

Managing the Risks of Organizational Accidents

JAMES REASON



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James Reason



Managing The Risks Of Organizational Accidents:

Managing the Risks of Organizational Accidents James Reason, 1997 Presents a set of principles related to the causes of major accidents in high technology systems and describes tools and techniques for managing risks of such organizational accidents that go beyond those currently available to system managers and safety professionals Deals with prevention of major accidents arising from human and organizational causes in many different domains from banks and insurance companies to nuclear power plants and transport For those working in management or regulation of hazardous technologies Annotation copyrighted by Book News Inc Portland OR [Managing the Risks of Organizational Accidents](#) James Reason, 2016-01-29 Major accidents are rare events due to the many barriers safeguards and defences developed by modern technologies But they continue to happen with saddening regularity and their human and financial consequences are all too often unacceptably catastrophic One of the greatest challenges we face is to develop more effective ways of both understanding and limiting their occurrence This lucid book presents a set of common principles to further our knowledge of the causes of major accidents in a wide variety of high technology systems It also describes tools and techniques for managing the risks of such organizational accidents that go beyond those currently available to system managers and safety professionals James Reason deals comprehensively with the prevention of major accidents arising from human and organizational causes He argues that the same general principles and management techniques are appropriate for many different domains These include banks and insurance companies just as much as nuclear power plants oil exploration and production companies chemical process installations and air sea and rail transport Its unique combination of principles and practicalities make this seminal book essential reading for all whose daily business is to manage audit and regulate hazardous technologies of all kinds It is relevant to those concerned with understanding and controlling human and organizational factors and will also interest academic readers and those working in industrial and government agencies

Organizational Accidents Revisited James Reason, 2016-05-26 *Managing the Risks of Organizational Accidents* introduced the notion of an organizational accident These are rare but often calamitous events that occur in complex technological systems operating in hazardous circumstances They stand in sharp contrast to individual accidents whose damaging consequences are limited to relatively few people or assets Although they share some common causal factors they mostly have quite different causal pathways The frequency of individual accidents usually lost time injuries does not predict the likelihood of an organizational accident The book also elaborated upon the widely cited Swiss Cheese Model *Organizational Accidents Revisited* extends and develops these ideas using a standardized causal analysis of some 10 organizational accidents that have occurred in a variety of domains in the nearly 20 years that have passed since the original was published These analyses provide the raw data for the process of drilling down into the underlying causal pathways Many contributing latent conditions recur in a variety of domains A number of these organizational issues design procedures and so on are

examined in close detail in order to identify likely problems before they combine to penetrate the defences in depth Where the 1997 book focused largely upon the systemic factors underlying organizational accidents this complementary follow up goes beyond this to examine what can be done to improve the error wisdom and risk awareness of those on the spot they are often the last line of defence and so have the power to halt the accident trajectory before it can cause damage The book concludes by advocating that system safety should require the integration of systemic factors collective mindfulness with individual mental skills personal mindfulness

Managing Risk Romney Beecher Duffey, John Walton Saull, 2008-09-15 The human element is the principle cause of incidents and accidents in all technology industries hence it is evident that an understanding of the interaction between humans and technology is crucial to the effective management of risk Despite this no tested model that explicitly and quantitatively includes the human element in risk prediction is currently available

Managing Risk the Human Element combines descriptive and explanatory text with theoretical and mathematical analysis offering important new concepts that can be used to improve the management of risk trend analysis and prediction and hence affect the accident rate in technological industries It uses examples of major accidents to identify common causal factors or echoes and argues that the use of specific experience parameters for each particular industry is vital to achieving a minimum error rate as defined by mathematical prediction New ideas for the perception calculation and prediction of risk are introduced and safety management is covered in depth including for rare events and unknown outcomes Discusses applications to multiple industries including nuclear aviation medical shipping chemical industrial railway offshore oil and gas Shows consistency between learning for large systems and technologies with the psychological models of learning from error correction at the personal level Offers the expertise of key leading industry figures involved in safety work in the civil aviation and nuclear engineering industries Incorporates numerous fascinating case studies of key technological accidents

