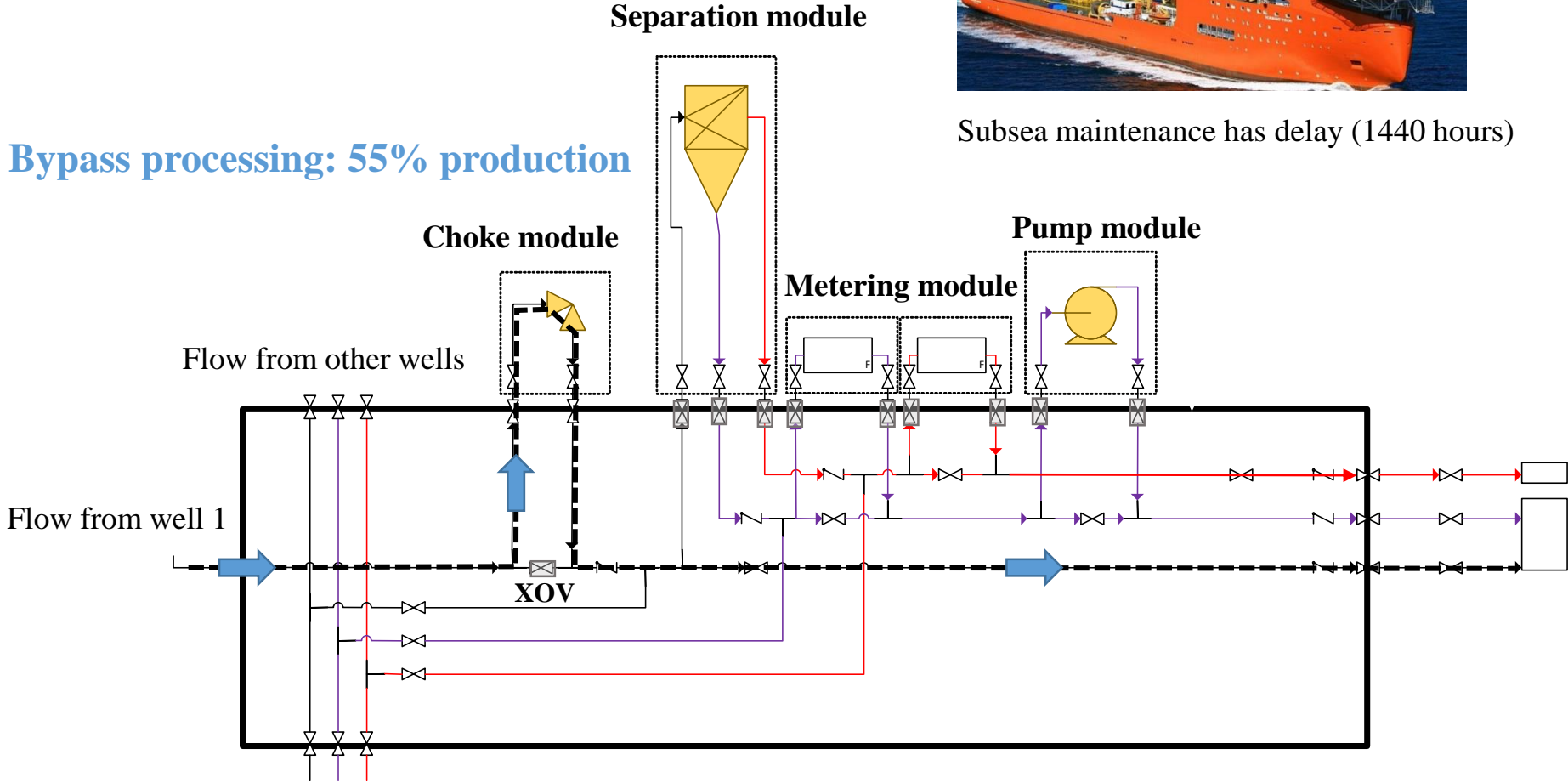


Bypass processing (SGB-BP)



Subsea maintenance has delay (1440 hours)

Bypass processing: 55% production



- - - - - Liquid + Gas
 - - - - - Liquid
 - - - - - Gas

Ref. (Mariana, 2017)

