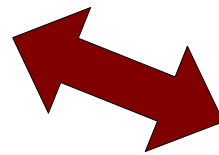


From FRAM
(Functional Resonance
Accident Model)



to FRAM
(Functional Resonance
Analysis Method)

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Risk in reality

Type of risk

History

Loss of property
during
transportation

4.000 – 3.000 B.C. (China, Babylon): "bottomry" contracts – insurance of commercial vessels. Later becomes maritime insurance. Oldest policy in existence from 24 April, 1384

Loss by gambling

1645 – Blaise Pascal develops probability calculus

Loss of property by
fire

The great fire of London (1666) marks the beginning of insurance against fire.

Loss of life or
capabilities

1759 first life-insurance company in the USA (Presbyterian Ministers' Fund)

First train accident

1830 William Huskisson killed in train accident

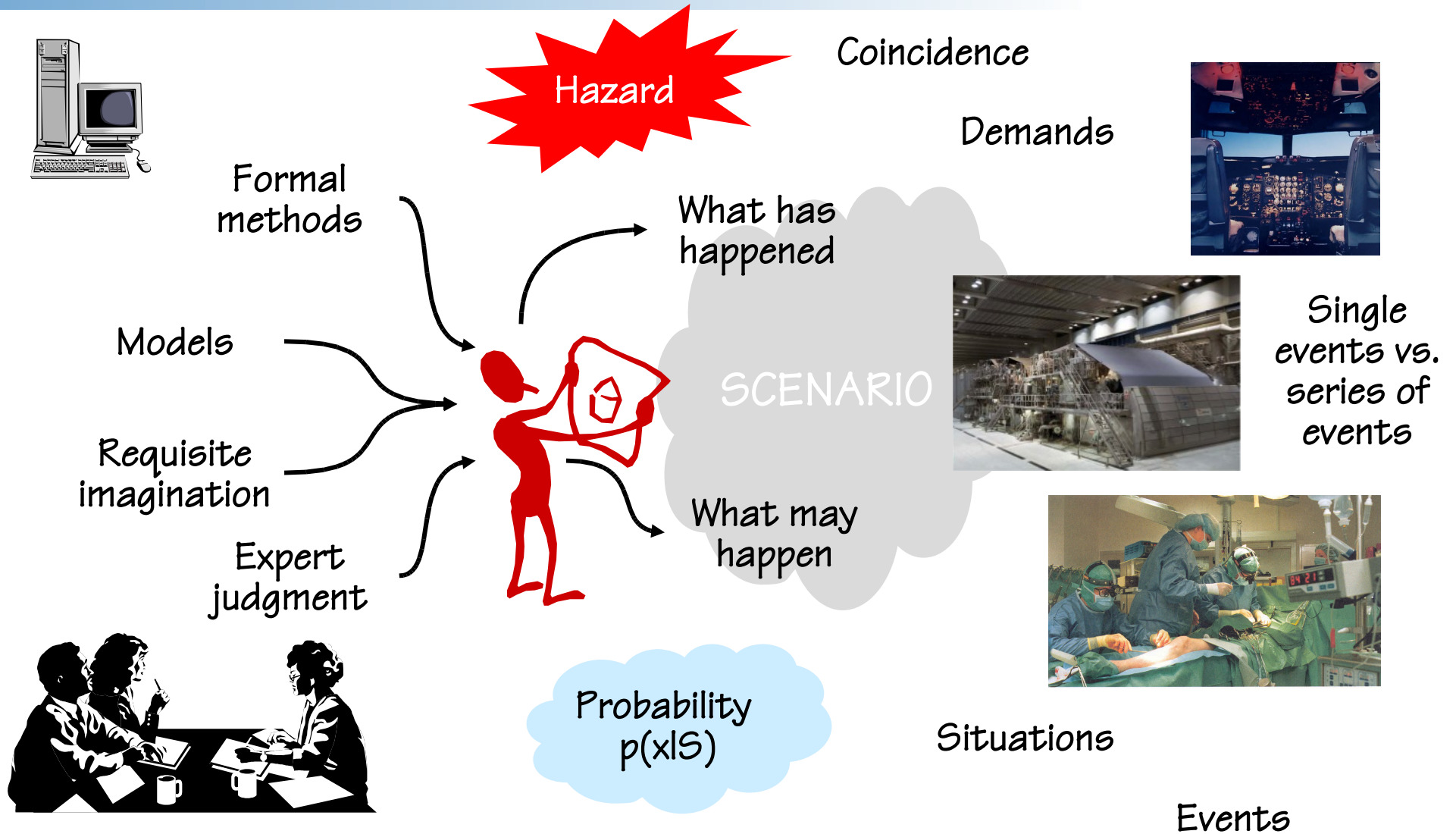
First car accident

1869 (Aug. 31) Mary Ward fell under the wheels of a steam car

Steam engine

1786, James Watt gets a patent on low pressure steam engine, warns against use of high pressure engines.
Many accidents in US Navy (1816-1848: 2 562 dead in 233 accidents).

Understanding risks



Understanding and assessing risks

1 Is it possible to understand what the **problem** is?

Recognise that there is a risk

NO SYSTEMS ARE INHERENTLY SAFE!

Understand the reasons for it (availability of examples)

2 Is it possible to imagine the **consequences** and to differentiate between large and small risks?

Envisage the consequences concretely

Understand failure “mechanism” (representativeness).

Intuitive feeling that the risks are real.

3 Are there any known **solutions** by which the risk can be reduced or eliminated?

Specify concrete solutions, i.e., specific actions or precautions.

Solutions must correspond to the failure “mechanisms”

If “safety = the freedom from unacceptable risk”, then how do we find the risk?

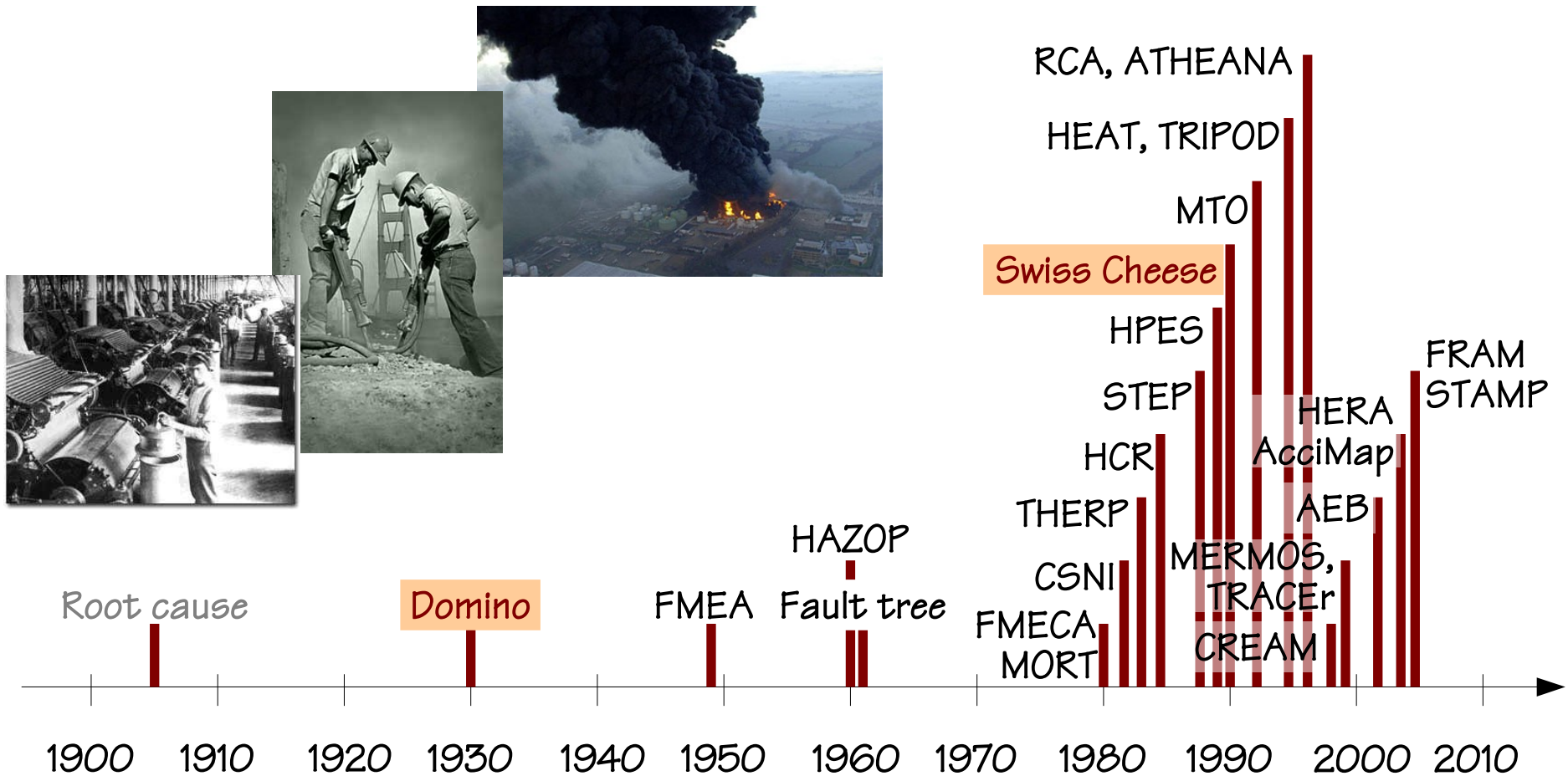
Accounting for the unpredictable

Risk assessment requires an *adequate* representation – or model – of the possible future events.

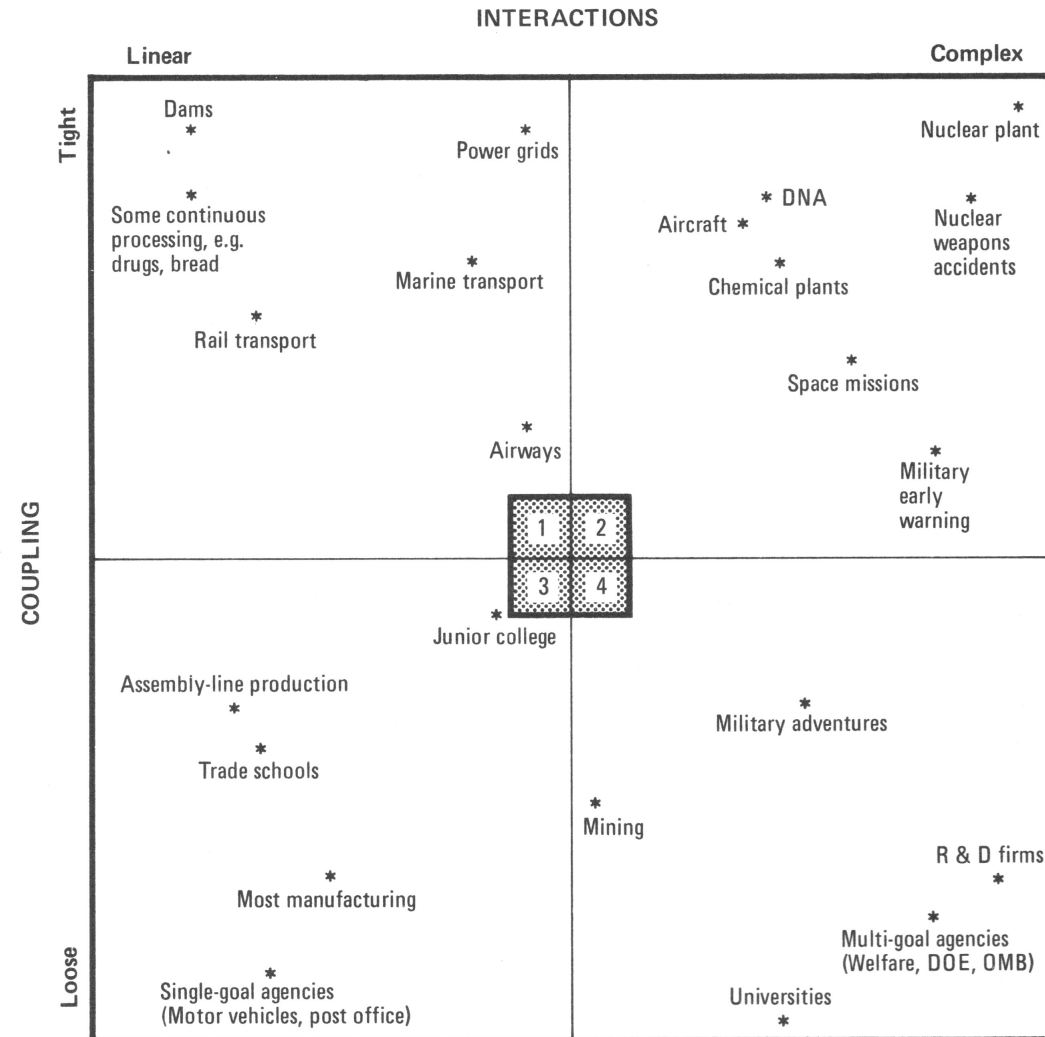
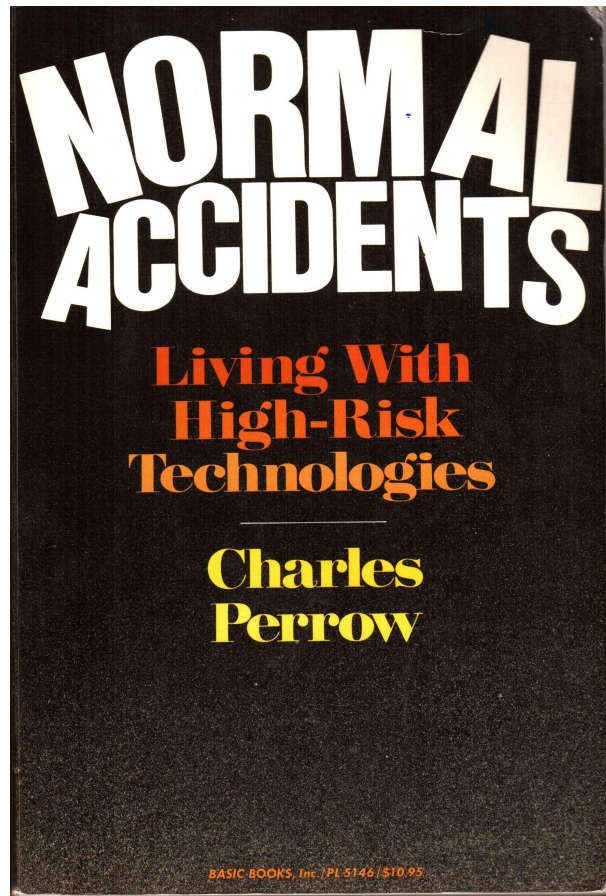


The representation must be powerful enough to capture the functional complexity of the system being analysed.

