# HFN 25 år

Prof. Sidney Dekker


The Field Guide to Understanding 'Human Error'
Sidney Dekker
Drift into Failure
From Hunting Broken Components to Understanding Complex Systems
Sidney Dekker
Sidney Dekker
THIRD EDITION
Just Culture
Restoring Trust and Accountability in Your Organization
SIDNEY DEKKER
Ten Questions About Human Error
A New View of Human Factors and System Safety
Sidney W. A. Dekke
SIDNEY DEKKER | TODD CONKLIN
DO SAFETY DIFFERENTLY
PATIENT SAFETY
A Human Factors Approach
THE SAFETY ANARCHIST
RELYING ON HUMAN EXPERTISE AND INNOVATION, REDUCING BUREAUCRACY AND COMPLIANCE
The End of Heaven
Disaster and suffering in a scientific age
FOUNDATIONS OF SAFETY SCIENCE
A Century of Understanding Accidents and Disasters
SIDNEY DEKKER
NOBODY GETS HURT TODAY!
DON'T TELL ME WHAT TO DO!
SIDNEY DEKKER
THE BUSINESS, MANAGEMENT AND SAFETY EFFECTS OF NEOLIBERALISM
Compliance Capitalism
How Free Markets Have Led to Unfree, Overregulated Workers
Safety Differently
Sidney Dekker
JUST CULTURE
Restorative Just Culture in Practice
Implementation and Practice
Edited by
Sidney Dekker • Joe Rafferty • Amanda Oates

The New York Times

# *Ex-Officer Who Held George Floyd's Legs Sentenced to 30 Months in Prison*

Thomas Lane, 39, helped to hold Mr. Floyd down while another officer fatally knelt on his neck. He was the only officer to suggest they should roll Mr. Floyd on his side so he could breathe.



# Old view

System is basically safe

'Human error' is major cause

Fix, fire, restrict human

People need to try harder, care more

# *HFN's contribution*

*Systems are not inherently safe: people need to create safety*

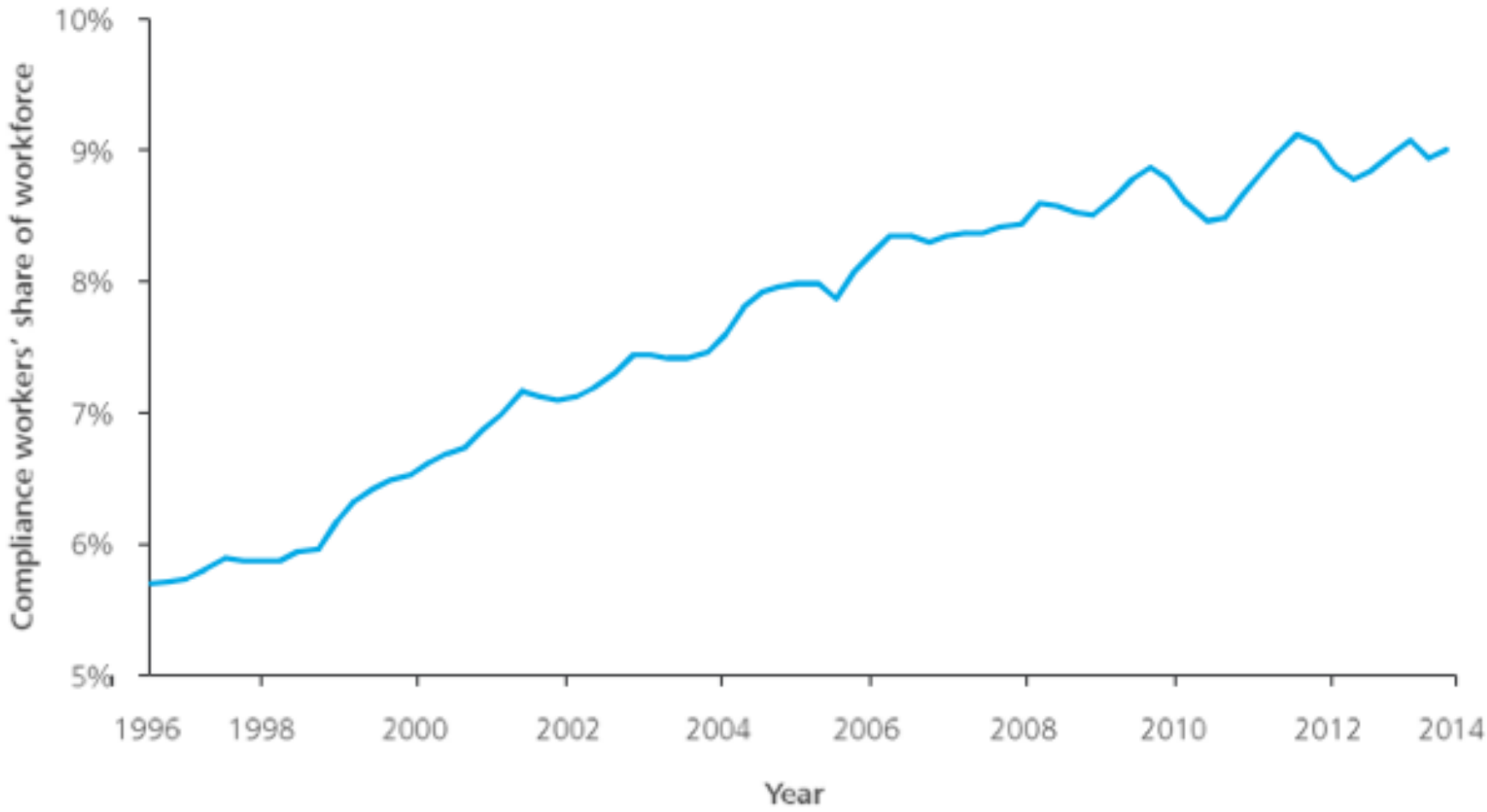
*'Human error' is consequence of trouble deeper inside system*