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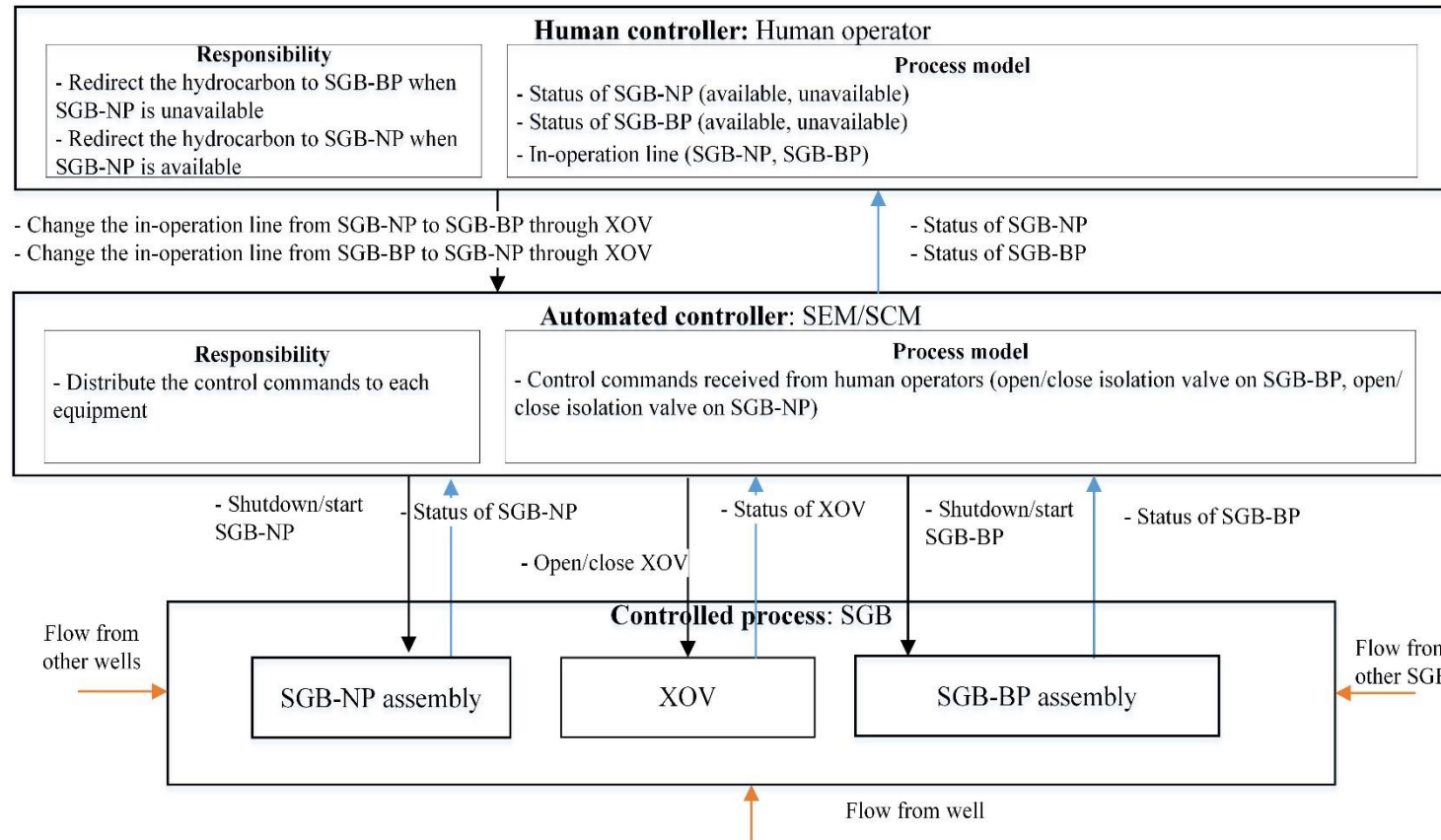
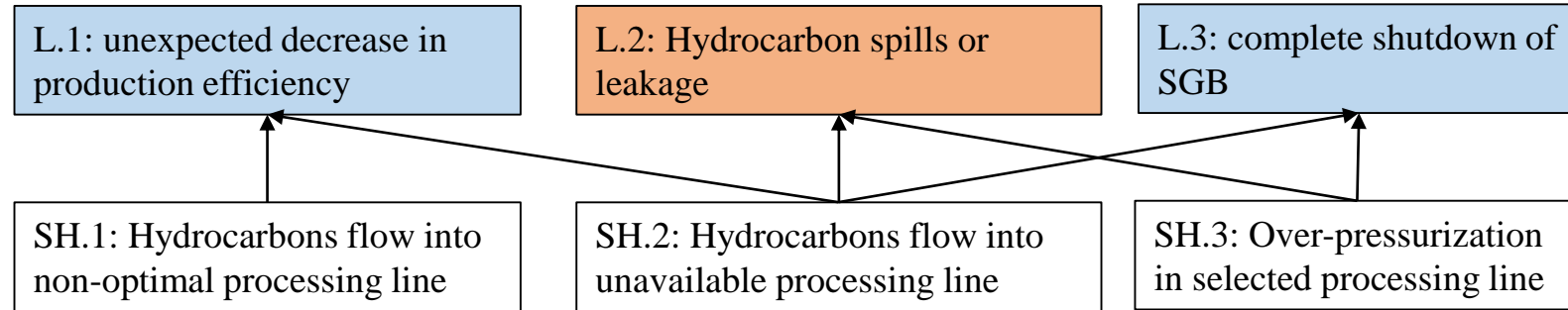
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Step I: Carry out STPA



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Step I: Carry out STPA

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Control action from SEM/SCM	Identification of UCAs			
	Not provided	Provided	Wrong timing or order	Too soon or too long
Change the in-operation line from SGB-NP to SGB-BP through XOV	UCA.1: Control command is not provided when SGB-NP is faulty and XOV is available [SH.1, SH.2,]	UCA.2: Control command is provided when both SGB-NP and XOV are available [SH.1]	UCA.4: Control command is provided too late when SGB-NP is faulty and XOV is available [SH.2, SH.3]	UCA.5: Control command is stopped too soon before XOV is fully closed when SGB-NP is faulty [SH.2, SH.3]
		UCA.3: Control command is provided when both SGB-NP and SGB-BP are faulty [SH.1, SH.2]		

UCA.1: Change the in-operation line from SGB-NP to SGB-BP through XOV is not provided by SCM/SEM on command from human operator when SGB-NP is faulty and XOV is available [SH.1, SH.2]	
Loss scenarios	Suggested countermeasures
SO.1 for UCA.1: Human operator receives correct feedback but interprets it incorrectly so SEM/SCM does not receive control command from human operator. The causal factor is that human operator lacks sufficient understanding for abnormal situation.	Must provide the sufficient training for operators to deal with specified hazardous situations.
SO.2 for UCA.1: Human operator receives correct feedback but makes mistakes so SEM/SCM does not receive control command from human operator. The causal factor is that human operator is overstressed when there are too many process to be considered.	The reference document must be presented to provide guidance for operation.
SO.3 for UCA.1: Human operator receives incorrect feedback about conditions of SGB-NP so wrongly believes that the SGB-NP is working but it is not. The casual factor is that the sensor on SGB-NP provides erratic readings.	Sensors must be monitored continuously and be calibrated when erratic reading was detected
Loss scenarios	Suggested countermeasures
SO.4: The control command is initiated by human operator but not received by SCM/SEM. The casual factor is that there is a critical failure on SEM/SCM [SH.1, SH.2].	The status of SCM/SEM must be checked before operation and after each updates.
SO.5: The control command is provided by SCM/SEM on command from human operator, but actuator does not responds to this control command. The casual factor is critical failures on XOV (actuator) [SH.1, SH.2].	XOV must be checked regularly and be repaired when critical failure is revealed.