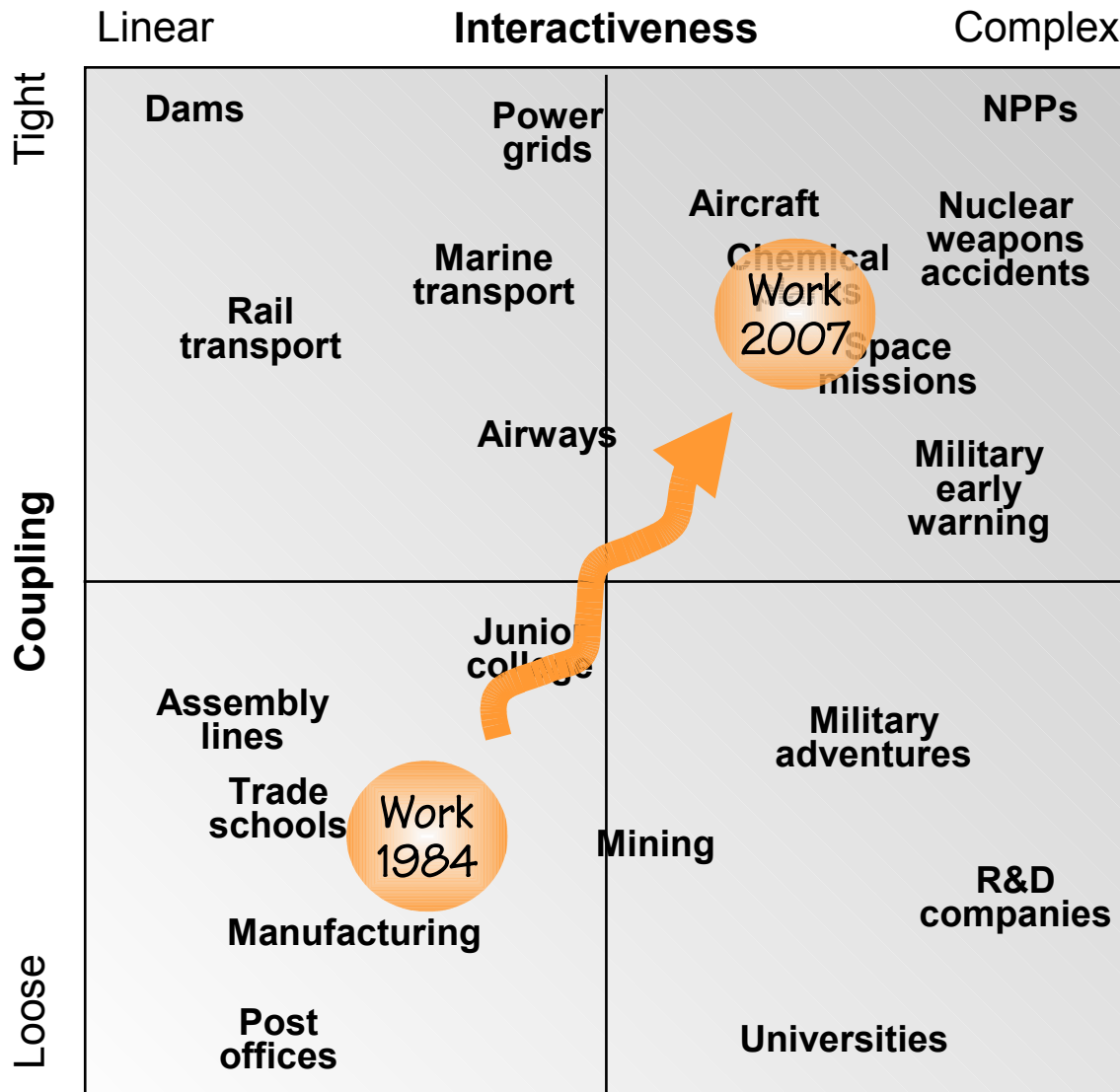
Accident & Risk Analysis Methods



Normal accident theory (1984)



Coupling and interactivensess



Complex systems / interactions:

Tight spacing / proximity
 Common-mode connections
 Interconnected subsystems
 Many feedback loops
 Indirect information
 Limited understanding

Tight couplings:

Delays in processing not possible
 Invariant sequence
 Little slack (supplies, equipment, staff)
 Buffers and redundancies designed-in
 Limited substitutability

“On the whole, we have complex systems because we don’t know how to produce the output through linear systems.”

Complexity or tractability?

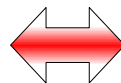
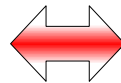
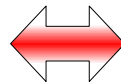
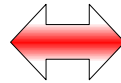
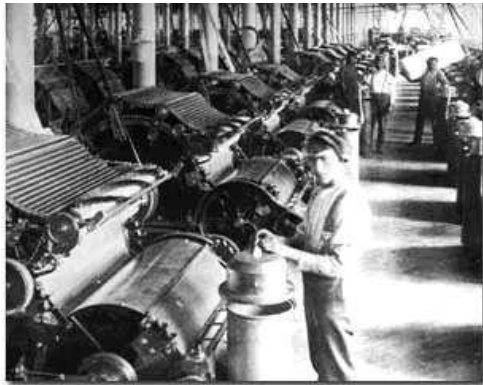
Tractable system

Principles of functioning are known

Description of system is easy and contains few details

Description can be made quickly

System does **not** change while being described



Intractable system

Principles of functioning are unknown or only partly known

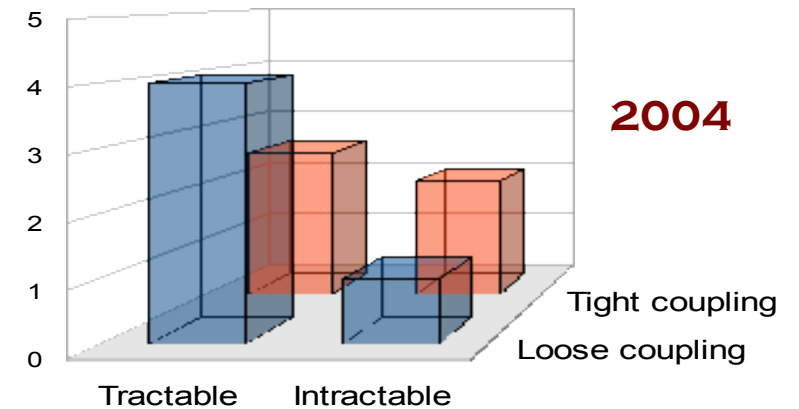
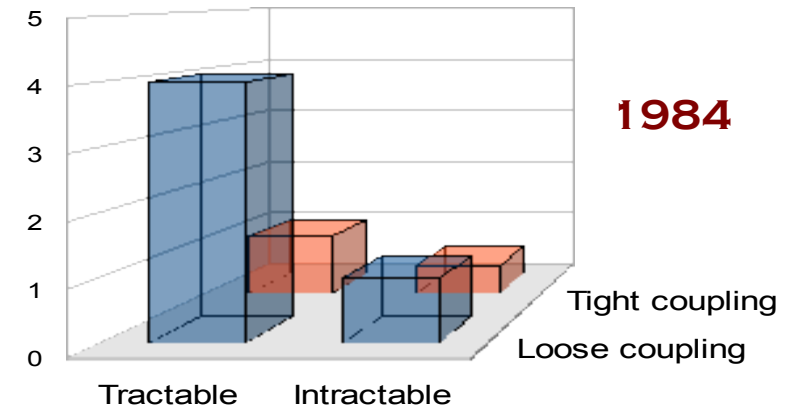
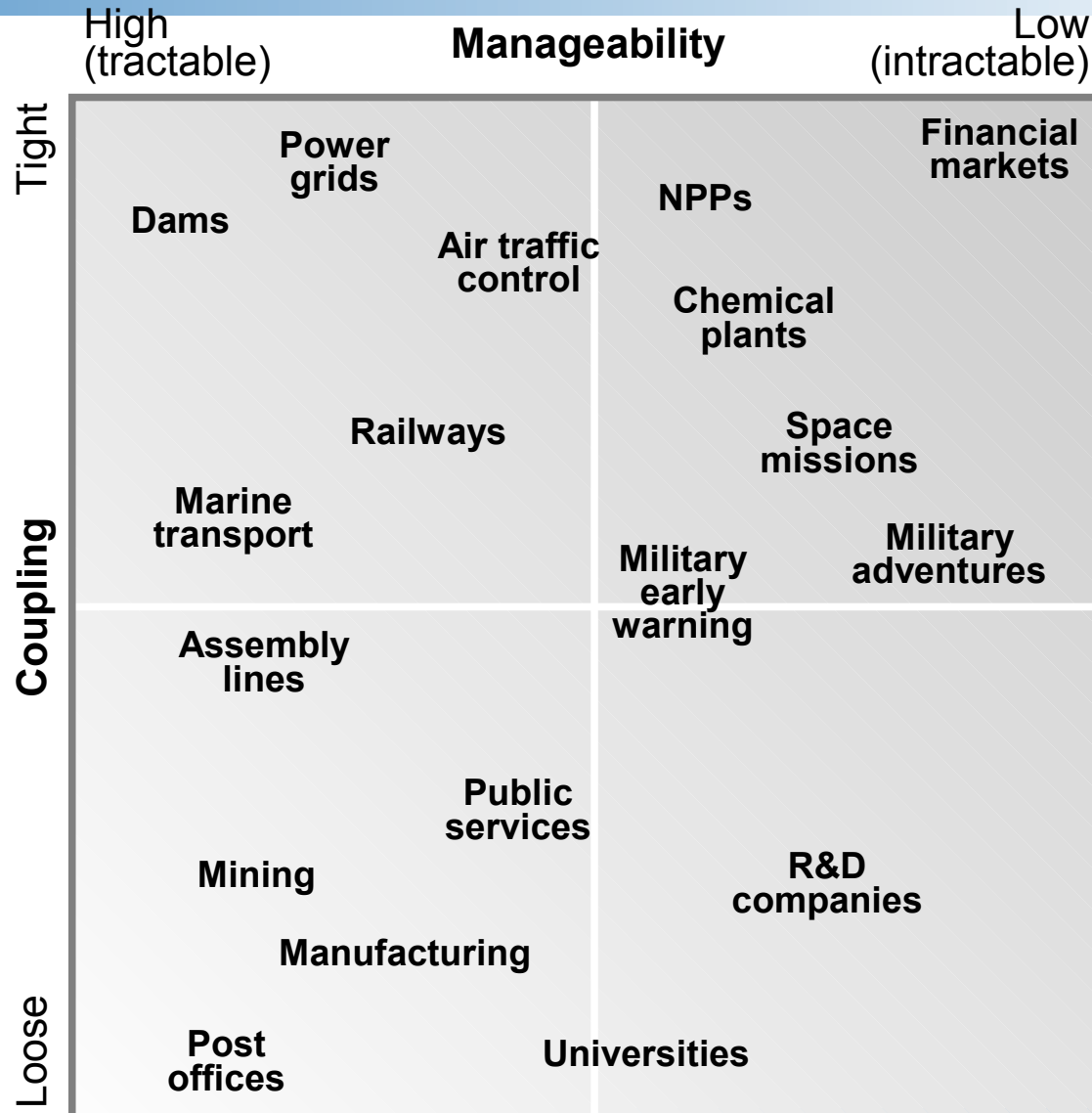
Description of system is difficult and contains many details

Description takes a long time to make

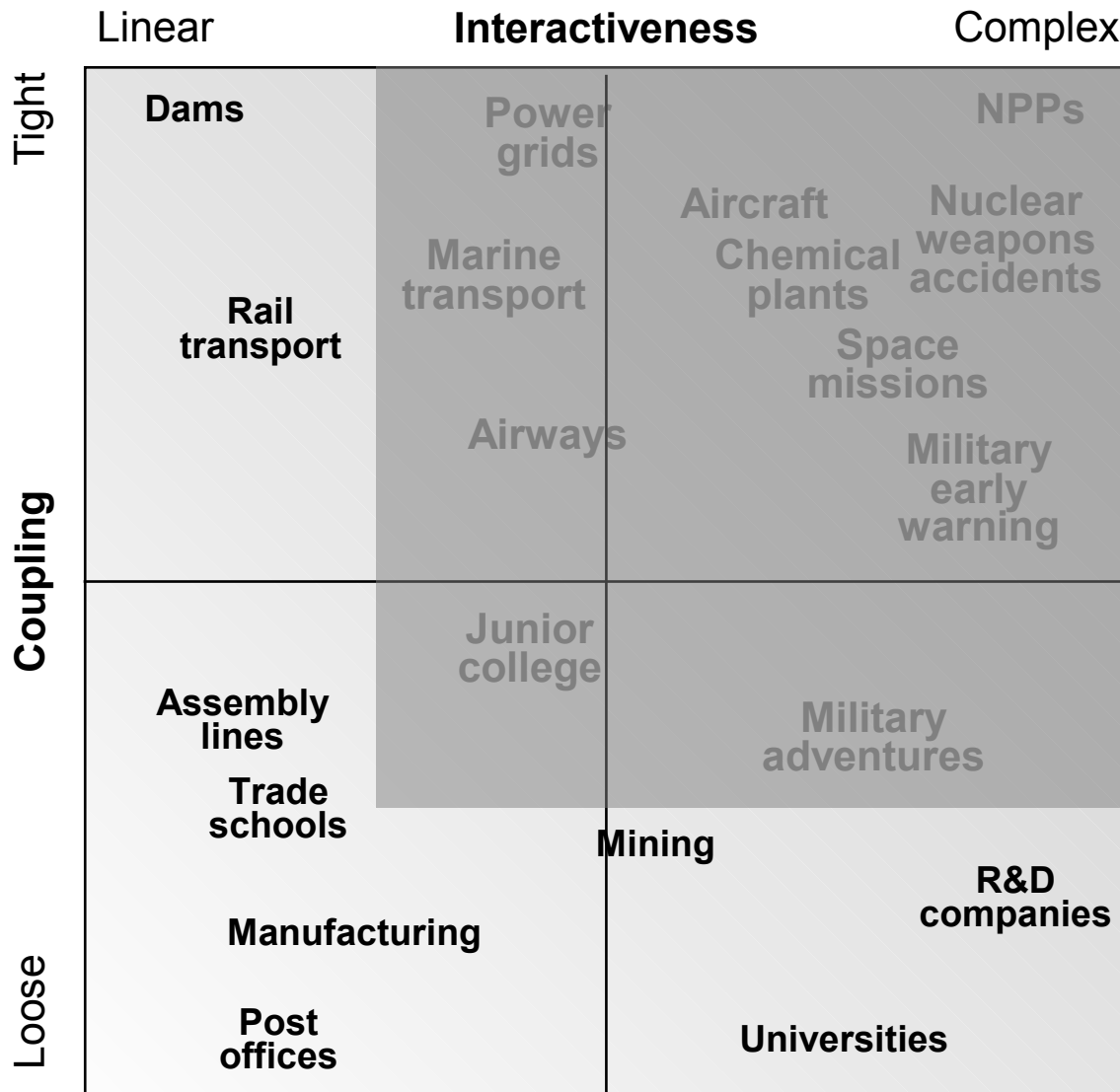
System changes before description is completed



From complexity to tractability



Systems and methods, pre-1930



Accidents often limited to single user-equipment system.

Interactiveness generally linear, hence easy to comprehend.

“The occurrence of a preventable injury is the natural culmination of a series of events or circumstances, **which invariably occur in a fixed and logical order.**”

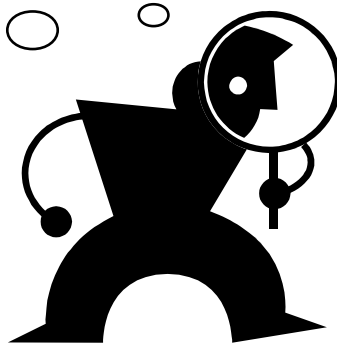


Understanding safety: linear models

Assumption: Accidents are the (natural) culmination of a **series of events** or circumstances, which occur in a specific and recognisable order.



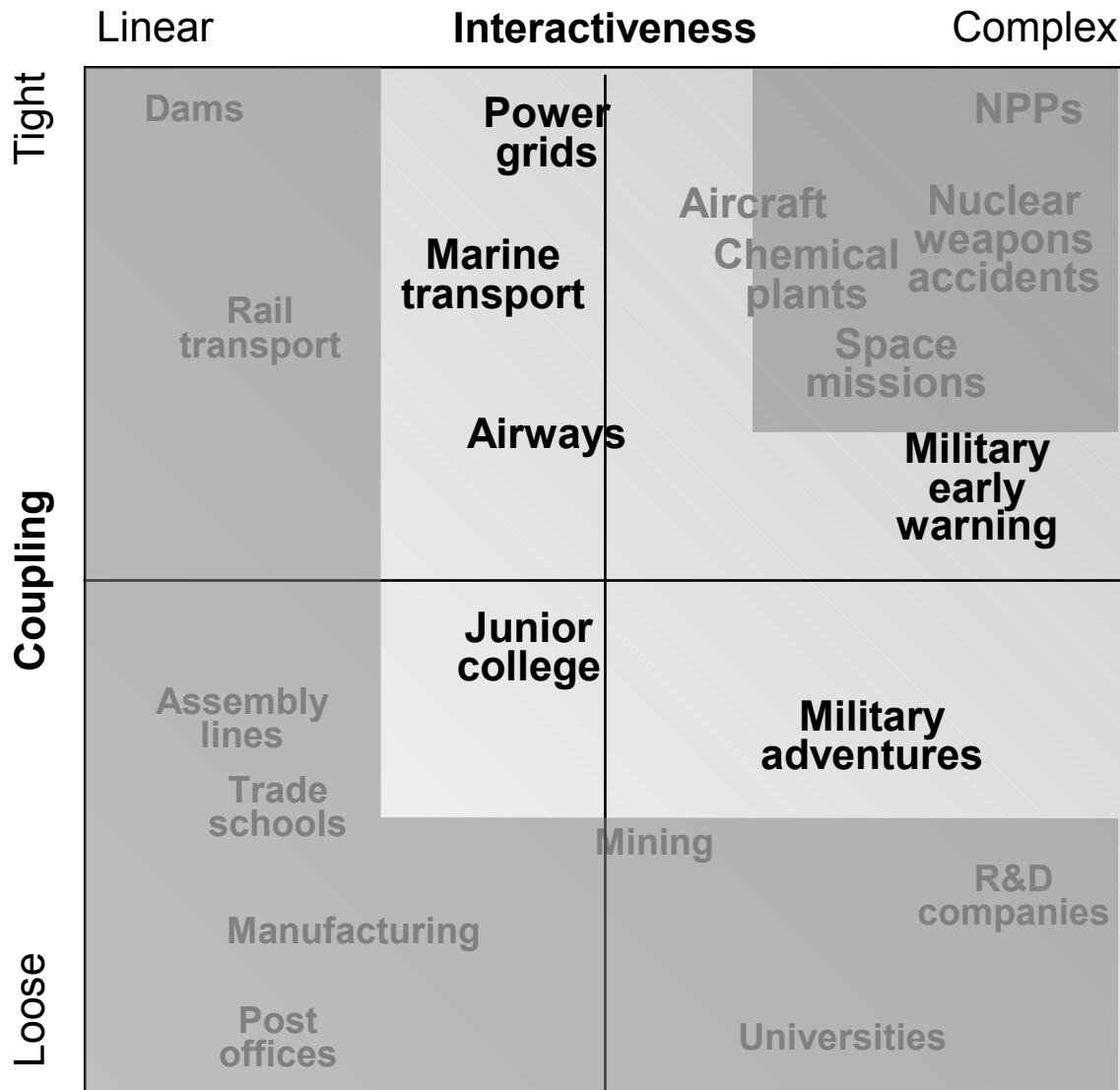
Domino model (Heinrich, 1930)



Consequence: Accidents are prevented by finding and **eliminating** possible causes.
Safety is ensured by improving the organisation's ability to **respond**.