Managing Risk the Human Element is an essential read for professional safety experts human reliability experts and engineers in all technological industries as well as risk analysts corporate managers and statistical analysts It is also of interest to professors researchers and postgraduate students of reliability and safety engineering and to experts in human performance congratulations on what appears to be at a high level of review a significant contribution to the literature I have found much to be admired in your research

Mr Joseph Fragola Vice President of Valador Inc The book is not only technically informative but also attractive to all concerned readers and easy to be comprehended at various level of educational background It is truly an excellent book ever written for the safety risk managers and analysis professionals in the engineering community especially in the high reliability organizations

Dr Feng Hsu Head of Risk Assessment and Management NASA Goddard Space Flight Center I admire your courage in confronting your theoretical ideas with such diverse ecologically valid data and your success in capturing a major trend in them I should add that I find all this quite inspiring The idea that you need to find the right measure of accumulated experience and not just routinely used calendar

time makes so much sense that it comes as a shock to realize that this is a new idea Professor Stellan Ohlsson Professor of Psychology University of Illinois at Chicago

Guidelines for Managing Process Safety Risks During Organizational Change CCPS (Center for Chemical Process Safety),2013-12-13 An understanding of organizational change management OCM an often overlooked subject is essential for successful corporate decision making with little adverse effect on the health and safety of employees or the surrounding community Addressing the myriad of issues involved this book helps companies bring their OCM systems to the same degree of maturity as other process safety management systems Topics include corporate standard for organizational change management modification of working conditions personnel turnover task allocation changes organizational hierarchy changes and organizational policy changes Organizational Accidents Revisited James Reason,2016-05-26 Managing the Risks of Organizational Accidents introduced the notion of an organizational accident These are rare but often calamitous events that occur in complex technological systems operating in hazardous circumstances They stand in sharp contrast to individual accidents whose damaging consequences are limited to relatively few people or assets Although they share some common causal factors they mostly have quite different causal pathways The frequency of individual accidents usually lost time injuries does not predict the likelihood of an organizational accident The book also elaborated upon the widely cited Swiss Cheese Model Organizational Accidents Revisited extends and develops these ideas using a standardized causal analysis of some 10 organizational accidents that have occurred in a variety of domains in the nearly 20 years that have passed since the original was published These analyses provide the raw data for the process of drilling down into the underlying causal pathways Many contributing latent conditions recur in a variety of domains A number of these organizational issues design procedures and so on are examined in close detail in order to identify likely problems before they combine to penetrate the defences in depth Where the 1997 book focused largely upon the systemic factors underlying organizational accidents this complementary follow up goes beyond this to examine what can be done to improve the error wisdom and risk awareness of those on the spot they are often the last line of defence and so have the power to halt the accident trajectory before it can cause damage The book concludes by advocating that system safety should require the integration of systemic factors collective mindfulness with individual mental skills personal mindfulness

Leadership and Management in Police Organizations Matthew J. Giblin,2016-09-16 Addresses the different management styles that are applicable to large as well as small police agencies Dr Michael Wigginton Jr University of Mississippi Built on a foundation of nearly 1 200 references Leadership and Management in Police Organizations is a highly readable text that shows how organizational theory and behavior can be applied to improve the operations leadership and management of law enforcement Author Matthew J Giblin emphasizes leadership and management as separate skills in successful police supervisors and executives illustrating to students how the two skills combine to improve individual and organizational efficacy in policing Readers will come away with a stronger understanding of why organizational decisions