Step I: Carry out STPA

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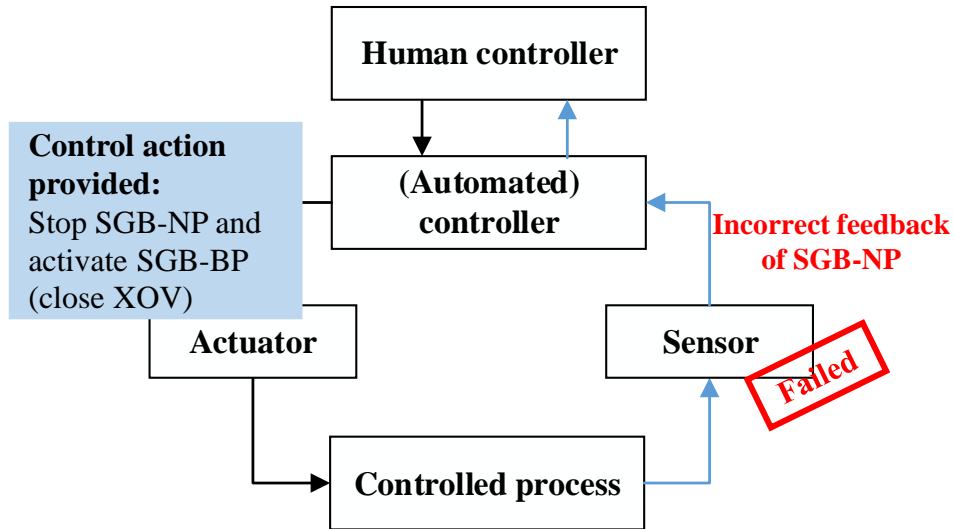
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Loss scenario 1

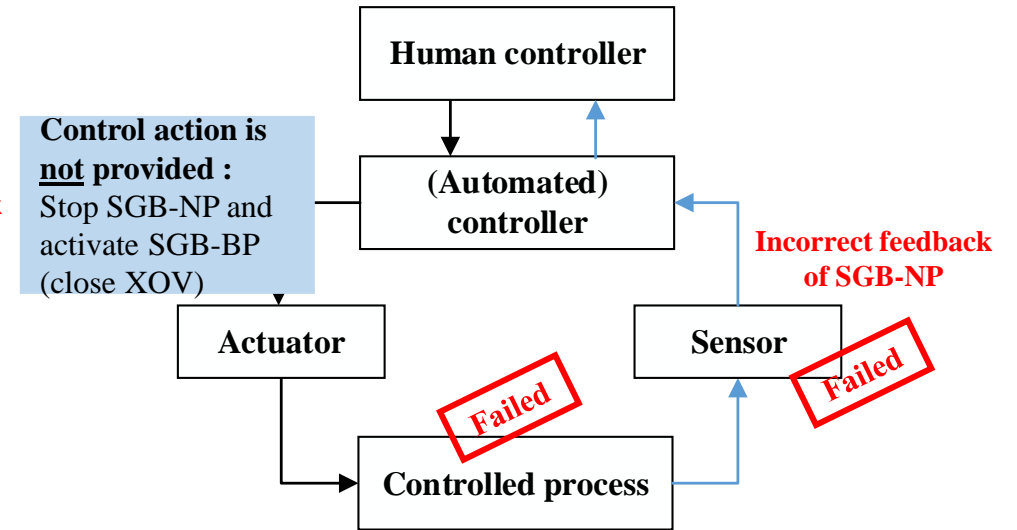
Flawed process model:
Operator believes SGB-NP is faulty when it is still working



Hazards and losses to controlled process:
Hydrocarbons flow into non-optimal processing line (SH.1). The system operates in bypassing for 360 hours. (L.1)

Loss scenario 2

Flawed process model:
Operator believes SGB-NP is still working when it is faulty



Hazards and losses to controlled process:
Hydrocarbons flow into non-optimal and unavailable processing line (SH.1,SH.2). The system complete shutdown (L.3) and hydrocarbon spills may occur (L.2)

Petri-nets for loss scenario 2 and safe scenario

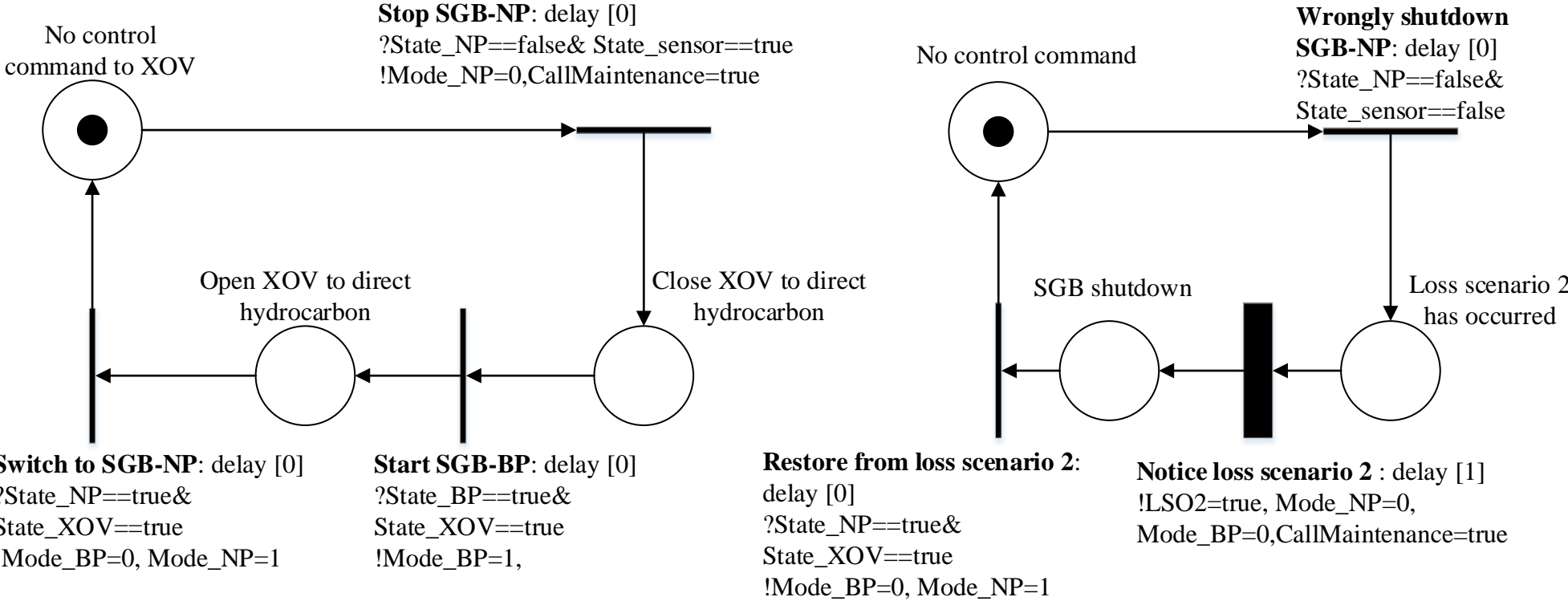
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Step II: Develop RAM model