Hazards-risks: Due to **component failures** (technical, human, organisational), hence looking for failure probabilities (event tree, PRA/HRA).
The future is a "mirror" image of the past.

Systems and methods, pre-1984



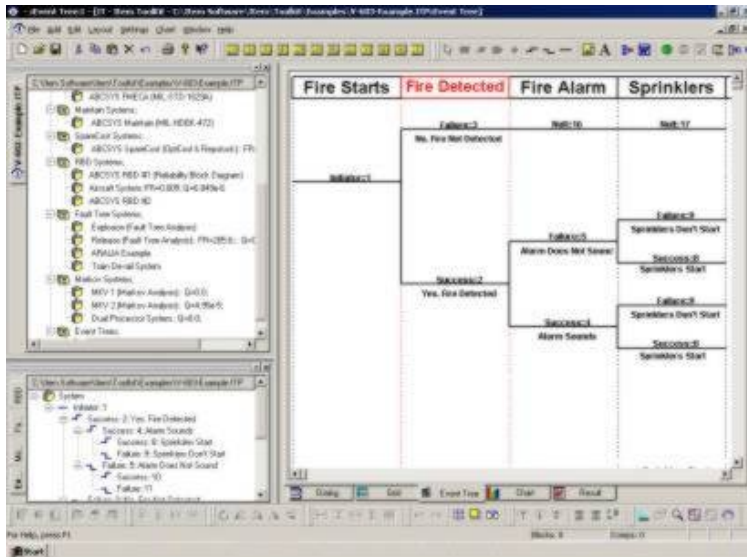
Accidents often have consequences beyond the single user-equipment system.

Interactiveness and dynamics often complex and difficult to comprehend.

Powerful technology drives system development.

Risks seen as caused by failures and malfunctions that can combine in so many ways that formal models and methods are needed.

Common assumptions



System can be decomposed into meaningful elements (components, events)

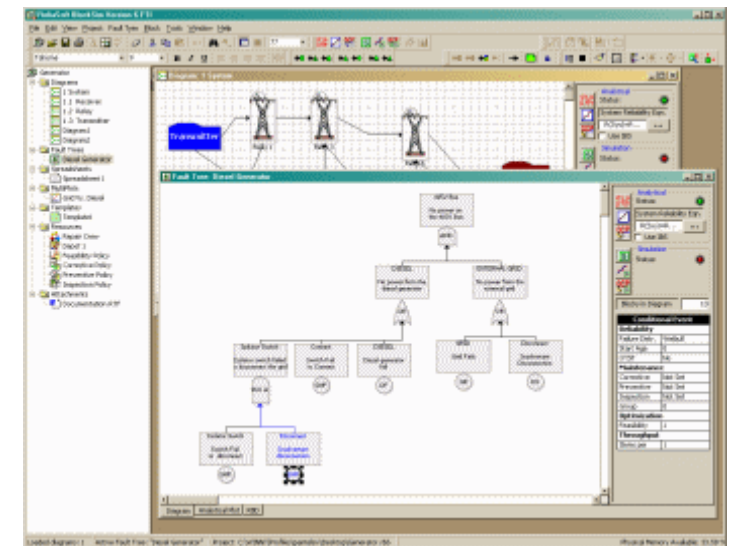
The function of each element is bimodal (true/false, work/fail)

The failure probability of elements can be analysed/described **individually**

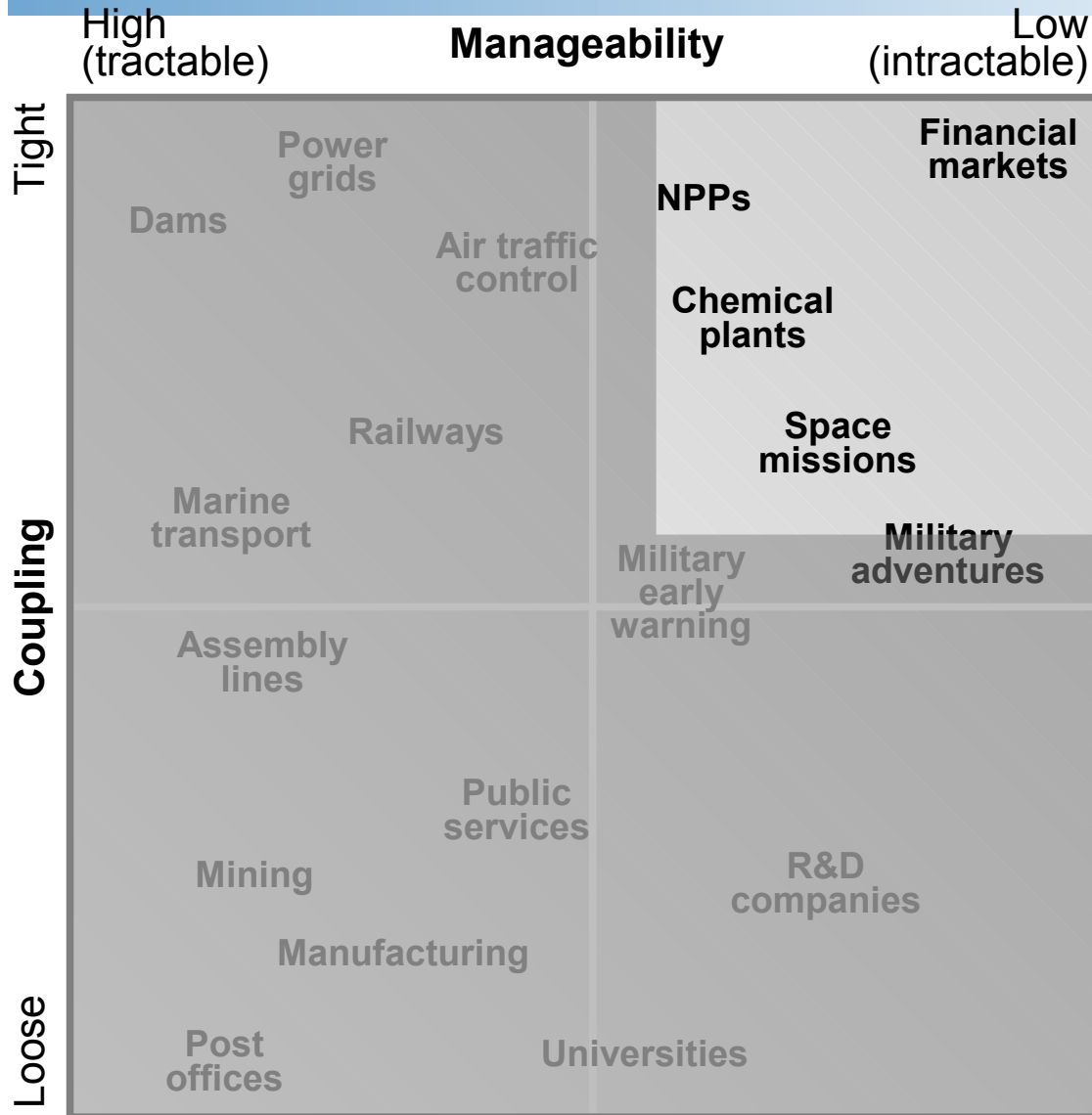
The order or sequence of events is **predetermined** and **fixed**

When combinations occur they can be described as **linear** (tractable, non-interacting)

The influence from **context/conditions** is limited and quantifiable



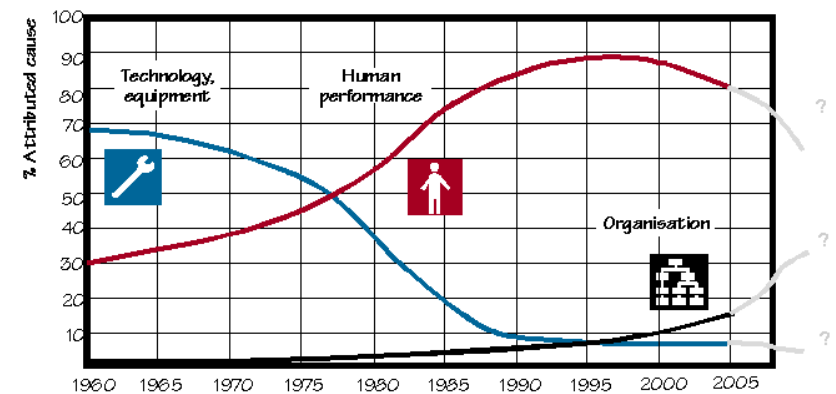
The post-NAT period



Accidents proposed as being normal occurrences.

Large scale systems stretch established methods to the limit.

Human and social factors become recognised as important contributors – both to accident and to safety.



The awakening of HRA

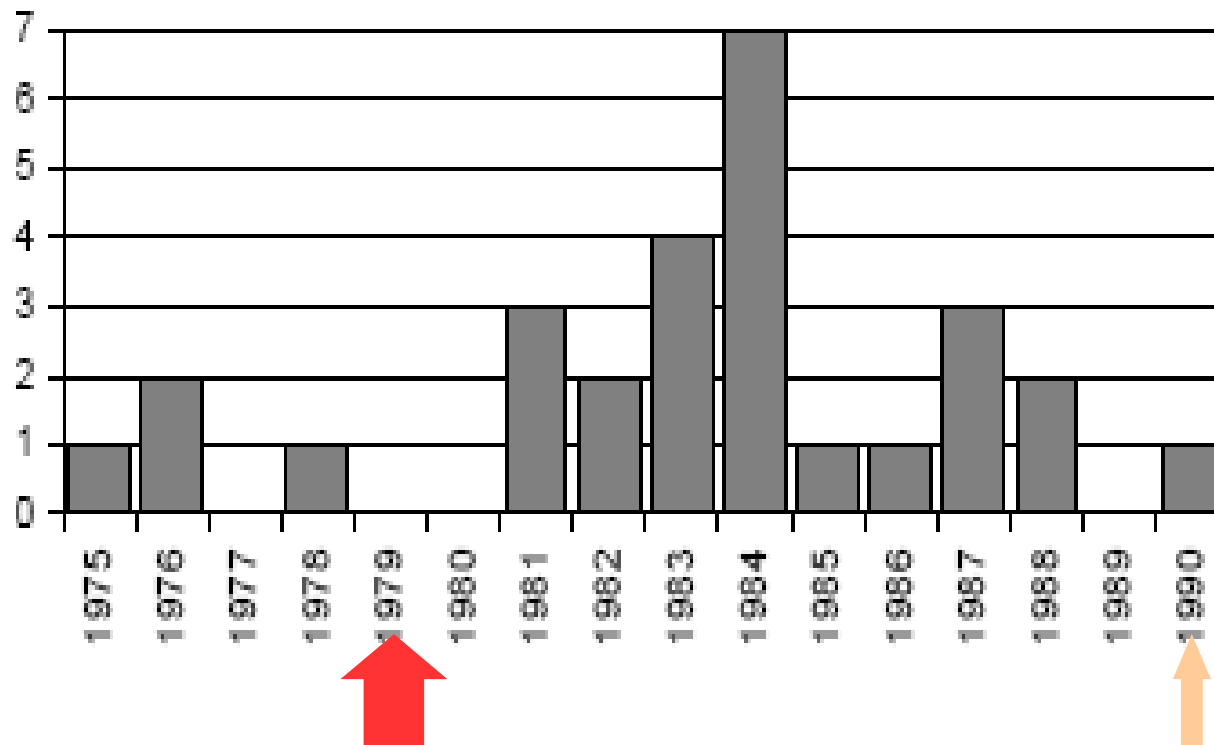


Figure 1: Distribution of HRA approaches according to year of publication.

TMI

RESS

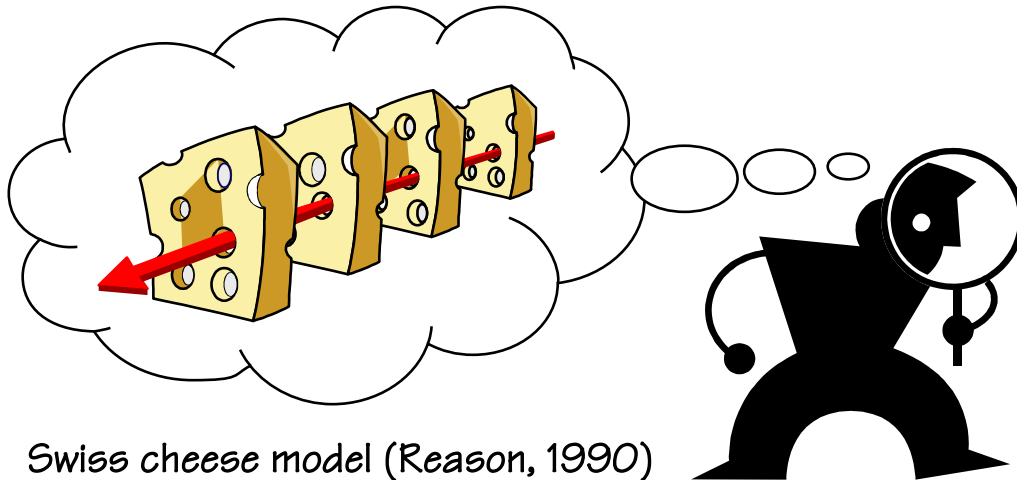


TMI-2 (1979)

TMI-2 underlined the importance of the human factor, and gave rise to the development of a large number of different assessment methods.

Understanding safety: linear models

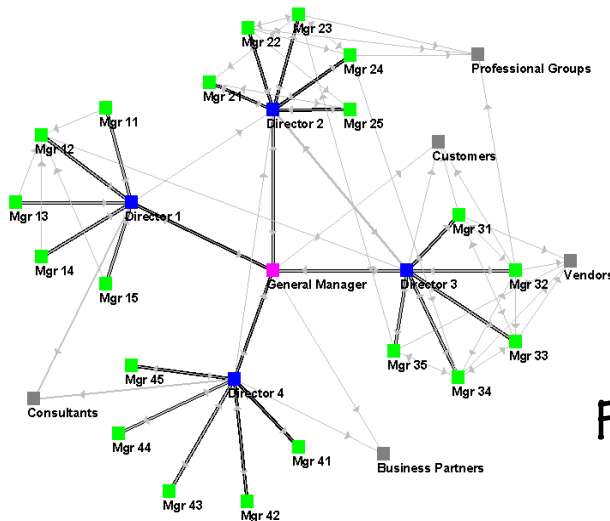
Assumption: Accidents result from a **combination** of active failures (unsafe acts) and latent conditions (hazards).



