Managing The Risks Of Organizational Accidents

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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.

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.

New Employee Safety - Christopher D. B. Burt 2016-10-09

This reference introduces an innovative new-employee safety risk model, keyed to a typical new worker becoming acclimated to a new job and workplace. It reviews risk factors, their root causes, and how they can be addressed and minimized through targeted strategies at each stage of a worker's early months on the job. The model and its supporting findings dovetail with current thinking on employee safety and organizational accountability. And, of extra benefit to employers, the risk management strategies to improve new employee safety can be undertaken with minimal expenditure of time, money, and disruption. The book's real-world framework: · Analyzes high accident rates among new hires. · Describes four basic types of job applicants and safety concerns common to each. · Examines the role of recruitment and selection processes in promoting employee safety. · Discusses safety benefits and risks surrounding pre-start training. · Models the use of new employees' job familiarization to minimize safety risks. · Identifies safety risks associated with helping behaviors. · Identifies employee measures that can be used in assessing job safety risk. · Integrates safety management strategies

with other human resource management activities New Employee Safety provides clear practical guidance to individuals involved in occupational safety management. The book makes a useful text for undergraduate and postgraduate courses on occupational safety management, and in fields such as behavioral science, psychology, business management, and human resources.

A Life in Error - Professor James Reason 2013-11-01

This succinct but absorbing book covers the main way stations on James Reason's 40-year journey in pursuit of the nature and varieties of human error. He presents an engrossing and very personal perspective, offering the reader exceptional insights, wisdom and wit as only James Reason can. A Life in Error charts the development of his seminal and hugely influential work from its original focus on individual cognitive psychology through the broadening of scope to embrace social, organizational and systemic issues.

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.

Human and Organisational Factors - Benoît Journé 2020-01-02

This open access book addresses several questions regarding the implementation of human and organisational factors (HOF) so that recent improvements in industrial safety can be built upon. It addresses sources of frustration in senior management with high expectations of operational recommendations and disquiet on the part of HOF specialists struggling to have an impact on high-level decision making. The brief explores these issues with an emphasis on examples and lessons learned based on the experience of its authors, who come from different academic disciplines and various industrial sectors such as oil and gas, energy and transportation. It then offers some ways forward for a better consideration of HOF in hazardous companies with a view of promoting safety and facing challenges in a rapidly changing world.

Risk Management in Outdoor and Adventure Programs - Aram Attarian 2012-05-10

Based on real-life experiences, Risk Management in Outdoor and Adventure Programs: Scenarios of Accidents, Incidents, and Misadventures offers both students and professionals practice in applying risk management strategies to situations encountered in outdoor and adventure programs. Written by Aram Attarian, an experienced professor and professional in outdoor and adventure recreation, Risk Management in Outdoor and Adventure Programs presents a systematic model for determining why an incident happened and what could be done to prevent a repeat occurrence. More than 50 real-life scenarios represent various situations encountered in outdoor and adventure programming, such as peanut allergies, bridge jumping, stalking by mountain lions, and lightning strikes. These scenarios offer guidance in analyzing hazardous situations and applying appropriate strategies in safety and risk management. Each scenario is followed by questions that can guide discussion or promote research in concepts or policies that are important to outdoor and adventure programming. Accidents and mishaps are a reality in outdoor and adventure programs. Applying risk management strategies to the scenarios in Risk Management in Outdoor and Adventure Programs gives outdoor adventure leaders increased knowledge of the inherent risks of their profession as well as their legal responsibilities in programming, leadership, and management. This text can help leaders and their participants

enjoy safe and successful adventures in the great outdoors.

Industrial Safety Management - J Maiti 2017-10-30

This edited volume focuses on research conducted in the areas of industrial safety. Chapters are extensions of works presented at the International Conference on Management of Ergonomic Design, Industrial Safety and Healthcare Systems. The book addresses issues such as occupational safety, safety by design, safety analytics and safety management. It is a useful resource for students, researchers, industrial professionals and engineers.

