

BEHIND HUMAN ERROR

Suppression Material

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Behind Human Error



Human error is definitely cited again and again as a reason behind incidents and incidents. For example, we should reduce the human role with an increase of automation, or regiment individual behavior by stricter monitoring, rules or procedures. The result can be a widespread perception of a 'human error issue', and solutions are believed to lie in changing the people or their part in the machine. The label 'human error' is normally prejudicial and hides a lot more than it reveals about how something functions or malfunctions. However in practice, items have proved never to be this basic. Part 3 explains the part of cognitive system elements - bringing understanding to bear, changing mindset as situations and priorities transformation, and managing objective conflicts - in operating safely at the razor-sharp end of systems. Divided into five parts, it starts by summarising the most important research results. Part 2 explores how systems thinking has radically changed our understanding of how incidents occur. This book goes behind the human mistake label. The potential for constructive change, for improvement on safety, lies behind the human error label. And Component 5 tells how the hindsight bias often enters into attributions of mistake, in order that what we label human error actually is the consequence of a cultural and psychological judgment procedure by stakeholders in the machine in question to spotlight only a facet of a couple of interacting contributors. If you believe you have a human error problem, understand that the label itself can be no explanation no guidebook to countermeasures. Part 4 studies the way the clumsy use of pc technology can raise the potential for erroneous activities and assessments in many different areas of practice.



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Important reading for contemporary enterprise IT Written by several leading error researchers, this was in no way an "easy read" since it required significant attention to grasp the arguments and implications, but I came across it very rewarding and almost instantly relevant to my day-to-day function within an extremely large enterprise It all organization that is quickly shifting to the *-as-a-Seruice delivery model. Business policy required completion of the activity in a few days and formal, created notification of the event and related findings to all other manufacturing plant life in the company."I was fascinated by among the book's case research, that of a chemical substance fire that occurred during regimen machine maintenance in a high-tech product manufacturing plant in the US.#1: Goal Conflicts:"One common hazard in the evaluation of incidents is the naive assessment of the strategic issues that confront practitioners. That is a perfect book for a class on human performance assessments that stray in to the thicket of troubles that surround the word "error". "that could by no means happen here"). As investigators, we have to fully understand these goal conflicts in order to avoid hindsight bias and in order to improve the team's strategies for assessing and balancing risks.""The obstacles to learning from failing are nearly as complex and delicate as the circumstances that surround a failure itself. Oftentimes, the actions which led to failure were the same actions which previously led to to success. Operators are normally able to skillfully and successfully balance these conflicting goals and risks as part of their daily routine. Also, it is necessary to understand a team's strategies for balancing dangers must evolve as do changes in the working context, and in the related goals and risks. Placing this into practice, my team lately had a postmortem dialogue about an outage that included unplanned adjustments to a production program. During the discussion, it had been enlightening to go over our objective conflicts and our decision-making procedure around making unplanned changes. We determined that eliminating unplanned changes was not the right plan of action - actually unplanned changes are occasionally essential. The idea that error is a discrete, scientific category of human being performance is finally buried by this work. The book benefits from having multiple authors while still getting coherent and obvious.#2: Distancing through Differencing"Do not discard other events because they appear in the surface to be dissimilar. At some degree of analysis, all occasions are unique; while at other levels of analysis, they reveal common patterns. Failures occur when the dangers are unsuccessfully balanced, but that does not mean the operators weren't skillful. A key resource on this topic This is a fantastic book on why failures occur and general approaches which you can use to lessen incidence of failures. Below are 3 suggestions from the reserve that I found particularly useful and insightful. This company was one which took safety very seriously, with good working circumstances, significant investment safely, and strong inspiration to examine all mishaps promptly and completely. I highly recommend it. High-level administration directed instant investigations, including complete debriefings of individuals, reviews of corporate background for similar events, and a "root cause" analysis. The book runs on the number of exciting (and occasionally terrifying) real-world illustrations from aviation, medicine, nuclear power, space plan, and others to describe that the act of attributing failing to "human error" will not do anything to describe why the failure happened, nor does it generally result in any constructive responses or improvements. The cost of the incident might have been more than a million dollars.#3: Design-induced failures"Automation surprises begin with miscommunication and misassessments between your automation and users, which lead to a gap between the user's understanding of what the automated systems are setup to do, what they are doing, and what they will do. Although better human being performance researchers have known and accepted this for more than a decade, the message offers percolated the bigger research community slowly -- mostly for want of a single text that covers the history and experience that lead to this conclusion."The book contains several chapters devoted to the ways in which the design of computer systems used by operators may induce failures. Later on, the accident occurred once again in america plant, this time during a different shift, and this third event was rationalized as having been due to lower level of skill of the workers for the reason that shift. The authors

utilize the term "Distancing through Differencing" to label the tendency of organizations and people to length ourselves from failures (i.e. Operators must frequently assess and resolve these objective conflicts by making trade-off decisions which necessarily involue risk, and frequently these decisions frequently should be made under period pressure. My takeaway is definitely that there is a great chance over the many teams now providing cloud providers in enterprise IT businesses such as my own to share information regarding each other's failures, look for the general patterns, and avoid repeating those incidents which have occurred within other services."The business's investigation of this incident focused on the machine, the maintenance procedures, and the operators who performed the maintenance and recognized multiple deficiencies which were corrected quickly. Both practitioners and the inner investigators considered the last event to end up being irrelevant since it had occurred in a non-US plant with a different security system to consist of fires and included a different model of the machine. These chapters detail a number of different aspects of this problem which is uitally important to business IT as both a technology supplier and as a technology consumer. Among the countless points raised here was that automation frequently introduces brand-new burdens on a single operators that it's intended to assist. I have seen this principle in action when teams put into action automation to perform manual tasks but regrettably do therefore in a way that does not provide users/operators with enough feedback to understand the proceedings when it generally does not work. This is an example of automation is definitely written without regard for the users, and it can add significant complexity and brittleness to the system. Because accidents constantly involve multiple contributors, your choice to spotlight one or another of the set, and therefore exactly what will be learned, is largely socially determined."The maker had a thorough safety plan that required instant and high-level responses to an incident like this, even though no personal injury occurred and damage was limited to the machine involved. and acknowledging that our operating context can be subject to transformation, we set a checkpoint to re-assess this technique three months later. I trust this, though I'd also note that there are still cases of gross carelessness, incompetence, and corruption which need to be addressed accordingly. The overall idea is that, instead of looking for scapegoats and attributing 'human mistake' to them, it's more productive to check out the systemic factors that impact behavior of people and organizations, and make systemic changes accordingly. Five Stars Great publication and great insight into a fascinating area for medical and Safety professional Best book on individual error ever! This is by far the most intelligent and comprehensive explanation of "error" in print. The authors are mostly first class experts about them (Cook is usually a poseur and wannabe) and the materials is both coherent and full. Rather we refined our decision making process for unplanned adjustments to the production system; The fascinating part of the case study was a broader review by outside investigators discovered that a very similar chemical substance fire had occurred in one of the business's other manufacturing plants in another country earlier that same yr, and that this prior event was popular by practitioners at the united states plant. Still, many people will continue to misunderstand the type of "error" as the first overview of this reserve demonstrates."When investigating failing, it is essential to identify that system operators are often dealing with multiple, competing goals. Behind Human Error Good, but most material is available elsewhere in other regular texts (apart from a few interesting case research, eg the Apollo 13 EECOM's telemetry display).



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