



U.S. ARMY COMBAT CAPABILITIES DEVELOPMENT COMMAND ARMAMENTS CENTER

Proving Fuze Safety

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INTRODUCTION

- Fuze safety requirements have a very long evolutionary history. Most safety requirements have been paid for with the lives of soldiers and civilians.
 - WW1 and earlier era fuzes- mostly relied on one safety mechanism and were typically inline systems. Warheads were prone to unintended functioning.
 - WW2 fuzes introduced the requirement of two independent environments for arming.
- Modern safety requirements for fuzing defined in MIL-STD-1316.
 - Base document predates 1967, Revision A circa 1969. Revision F in 2017.
 - New technology creates new safety concerns and the need for continual updating.
- Failure mechanisms become less obvious as technology and design complexity increases.

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INTRODUCTION

Safety and arming are primary roles performed by a fuze:

- Maintains munition safety throughout the Life Cycle Environmental Profile (stockpile-to-target sequence)
- Initiates the munition's warhead when the target is detected

- The **purpose** of MIL STD 1316 is to establish design safety criteria for fuzes and Safety and Arming (S&A) devices that are subsystems of fuzes.
 - Establishes Design Safety Criteria for Fuzes
 - Mandatory elements of design, engineering, production and procurement of fuzes
 - Design Approval
 - **Verification**

The **inadvertent arming and firing of a fuze system** can result in **Catastrophic** material damage & injury or **Death** to personnel.

- Every effort must be made during the development of the munitions' fuze safety system to achieve a **high degree of safety during the lifecycle:**
 - Prior to intentional initiation of the arming sequence (shipping and handling)
 - Prior to tube exit
 - Prior to safe separation

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METHODS FOR ENSURING SAFETY

- Safety cannot be inspected in; It must be designed in!
 - Analysis
 - Failure Mode Effects Analysis (FMEA).
 - Failure Mode Effects Critical Analysis (FMECA). Includes criticality, assurances and controls.
 - Fault Tree Analysis (FTA).
 - Probability of unintended function.
 - Reliability Analysis.
 - Probability of intended function.
 - Testing
 - Developmental testing – Does it meet the design requirement?
 - Qualification testing – Does it meet the user requirement?
 - Reviews
 - Peer reviews.
 - Review boards.

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METHODS FOR ENSURING SAFETY

➤ REVIEW BOARDS

- Responsible for compliance. Examines safety prior to and including launch.
 - Production, shipping, handling, storage, loading, launch, safe separation.
 - Each service has their own review but meet jointly when fuzes are used on common munitions. All work together to ensure user safety across all services.
 - ✓ Army Fuze Safety Review Boards – AFSRB.
 - ✓ Navy Fuze & Initiation Systems Technical Review Panel – FISTRP.
 - ✓ Air Force Nonnuclear Munitions Safety Board (NNMSB).
 - ✓ Joint Service Fuze and Ignition Systems Safety Authorities (JS-FISSA)
 - Each requires intimate knowledge of how the fuze works (no secret sauce).
- In addition, the System Safety Review Board (SSRB) is concerned with overall safety, including:
 - Overhead safety.
 - Reliability.
 - UXO.

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UNDERSTANDING THE SYSTEM SAFETY ISSUES

- What is the safety issue
 - Catastrophic loss of life or property.
- It is critical to understand and communicate how the system is intended to operate
 - State diagrams.
 - Logic diagrams.
 - Schematic diagrams.
 - During safe separation.
- It is critical to understand and communicate how the system can fail
 - This requires imagination
 - Is never 100% inclusive
 - Murphy's law applies, If anything can go wrong just assume it will.

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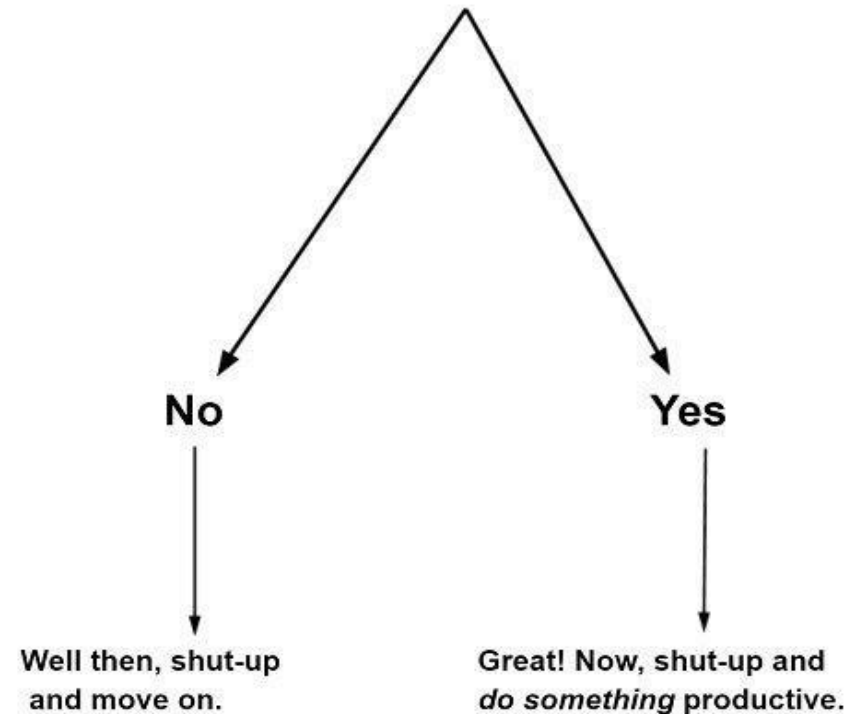