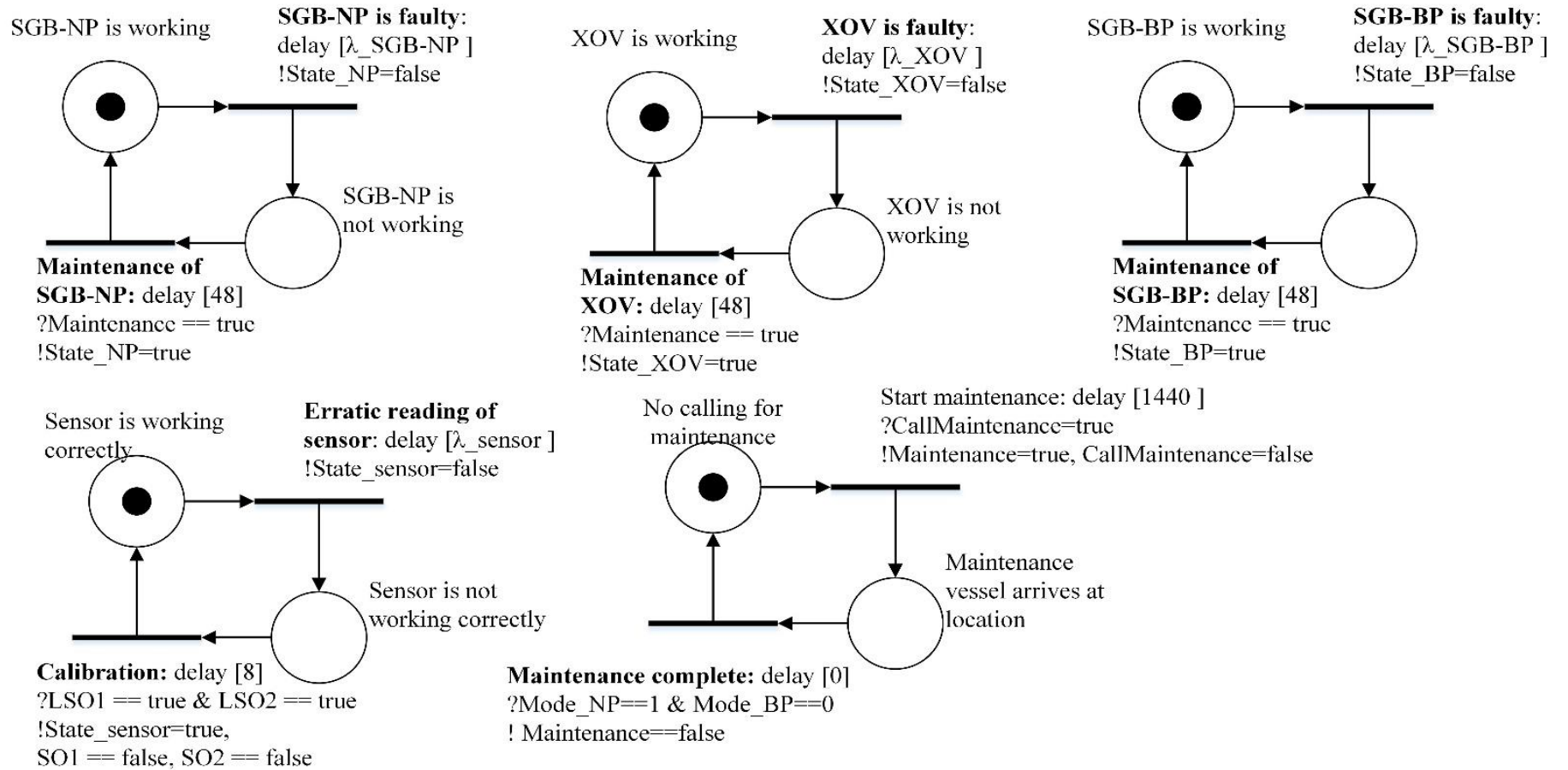
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Case 0: $\lambda_{\text{sensor}} = 0 \times 10^{-5} \text{ hour}^{-1}$ → Only safe scenario

Case 1: $\lambda_{\text{sensor}} = 0.5 \times 10^{-5} \text{ hour}^{-1}$
 Case 2: $\lambda_{\text{sensor}} = 1 \times 10^{-5} \text{ hour}^{-1}$
 Case 3: $\lambda_{\text{sensor}} = 1.5 \times 10^{-5} \text{ hour}^{-1}$ } Loss scenario 1 & 2

Numerical results

	Loss scenario 1 (L.1)	Loss scenario 2 (L.1, L.2, L.3)
Case 1	$7.028 \times 10^{-2} \text{ year}^{-1}$	$3.3 \times 10^{-4} \text{ year}^{-1}$
Case 2	$1.427 \times 10^{-1} \text{ year}^{-1}$	$5.7 \times 10^{-4} \text{ year}^{-1}$
Case 3	$2.033 \times 10^{-1} \text{ year}^{-1}$	$7.9 \times 10^{-4} \text{ year}^{-1}$