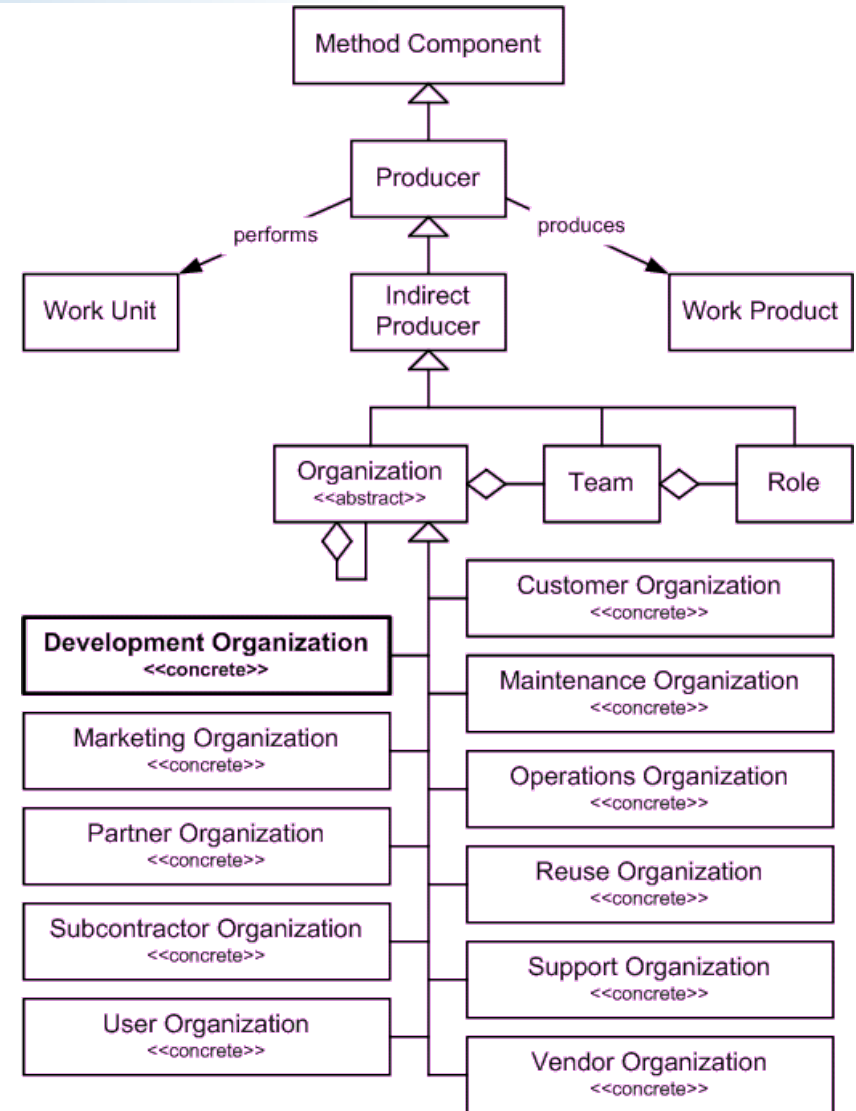
Consequence: Accidents are prevented by **strengthening** barriers and defences. Safety is ensured by **measuring/sampling** performance indicators.

Hazards-risks: Due to **degradation** of components (organisational, human, technical), hence looking for drift, degradation and weaknesses
The future is described as a combination of past events and conditions.

Organizational malfunctions



Failure mode?
Failure probability?
MTBF?





Hazards-risks: **Emerge** from combinations of normal variability (socio-technical system), hence looking for ETTO* and sacrificing decision

* ETTO = Efficiency-Thoroughness Trade-Off

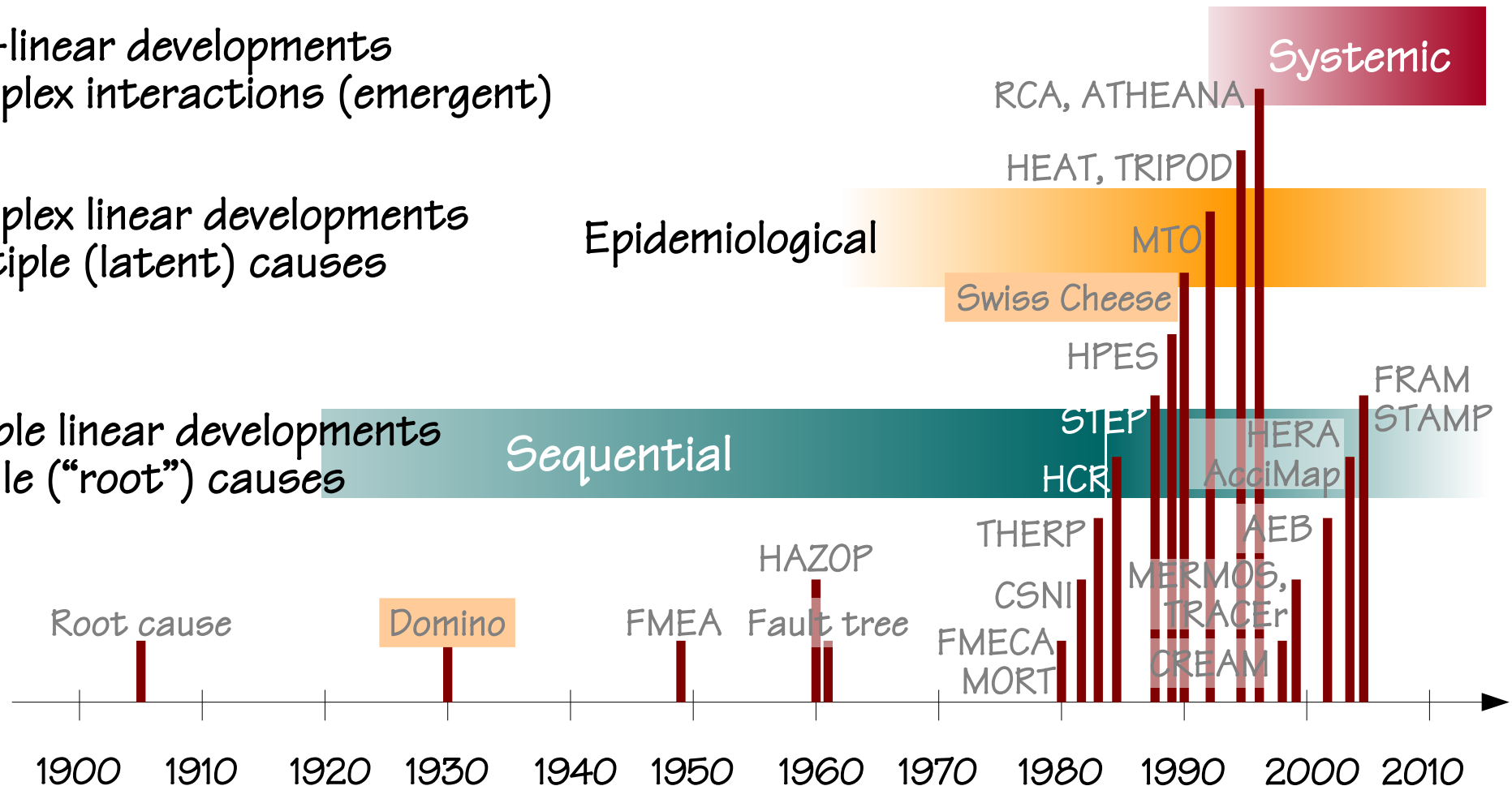
The future can be understood by considering the characteristic variability of the present.

Accident & Risk Analysis Methods

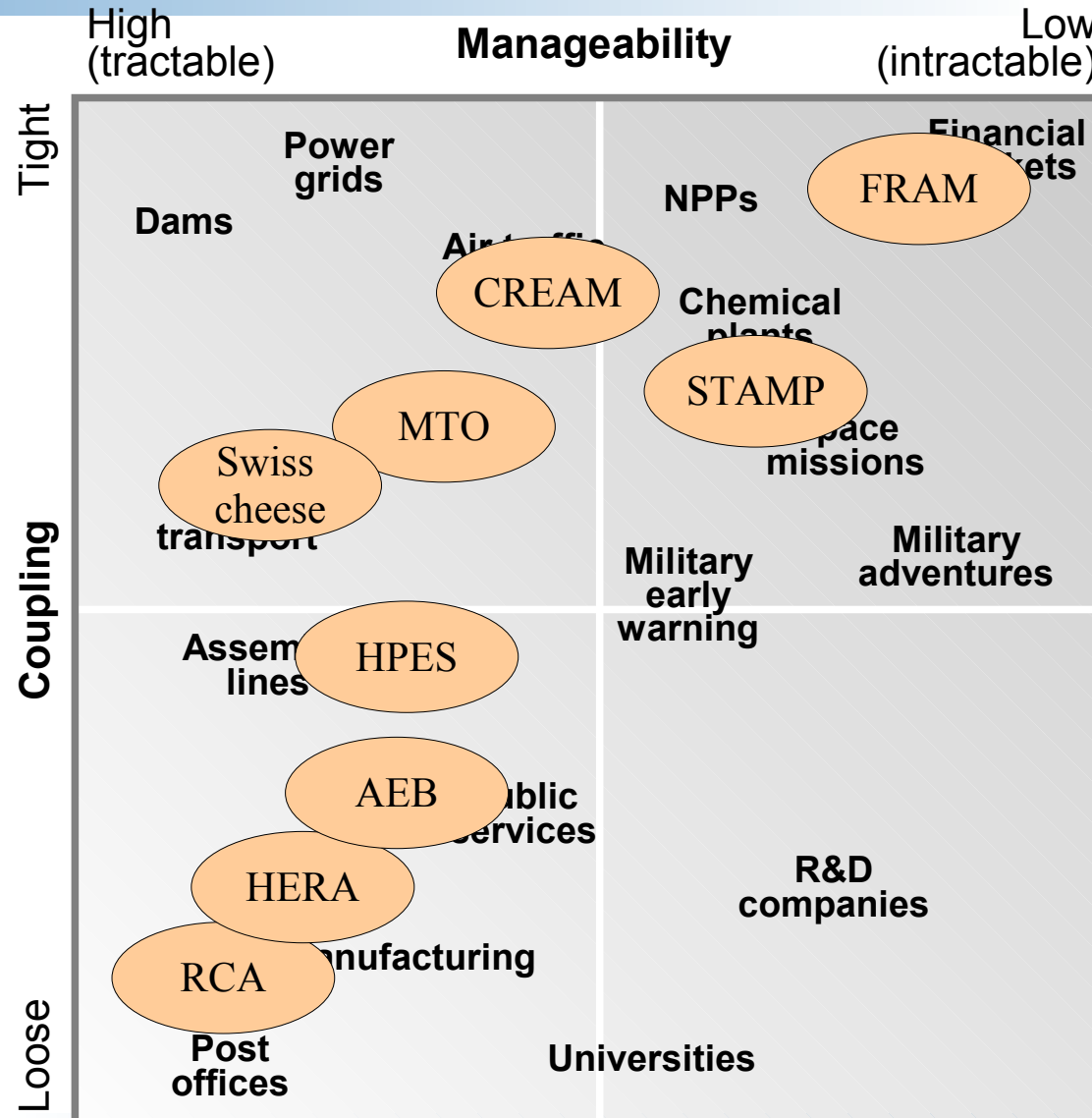
Non-linear developments
Complex interactions (emergent)

Complex linear developments
Multiple (latent) causes

Simple linear developments
Single ("root") causes



Relation between methods and systems



Principles for FRAM

- I THE PRINCIPLE OF EQUIVALENCE OF
SUCCESSES AND FAILURES.
- II THE PRINCIPLE OF APPROXIMATE
ADJUSTMENTS.
- III THE PRINCIPLE OF EMERGENCE.
- IV THE PRINCIPLE OF FUNCTIONAL
RESONANCE.

Equivalence of successes and failures

FRAM adheres to the resilience engineering view that failures represent the flip side of the adaptations necessary to cope with the real world complexity rather than a failure of normal system functions. Success depends on the ability of organisations, groups and individuals to anticipate risks and critical situations, to recognise them in time, and to take appropriate action; failure is due to the temporary or permanent absence of that ability.



“Knowledge and error flow from the same mental sources, only success can tell one from the other.”

(Ernst Mach, 1838-1916; “Knowledge and error”, 1905)

Success and failure

Failure is normally explained as a **breakdown** or **malfunctioning** of a system and/or its components.

This view assumes that success and failure are of a fundamentally different nature.

Most systems (work environments) and tasks are underspecified. Work can therefore not simply follow prescriptions / procedures). Individuals and organisations must **adjust** to the current conditions in **everything** they do.

→ **Success** is due to the ability of organisations, groups and individuals correctly to make these adjustments, in particular correctly to **anticipate** risks before failures and harm occur.

→ **Failure** can be explained as the **absence** of that ability – either temporarily or permanently.



The aim of Resilience Engineering is to **strengthen** that ability, rather than just to avoid or eliminate failures.

Principle of approximate adjustments

Systems are so complex that work situations always are **underspecified** – hence partly **unpredictable**

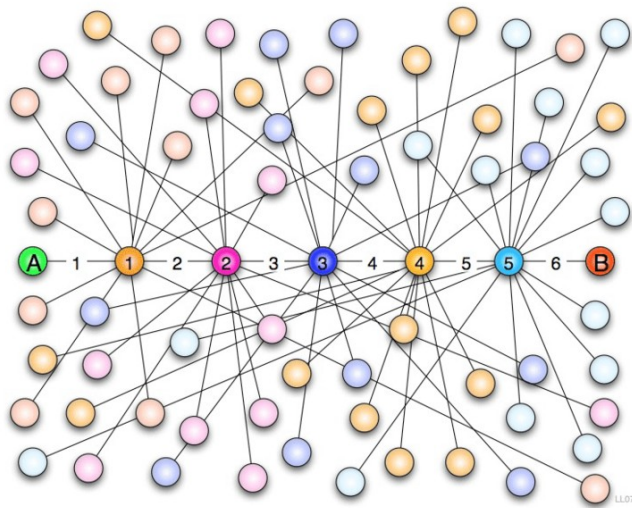
Few – if any – tasks can successfully be carried out unless procedures and tools are adapted to the situation. **Performance variability is both normal and necessary.**



Because many socio-technical systems are intractable, the conditions of work never completely match what has been specified or prescribed. Individuals, groups, and organisations must normally adjust their performance so that it can succeed under the existing conditions, specifically the actual resources and requirements. Because resources (time, manpower, information, etc.) always are finite, such adjustments are invariably approximate rather than exact.

Principle of emergence

The variability of normal performance is rarely large enough to be the cause of an accident in itself or even to constitute a malfunction. But the variability from multiple functions may combine in unexpected ways, leading to consequences that are disproportionally large, hence produce a non-linear effect. Both failures and normal performance are emergent rather than resultant phenomena, because neither can be attributed to or explained only by referring to the (mal)functions of specific components or parts.



The Small World Problem

Socio-technical systems are intractable because they change and develop in response to conditions and demands. It is therefore impossible to know all the couplings in the system, hence impossible to anticipate more than the regular events. The couplings are mostly useful, but can also constitute a risk.

Principle of functional resonance

The variability of a number of functions may every now and then resonate, i.e., reinforce each other and thereby cause the variability of one function to exceed normal limits. The consequences may spread through tight couplings rather than via identifiable and enumerable cause-effect links, e.g., as described by the Small World Phenomenon. This can be described as a resonance of the normal variability of functions, hence as functional resonance. The resonance analogy emphasises that this is a dynamic phenomenon, hence not attributable to a simple combination of causal links.