UNDERSTANDING THE SYSTEM

Caution 1

Oversimplifying a complex system

**This problem/situation I'm dealing with:
Can I influence the outcome?**



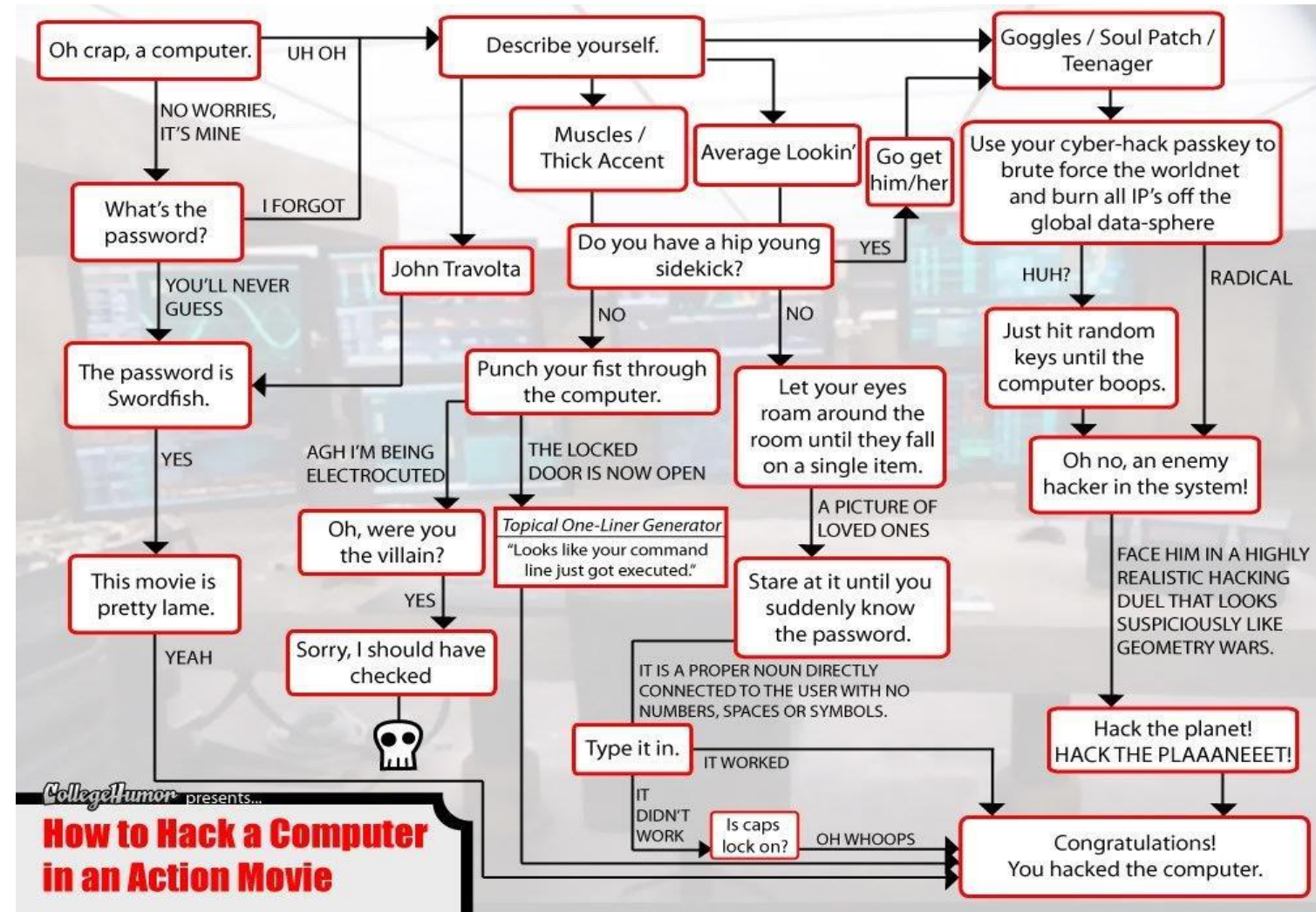
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UNDERSTANDING THE SYSTEM