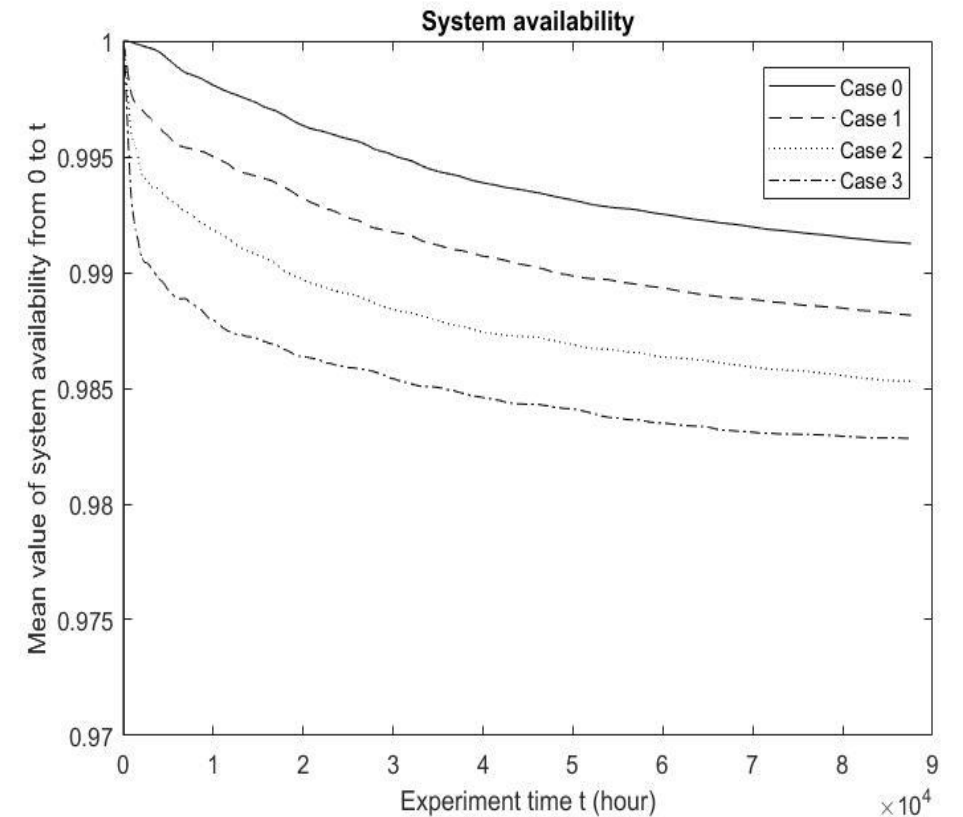
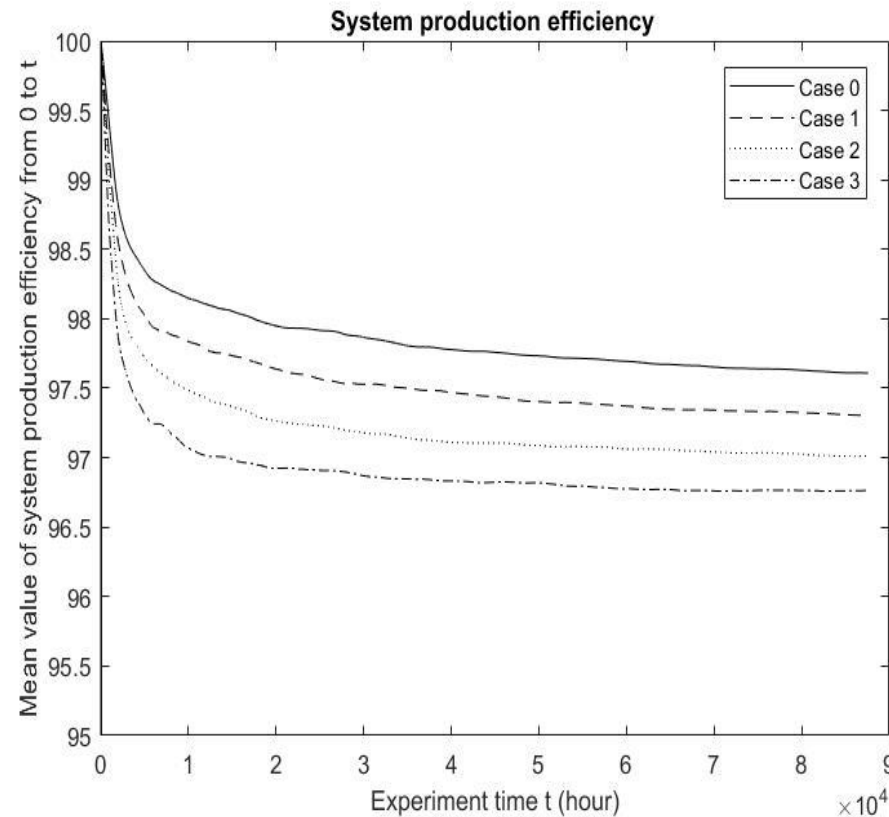
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Uncertainty level

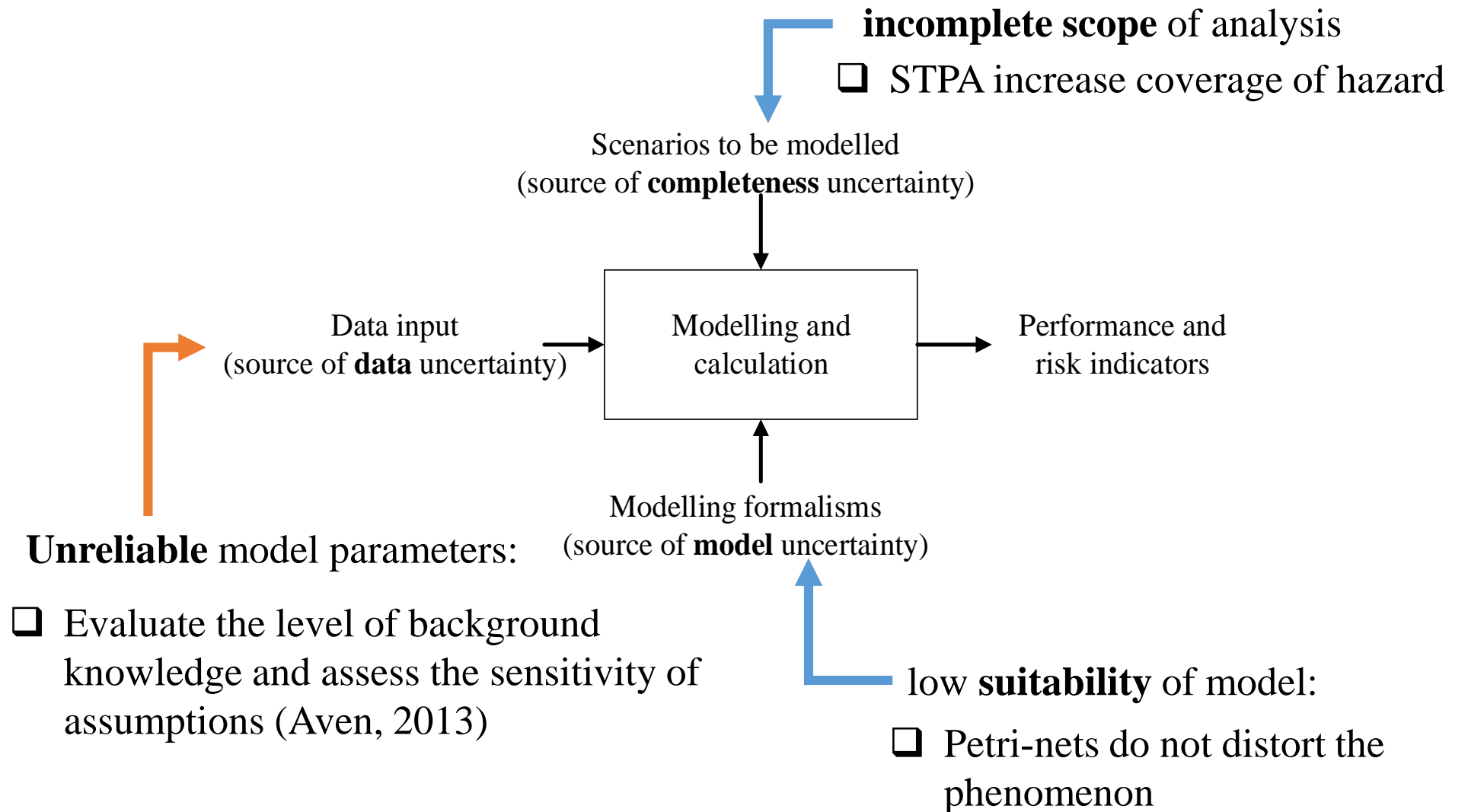
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Potential for modelling human and software

