

# The Field Guide to Understanding 'Human Error'

**Sidney Dekker**



An **Ashgate** Book

**THIRD EDITION**

# Field Guide To Understanding Human Error

**Sonja Dieterich, Eric Ford, Daniel  
Pavord, Jing Zeng**



## **Field Guide To Understanding Human Error:**

The Field Guide to Understanding Human Error Sidney Dekker, 2006 The old Bad Apple Theory of human error promotes the idea that a system is basically safe with the exception of a few unreliable people Breaking new ground beyond its successful predecessor The Field Guide to Understanding Human Error guides you through the traps and misconceptions of the old view Sidney Dekker presents the view that human error is an organizational problem and suggests how to apply new theories to your organization handling questions about accountability and constructing meaningful countermeasures

**The Field Guide to Understanding 'Human Error'** Professor Sidney Dekker, 2014-12-28 This latest edition of The Field Guide to Understanding Human Error will help you understand how to move beyond human error how to understand accidents how to do better investigations how to understand and improve your safety work You will be invited to think creatively and differently about the safety issues you and your organization face In each you will find possibilities for a new language for different concepts and for new leverage points to influence your own thinking and practice as well as that of your colleagues and organization

The Field Guide to Human Error Investigations Sidney Dekker, 2017-11-01 This title was first published in 2002 This field guide assesses two views of human error the old view in which human error becomes the cause of an incident or accident or the new view in which human error is merely a symptom of deeper trouble within the system The two parts of this guide concentrate on each view leading towards an appreciation of the new view in which human error is the starting point of an investigation rather than its conclusion The second part of this guide focuses on the circumstances which unfold around people which causes their assessments and actions to change accordingly It shows how to reverse engineer human error which like any other component needs to be put back together in a mishap investigation

**The Field Guide to Understanding Human Error** Sidney Dekker, 2017-04-07 When faced with a human error problem you may be tempted to ask Why didn't they watch out better How could they not have noticed You think you can solve your human error problem by telling people to be more careful by reprimanding the miscreants by issuing a new rule or procedure These are all expressions of The Bad Apple Theory where you believe your system is basically safe if it were not for those few unreliable people in it This old view of human error is increasingly outdated and will lead you nowhere The new view in contrast understands that a human error problem is actually an organizational problem Finding a human error by any other name or by any other human is only the beginning of your journey not a convenient conclusion The new view recognizes that systems are inherent trade offs between safety and other pressures for example production People need to create safety through practice at all levels of an organization Breaking new ground beyond its successful predecessor The Field Guide to Understanding Human Error guides you through the traps and misconceptions of the old view It explains how to avoid the hindsight bias to zoom out from the people closest in time and place to the mishap and resist the temptation of counterfactual reasoning and judgmental language But it also helps you look forward It suggests how to apply the new view in building your

safety department handling questions about accountability and constructing meaningful countermeasures It even helps you in getting your organization to adopt the new view and improve its learning from failure So if you are faced by a human error problem abandon the fallacy of a quick fix Read this book **The Field Guide to Understanding 'Human Error'**