Caution 2

Misrepresenting a
Complex system



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UNDERSTANDING THE SYSTEM

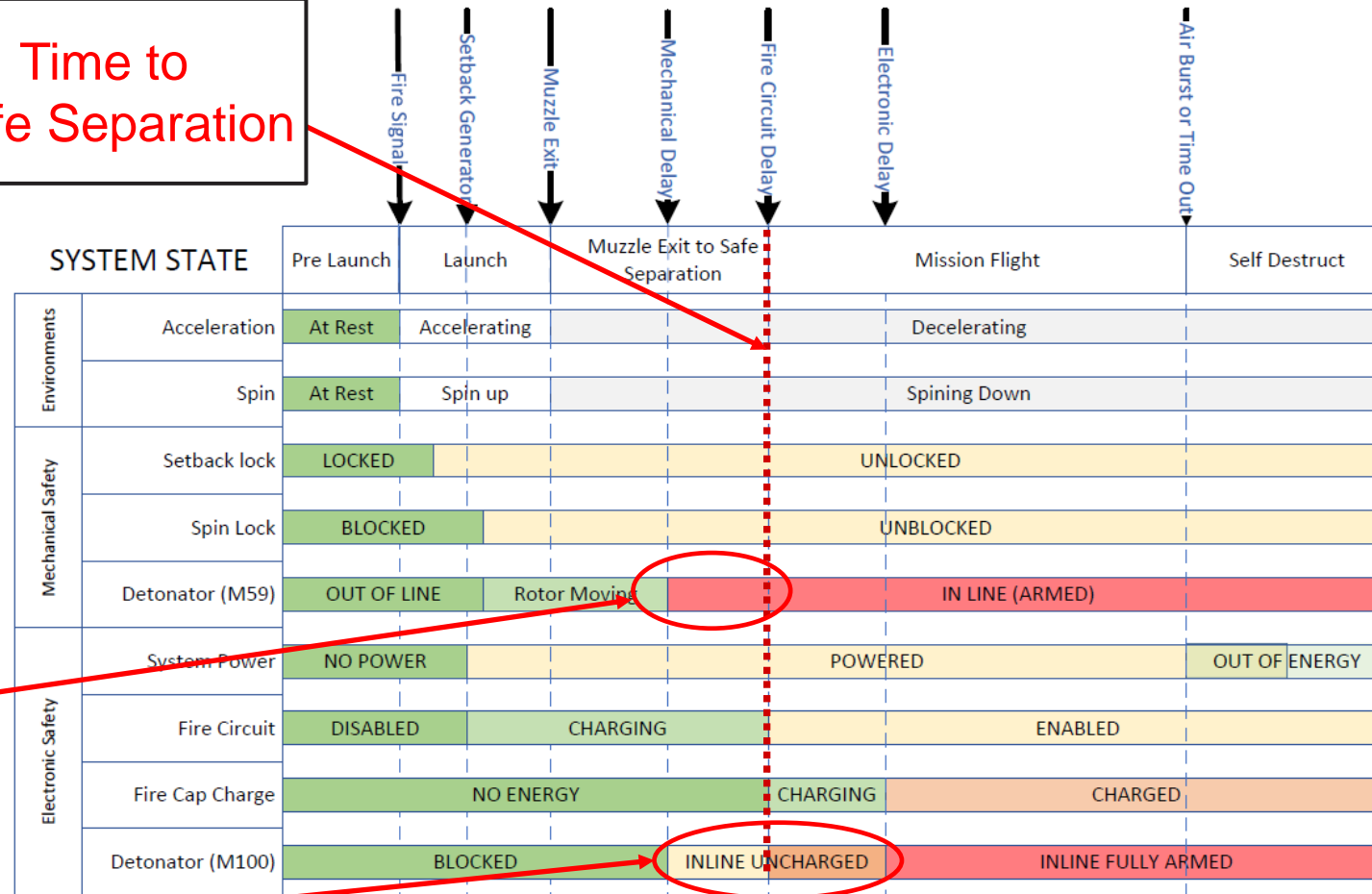
A real example

FUZE ARMING SEQUENCE

Time to Safe Separation

Safety Issue

Mitigation Logic



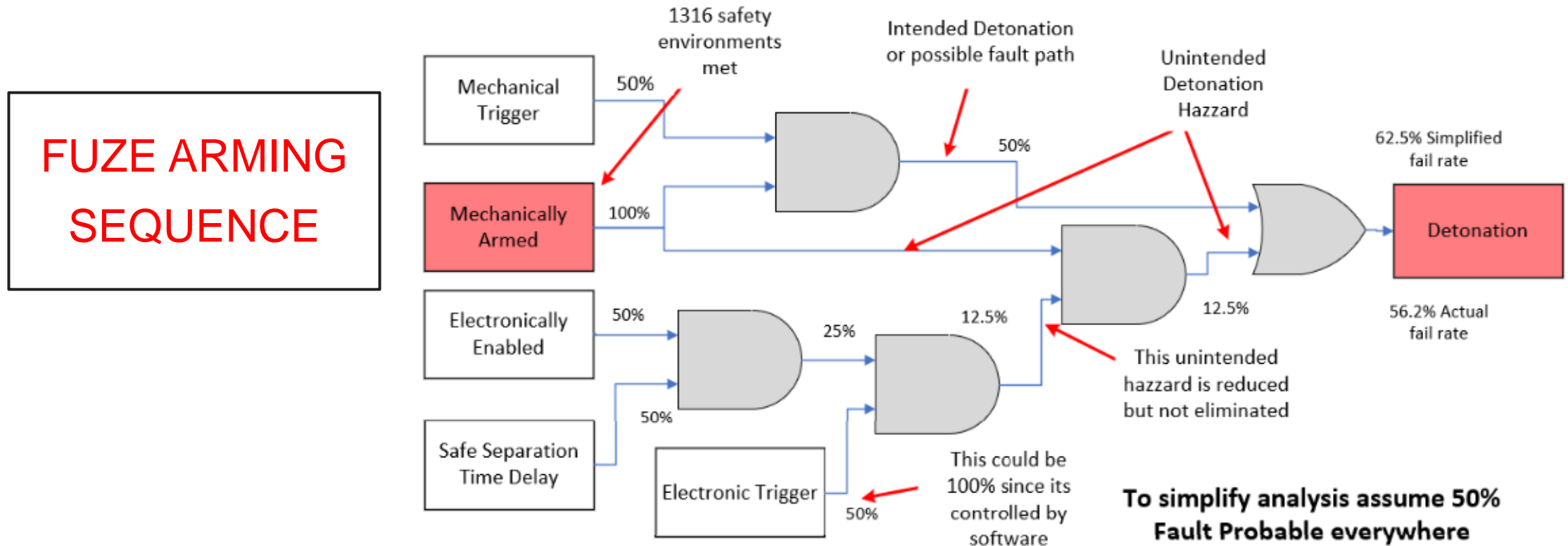
An Arming Sequence/State Diagram

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UNDERSTANDING THE SYSTEM

- A real Example



Arming Sequence as a Logic Diagram for FTA

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FAULT TREE ANALYSIS

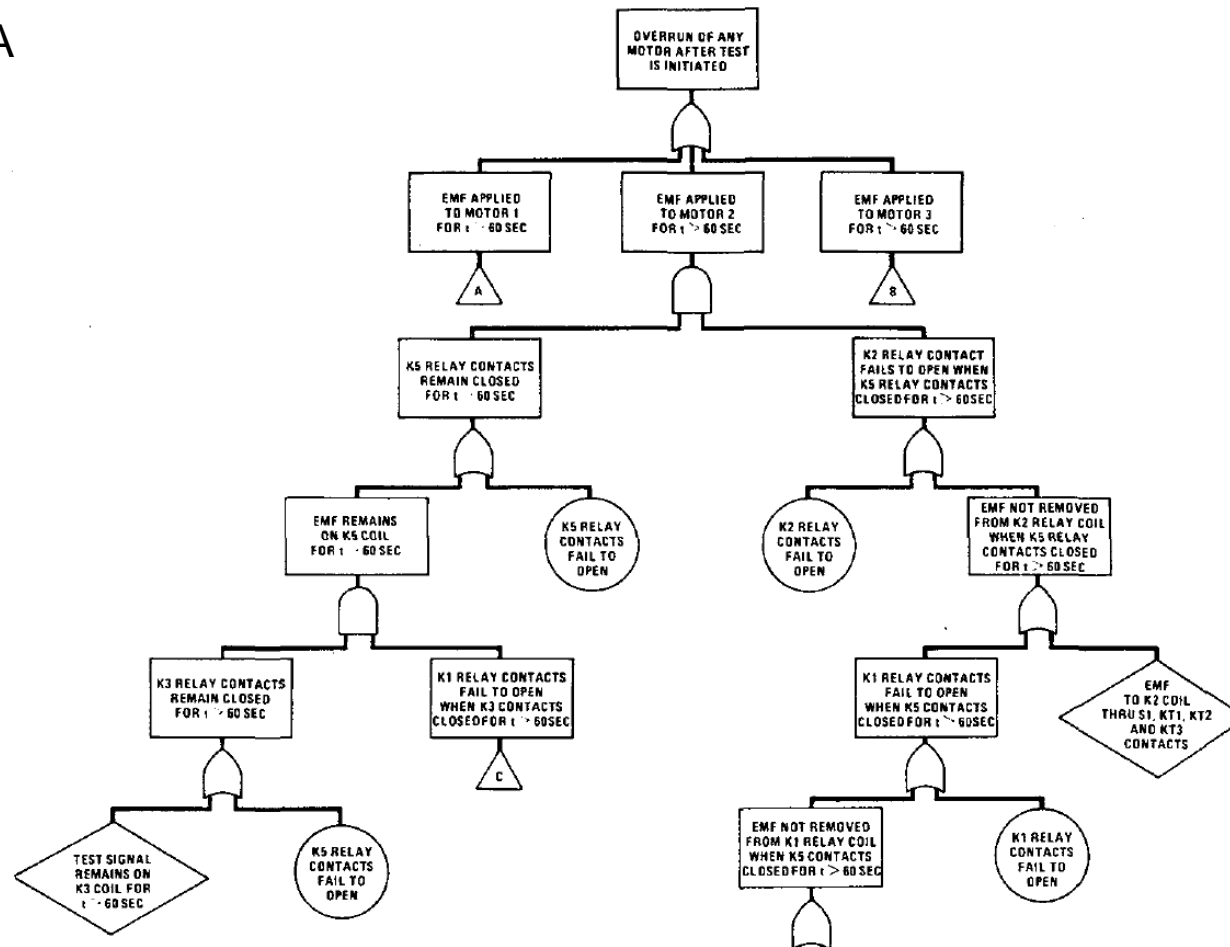
- What is the probability of unintended functioning.
 - During assembly.
 - During shipping and handling.
 - During launch.
 - During safe separation.
- Not concerned with functioning as intended.
- A necessary safety document for review boards.
- Guidance for performing the FTA is not well documented in a single standard but it is a necessity for proving safety. Work is ongoing on formalizing guidance in a new JOTP (Joint Ordinance Testing Procedure) through the work of the FESWG (Fuze Engineering Standardization Working Group).
 - A logic diagram of the safety critical system is required. System operation must be clearly understood.
 - Multiple documents/requirements exist.
 - FTA calculations with probabilities greater than 100% indicate a lack of understanding.
 - FTA calculations depending on probabilities smaller than 10^{-12} also misses the point of the analysis