Managing the Risk of Workplace Stress - Sharon Clarke 2004-07-31

Working in a stressful environment not only increases the risk of physical illness or distress, but also increases the likelihood of workplace accidents. While legislation provides some guidelines for risk assessment of physical hazards, there remains limited guidance on the risks of psychosocial hazards, such as occupational stress. This book takes the risk management approach to stress evaluation in the workplace, offering practical guidelines for the audit, assessment and mitigation of workplace stressors. Based on research and case studies, this book provides a comprehensive source of theoretical and practical information for students and practitioners alike. It includes chapters on: * environmental stress factors * psychological stress factors * work-related accidents * job stress evaluation methods With its up-to-

date approach to a fascinating area of study, this is key reading for all students of organizational psychology and those responsible for workplace safety.

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).

The Coupling of Safety and Security - Corinne Bieder 2020-08-21

This open access book explores the synergies and tensions between safety and security management from a variety of perspectives and by combining input from numerous disciplines. It defines the concepts of safety and security, and discusses the methodological, organizational and institutional implications that accompany approaching them as separate entities and combining them, respectively. The book explores the coupling of safety and security from different perspectives, especially: the concepts and methods of risk, safety and security; the managerial aspects; user experiences in connection with safety and security. Given its scope, the book will be of interest to researchers and practitioners in the fields of safety and security, and to anyone

working at a business or in an industry concerned with how safety and security should be managed.

Human Error - James Reason 1990-10-26

This 1991 book is a major theoretical integration of several previously isolated literatures looking at human error in major accidents.

Safety at the Sharp End - Rhona Flin 2017-05-15

Many 21st century operations are characterised by teams of workers dealing with significant risks and complex technology, in competitive, commercially-driven environments. Informed managers in such sectors have realised the necessity of understanding the human dimension to their operations if they hope to improve production and safety performance. While organisational safety culture is a key determinant of workplace safety, it is also essential to focus on the non-technical skills of the system operators based at the 'sharp end' of the organisation. These skills are the cognitive and social skills required for efficient and safe operations, often termed Crew Resource Management (CRM) skills. In industries such as civil aviation, it has long been appreciated that the majority of accidents could have been prevented if better non-technical skills had been demonstrated by personnel operating and maintaining the system. As a result, the aviation industry has pioneered the development of CRM training. Many other organisations are now introducing non-technical skills training, most notably

within the healthcare sector. Safety at the Sharp End is a general guide to the theory and practice of non-technical skills for safety. It covers the identification, training and evaluation of non-technical skills and has been written for use by individuals who are studying or training these skills on CRM and other safety or human factors courses. The material is also suitable for undergraduate and post-experience students studying human factors or industrial safety programmes.

Safer Healthcare - Charles Vincent 2016-01-13

The authors of this book set out a system of safety strategies and interventions for managing patient safety on a day-to-day basis and improving safety over the long term. These strategies are applicable at all levels of the healthcare system from the frontline to the regulation and governance of the system. There have been many advances in patient safety, but we now need a new and broader vision that encompasses care throughout the patient's journey. The authors argue that we need to see safety through the patient's eyes, to consider how safety is managed in different contexts and to develop a wider strategic and practical vision in which patient safety is recast as the management of risk over time. Most safety improvement strategies aim to improve reliability and move closer toward optimal care. However, healthcare will always be under pressure and we also require ways of managing safety when conditions are

difficult. We need to make more use of strategies concerned with detecting, controlling, managing and responding to risk. Strategies for managing safety in highly standardised and controlled environments are necessarily different from those in which clinicians constantly have to adapt and respond to changing circumstances. This work is supported by the Health Foundation. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. The charity's aim is a healthier population in the UK, supported by high quality health care that can be equitably accessed. The Foundation carries out policy analysis and makes grants to front-line teams to try ideas in practice and supports research into what works to make people's lives healthier and improve the health care system, with a particular emphasis on how to make successful change happen. A key part of the work is to make links between the knowledge of those working to deliver health and health care with research evidence and analysis. The aspiration is to create a virtuous circle, using what works on the ground to inform effective policymaking and vice versa. Good health and health care are vital for a flourishing society. Through sharing what is known, collaboration and building people's skills and knowledge, the Foundation aims to make a difference and contribute to a healthier population.