Professor Sidney Dekker,2014-12-28 This latest edition of The Field Guide to Understanding Human Error will help you understand how to move beyond human error how to understand accidents how to do better investigations how to understand and improve your safety work You will be invited to think creatively and differently about the safety issues you and your organization face In each you will find possibilities for a new language for different concepts and for new leverage points to influence your own thinking and practice as well as that of your colleagues and organization *The Field Guide to Understanding Human Error* Dekker Sidney,2006 When faced with a human error problem you may be tempted to ask Why didn't they watch out better How could they not have noticed You think you can solve your human error problem by telling people to be more careful by reprimanding the miscreants by issuing a new rule or procedure These are all expressions of The Bad Apple Theory where you believe your system is basically safe if it were not for those few unreliable people in it This old view of human error is increasingly outdated and will lead you nowhere The new view in contrast understands that a human error problem is actually an organizational problem Finding a human error by any other name or by any other human is only the beginning of your journey not a convenient conclusion The new view recognizes that systems are inherent trade offs between safety and other pressures for example production People need to create safety through practice at all levels of an organization Breaking new ground beyond its successful predecessor The Field Guide to Understanding Human Error guides you through the traps and misconceptions of the old view It explains how to avoid the hindsight bias to zoom out from the people closest in time and place to the mishap and resist the temptation of counterfactual reasoning and judgmental language But it also helps you look forward It suggests how to apply the new view in building your safety department handling questions about accountability and constructing meaningful countermeasures It even helps you in getting your organization to adopt the new view and improve its learning from failure So if you are faced by a human error problem abandon the fallacy of a quick fix Read this book Cause Analysis Manual Fred Forck, CPT,2016-10-05 A failure or accident brings your business to a sudden halt How did it happen What's at the root of the problem What keeps it from happening again Industry pioneer Fred Forck's 7 step cause analysis methodology guides you to the root of the incident enabling you to act effectively to avoid loss of time money productivity quality Risk-Reduction Methods for Occupational Safety and Health Roger C. Jensen,2019-10-01 Provides a thorough overview of systematic methods for reducing risks encountered in diverse work places Filled with more theory numerous case examples and references to new material than the original text this latest edition of a highly acclaimed book on occupational safety and health includes substantial updates and expanded material on management systems risk assessment methods and OSH relevant concepts principles and models

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**Management** Fred A. Manuele, 2020-03-13 Establishes sound safety management principles and focuses on the revised Z10 0 safety standard the new 45001 safety standard and serious injury prevention Filled with updated chapters and information throughout this book covers the provisions of ANSI ASSP Z10 0 2019 the American standard for Occupational Health and Safety Management Systems It expands in detail on the principles for advanced safety management the content of the revised Z10 0 standard and the newly adopted international standard ISO 45001 It also emphasizes the need to reduce the occurrence of serious injuries illnesses and fatalities Advanced Safety Management Focusing on Z10 0 45001 and Serious Injury Prevention Third Edition expands on the material in previous editions and includes several new chapters emphasizing culture systems design and incident investigations Beginning with an overview of ANSI ASSP Z10 0 2019 and ANSI ASSP ISO 45001 2018 it goes on to offer chapters on Essentials for the Practice of Safety Human Error Avoidance Hazards Analyses and Risk Assessments Three and Four Dimensional Risk Scoring Systems Safety Design Reviews The Procurement Process Audit Requirements The Management Oversight and Risk Tree MORT and more Expands in detail on the principles for advanced safety management the content of the revised ANSI ASSP Z10 0 standard and the newly adopted international standard ISO 45001 New chapters cover the Significance of An Organization's Culture Fundamental Concepts and Systems Macro Thinking Places emphasis on the more prominent risk based approach in the practice of safety Provides methods to align safety operational and financial goals along with quality and environmental standards Explains the concepts of risk reduction waste reduction environmental impact deduction and Prevention through Design PtD Advanced Safety

Management is an important book for safety professionals industrial hygienist plant managers OSHA and EPA advocates students majoring in safety or industrial hygiene and union leaders