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FAULT TREE ANALYSIS

- Example FTA



Example FTA Logic Diagram from NUREG-492

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FAULT TREE ANALYSIS (FTA)

Requirements from MIL-STD-1316 for Launched Munitions

| EVENT | SCENARIO | ACCEPTABLE PROBABLY |
|-------------|---------------------------|----------------------------------|
| ARMING | Prior to Launch | 1 E ⁻⁶ (1: 1,000,000) |
| | Prior to Launch Tube Exit | 1 E ⁻⁴ (1: 10,000) |
| | Prior to Safe Separation | 1 E ⁻³ (1: 1,000) |
| FUNCTIONING | Prior to Launch | 1 E ⁻⁶ (1: 1,000,000) |
| | Prior to Launch Tube Exit | 1 E ⁻⁶ (1: 1,000,000) |
| | Prior to Safe Separation | As Low as Practical |

- Primary Intent is to **demonstrate there are no single point failure modes** in the design
- FTA should therefore be evaluated based on the **FUZE DESIGN Robustness**, and not weighted on production/quality assurance history (in other words, safety performance should be assured by design with less reliance on inspection)
- Source for component failure probability numbers: **conservative** engineering judgment; numerous software FTA programs and historical documents; MIL-HDBK-217F for electronic components

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FAULT TREE ANALYSIS

- A Logic diagram is essential – Based on fundamental understanding of the system.
 - All functional elements can be reduced to a series of logical operations involving ‘AND’, ‘OR’, and NOT gates. (Symbols can include XOR, NAND, NOR).
 - A conservative and realistic probability of failure/fault is assigned to each component of the operation. These can be reduced with rationale on subsequent passes if needed.
 - ‘AND’ operations will decrease probabilities. Cascaded operation will asymptotically reduce probabilities to zero but never reach zero.

AND Probabilities simply multiply: $P = A * B$ Exact

- ‘OR’ operations will increase probabilities. Cascaded operation will asymptotically increase probabilities to 100% but never exceed 100%.

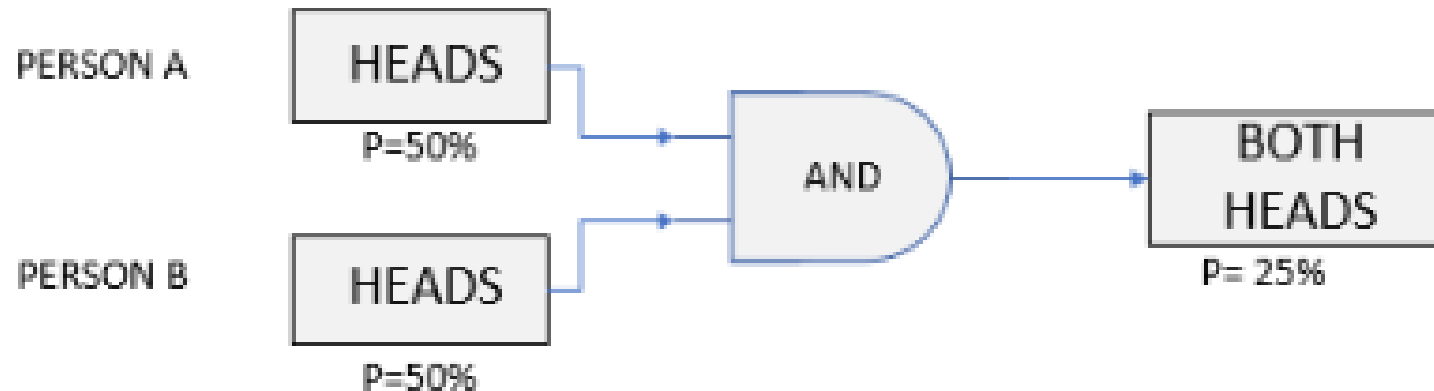
OR probabilities are complicated: $P = (A + B) - (A * B)$ Exact
 $P = A + B$ Simplified

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FAULT TREE ANALYSIS

- EXAMPLE1. What is the probability of two individuals getting 'heads' when flipping a coin?
 - As common sense would predict: The individual probabilities multiply.