*Understand and leverage human capacities in complex systems*

# Challenges

1. *Safety clutter and bureaucracy, asymptote in progress*
2. *Lack of good safety measures*
3. *Blame and risk secrecy*

Chart 9: The rise and rise of Australia's compliance culture – and workers




Source: Australian Bureau of Statistics

# Safety level

$10^{-1}$

$10^{-3}$

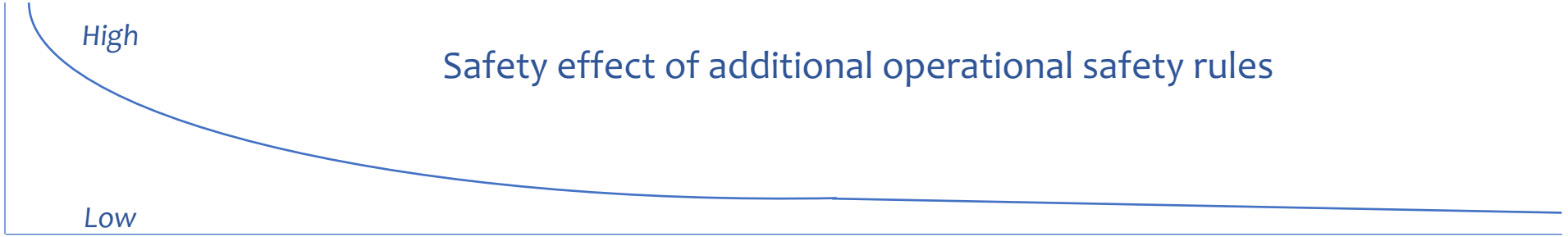

$10^{-5}$

$10^{-7}$

Amalberti, 2001

The paradoxes of almost totally safe transportation systems

R. Amalberti



# How many policies for a ward nurse to follow every day?



Professor Jeffrey Braithwaite, PhD
Centre for Clinical Governance Research
Australian Institute of Health Innovation

# How many policies for a ward nurse to follow every day?

## 600


How many policies for a ward nurse to follow every day?

600



Professor Jeffrey Braithwaite, PhD
Centre for Clinical Governance Research
Australian Institute of Health Innovation

And how many can the nurse recite back to you?

How many policies for a ward nurse to follow every day?

600


And how many can the nurse recite back to you?