Normal Accidents -

Charles Perrow 2011-10-12
Normal Accidents analyzes the social side of technological risk. Charles Perrow argues that the conventional engineering approach to ensuring safety--building in more warnings and safeguards--fails because systems complexity makes failures inevitable. He asserts that typical precautions, by adding to complexity, may help create new categories of accidents. (At Chernobyl, tests of a new safety system helped produce the meltdown and subsequent fire.) By recognizing two dimensions of risk--complex versus linear interactions, and tight versus loose coupling--this book provides a powerful framework for analyzing risks and the organizations that insist we run them. The first edition fulfilled one reviewer's prediction that it "may mark the beginning of accident research." In the new afterword to this edition Perrow reviews the extensive work on the major accidents of the last fifteen years, including Bhopal, Chernobyl, and the Challenger disaster. The new postscript probes what the author considers to be the "quintessential 'Normal Accident'" of our time: the Y2K computer problem.

Critical Thinking in Clinical Practice - Eileen Gambrill 2006-03-06
Decisions are influenced by a variety of fallacies and biases that we can learn how to avoid. Critical thinking values, knowledge, and skills, therefore, are integral to evidence-based practice. These emphasize the importance of recognizing ignorance

as well as knowledge and the vital role of criticism in discovering how to make better decisions. This book is for clinicians--clinicians who are willing to say "I don't know." Critical Thinking in Clinical Practice, Second Edition is designed to enhance readers' skills in making well-informed, ethical decisions. Making such decisions is no easy task. Decisions are made in uncertain, changing environments with time pressures. Interested parties, such as the pharmaceutical industry, spend millions of dollars to influence decisions made. Drawing on a wide range of related literature, this book describes common pitfalls in clinical reasoning as well as strategies for avoiding them--sometimes called mind-tools. Mental health and allied professionals will come away from this text with knowledge of how classification decisions, a focus on pathology, and reliance on popularity can cause errors. Hazards involved in data collection and team decision making such as groupthink are discussed. Part 1 provides an overview of the context in which clinicians make decisions. Part 2 describes common sources of error. Part 3 describes decision aids including the process of evidence-based practice. Part 4 describes the application of related content to different helping phases including assessment, intervention, and evaluation. Part 5 suggests obstacles to making well-informed decisions and how to encourage lifelong learning. This new Second Edition has been

completely updated with expanded coverage on: Evidence-based practice Screening issues and practice errors Lifelong learning Problem solving Decision making An interactive, dynamic book filled with insightful examples, useful lists and guidelines, and exercises geared to encourage critical thinking, Critical Thinking in Clinical Practice, Second Edition provides an essential resource for helping professionals and students.

Pre-Accident Investigations - Dr Todd Conklin 2012-10-28

This book is a set of new skills written for the managers that drive safety in their workplace. This is Human Performance theory made simple. If you are starting a new program, revamping an old program, or simply interested in understanding more about safety performance, this guide will be extremely helpful.

Risk Management Handbook - Federal Aviation Administration 2012-07-03

Every day in the United States, over two million men, women, and children step onto an aircraft and place their lives in the hands of strangers. As anyone who has ever flown knows, modern flight offers unparalleled advantages in travel and freedom, but it also comes with grave responsibility and risk. For the first time in its history, the Federal Aviation Administration has put together a set of easy-to-understand guidelines and principles that will help pilots of any skill level minimize risk and maximize safety while in the air. The Risk Management Handbook

offers full-color diagrams and illustrations to help students and pilots visualize the science of flight, while providing straightforward information on decision-making and the risk-management process.

Prevention of Accidents and Unwanted Occurrences - Urban Kjellen 2017-03-07

This new edition comes after about 15 years of development in the field of safety science and practice. The book addresses the question of how to improve risk assessments, investigations, and organizational learning inside companies in order to prevent unwanted occurrences. The book helps the reader in analyzing the subject from different scientific perspectives to demonstrate how they contribute to an overall understanding. It also gives a comprehensive overview of different methods and tools for use in safety practice and helps the reader in analyzing their scope, merits, and shortcomings. The book raises a number of critical issues to be addressed in the improvement process.

Close Calls - C. Macrae 2014-03-05

Drawing on extensive and detailed fieldwork within airlines-an industry that pioneered near-miss analysis- this book develops a clear set of practical implications and theoretical propositions regarding how all organizations can learn from 'near-miss' events and better manage risk and resilience.