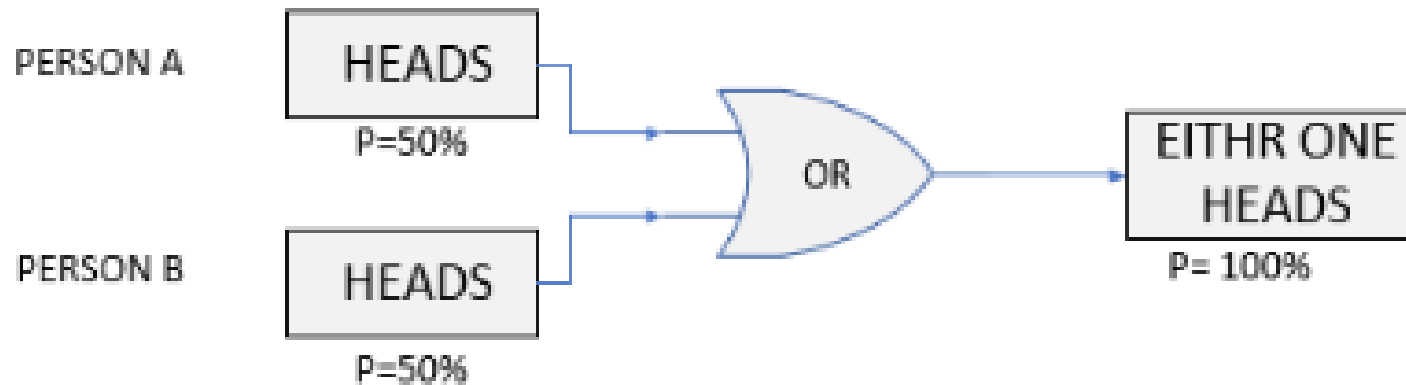
- This makes sense! If you want to make your system safer, require more things to go wrong in parallel. i.e. Safety depends on two independent environments.

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FAULT TREE ANALYSIS

- EXAMPLE2. What is the probability of one individual getting 'heads' when flipping a coin?
 - If we use simplified logic.



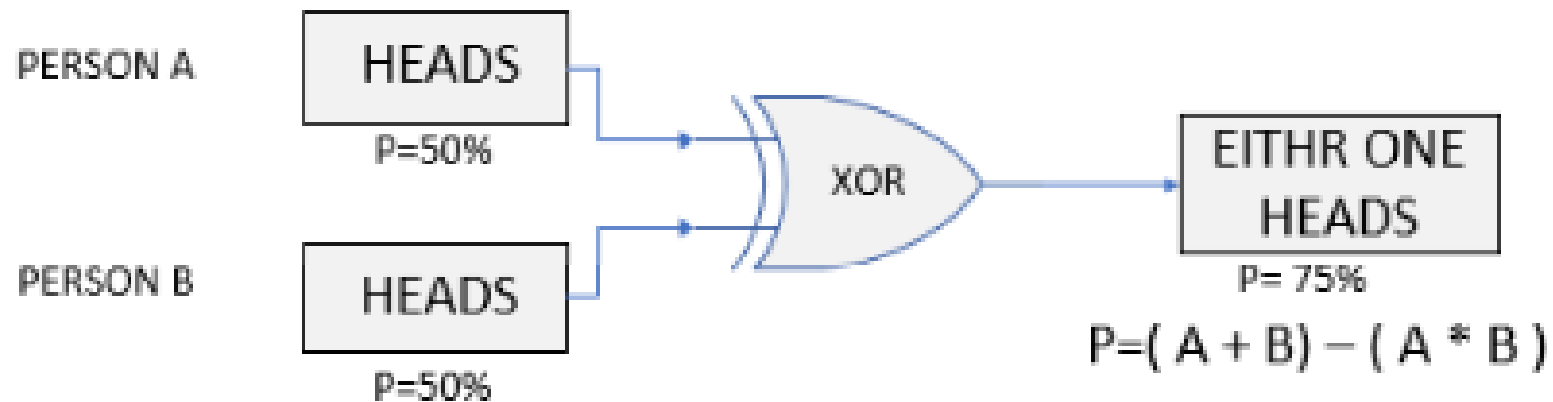
- Hmm... Something seems wrong here! What happens when we add a third person? 150% chance of getting heads cannot be correct!
- This result is nonsense and damages the credibility of the analysis.

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FAULT TREE ANALYSIS

- EXAMPLE3. What is the probability of one individual getting 'heads' when flipping a coin?
 - If we use exact logic 'OR' becomes 'EXCLUSIVE OR'.