### **Killed by a Traffic Engineer** Wes

Marshall, 2024-06-04 In the US we are nearing four million road deaths since we began counting them in 1899 The numbers are getting worse in recent years yet we continue to accept these deaths as part of doing business There has been no examination of why we engineer roads that are literally killing us Fixing the carnage on our roadways requires a change in mindset and a dramatic transformation of transportation This goes for traffic engineers in particular because they are still the ones in charge of our streets In **Killed by a Traffic Engineer** civil engineering professor Wes Marshall shines a spotlight on how little science there is behind the way that our streets are engineered which leaves safety as an afterthought While traffic engineers are not trying to cause deliberate harm to anyone he explains they are guilty of creating a transportation system whose designs remain largely based on plausible but unproven conjecture Thoroughly researched and compellingly written **Killed by a Traffic Engineer** shows how traffic engineering research is outdated and unexamined at its best and often steered by an industry and culture considering only how to get from point A to B the fastest way possible to the detriment of safety quality of life equality and planetary health Marshall examines our need for speed and how traffic engineers disconnected it from safety the focus on capacity and how it influences design blaming human error relying on faulty data how liability drives reporting measuring road safety outcomes and the education and reeducation of traffic engineers **Killed by a Traffic Engineer** is ultimately hopeful about what is possible once we shift our thinking and demand streets engineered for the safety of people both outside and inside of cars It will make you look at your city and streets and traffic engineers in a new light and inspire you to take action

### **Restorative Just Culture in Practice** Sidney Dekker, Amanda Oates, Joseph

Rafferty, 2022-06-15 A restorative just culture has become a core aspiration for many organizations in healthcare and elsewhere Whereas just culture is the topic of some residual conceptual debate e g retributive policies organized around rules violations and consequences are sold as just culture the evidence base on and business case for restorative practice has been growing and is generating increasing global interest In the wake of an incident restorative practices ask who are impacted what their needs are and whose obligation it is to meet those needs Restorative practices aim to involve participants from the entire community in the resolution and repair of harms This book offers organization leaders and stakeholders a practical guide to the experiences of implementing and evaluating restorative practices and creating a sustainable just restorative culture It contains the perspectives from leaders theoreticians regulators employees and patient representatives To the best of our knowledge there is no book on the market today that can function as a guide for the implementation and evaluation of a just and learning culture and restorative practices This book is intended to fill this gap This book will provide among other topics an overview of restorative just culture principles and practices a balanced treatment of the various implementations and evaluations of just culture and restorative processes a guide for leaders about

what to stop start increase and decrease in their own organizations and an attentive to philosophical and historical traditions and assumptions that underlie just culture and restorative approaches The interest in just culture not just in healthcare but also in other fields of safety critical practice has been steadily growing over the past decade It is a trending area In this it has become clear that 20 year old retributive models not only hinder the acceleration of performance and organizational improvement but have also in some cases become a blunt HR instrument an expression of power over justice and a way to stifle honesty reporting and learning What is new in this then is the restorative angle on just culture as it has been developed over the last few years and now is practised and applied to HR suicide prevention healthcareimprovement regulatory innovations and other areas

**Causal Factors Analysis** Babcock & Wilcox Technical Services Pantex,2008

**Process Safety Management and Human Factors** Waddah S. Ghanem Al Hashmi,2020-11-13 Process Safety Management and Human Factors A Practitioner s Experiential Approach addresses human factors in process safety management PSM from a reflective learning approach The book is written by engineers and technical specialists who spent the last 15 20 years of their professional career looking at behavioral based safety human factor research and safety culture development in organizations It is a fundamental resource for operational technical and safety managers in high risk industries who need to focus on personal and occupational safety management to prevent safety accidents Real life examples illustrate how a good effective understanding of human factors supports PSM and positive impacts on accident occurrence Covers the evolution and background of process safety management Shows how to integrate and augment process safety management with operational excellence and health safety and environment management systems Focuses on human factors in process safety management Includes many real life case studies from the collective experience of the book s authors

There Are No Accidents Jessie Singer,2023-02-28 A journalist recounts the surprising history of accidents and reveals how they ve come to define all that s wrong with America We hear it all the time Sorry it was just an accident And we ve been deeply conditioned to just accept that explanation and move on But as Jessie Singer argues convincingly There are no such things as accidents The vast majority of mishaps are not random but predictable and preventable Singer uncovers just how the term accident itself protects those in power and leaves the most vulnerable in harm s way preventing investigations pushing off debts blaming the victims diluting anger and even sparking empathy for the perpetrators As the rate of accidental death skyrockets in America the poor and people of color end up bearing the brunt of the violence and blame while the powerful use the excuse of the accident to avoid consequences for their actions Born of the death of her best friend and the killer who insisted it was an accident this book is a moving investigation of the sort of tragedies that are all too common and all too commonly ignored In this revelatory book Singer tracks accidental death in America from turn of the century factories and coal mines to today s urban highways rural hospitals and Superfund sites The automobile industry popularized the idea of jaywalking to redirect blame away from cars and their drivers Racist planning policies built hazardous highway conditions straight through