matter and the impact research can have on police departments

Organizational Accidents Revisited Professor James Reason, 2016-01-28 Managing the Risks of Organizational Accidents introduced the notion of an organizational accident. These are rare but often calamitous events that occur in complex technological systems operating in hazardous circumstances. They stand in sharp contrast to individual accidents whose damaging consequences are limited to relatively few people or assets. Although they share some common causal factors they mostly have quite different causal pathways. The frequency of individual accidents usually lost time injuries does not predict the likelihood of an organizational accident. The book also elaborated upon the widely cited Swiss Cheese Model. Organizational Accidents Revisited extends and develops these ideas using a standardised causal analysis of some 10 organizational accidents that have occurred in a variety of domains in the nearly 20 years that have passed since the original was published. These analyses provide the raw data for the process of drilling down into the underlying causal pathways. Many contributing latent conditions recur in a variety of domains. A number of these organizational issues design procedures and so on are examined in close detail in order to identify likely problems before they combine to penetrate the defences in depth. Where the 1997 book focused largely upon the systemic factors underlying organisational accidents this complementary follow up goes beyond this to examine what can be done to improve the error wisdom and risk awareness of those on the spot they are often the last line of defence and so have the power to halt the accident trajectory before it can cause damage. The book concludes by advocating that system safety should require the integration of systemic factors collective mindfulness with individual mental skills personal mindfulness.

Managing Risk and Complexity through Open Communication and Teamwork Phillip K. Tompkins, 2015-06-15 Along with increased complexities in work and life in general in the twenty first century come new and dangerous risks to workers customers and the general public. Drawing on decades of experience as a researcher and consultant for a range of organizations and individuals in high risk domains the author of this book presents a powerful theory of open communication and teamwork. This unites a range of communication practices and principles that have proven to combat risk and complexity in organizations. The book initially focuses on NASA an organization that experiences and engages with high complexity and risk daily. As a participant observer in the Apollo program the author witnessed pioneering communication practices that for example empowered engineers with automatic responsibility for any technical problem they perceived. It was partly the failure to follow such protocols that resulted in the catastrophes experienced in the Challenger and Columbia tragedies as the author shows. Using the lessons learned from the space program the book then explores complexity and risk in medicine aviation the fighting of forest fires and homelessness again consistently finding communication practices that worked and did not work. Based on detailed research conducted over several decades the book presents a unified theory linked to generally applicable communication practices. Case studies include the results of an international experiment of surgery conducted in ten countries that produced a highly significant reduction of deaths and

infections in Africa India and other parts of the world to the creation of innovative communication practices that significantly reduced risks in the US aviation industry Harnessing the Power of Failure John Steven Newman, Stephen M.

Wander, 2018-09-13 In this book the authors employ the SFCS approach to explore a vast array of failure events in multiple sectors of transportation industry aerospace construction and critical infrastructure Controlling Risk in a Dangerous

World Jim Wetherbee, 2016-07-12 A five time Space Shuttle commander reveals what astronauts know about improving performance and productivity under pressure Jim Wetherbee the only five time Space Shuttle commander presents thirty techniques that astronauts use not only to stay alive in the unforgiving and deadly environment of space but also to conduct high quality operations and accomplish complex missions These same techniques based on the foundational principles of operating excellence can help anyone be successful in high hazard endeavors ordinary business and everyday life Controlling Risk in a Dangerous World shows you how to embrace these techniques as a way of operating and living your life so you can predict and prevent your next accident while improving performance and productivity to take your company higher **The**

Leader's Guide to Managing Risk K. Scott Griffith, 2023-11-07 Be prepared for the dangerous and largely unknown risks that threaten your business and learn how to survive and thrive when uncertainty hits Leaders today must navigate their teams and organizations through unprecedented levels of uncertainty It feels like every year there is some game changing technology or catastrophe that gives rise to a new normal and sends businesses scrambling for how to rethink themselves to operate under these new conditions In The Leader's Guide to Managing Risk K Scott Griffith a former airline pilot socio technical physicist and author of the first independently audited high reliability and just culture model offers practical and proven methods to build processes that will withstand the winds of uncertainty while driving success By understanding that organizations are people operating within systems leaders of all kinds will build reliability and resiliency into their culture and set up their business to withstand the next big changes that come their way Learn a new way of seeing understanding and managing risk Understand how people and systems interact in organizations and how to build processes that increase resilience and performance Collaborate with all stakeholders including employees to help you foresee dangers and achieve sustainable reliability Implement proven methods from Scott's award winning model that is being used in some of the most prestigious healthcare EMS and transportation companies in the world Achieve independent validation of success through certification Risk Management in the Marine Transportation System National Research Council (U.S.). Transportation