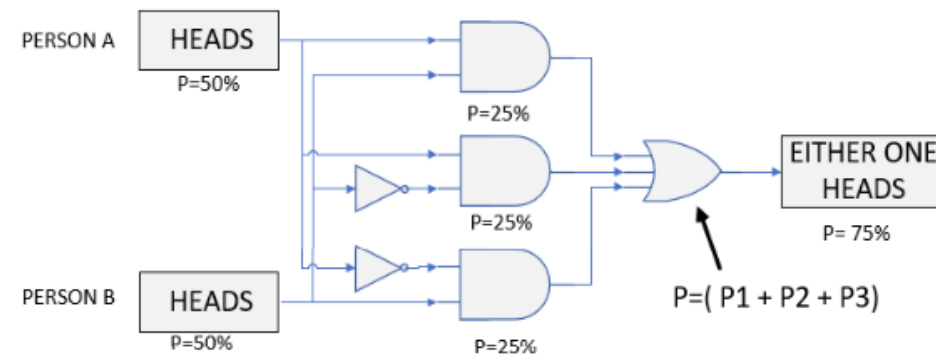
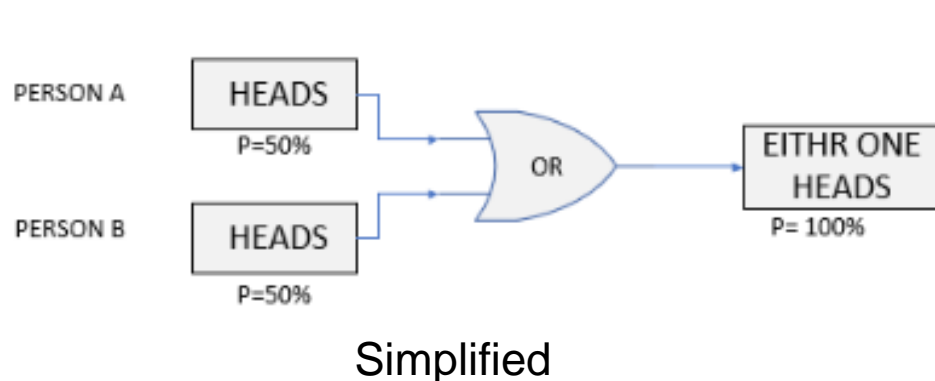
- This works, but why?
 - We want an 'exclusive or' condition! We need to subtract the possibility that both were heads since any one result constitutes a 'failure'.
 - i.e. The system fails when A or B fails. We do not care if both fail.

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FAULT TREE ANALYSIS

- When adding (OR'ing) failure mechanisms its easy to use the wrong logic!



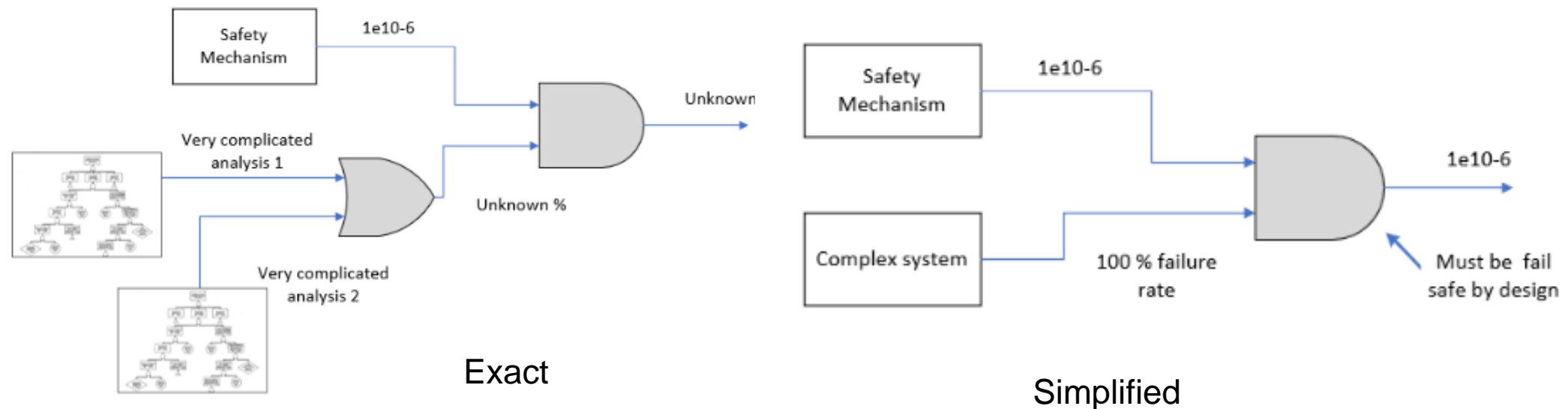
- Simplified logic only works when input probabilities are small! (i.e. probabilities less than 5% result in a .25% error / 50% probabilities result in 25% error).
 - As per AFSRB guidance: Software and microprocessor logic introduces terms on the order of 100%. This is where the conventional ‘simplified’ analysis falls apart. Nobody would ever intentionally design in a failure mechanism with a 50% or higher fail probability.