Ways of looking at the future:

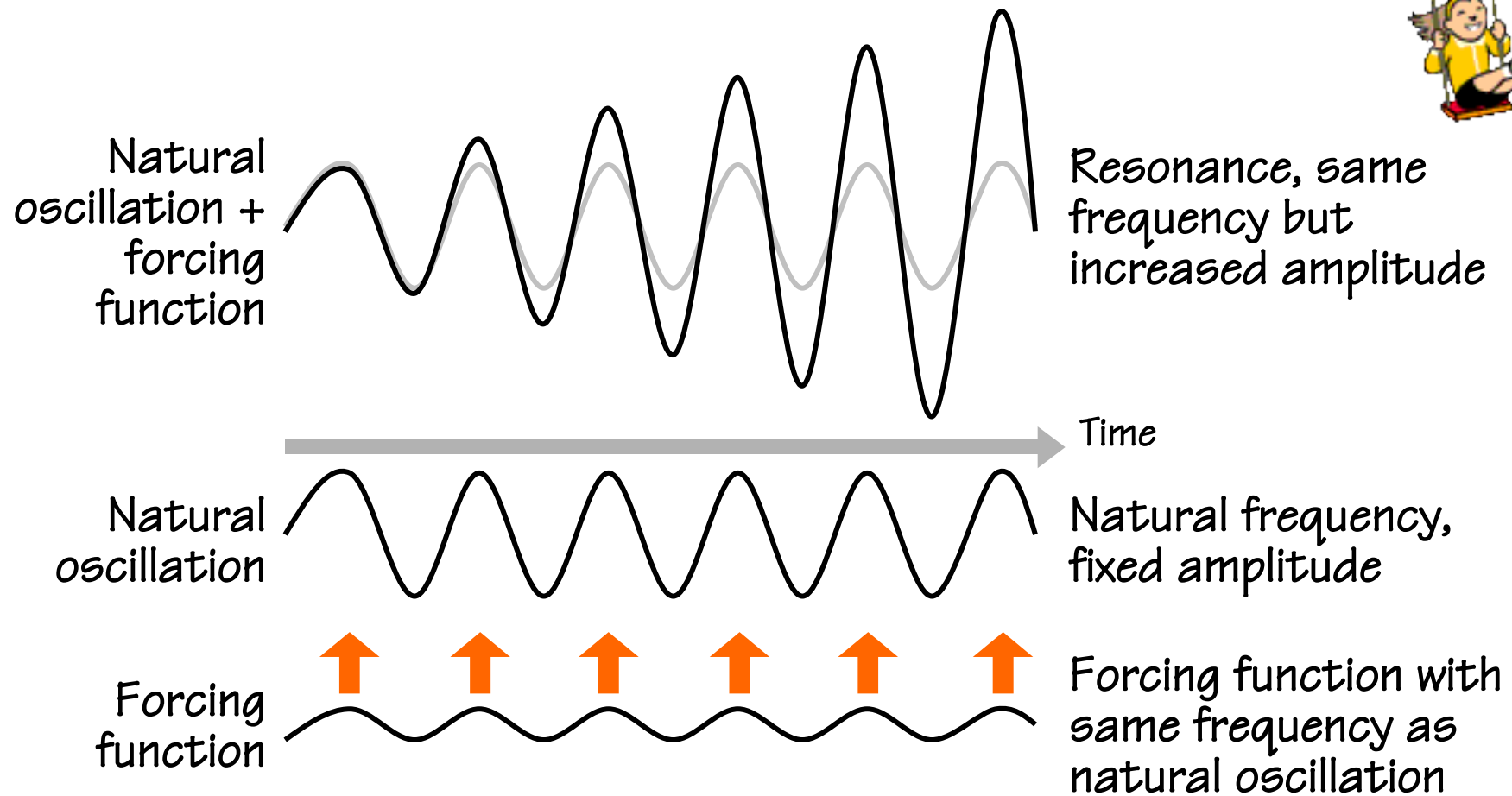
- As a repetition or recurrence of the past (deterministic or probabilistic).

- As a linear extrapolation of the past (combinatorial, probabilistic).

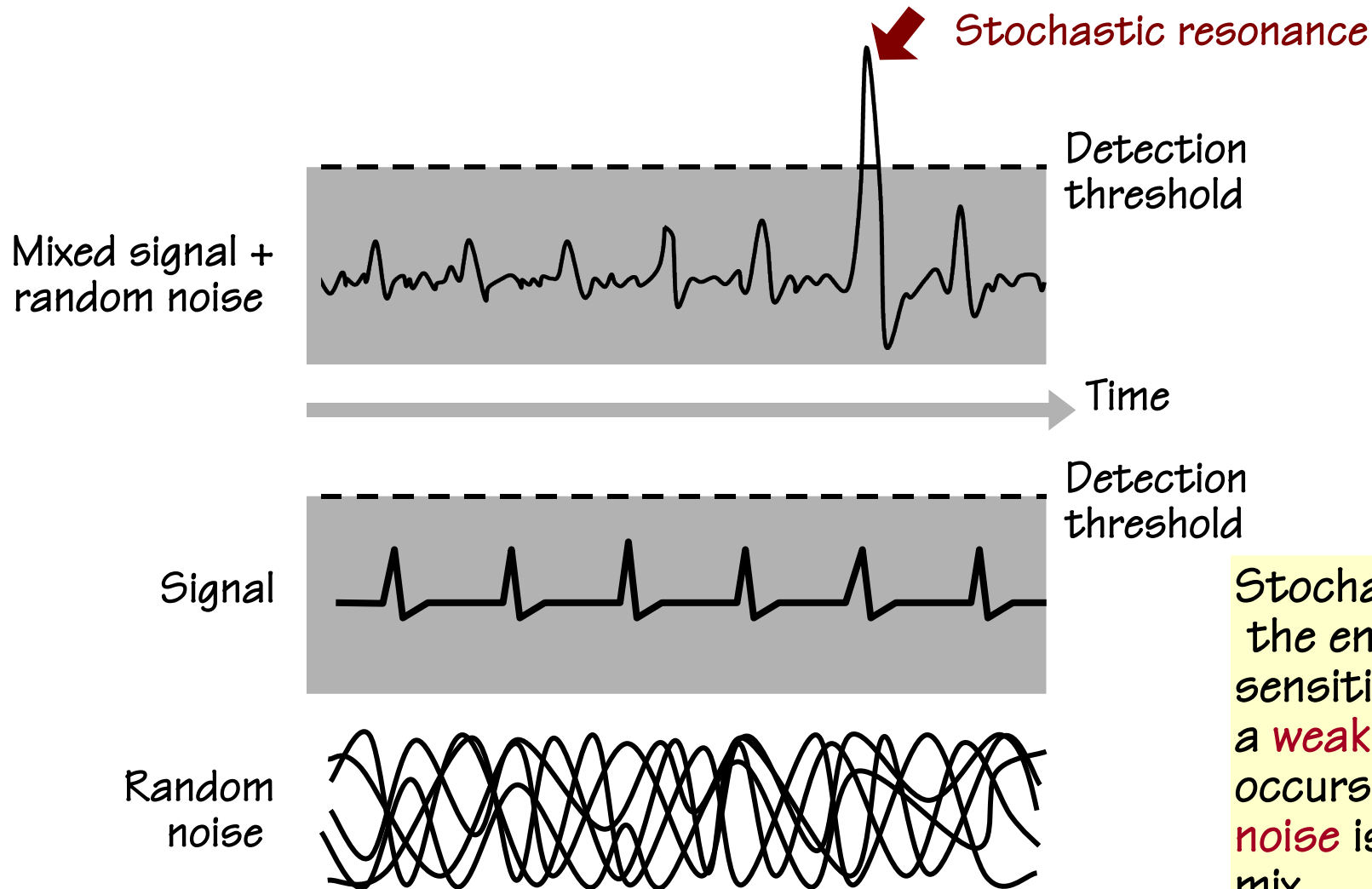
- As randomly occurring events (defaitism).

- As a non-linear but also non-random development (functional resonance),

Resonance



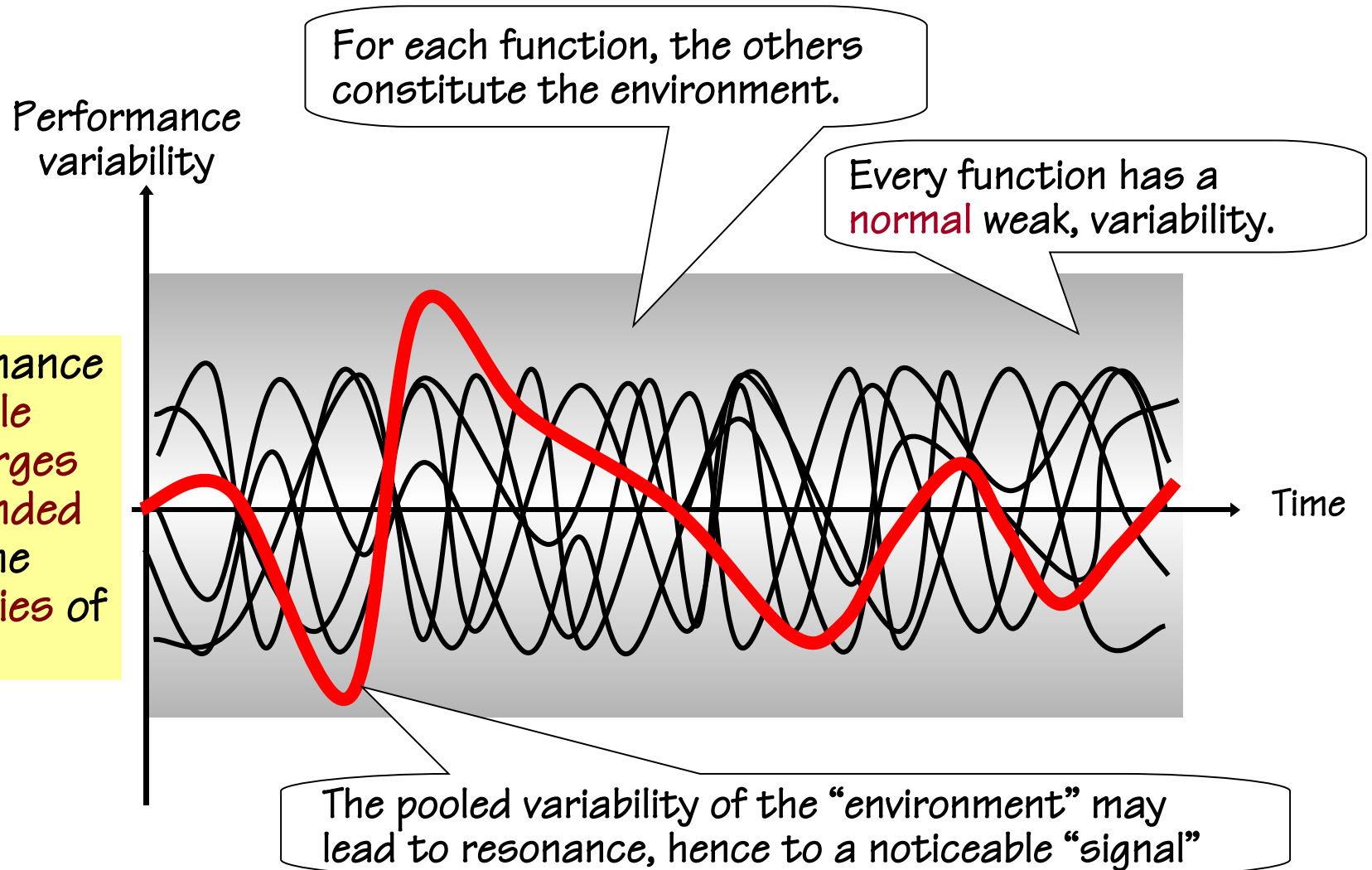
Stochastic resonance



Stochastic resonance is the enhanced sensitivity of a device to a **weak signal** that occurs when **random noise** is added to the mix.

Functional resonance accident model

Functional resonance is the **detectable** signal that **emerges** from the **unintended interaction** of the **normal variabilities** of many signals.



London Millennium Bridge

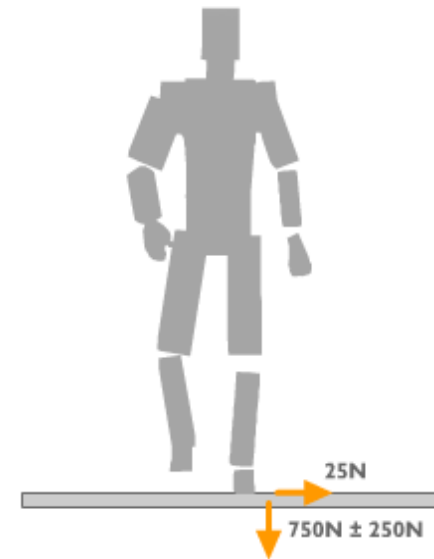


Opened June 10, 2000

Closed June 12, 2000.

Reason: bridge swayed severely as people walked across it.

Reopened after reconstruction,
January 2002



Traffic and randomness

Traffic is a system in which millions of cars every day move so that their driving paths cross each other and critical situations arise due to pure random processes:

cars meet with a speed difference of 100 to more than 200 km/h, separated only by a few meters, with variability of the drivers' attentiveness, the steering, the lateral slope of the road, wind and other factors.



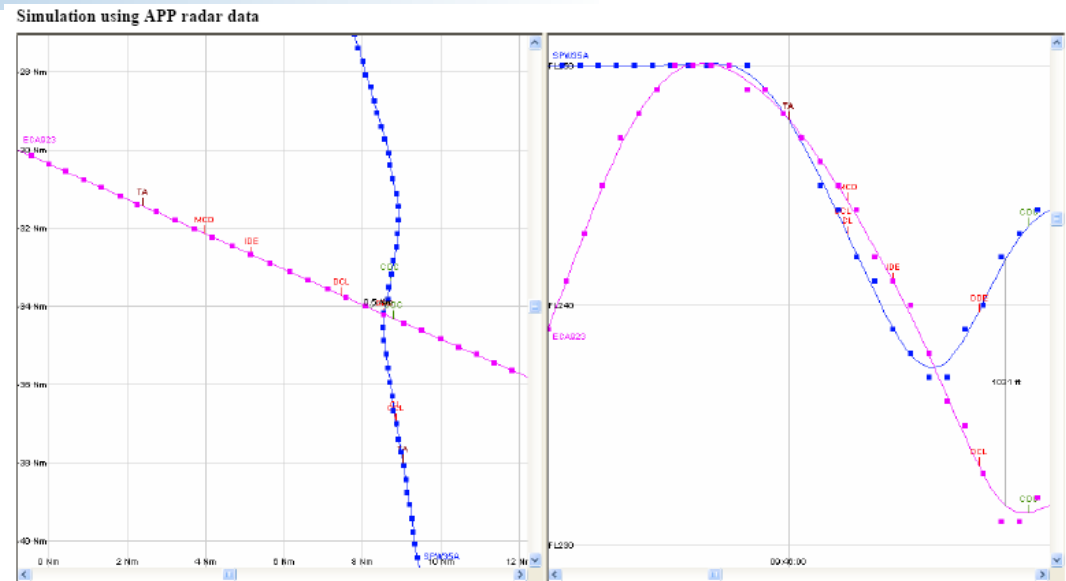
Drivers learn by experience the dimensions of the own car and of other cars, how much space is needed and how much should be allocated to other road users, the maximum speed to approach a curve ahead, etc. If drivers anticipate that these minimum safety margins will be violated, they will shift behavior.

The very basis of traffic accidents consists of random processes, of the fact that we have complicated traffic system with many participants and much kinetic energy involved.

When millions of drivers habitually drive at too small safety margins and make insufficient allowance for (infrequent) deviant behavior or for (infrequent) coincidences, this very normal behavior results in accidents.

Summala (1985)

As the analysis shows there is no root cause. Deeper investigation would most probably bring up further contributing factors. A set of working methods that have been developed over many years, suddenly turn out as insufficient for this specific combination of circumstances.



The change of concept was created from the uncertainty of the outcome of the original plan that had been formed during a sector handover. The execution of this and the following concepts were hampered by goal conflicts between two sectors. Time- and environmental- constraints created a demand resource mismatch in the attempt to adapt to the developing situation. This also included coordination breakdowns and automation surprises (TCAS).

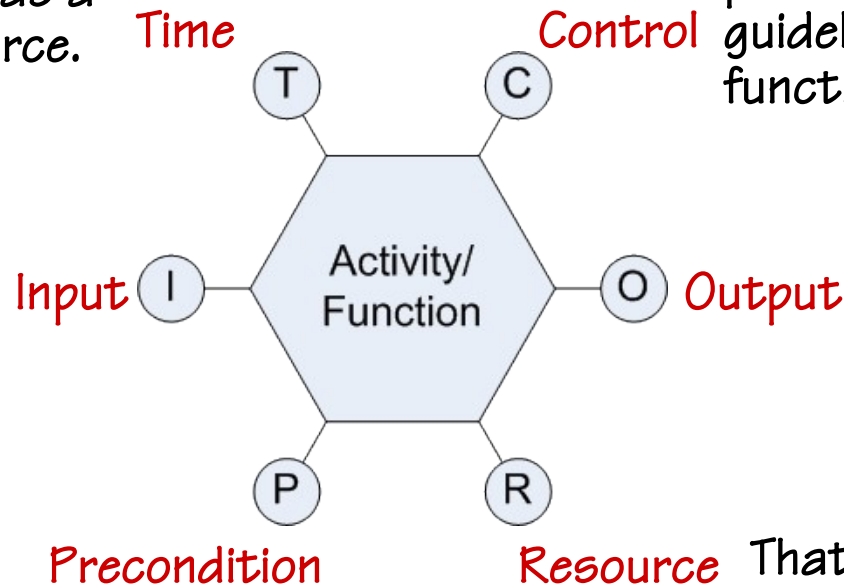
The combination of this and further contributing factors of which some are listed above, lead to an airprox with a minimum separation of 1.6NM/400 ft.

FRAM functional unit (module)

Time available: This can be a constraint but can also be considered as a special kind of resource.

That which supervises or adjusts a function. Can be plans, procedures, guidelines or other functions.

That which is used or transformed to produce the output. Constitutes the link to previous functions.