Black neighborhoods and then blamed Black and Latino victims Drawing connections between traffic accidents accidental opioid overdoses and accidental oil spills Singer proves that what we call accidents are hardly random Rather who lives and dies by an accident in America is defined by money and power She also presents a variety of actions we can take as individuals and as a society to stem the tide of accidents saving lives and holding the guilty to account

**Behind Human Error** David Woods, Sidney Dekker, Richard Cook, Leila Johannesen, Nadine Sarter, 2017-09-18 Human error is cited over and over as a cause of incidents and accidents The result is a widespread perception of a human error problem and solutions are thought to lie in changing the people or their role in the system For example we should reduce the human role with more automation or regiment human behavior by stricter monitoring rules or procedures But in practice things have proved not to be this simple The label human error is prejudicial and hides much more than it reveals about how a system functions or malfunctions This book takes you behind the human error label Divided into five parts it begins by summarising the most significant research results Part 2 explores how systems thinking has radically changed our understanding of how accidents occur Part 3 explains the role of cognitive system factors bringing knowledge to bear changing mindset as situations and priorities change and managing goal conflicts in operating safely at the sharp end of systems Part 4 studies how the clumsy use of computer technology can increase the potential for erroneous actions and assessments in many different fields of practice And Part 5 tells how the hindsight bias always enters into attributions of error so that what we label human error actually is the result of a social and psychological judgment process by stakeholders in the system in question to focus on only a facet of a set of interacting contributors If you think you have a human error problem recognize that the label itself is no explanation and no guide to countermeasures The potential for constructive change for progress on safety lies behind the human error label

*Safety Management and Human Factors* Pedro Arezes, Anne Garcia, 2024-07-24 Proceedings of the 15th International Conference on Applied Human Factors and Ergonomics and the Affiliated Conferences Nice France 24 27 July 2024

*Qualitative Research Methods in Air Transport Management* Kurt, Yeşim, 2025-02-06 Qualitative research methods play an important role in air transport management by providing insights into the complexities of the industry that quantitative data cannot capture alone Through techniques such as interviews case studies focus groups and observational research qualitative methods allow researchers and practitioners to explore the human organizational and cultural factors that influence decision making customer experiences and operational efficiency in air transport This approach enables a deeper understanding of passenger behaviors airline management practices regulatory impacts and industry trends By focusing on the nuances and subjective experiences of stakeholders qualitative research contributes to the development of more effective strategies policies and innovations within the air transport sector Qualitative Research Methods in Air Transport Management reveals the relationship between qualitative research methods and academics researchers and industry professionals who carry out studies related to the air transport sector It exemplifies qualitative research practices in



the aviation sector while providing in depth analysis and discusses the importance of qualitative research for understanding the structures in the sector and the experiences of aviation professionals This book covers topics such as traffic control aviation engineering and air transportation and is a useful resource for business owners researchers engineers data scientists and academicians