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PRUNING THE FAULT TREE

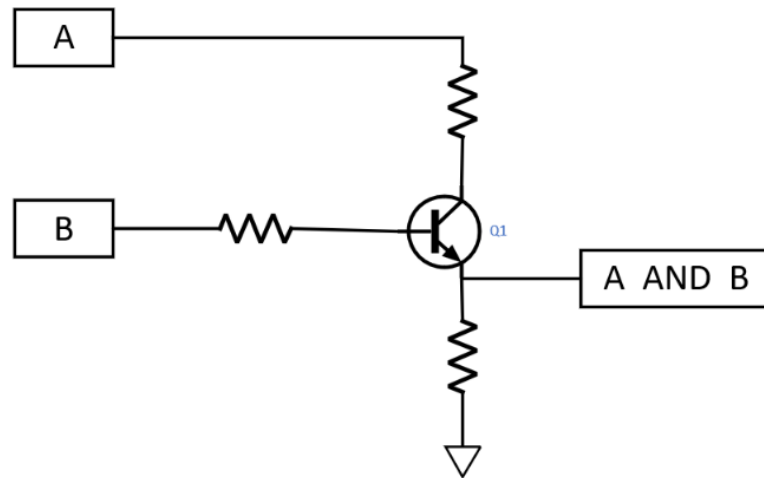
- Why?
 - To avoid analyzing paths that are overcomplex
- How?
 - By assuming a probability of failure of 100% we eliminate all contributing elements in this path
- When can you do this?
 - When the outcome is gated (AND'ed) out by a low probability of failure and the result meets the safety criteria. Software controlled trigger are a perfect example



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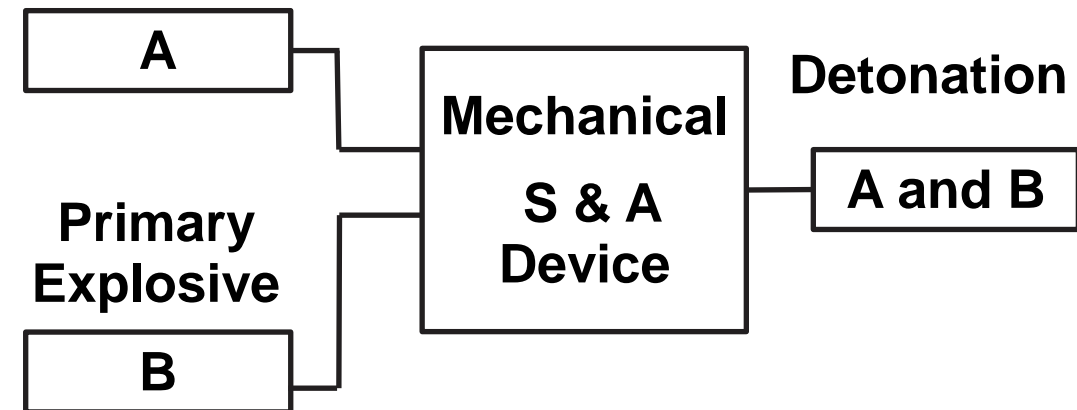


PRUNING THE FAULT TREE



Electrical And Gate

Environments



Mechanical And Gate

Fail Safe AND Gates

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IN GENERAL

- Fault trees are built from a logical model of the system. This includes a sequence of events (outcomes) fed by the logic or input to the system from the lowest levels.
 - A bottom-up analysis.
- Results are dependent on assumed probabilities of fault mechanisms.
 - Physical factors.
 - An electronic component fails.
 - A mechanical component breaks.
 - Environments cause freezing / melting.
 - Human factors.
 - An operator installs the wrong component.
 - An operator skips a step in assembly.
 - Something is mislabeled.
 - MIL-STD-882, System Safety provides guidance for root cause probabilities.

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YOU CAN ALWAYS EXPECT THE UNEXPECTED

- Despite rigorous analysis, testing and review, safety critical systems can manage to find new ways to fail.
 - Most will involve human factors.
 - All will involve mechanisms and interactions never conceived of. Examples from my 40 years of experience.
 - Example1: Early termination of STS-83 in 1997. Root cause: Technician not cutting strings with scissors as per documented instructions.
 - Fuel cell failure leads to shut down of non-critical systems.
 - Excessive moisture build up and condensation in cabin.
 - One IMU (Inertial Measurement Unit) fails causing early mission termination IAW flight safety rules (i.e. three guidance IMU's required at all times).
 - Example2: Aperiodic network outages for over 2 years. Root cause: Landscape service not reading English.
 - Example3: Certified component failures. Root cause: Marking component with 'pass'.

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IN CONCLUSION

- You can claim a system is 100% safe but not 100% of the time.
- In the end, safety will depend on the quality of the assumptions made in the analysis.

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- DOD, MIL-HDBK-338B, Electronic Reliability Design Handbook, Oct 1998
- Texas A & M University, Fault Tree Analysis, Construction/Evaluation/ Application. Preston I. Parker, 1977
- DOD, MIL-STD 1316F, Fuze Design Safety Criteria, 2017
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- DOD, MIL-STD-882D, System Safety
- Fault Tree Handbook, NUREG-0492, 1981

QUESTIONS?

THANK YOU.

For more information feel free to contact:

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