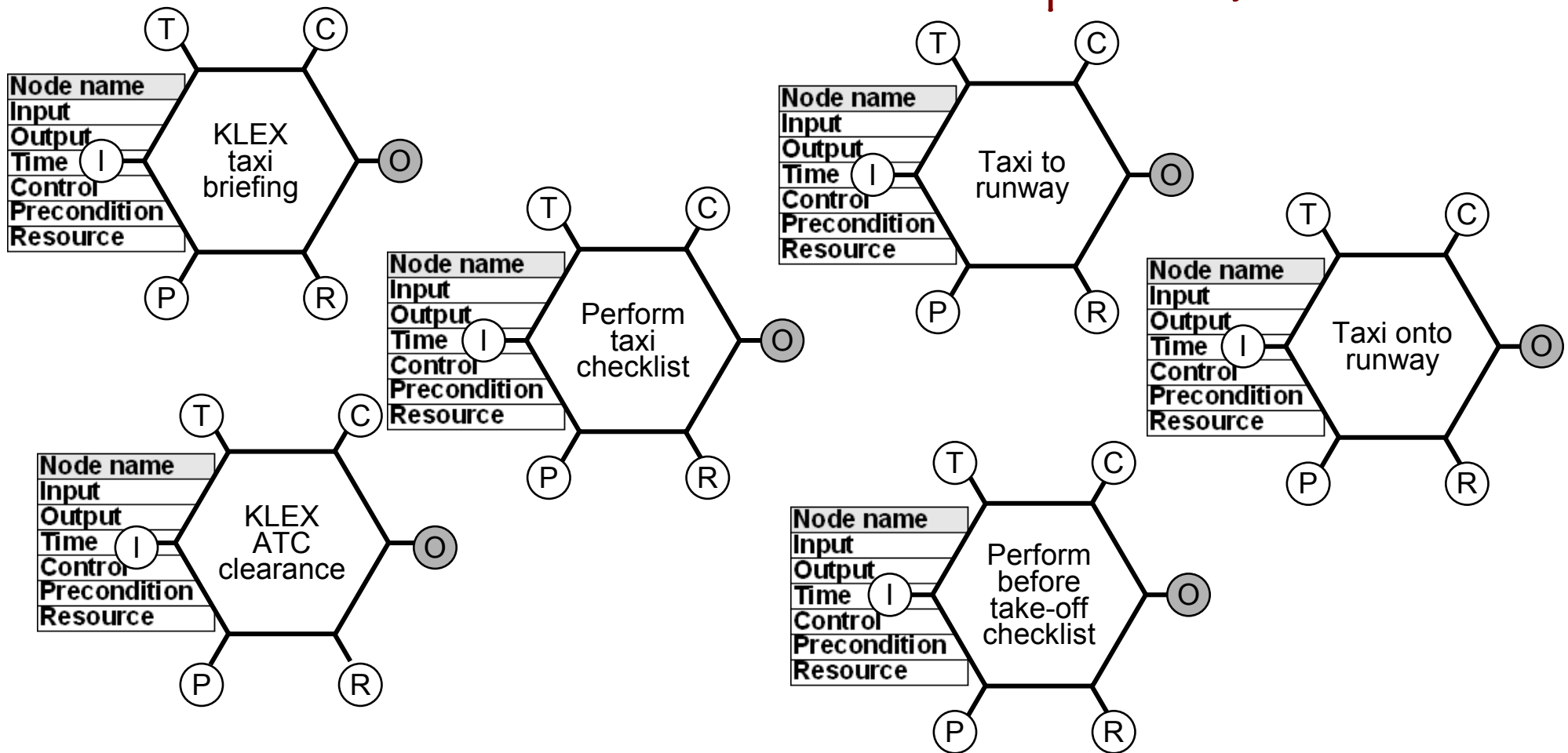
That which is produced by function. Constitute links to subsequent functions.

System conditions that must be fulfilled before a function can be carried out.

That which is needed or consumed by function to process input (e.g., matter, energy, hardware, software, manpower).

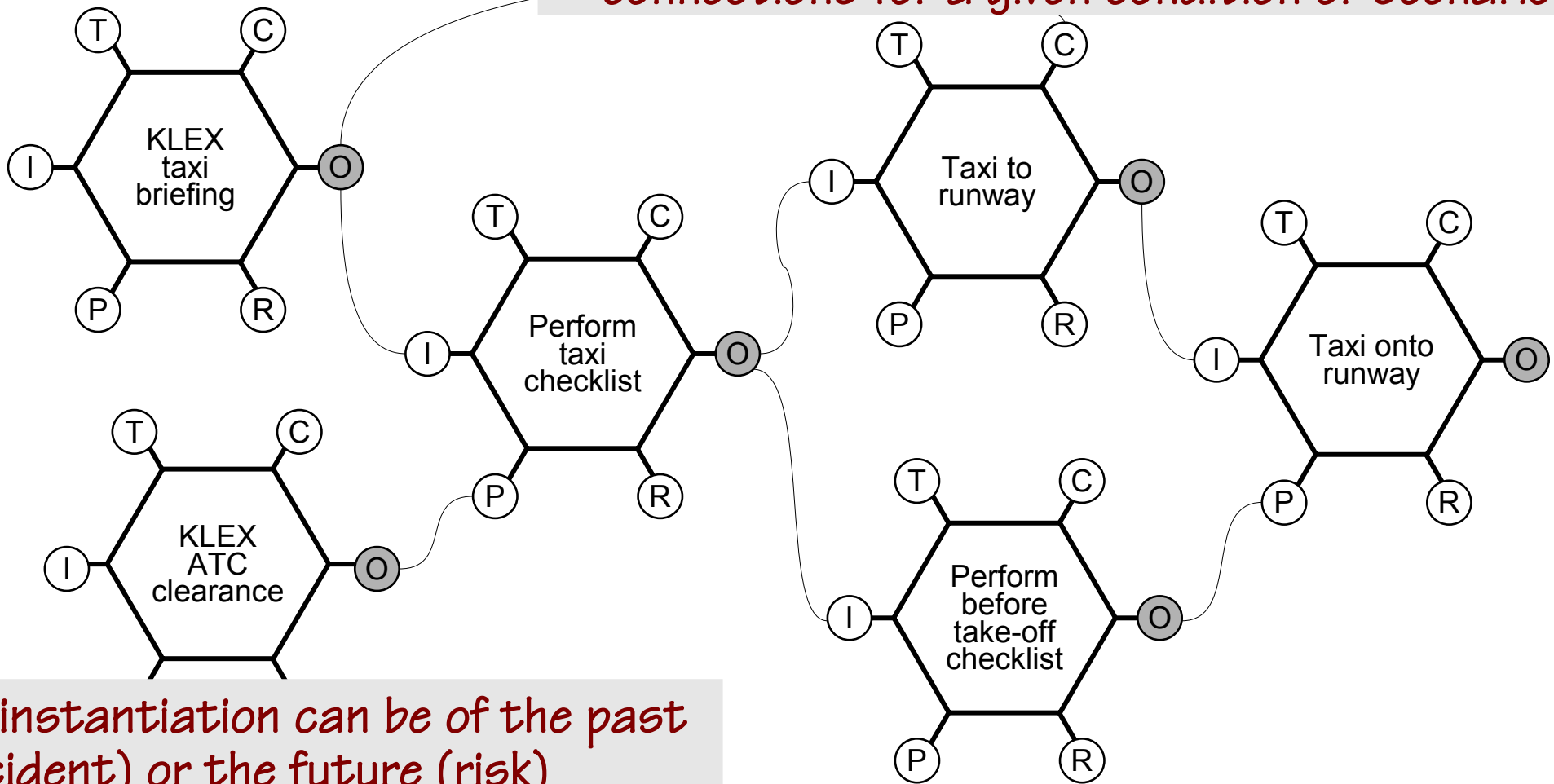
This is a FRAM

The couplings / connections between the nodes of a model are potential, but not actual



This is an instantiation of a FRAM

The links show the instantiation of couplings / connections for a given condition or scenario.



The instantiation can be of the past (accident) or the future (risk)

For the predictive use of FRAM (risk assessment), the basis is often an existing task description or a flowchart.

EATMP2 (1999, p. 47):
Solving Conflicts

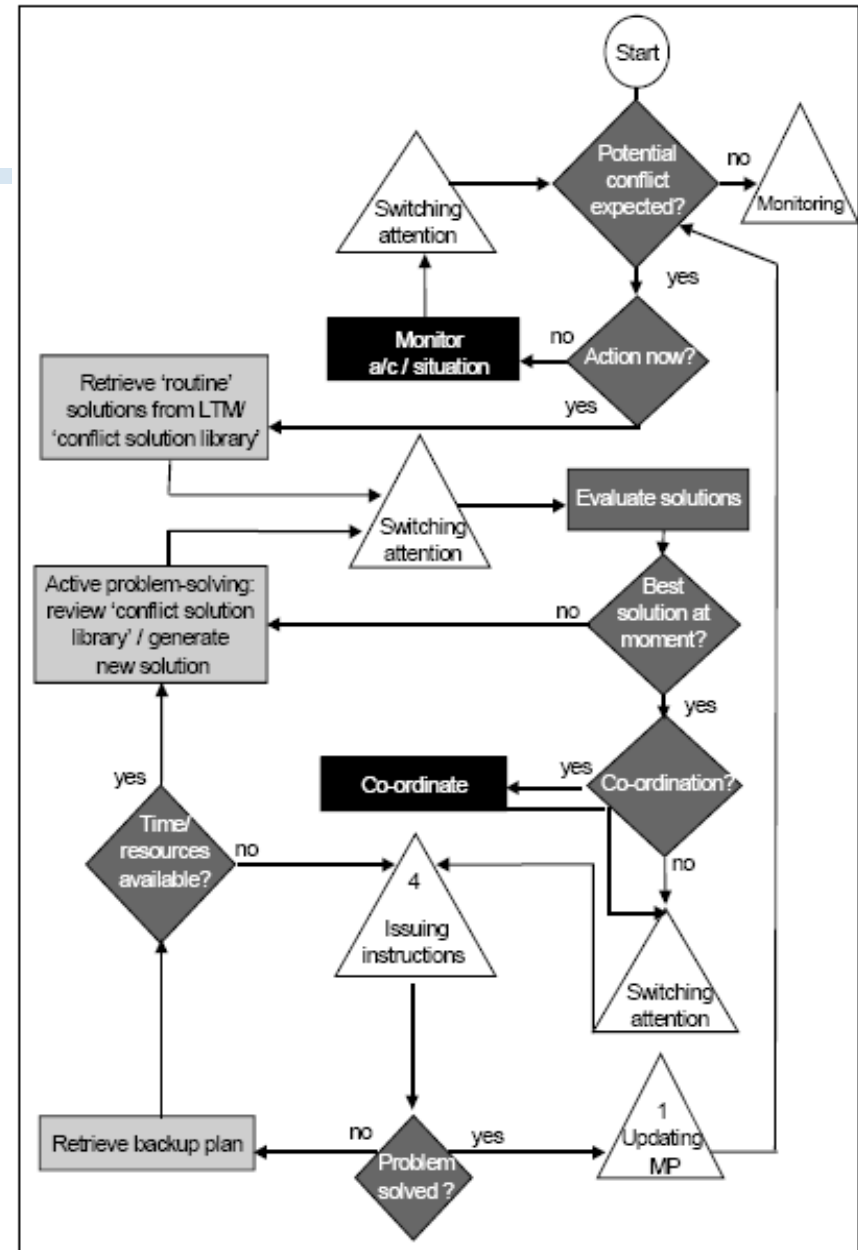
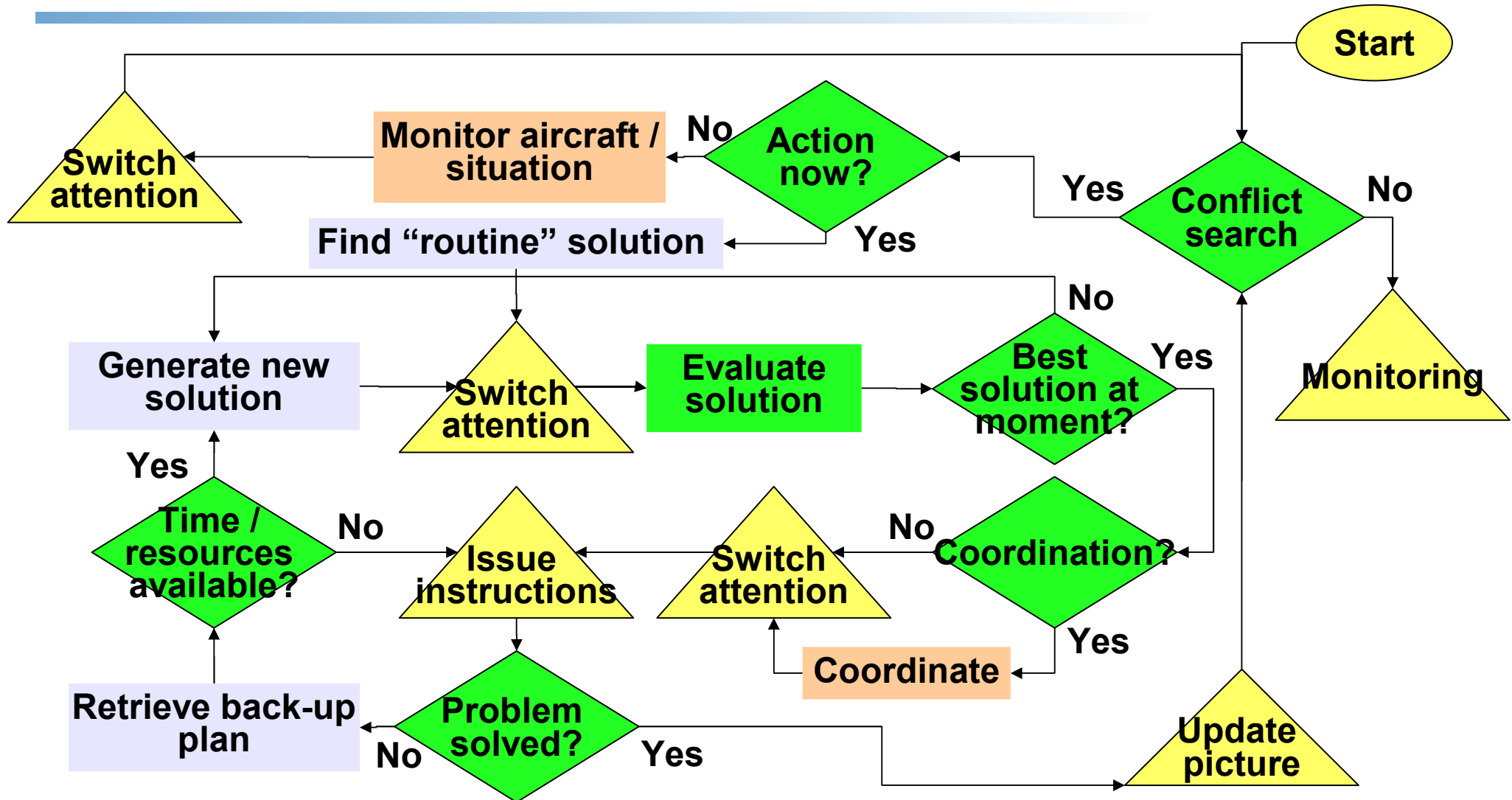
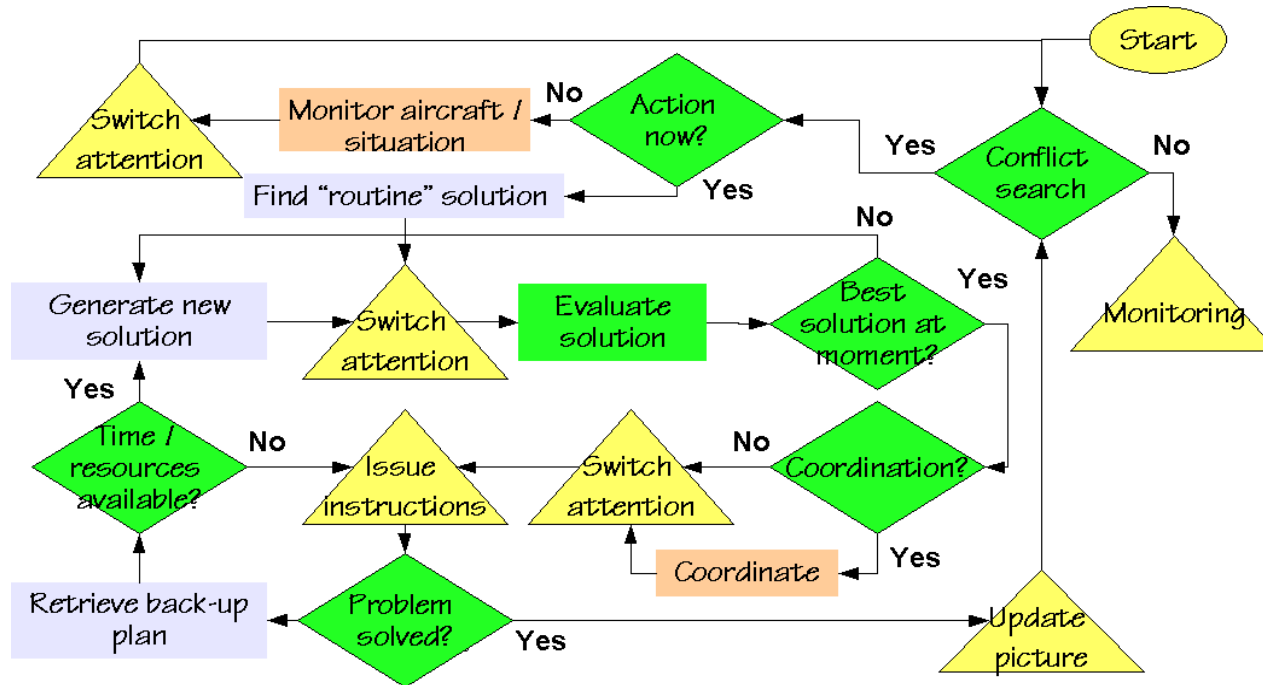