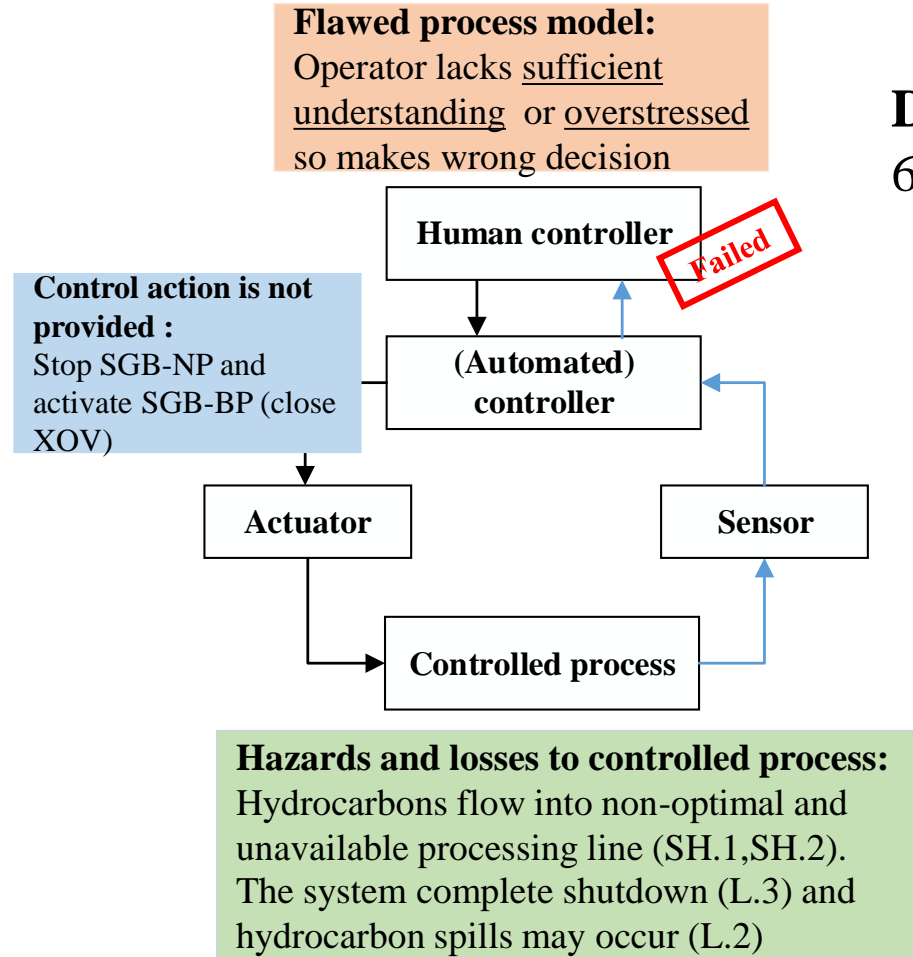
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Different strategies for human factors in IEC 61508 (2010) and ISO TR 12489 (2013)

Prioritization and screening

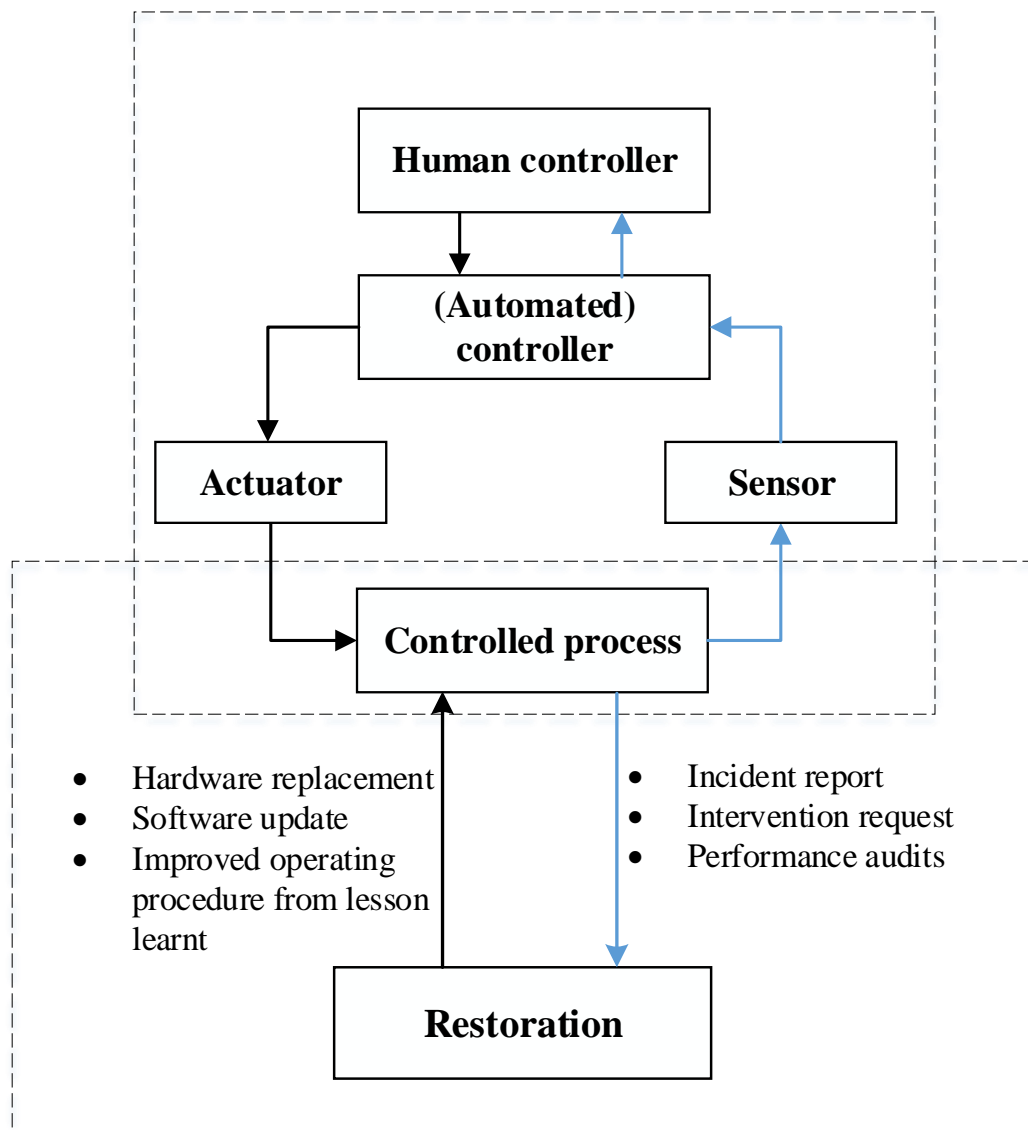
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Additional step: Screen out critical scenarios