Between 2 and 3

# How many years of reading all rules and guidelines for US anesthetist?


ANESTHESIOLOGY NEWS

SECTIONS ▾ EDUCATION ▾ BUYER'S GUIDE MULTIMEDIA MEETINGS CLASSIFIEDS SUBS

Commentary

MARCH 3, 2017

## Glut of Anesthesia Guidelines a Disservice, Except for Lawyers

By Robert E. Johnstone, MD

Anesthesia practice guidelines are out of control—too many to adopt, too anecdotal to accept and too political to take seriously! Every society seems to issue them now, in order to announce their existence, promote their brand or troll for members. I would ignore most of them, but unfortunately lawyers use society guidelines as standards of practice for malpractice suits, to evidence actionable breaches. I might try to follow them.

How many years of reading all rules and guidelines for US anesthetist?

2,000 years

ANESTHESIOLOGY NEWS

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# More safety bureaucracy

40% from government

60% self-inflicted

Deloitte.

Building the Lucky Country #4

Business imperatives for a prosperous Australia

Get out of your own way

Unleashing productivity

THE BUSINESS, MANAGEMENT AND SAFETY EFFECTS OF NEOLIBERALISM

# Compliance Capitalism

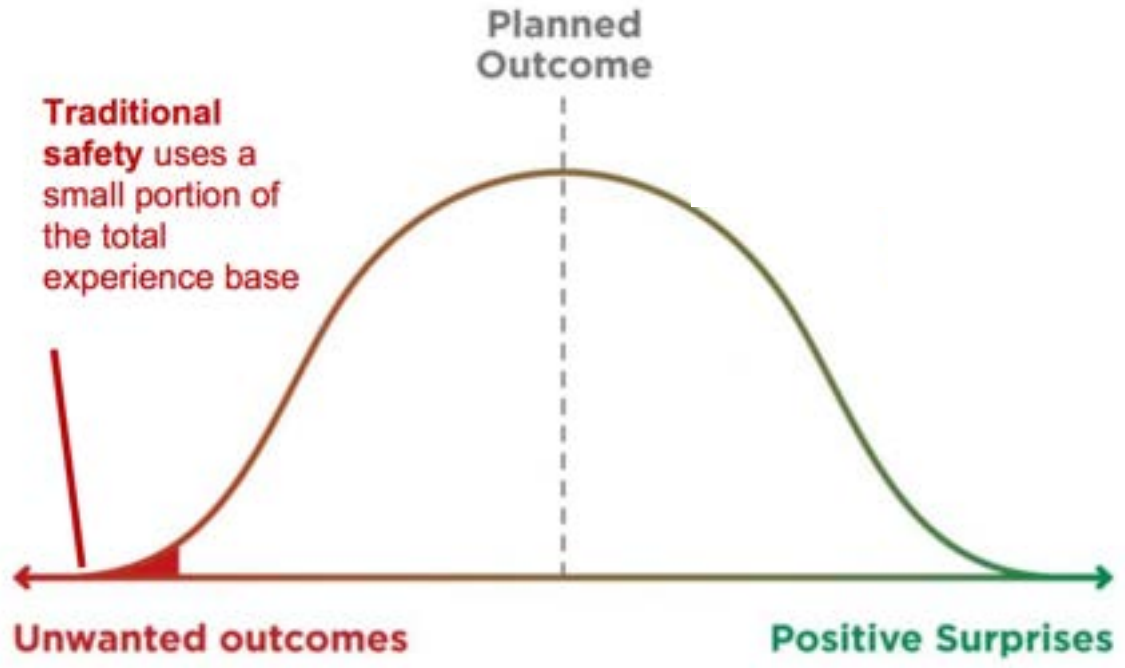
## How Free Markets Have Led to Unfree, Overregulated Workers