Figure 11: Task process 5: solving conflicts

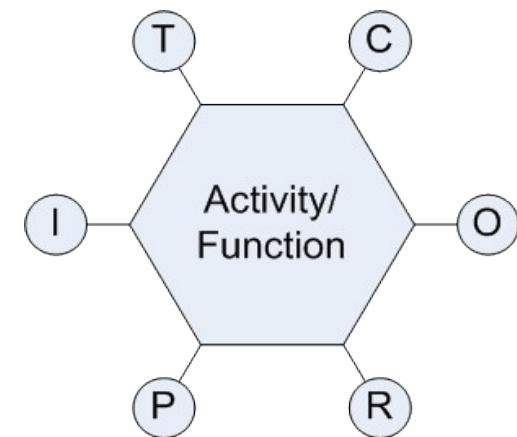
EATMP2 (1999, p. 47): Solving Conflicts



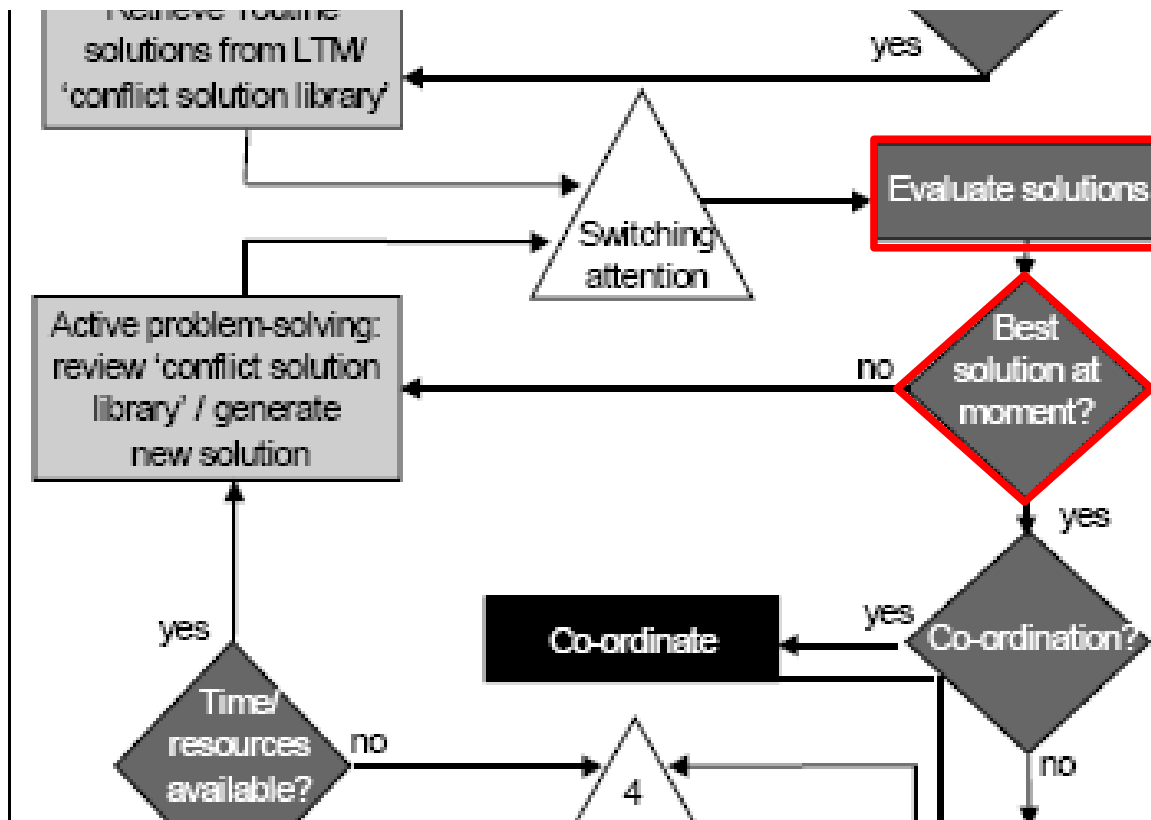
Which functions should be analysed?



Conflict search and monitoring
 Determine action urgency
 Find solution (routine, novel)
 Evaluate and assess solution
 Implement solution

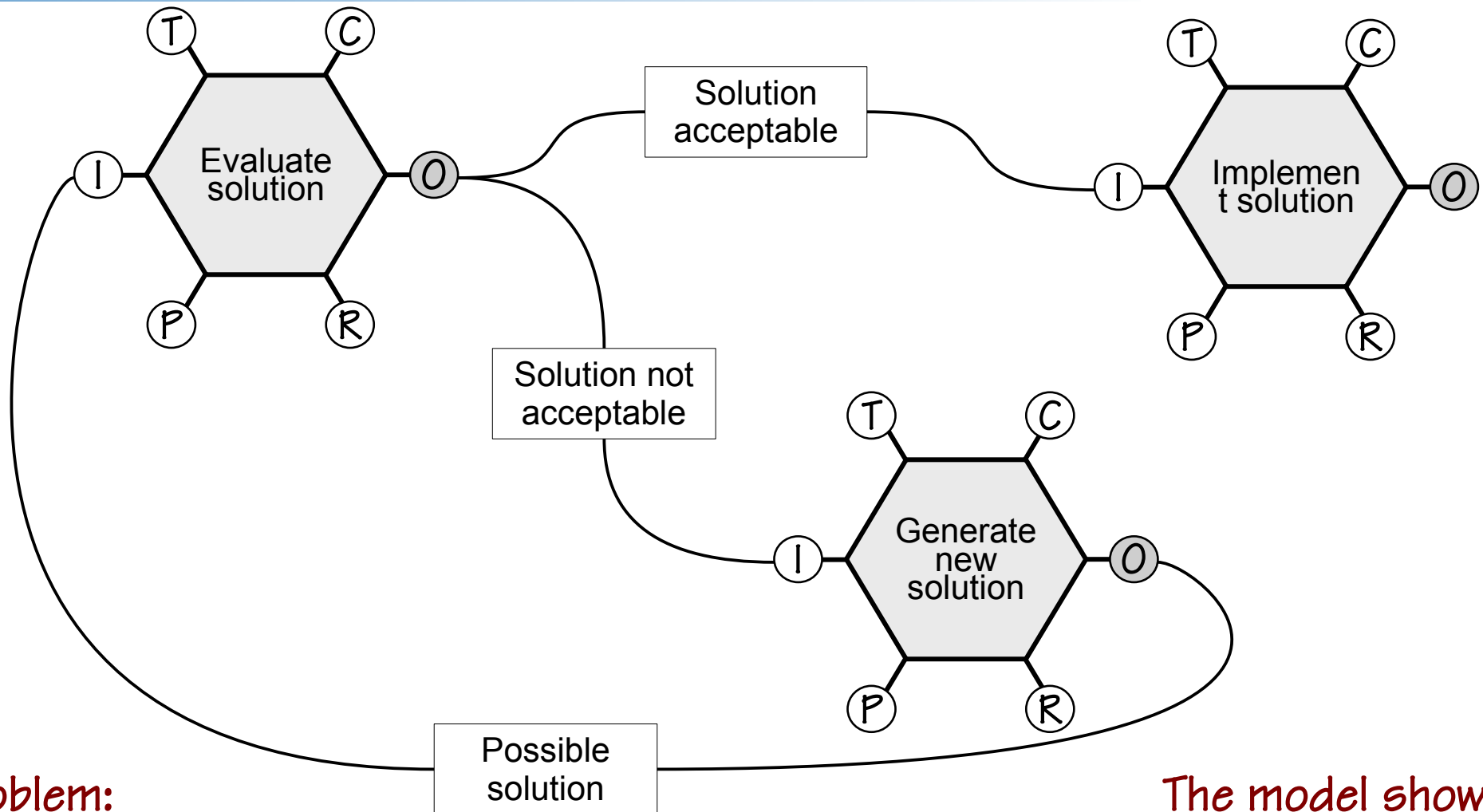


Evaluate and assess solution



It is almost irresistible to model this in the same way with FRAM.
But how should the decision node be described?

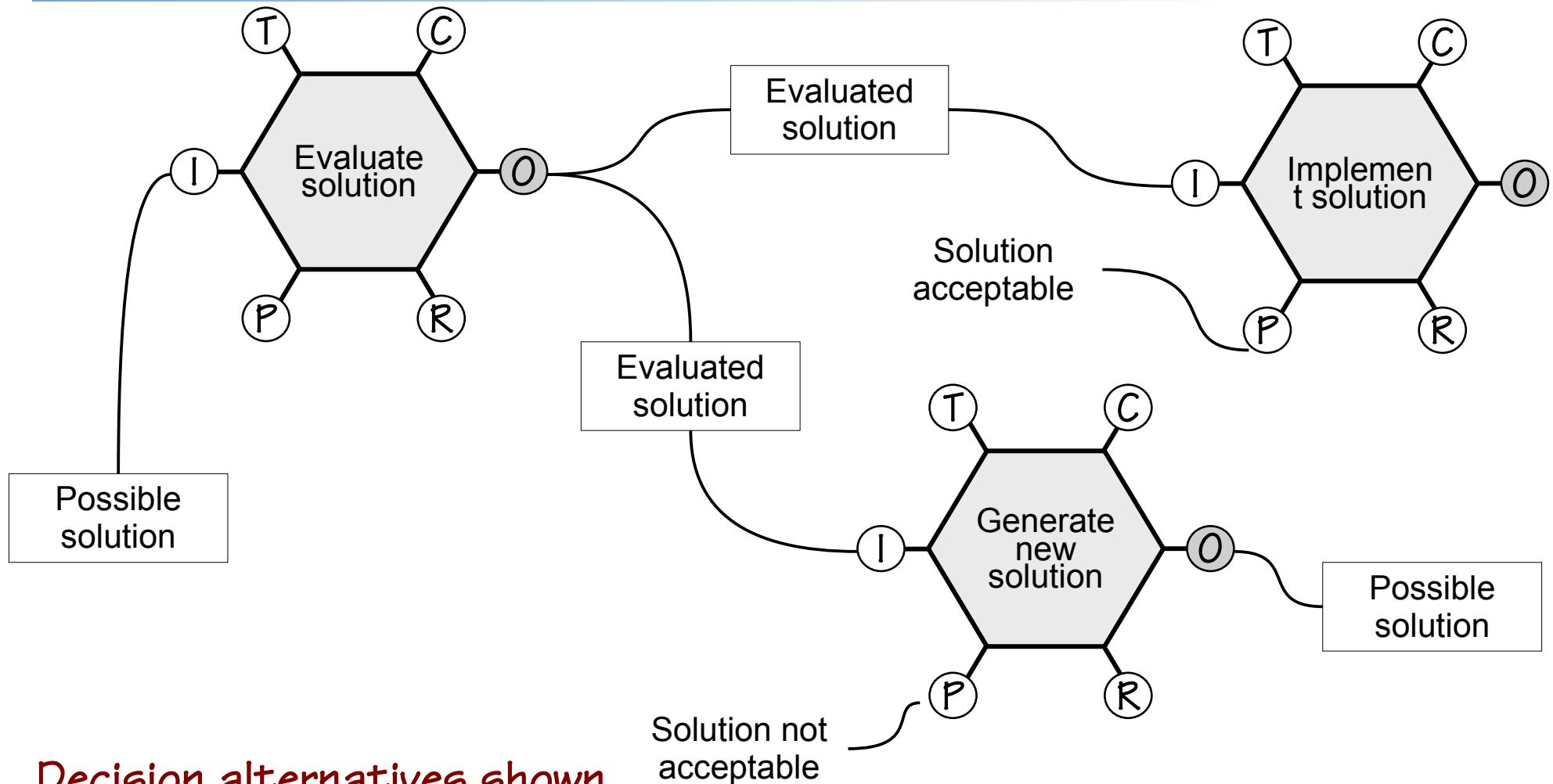
FRAM as a flow chart?



Problem:
alternative outputs!

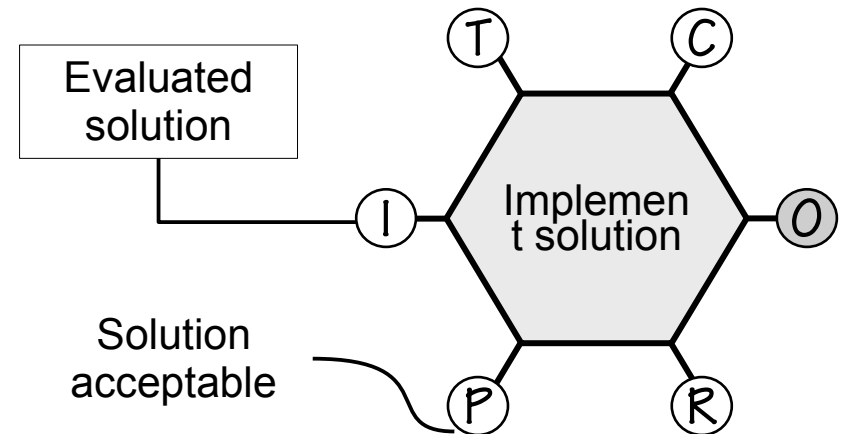
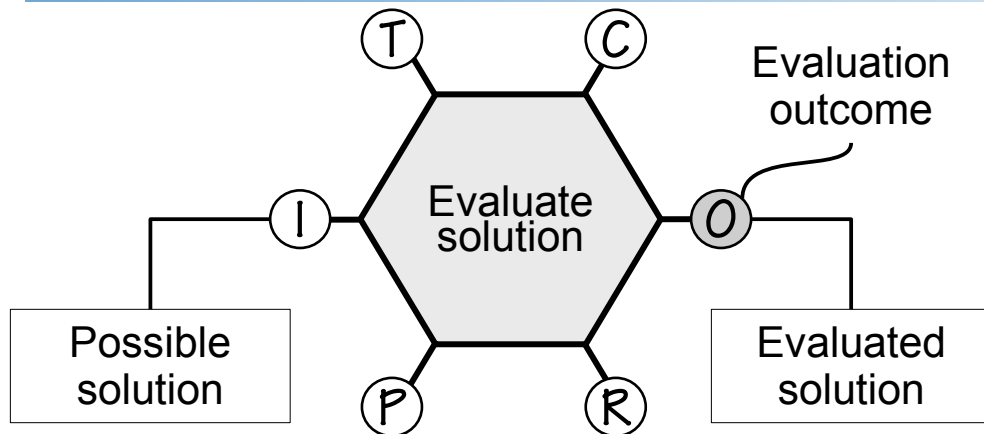
The model shows
multiple instances!