Step I: Carry out STPA

Selection of experiments

Step II: Develop RAM model

Concluding remarks

Conclusion:

- The proposed approach clarifies (1) how to devise better simulation on basis of STPA output (2) to what extent STPA can contribute to decision-making (e.g. system production, maintenance and emergency management)

Future work:

- There is a need to screen out the most critical scenario to **decrease computational burden** in simulation.
- **Managing data uncertainty** is the potential improvement to the proposed approach .

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Thanks for listening!



Any questions?

```

domain Submodulestate = {Working, Degraded, Failed,
In_Repair}
domain Mode = {Operation, Maintenance}
class Compressor
    Modulestate state (init= Working);
    Mode phase (init= Operation);
    Mode command (init= Operation) ;
    event degradation (delay=0),
    event failure (delay=exponential(lambda)),
    event repair (delay=mu),
    event startRepair (delay=0),
    event endRepair (delay=0);
    parameter Real lambda =1.0e-6,
    parameter Real mu =1440;
    transition
        degradation : state==Working and
phase==Operation and loss==true -> state:= Degraded;
        failure : state==Degraded and
phase==Operation -> state:= Failed;
        repair: state==In_Repair -> state:= Working;
        startRepair: phase ==Operation and command
== Maintenance -> phase := Maintenance;
        endRepair: phase == Maintenance and
command==Operation -> {phase := Operation;
if state==Failed then state:= In_Repair;
if state==Degraded then state:= In_Repair};
end

```

```

class Separation
    Mode command (init=Operation);
    Mode state(init= Operation);
    event startRepair (delay=gamma),
    event failure (delay=exponential(lambda))
    event endRepair (delay=0);
    parameter Real gamma =720;
    transition
        startRepair: state==
Maintenance -> command := Maintenance;
        endRepair : state==
Operation -> command := Operation;
end

```

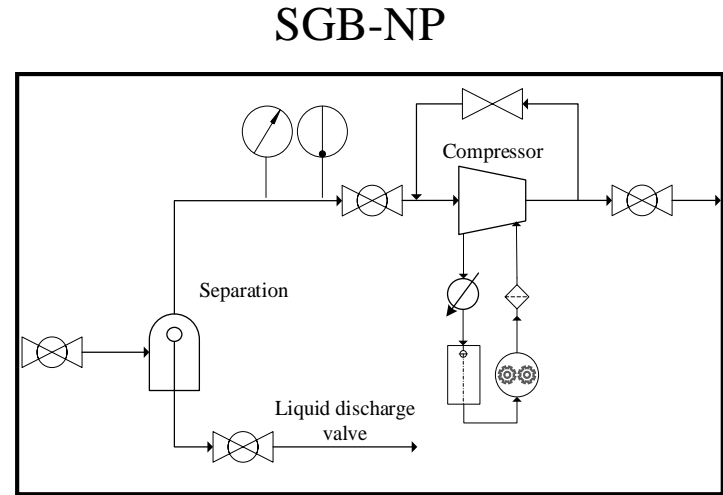
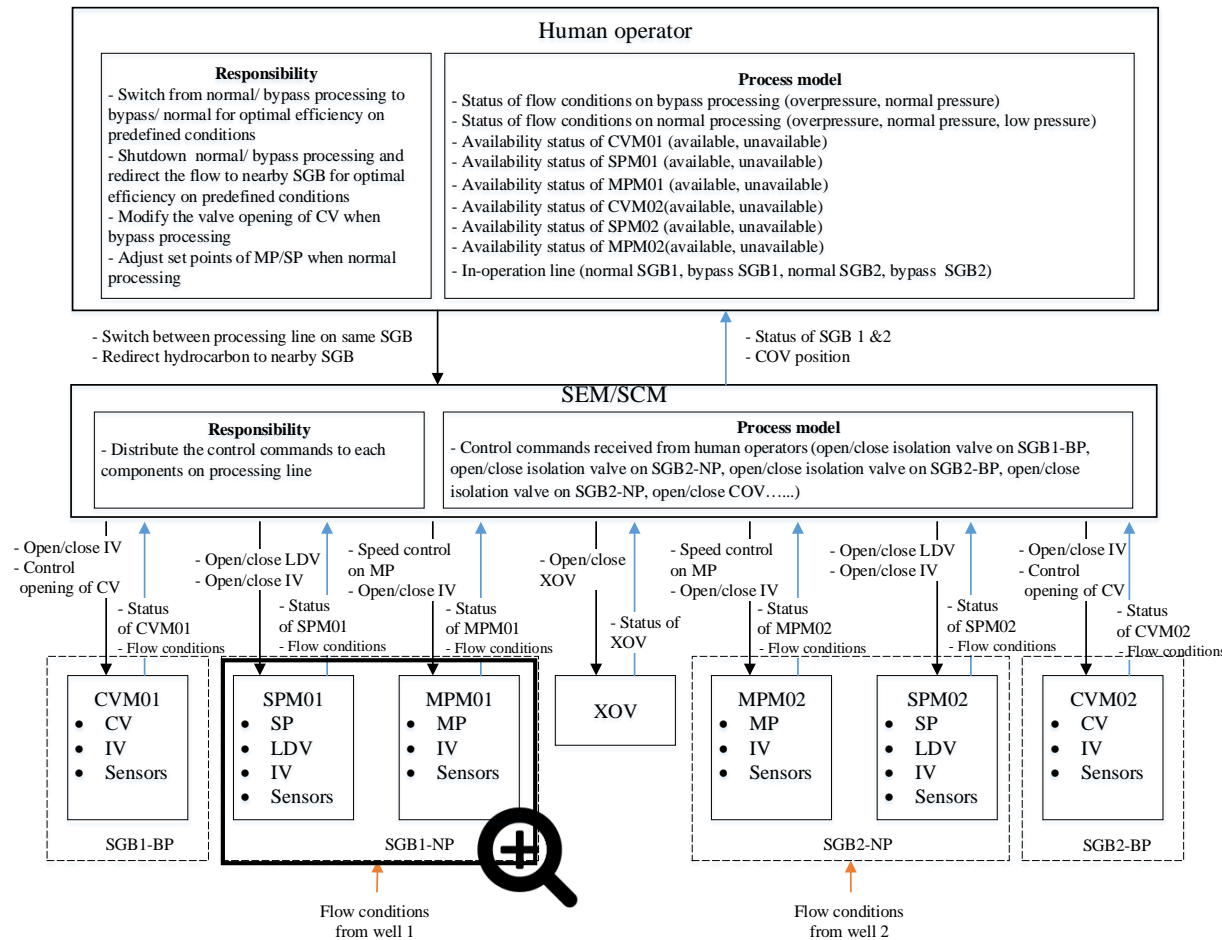
```

block Controller
Submodule Compressor, Separation;
Operator O;
assertion
O.state:= if Compressor.state== Failed or
Separation.state==Failed then Maintenance else
Operation;
end