Bow Ties in Risk Management - CCPS (Center for Chemical Process Safety) 2018-08-31

AN AUTHORITATIVE GUIDE

THAT EXPLAINS THE EFFECTIVENESS AND IMPLEMENTATION OF BOW TIE ANALYSIS, A QUALITATIVE RISK ASSESSMENT AND BARRIER MANAGEMENT METHODOLOGY From a collaborative effort of the Center for Chemical Process Safety (CCPS) and the Energy Institute (EI) comes an invaluable book that puts the focus on a specific qualitative risk management methodology – bow tie barrier analysis. The book contains practical advice for conducting an effective bow tie analysis and offers guidance for creating bow tie diagrams for process safety and risk management. Bow Ties in Risk Management clearly shows how bow tie analysis and diagrams fit into an overall process safety and risk management framework. Implementing the methods outlined in this book will improve the quality of bow tie analysis and bow tie diagrams across an organization and the industry. This important guide: Explains the proven concept of bow tie barrier analysis for the preventing and mitigation of incident pathways, especially related to major accidents Shows how to avoid common pitfalls and is filled with real-world examples Explains the practical application of the bow tie method throughout an organization Reveals how to treat human and organizational factors in a sound and practical manner Includes additional material available online Although this book is written primarily for anyone involved with or responsible for managing process safety risks, this book is applicable to anyone using bow tie risk management

practices in other safety and environmental or Enterprise Risk Management applications. It is designed for a wide audience, from beginners with little to no background in barrier management, to experienced professionals who may already be familiar with bow ties, their elements, the methodology, and their relation to risk management. The missions of both the CCPS and EI include developing and disseminating knowledge, skills, and good practices to protect people, property and the environment by bringing the best knowledge and practices to industry, academia, governments and the public around the world through collective wisdom, tools, training and expertise. The CCPS has been at the forefront of documenting and sharing important process safety risk assessment methodologies for more than 30 years. The EI's Technical Work Program addresses the depth and breadth of the energy sector, from fuels and fuels distribution to health and safety, sustainability and the environment. The EI program provides cost-effective, value-adding knowledge on key current and future international issues affecting those in the energy sector.

A Life in Error - James Reason 2017-03-02

This succinct but absorbing book covers the main way stations on James Reason’s 40-year journey in pursuit of the nature and varieties of human error. In it he presents an engrossing and very personal perspective, offering the reader exceptional insights, wisdom and wit as only James Reason can. The journey begins

with a bizarre absent-minded action slip committed by Professor Reason in the early 1970s - putting cat food into the teapot - and continues up to the present day, conveying his unique perceptions into a variety of major accidents that have shaped his thinking about unsafe acts and latent conditions. A Life in Error charts the development of his seminal and hugely influential work from its original focus into individual cognitive psychology through the broadening of scope to embrace social, organizational and systemic issues. The voyage recounted is both hugely entertaining and educational, imparting a real sense of how James Reason’s ground-breaking theories changed the way we think about human error, and why he is held in such esteem around the world wherever humans interact with technological systems. This book is essential reading for students, academics and safety professionals of all kinds who are interested in avoiding breakdowns that can cause serious damage to people, assets and the environment.

Risk Management and Assessment - Jorge Rocha 2020-10-14

Risk analysis, risk evaluation and risk management are the three core areas in the process known as 'Risk Assessment'. Risk assessment corresponds to the joint effort of identifying and analysing potential future events, and evaluating the acceptability of risk based on the risk analysis, while considering influencing factors. In short, risk assessment analyses what

can go wrong, how likely it is to happen and, if it happens, what are the potential consequences. Since risk is a multi-disciplinary domain, this book gathers contributions covering a wide spectrum of topics with regard to their theoretical background and field of application. The work is organized in the three core areas of risk assessment.

An Engineer's View of Human Error - Trevor A. Kletz 2008

This title looks at how people, as opposed to technology and computers within plants, are arguably the most unreliable factor, leading to dangerous situations.

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.

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

The Illusion of Risk Control - Gilles Motet 2017-08-01

This book is open access under a CC BY 4.0 license. This book explores the implications of acknowledging uncertainty and black swans for regulation of high-hazard technologies, for stakeholder acceptability of potentially hazardous activities and for risk governance. The conventional approach to risk assessment, which combines the likelihood of an event and the severity of its consequences, is poorly suited to situations where uncertainty and ambiguity are prominent features of the risk landscape. The new definition of risk used by ISO, “the effect of uncertainty on [achievement of] one’s objectives”, recognizes this paradigm change. What lessons can we draw from the management of fire hazards in Edo-era Japan? Are there situations in which increasing uncertainty allows more effective safety management? How should society address the risk of potentially planet-destroying scientific experiments? This book presents insights from leading scholars in different disciplines to challenge current risk governance and safety management practice.