FRAM showing actual couplings



*Decision alternatives shown
as outputs + preconditions*

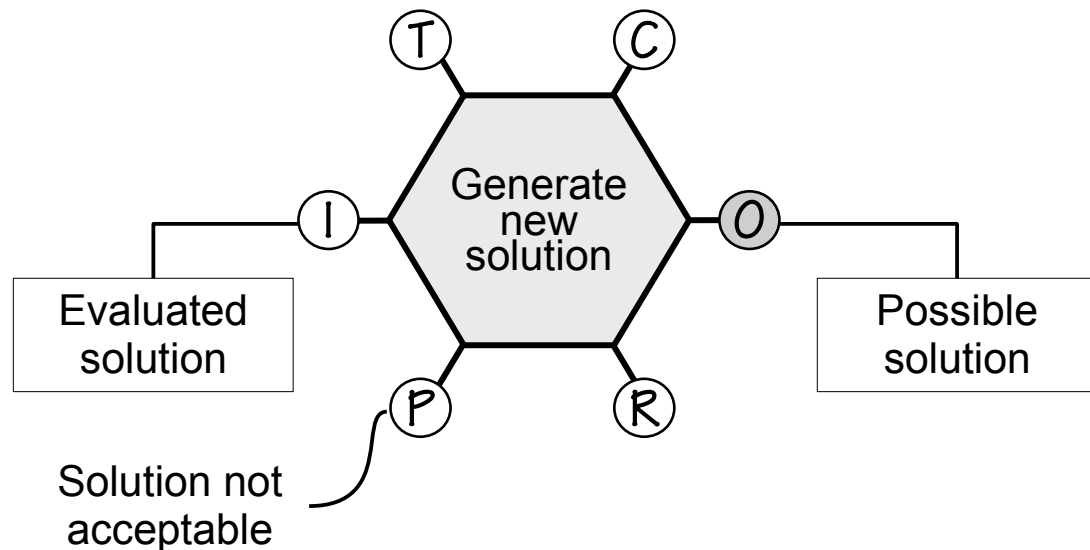
FRAM showing potential couplings



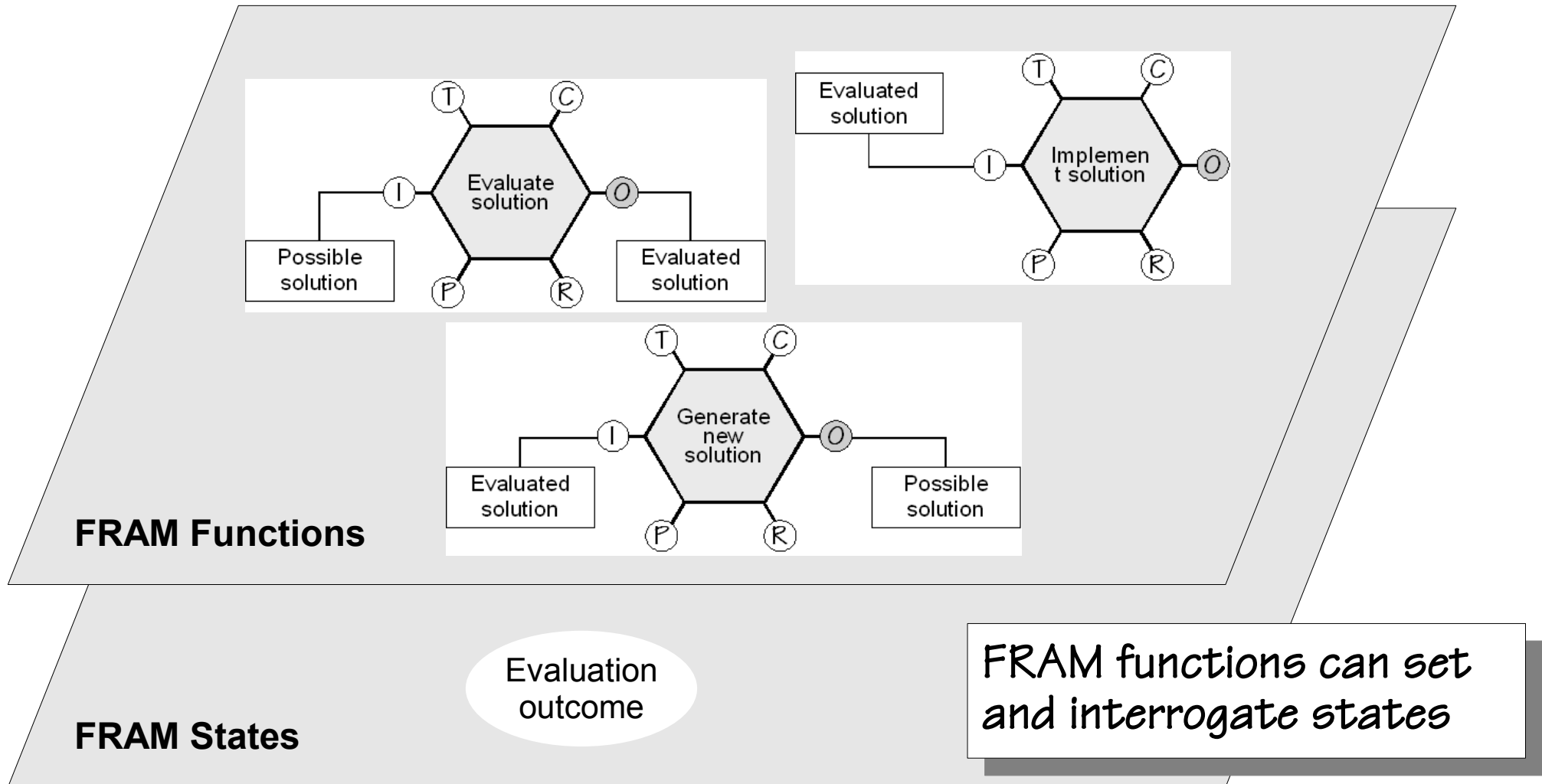
Decision alternatives shown
as output + state
(evaluation outcome)

States can be changed
and interrogated

States are not functions!



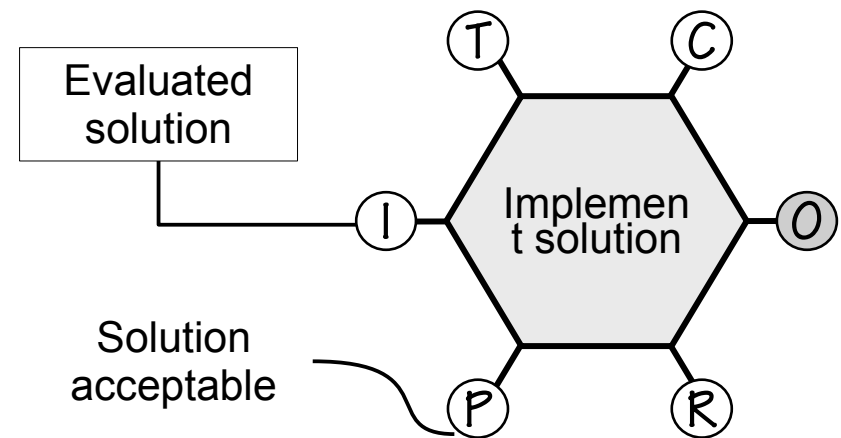
FRAM: functions and states



FRAM: performance variability

The performance may be variable, e.g., because time is too short (or too long), because resources are missing, because controls are inadequate, etc.)

The relation between performance conditions and functions may be
1:n,
n:1, or
n:n



If the performance of a function is variable, it may be carried out even if, e.g., an input is missing or a precondition is not fulfilled.

FRAM: performance variability

If functions are by the same entity:

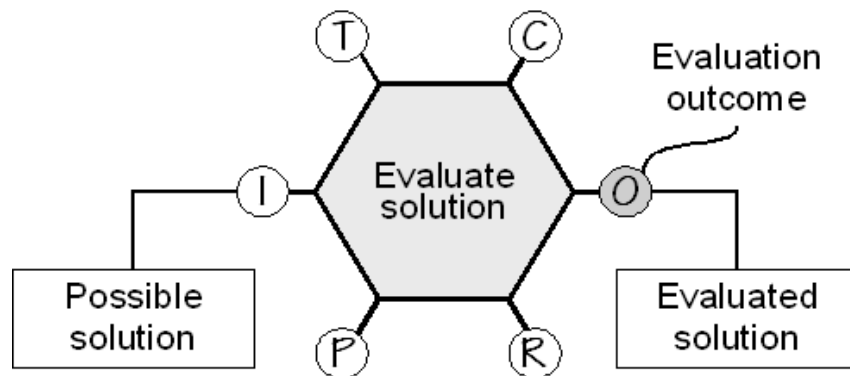
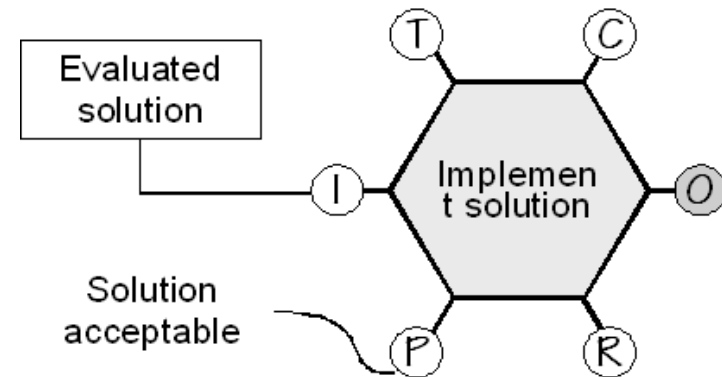
Efficiency-thoroughness trade-off (ETTO)

Habit

External resource-demand variability

External pressures

Endogenous variability



If functions are by different entities:

Working methods,

Expectations (ETTO),

Misunderstanding of cues/signals,

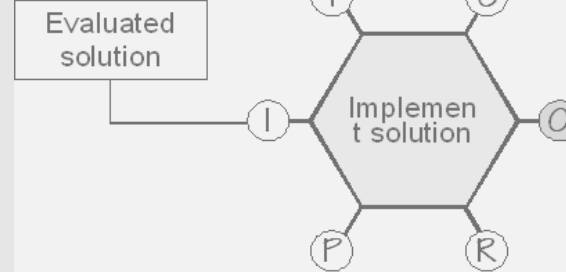
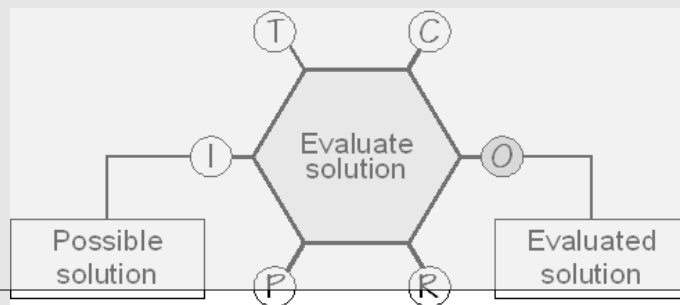
Miscommunication

Exogenous variability

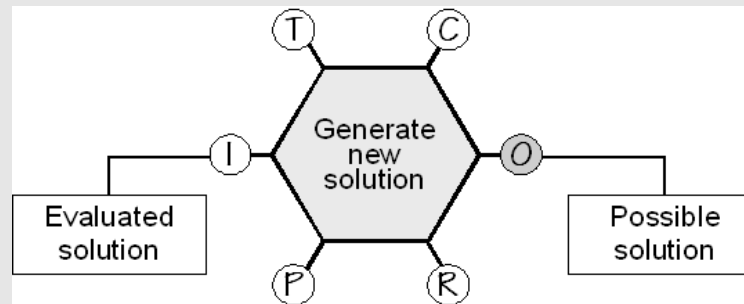
FRAM: conditions, functions and states

FRAM performance conditions

Performance conditions
can affect functions



FRAM Functions



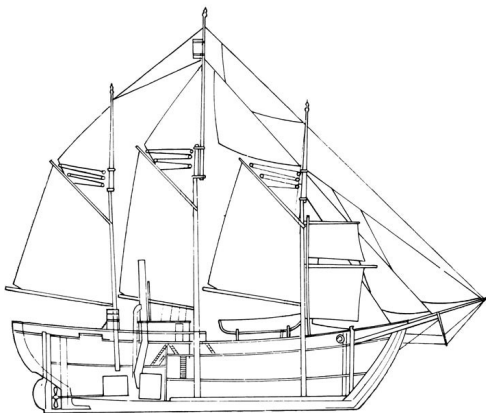
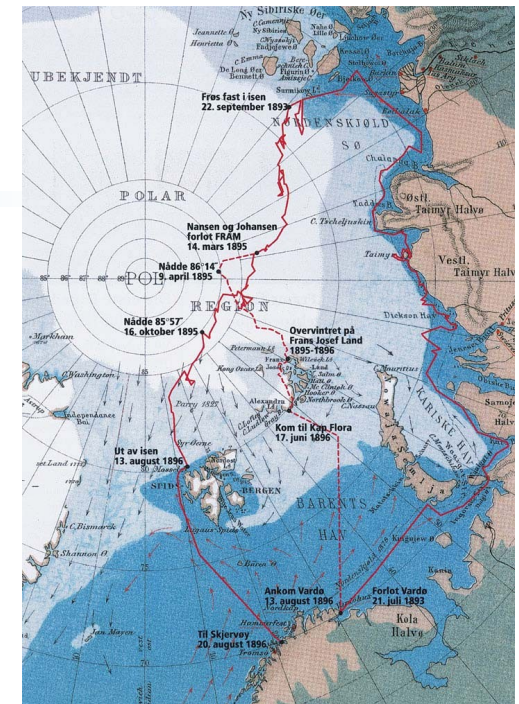
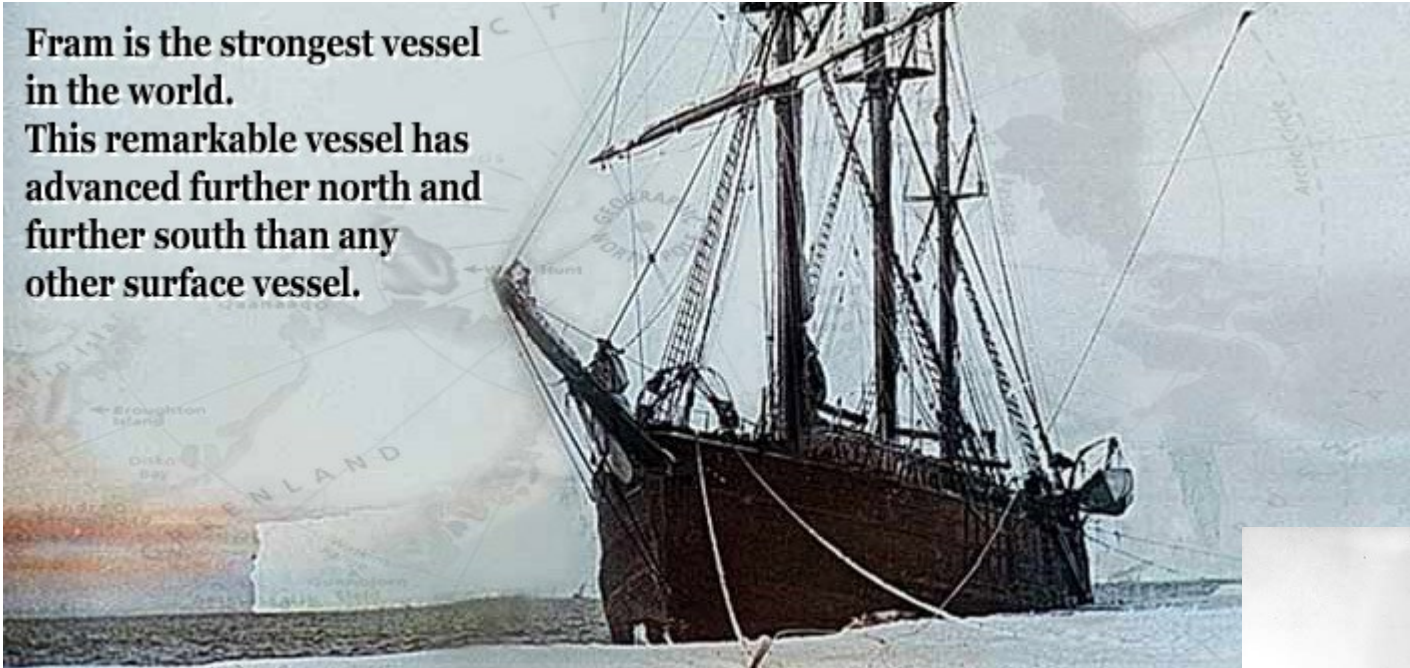
FRAM States

Evaluation
outcome

FRAM functions can set
and interrogate states

The real FRAM

Fram is the strongest vessel in the world.
This remarkable vessel has advanced further north and further south than any other surface vessel.



Design: Colin Archer
Launched: 1892





du 9. Septembre 1896.

Potage tortue clair
Lunch à l'Impériale
Brissotins de volaille au suprême
Hies, See Norvégienne
Selle de renne piquée, Légumes
Filets de poulets à la Périgord
Lain d'Ecrevisses à la Dartois
Poules de neige rôties, Salade
Fonds d'Artichauts à la Lyonnaise
Louding à la Montreuil
Fromage, Beurre, Cakes



DESSERT

Glaces Assorties
Compote, petits gâteaux
Fruits
Bonbons