```



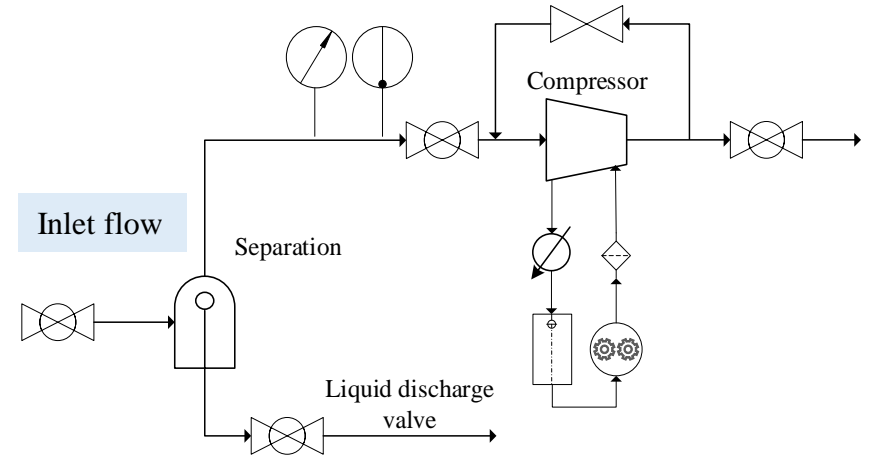
Detailed STPA:



Example: SO.xx-UCA.xx: The liquid level in separator is above defined value, but the operator does not provide the valve open command. The causal factor is that the signal cable from the transmitter is disconnected. As a result, liquid may flow into the gas compressor [SH.xx].

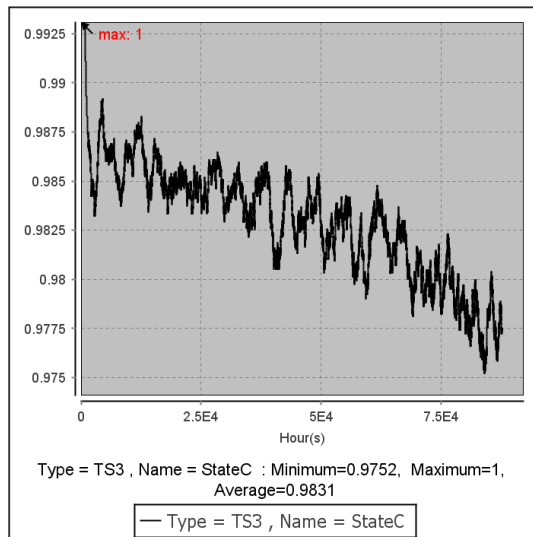
Detailed modelling:

Loss scenario: The **liquid level** in separator is above defined value, but the operator does not provide the valve open command. The causal factor is that the signal cable from the transmitter is disconnected. As a result, liquid may flow into the gas compressor [SH.xx].

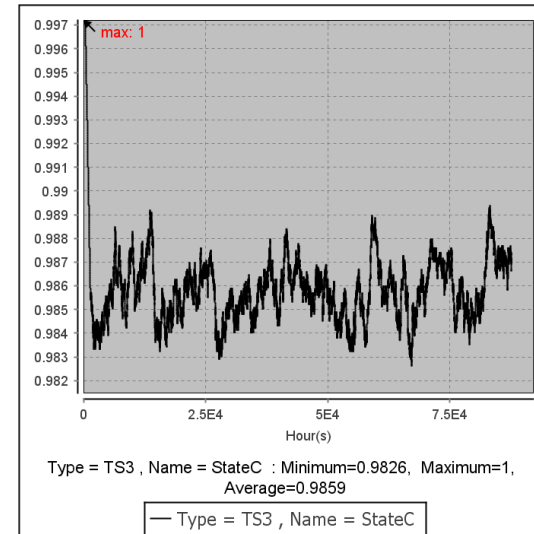


Open/close of Liquid Discharge Valve

Consider loss scenario



Without considering loss scenario



Risk-based decision context

How worse are L.1 and L.3?

If assume that SGB can produce 2 million Norwegian kroner (NOK) worth oil and gas per day, then the expected difference between case 0 and case 3 is 6.862 million NOK per year in stakeholder's favor.

How worse are L.2?

Need further information about emergency barrier, e.g. Event tree analysis