Research Board, 2000 The goal of the symposium was to promote interactive discussion between risk assessment experts and port safety managers and to link expertise in the theories and methodologies of risk assessment and the use of data to real world applications for risk assessment in the interest of improving the safety and efficiency of the nation's marine transportation system The Proceedings contain the coauthors overview of the discussions and presentations all the formal papers and presentations and the discussion group summaries and excerpts from the question and answer sessions after the

presentations by discussion group leaders The symposium program list of attendees and biographies of the cochair presenters and discussion group leaders are provided in the Appendixes

Liability of Corporate Groups and Networks Christian A. Witting, 2018-01-11 What happens when a corporate subsidiary or network company is unable to pay personal injury victims in full This book sets out to tackle the insolvent entity problem especially as it arises in cases of mass wrongdoing such as those involving asbestos exposure and defective pharmaceuticals After discussing the nature of corporate groups and networks from the perspectives of business history organisation studies and social theory the book assesses a range of rules and proposed rules for extending liability for personal injuries beyond insolvent entities New proposals are put for an exception to the rule of limited liability and for the development of a flexible new tort based on conspiracy that encompasses not only control based relationships but also horizontal coordination between companies The book concludes with a general discussion of lessons learned from debates about extended liability and provides guidelines for the development of new liability rules

Patient Safety and Managing Risk in Nursing Melanie Fisher, Margaret Scott, 2013-11-14 Patient safety is a predominant feature of quality healthcare and something that every patient has the right to expect As a nurse you must consider the safety of the patient as paramount in every aspect of your role and it is now an increasingly important topic in pre registration nursing programmes This book aims to provide you with a greater understanding of how to manage patient safety and risk in your practice The book focuses on the essentials that you need to know and therefore provides a clear pathway through what can sometimes seem an overwhelmingly complex mass of rules procedures and possible options Key features A practical introduction to patient safety and risk management written specifically for nurses and nursing students Case studies and scenarios help you to apply patient safety and risk management principles to actual practice Each chapter is mapped to the relevant NMC standards and Essential Skills Clusters so that you can see how you are meeting the professional requirements Activities throughout help you to think critically and reflect on practice

Risk Assessment Marvin Rausand, Stein Haugen, 2020-03-31 Introduces risk assessment with key theories proven methods and state of the art applications Risk Assessment Theory Methods and Applications remains one of the few textbooks to address current risk analysis and risk assessment with an emphasis on the possibility of sudden major accidents across various areas of practice from machinery and manufacturing processes to nuclear power plants and transportation systems Updated to align with ISO 31000 and other amended standards this all new 2nd Edition discusses the main ideas and techniques for assessing risk today The book begins with an introduction of risk analysis assessment and management and includes a new section on the history of risk analysis It covers hazards and threats how to measure and evaluate risk and risk management It also adds new sections on risk governance and risk informed decision making combining accident theories and criteria for evaluating data sources and subjective probabilities The risk assessment process is covered as are how to establish context planning and preparing and identification analysis and evaluation of risk Risk Assessment also offers new

coverage of safe job analysis and semi quantitative methods and it discusses barrier management and HRA methods for offshore application Finally it looks at dynamic risk analysis security and life cycle use of risk Serves as a practical and modern guide to the current applications of risk analysis and assessment supports key standards and supplements legislation related to risk analysis Updated and revised to align with ISO 31000 Risk Management and other new standards and includes new chapters on security dynamic risk analysis as well as life cycle use of risk analysis Provides in depth coverage on hazard identification methodologically outlining the steps for use of checklists conducting preliminary hazard analysis and job safety analysis Presents new coverage on the history of risk analysis criteria for evaluating data sources risk informed decision making subjective probabilities semi quantitative methods and barrier management Contains more applications and examples new and revised problems throughout and detailed appendices that outline key terms and acronyms Supplemented with a book companion website containing Solutions to problems presentation material and an Instructor Manual Risk Assessment Theory Methods and Applications Second Edition is ideal for courses on risk analysis risk assessment and systems engineering at the upper undergraduate and graduate levels It is also an excellent reference and resource for engineers researchers consultants and practitioners who carry out risk assessment techniques in their everyday work