Just Culture - Sidney Dekker 2012

While many organizations see the value of creating a just culture they struggle when it comes to developing it. In this Second Edition, Dekker expands his views, additionally tackling the key issue of how justice is created inside organizations. Dekker also introduces new material on ethics and on caring for the'

second victim' (the professional at the centre of the incident). Consequently, we have a natural evolution of the author's ideas.

Managing the Risks of Organizational Accidents - J. T. Reason 1997

Proactive Risk Management in a Dynamic Society - Jens Rasmussen 2010-09

Managing Risk in Organizations - J. Davidson Frame 2003-08-05

Managing Risk in Organizations offers a proven framework forhandling risks across all types of organizations. In thiscomprehensive resource, David Frame—a leading expert in riskmanagement—examines the risks routinely encountered inbusiness, offers prescriptions to assess the effects of variousrisks, and shows how to develop effective strategies to cope withrisks. In addition, the book is filled with practical tools andtechniques used by professional risk practitioners that can bereadily applied by project managers, financial managers, and anymanager or consultant who deals with risk within an organization.Managing Risk in Organizations is filled with illustrativecase studies and Outlines the various types of risk—pure, operational,project, technical, business, and political Reveals what risk management can and cannot accomplish Shows how to organize risk management efforts to conduct riskassessments, manage crises, and recover from disasters Includes a systematic risk management processrisk managementplanning, risk

identification, qualitative impact analysis,quantitative impact analysis, risk response planning, andmonitoring control Provides quantitative and qualitative tools to identify andhandle risks This much-needed book will enable organizations to take riskseriously and act proactively.

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 componant, needs to be put back together in a mishap investigation.

Managing Maintenance Error - James Reason 2017-03-02 Situations and systems are easier to change than the human condition - particularly when people are well-trained and well-motivated, as they usually are in maintenance organisations. This is a down-to-earth practitioner’s guide to managing maintenance error, written in Dr. Reason’s highly readable

style. It deals with human risks generally and the special human performance problems arising in maintenance, as well as providing an engineer's guide for their understanding and the solution. After reviewing the types of error and violation and the conditions that provoke them, the author sets out the broader picture, illustrated by examples of three system failures. Central to the book is a comprehensive review of error management, followed by chapters on:- managing person, the task and the team; - the workplace and the organization; - creating a safe culture; It is then rounded off and brought together, in such a way as to be readily applicable for those who can make it work, to achieve a greater and more consistent level of safety in maintenance activities. The readership will include maintenance engineering staff and safety officers and all those in responsible roles in critical and systems-reliant environments, including transportation, nuclear and conventional power, extractive and other chemical processing and manufacturing industries and medicine.

The Human Contribution - James Reason 2017-03-02

This book explores the human contribution to the reliability and resilience of complex, well-defended systems. Usually the human is considered a hazard - a system component whose unsafe acts are implicated in the majority of catastrophic breakdowns. However there is another perspective that has been relatively little studied in its own right - the human as hero,

whose adaptations and compensations bring troubled systems back from the brink of disaster time and again. What, if anything, did these situations have in common? Can these human abilities be 'bottled' and passed on to others? The Human Contribution is vital reading for all professionals in high-consequence environments and for managers of any complex system. The book draws its illustrative material from a wide variety of hazardous domains, with the emphasis on healthcare reflecting the author's focus on patient safety over the last decade. All students of human factors - however seasoned - will also find it an invaluable and thought-provoking read.

Keeping Patients Safe - Institute of Medicine 2004-03-27

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nurses' working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and

delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

Safety Cultures, Safety Models - Claude Gilbert 2018-09-21

The objective of this book is to help at-risk organizations to decipher the “safety cloud”, and to position themselves in terms of operational decisions and improvement strategies in safety, considering the path already travelled, their context, objectives and constraints. What link can be established between safety culture and safety models in order to increase safety within companies carrying out dangerous activities? First, while the term “safety culture” is widely shared among the academic and industrial world, it leads to various interpretations and therefore different positioning when it comes to assess, improve or change it. Many safety theories, concepts, and models coexist today, being more or less appealing

and/or directly useful to the industry. How, and based on which criteria, to choose from the available options? These are some of the questions addressed in this book, which benefits from the expertise of its worldwide famous authors in several industrial sectors.