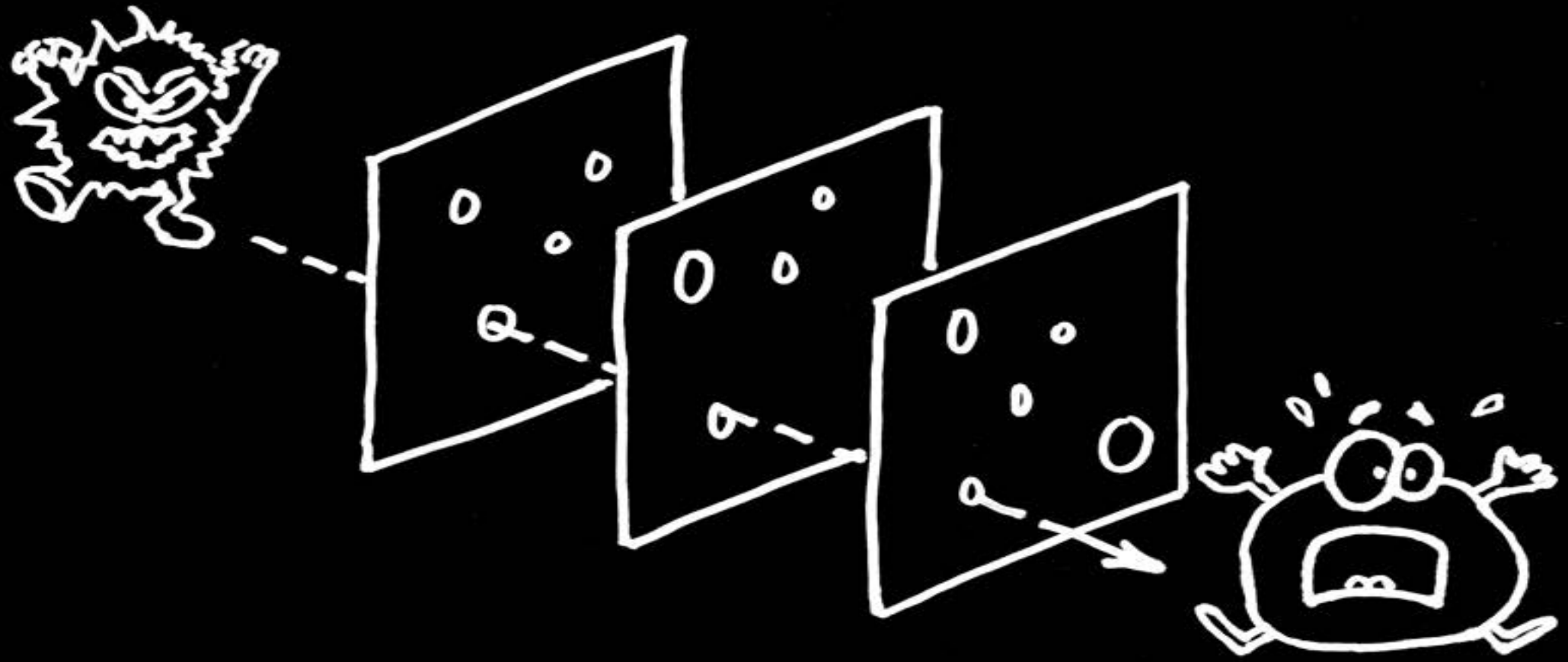

SIDNEY DEKKER

# Safety traditionally

## Absence of negative events

*Stopping things from going wrong*





The Telegraph



# Spanish prostitutes ordered to wear reflective vests for their own safety

Prostitutes working on the street outside a town northern Spain have been ordered to wear reflective vests to make them visible to passing traffic and reduce the risk of accidents.