Riskwork Michael Power, 2016-09-09 This collection of essays deals with the situated management of risk in a wide variety of organizational settings aviation mental health railway project management energy toy manufacture financial services chemicals regulation and NGOs Each chapter connects the analysis of risk studies with critical themes in organization studies more generally based on access to and observations of actors in the field The emphasis in these contributions is upon the variety of ways in which organizational actors in combination with a range of material technologies and artefacts such as safety reporting systems risk maps and key risk indicators accomplish and make sense of the normal work of managing risk riskwork In contrast to a preoccupation with disasters and accidents after the event the volume as whole is focused on the situationally specific character of routine risk management work It emerges that this riskwork is highly varied entangled with material artefacts which represent and construct risks and importantly is not confined to formal risk management departments or personnel Each chapter suggests that the distributed nature of this riskwork lives uneasily with formalized risk management protocols and accountability requirements In addition riskwork as an organizational process makes contested issues of identity and values readily visible These back stage back office encounters with risk are revealed as being as much emotional as they are rationally calculative Overall the collection combines constructivist sensibilities about risk objects with a micro sociological orientation to the study of organizations

Implementing Safety Management Systems in Aviation Alan J. Stolzer, Carl Halford, John J. Goglia, 2016-05-13 The International Civil Aviation Organization has mandated that all of its member states implement Safety Management Systems SMS in their aviation industries Responding to that call many countries are now in various stages of SMS development implementation and

rulemaking In their first book *Safety Management Systems in Aviation* Stolzer Halford and Goglia provided a strong theoretical framework for SMS along with a brief discourse on SMS implementation This follow up book provides a very brief overview of SMS and offers significant guidance and best practices on implementing SMS programs Very specific guidance is provided by industry experts from government industry academia and consulting who share their invaluable insights from first hand experience of all aspects of effective SMS programs The contributing authors come from all facets of aviation including regulation and oversight airline general aviation military airport maintenance and industrial safety Chapters address important topics such as how to develop a system description and perform task analyses perspectives on data sharing strategies for gaining management support establishing a safety culture approaches to auditing integrating emergency planning and SMS and more Also included is a fictional narrative story that can be used as a case study on SMS implementation *Implementing Safety Management Systems in Aviation* is written for safety professionals and students alike

Merry and McCall Smith's Errors, Medicine and the Law Alan Merry, Warren Brookbanks, 2017-04-03 There is an understandable tendency or desire to attribute blame when patients are harmed by their own healthcare However many cases of iatrogenic harm involve little or no moral culpability Even when blame is justified an undue focus on one individual often deflects attention from other important factors within the inherent complexity of modern healthcare This revised second edition advocates a rethinking of accountability in healthcare based on science the principles of a just culture and novel therapeutic legal processes Updated to include many recent relevant events including the Keystone Project in the USA and the Mid Staffordshire scandal in the UK this book considers how the concepts of a just culture have been successfully implemented so far and makes recommendations for best practice This book will be of interest to anyone concerned with patient safety medical law and the regulation of healthcare

Accident Precursor Analysis and Management National Academy of Engineering, 2004-09-16 In the aftermath of catastrophes it is common to find prior indicators missed signals and dismissed alerts that had they been recognized and appropriately managed before the event could have resulted in the undesired event being averted These indicators are typically called precursors *Accident Precursor Analysis and Management Reducing Technological Risk Through Diligence* documents various industrial and academic approaches to detecting analyzing and benefiting from accident precursors and examines public sector and private sector roles in the collection and use of precursor information The book includes the analysis findings and recommendations of the authoring NAE committee as well as eleven individually authored background papers on the opportunity of precursor analysis and management risk assessment risk management and linking risk assessment and management

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