**Practical Radiation Oncology Physics** Sonja Dieterich, Eric Ford, Daniel Pavord, Jing Zeng, 2015-08-21 Perfect for radiation oncologists medical physicists and residents in both fields Practical Radiation Oncology Physics provides a concise and practical summary of the current practice standards in therapeutic medical physics A companion to the fourth edition of Clinical Radiation Oncology by Drs Leonard Gunderson and Joel Tepper this indispensable guide helps you ensure a current state of the art clinical practice Covers key topics such as relative and in vivo dosimetry imaging and clinical imaging stereotactic body radiation therapy and brachytherapy Describes technical aspects and patient related aspects of current clinical practice Offers key practice guideline recommendations from professional societies throughout including AAPM ASTRO ABS ACR IAEA and others Includes therapeutic applications of x rays gamma rays electron and charged particle beams neutrons and radiation from sealed radionuclide sources plus the equipment associated with their production use measurement and evaluation Features a For the Physician box in each chapter which summarizes the key points with the most impact on the quality and safety of patient care Provides a user friendly appendix with annotated compilations of all relevant recommendation documents Includes an enhanced Expert Consult eBook with open ended questions ideal for self assessment and highlighting key points from each chapter Download and search all of the text figures and references on any mobile device

[The Art of Agile Development](#) James Shore, Shane Warden, 2021-10-12 Most companies developing software employ something they call Agile But there s widespread misunderstanding of what Agile is and how to use it If you want to improve your software development team s agility this comprehensive guidebook s clear concrete and detailed guidance explains what to do and why and when to make trade offs In this thorough update of the classic Agile how to guide James Shore provides no nonsense advice on Agile adoption planning development delivery and management taken from over two decades of Agile experience He brings the latest ideas from Extreme Programming Scrum Lean DevOps and more into a cohesive whole Learn how to successfully bring Agile development to your team and organization or discover why Agile might not be for you This book explains how to Improve agility create the conditions necessary for Agile to succeed and scale in your organization Focus on value work as a team understand priorities provide visibility and improve continuously Deliver software reliably share ownership decrease development costs evolve designs and deploy continuously Optimize value take ownership of product plans budgets and experiments and produce market leading software

[Second Victim](#) Sidney Dekker, 2013-03-26 How do people cope with having caused a terrible accident How do they cope when they survive and have to live with the consequences ever after We tend to blame and forget professionals who cause incidents and accidents but they are victims too They are second victims whose experiences of an incident or

adverse event can be as traumatic as that of the first victims Yet information on second victimhood and its relationship to safety about what is known and what organizations might need to do is difficult to find Thoroughly exploring an emerging topic with great relevance to safety culture *Second Victim Error Guilt Trauma and Resilience* examines the lived experience of second victims It goes through what we know about trauma guilt forgiveness and injustice and how these might be felt by the second victim The author discusses how to conduct investigations of incidents that do not alienate second victims or make them feel even worse It explores the importance support and resilience and where the responsibilities for creating it may lie Drawing on his unique background as psychologist airline pilot and safety specialist and his own experiences with helping second victims from a variety of backgrounds Sidney Dekker has written a powerful moving account of the experience of the second victim It forms compelling reading for practitioners risk managers human resources managers safety experts mental health workers regulators the judiciary and many other professionals Dekker provides a strong theoretical background to promote understanding of the situation of the second victim and solid practical advice about how to deal with trauma that continues after an event leading to preventable harm or even avoidable death of a patient consumer or colleague Listen to Sidney Dekker speak about his book

## Unveiling the Power of Verbal Beauty: An Emotional Sojourn through **Field Guide To Understanding Human Error**

In a global inundated with screens and the cacophony of fast interaction, the profound power and psychological resonance of verbal artistry often fade into obscurity, eclipsed by the constant assault of sound and distractions. Yet, nestled within the musical pages of **Field Guide To Understanding Human Error**, a captivating function of fictional splendor that impulses with raw thoughts, lies an unforgettable trip waiting to be embarked upon. Published by way of a virtuoso wordsmith, that interesting opus instructions viewers on a psychological odyssey, lightly exposing the latent potential and profound influence stuck within the complex internet of language. Within the heart-wrenching expanse of this evocative evaluation, we shall embark upon an introspective exploration of the book is central subjects, dissect their charming writing type, and immerse ourselves in the indelible effect it leaves upon the depths of readers souls.

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