Safety and Reliability – Safe Societies in a Changing World - Stein Haugen 2018-06-15 Safety and Reliability – Safe Societies in a Changing World collects the papers presented at the 28th European Safety and Reliability Conference, ESREL 2018 in Trondheim, Norway, June 17-21, 2018. The contributions cover a wide range of methodologies and application areas for safety and reliability that contribute to safe societies in a changing world. These methodologies and applications include: - foundations of risk and reliability assessment and management - mathematical methods in reliability and safety - risk assessment - risk management - system reliability - uncertainty analysis - digitalization and big data - prognostics and system health management - occupational safety - accident and incident modeling - maintenance modeling and applications - simulation for safety and reliability analysis - dynamic risk and barrier management - organizational factors and safety culture - human factors and human reliability - resilience engineering - structural reliability - natural hazards - security - economic analysis in risk management Safety and Reliability – Safe Societies in a Changing

World will be invaluable to academics and professionals working in a wide range of industrial and governmental sectors: offshore oil and gas, nuclear engineering, aeronautics and aerospace, marine transport and engineering, railways, road transport, automotive engineering, civil engineering, critical infrastructures, electrical and electronic engineering, energy production and distribution, environmental engineering, information technology and telecommunications, insurance and finance, manufacturing, marine transport, mechanical engineering, security and protection, and policy making.

Natech Risk Assessment and Management - Elisabeth Krausmann 2016-11-01

Natech Risk Assessment and Management: Reducing the Risk of Natural-Hazard Impact on Hazardous Installations covers the entire spectrum of issues pertinent to Natech risk assessment and management. After a thorough introduction of the topic that includes definitions of terms, authors Krausmann, Cruz, and Salzano discuss various examples of international frameworks and provide a detailed view of the implementation of Natech Risk Management in the EU and OECD. There is a dedicated chapter on natural-hazard prediction and measurement from an engineering perspective, as well as a consideration of the impact of climate change on Natech risk. The authors also discuss selected Natech

accidents, including recent examples, and provide specific ‘lessons learned’ from each, as well as an analysis of all essential elements of Natech risk assessment, such as plant layout, substance hazards, and equipment vulnerability. The final section of the book is dedicated to the reduction of Natech risk, including structural and organizational prevention and mitigation measures, as well as early warning issues and emergency foreword planning. Teaches chemical engineers and safety managers how to safeguard chemical processing plants and pipelines against natural disasters Includes international regulations and explains how to conduct a natural hazards risk assessment, both of which are supported by examples and case studies Discusses a broad range of hazards and the multidisciplinary aspects of risk assessment in a detailed and accessible style

Risk Governance of Offshore Oil and Gas Operations - Preben Hempel Lindøe 2014

This book evaluates and compares risk regulation and safety management for offshore oil and gas operations in the United States, United Kingdom, Norway, and Australia. It provides an interdisciplinary approach with legal, technological, and sociological perspectives on their efforts to assess and prevent major accidents and improve safety performance offshore. Presented in three parts, the volume begins with a review of the technical, legal, behavioral, and

sociological factors involved in designing, implementing, and enforcing a regulatory regime for industrial safety. It then evaluates the four regulatory regimes that encompass the cultural, legal, and other contextual factors that influence their design and implementation, along with their reliance on industrial expertise and standards and the use of performance indicators. The final section presents an assessment of the resilience of the Norwegian regime and its capacity to keep pace with new technologies and emerging risks, respond to near miss incidents, encourage safety culture, incorporate vested rights of labor, and perform inspection and self-audit functions. This book is highly relevant for those in government, business, academia, and elsewhere in civil society who are involved in offshore safety issues, including regulatory authorities and industrial safety professionals.

The Human Contribution - J. T. Reason 2008

The Human Contribution is vital reading for all professionals in high-consequence environments and for managers of any complex system. The book draws its illustrative material from a wide variety of hazardous domains, with the emphasis on healthcare reflecting the author's focus on patient safety over the last decade. All students of human factors - however seasoned - will also find it an invaluable and thought-provoking read.