Prostitutes wearing high visibility vests in Els Alamus Photo: REX

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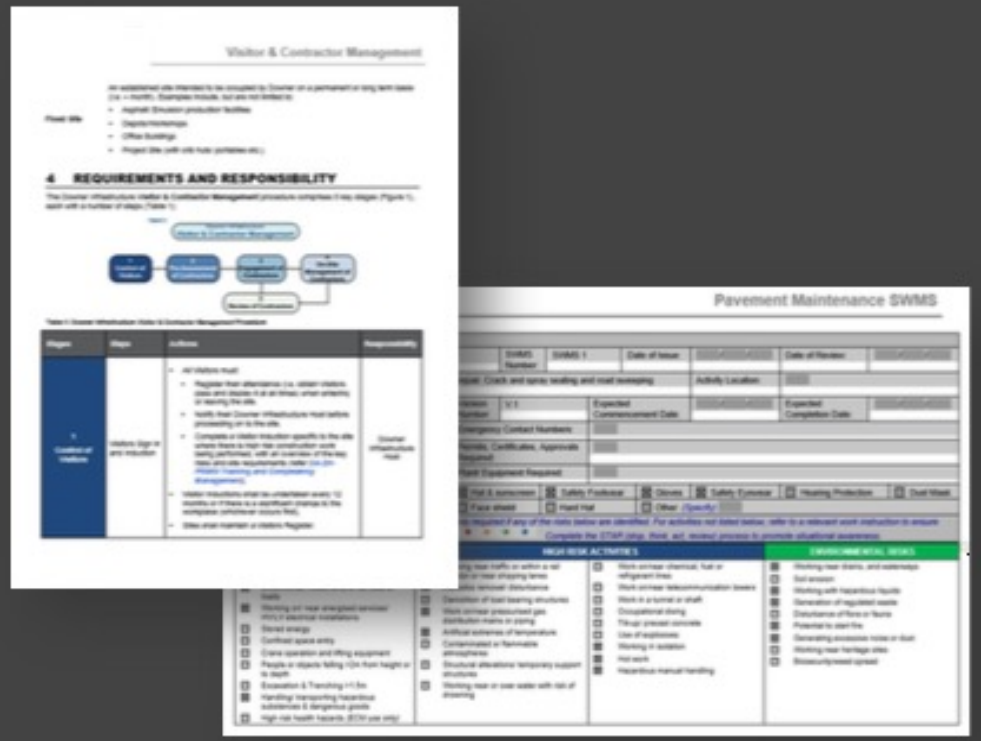
DRUG ROUND
IN
PROGRESS
DO NOT
DISTURB

# work as imagined




- what managers think should happen
- ordered - without surprise
- everything runs by the book

VS

# work as done

- what actually happens
- messy - lots of variation, adaptive
- driven by operational demands and needs, not procedures

# Don’t ask

Why are you violating

Who is responsible for this

What should the consequences be

# Do ask

Help me understand why makes more sense this way

What is responsible for putting you in this position

What is the stupidest thing we’re asking you to comply with


DR
RC
CC
CS
CN

## Saddleback Fire Learning Review

CONTENTS:



"The greatest obstacle to discovery is not ignorance – It is the illusion of knowledge."

Daniel J. Boorstin


*Proceedings of the 53rd ESReDA Seminar, Ispra, Italy, 14 – 15 November 2017*
*European Commission Joint Research Centre*


# The Learning Review: Adding to the accident investigation toolbox


Ivan Pupulidy
*US Forest Service, Innovation and Organizational Learning*

Crista Vesel
*Dynamic Inquiry LLC*



**Abstract**

*Accident investigation techniques have remained essentially the same for many decades, yet the recognition that complexity is increasing in most organizations demands an added form of inquiry. The Learning Review, first adopted by the U.S. Forest Service, explores the human contribution to accidents, safety, and normal work. It is specifically designed to facilitate the understanding of the factors and conditions that influence human actions and decisions by encouraging individual and group sensemaking at all levels of the organization. The Learning Review introduces the need to create a narrative inclusive of multiple perspectives from which a network of influences map can be created. This map depicts the factors that influence behaviors and can aid the organizational leadership to effect meaningful changes to the conditions while simultaneously helping field personnel to understand and manage system pressures.*



## LEARNING REVIEWS

June 2021

Dr. Sidney Dekker
sidneydekker.com


1 in 13

# In 1 that went wrong

Workarounds
Shortcuts
Violations
Guidelines not followed
Errors, miscalculations
Unfindable people or tools
Unreliable instruments
User-unfriendly technologies
Organizational frustrations
Supervisory obstacles

# In 12 that went well

Workarounds
Shortcuts
Violations
Guidelines not followed
Errors, miscalculations
Unfindable people or tools
Unreliable instruments
User-unfriendly technologies
Organizational frustrations
Supervisory obstacles

# Difference

Diversity of opinion/dissent

Keep discussion of risk live

Past success not taken as guarantee

Ability to say stop

Deference to expertise

Don’t wait for inspections, audits

Break down departmental/hierarchical barriers

Pride of workmanship

# Capacity index

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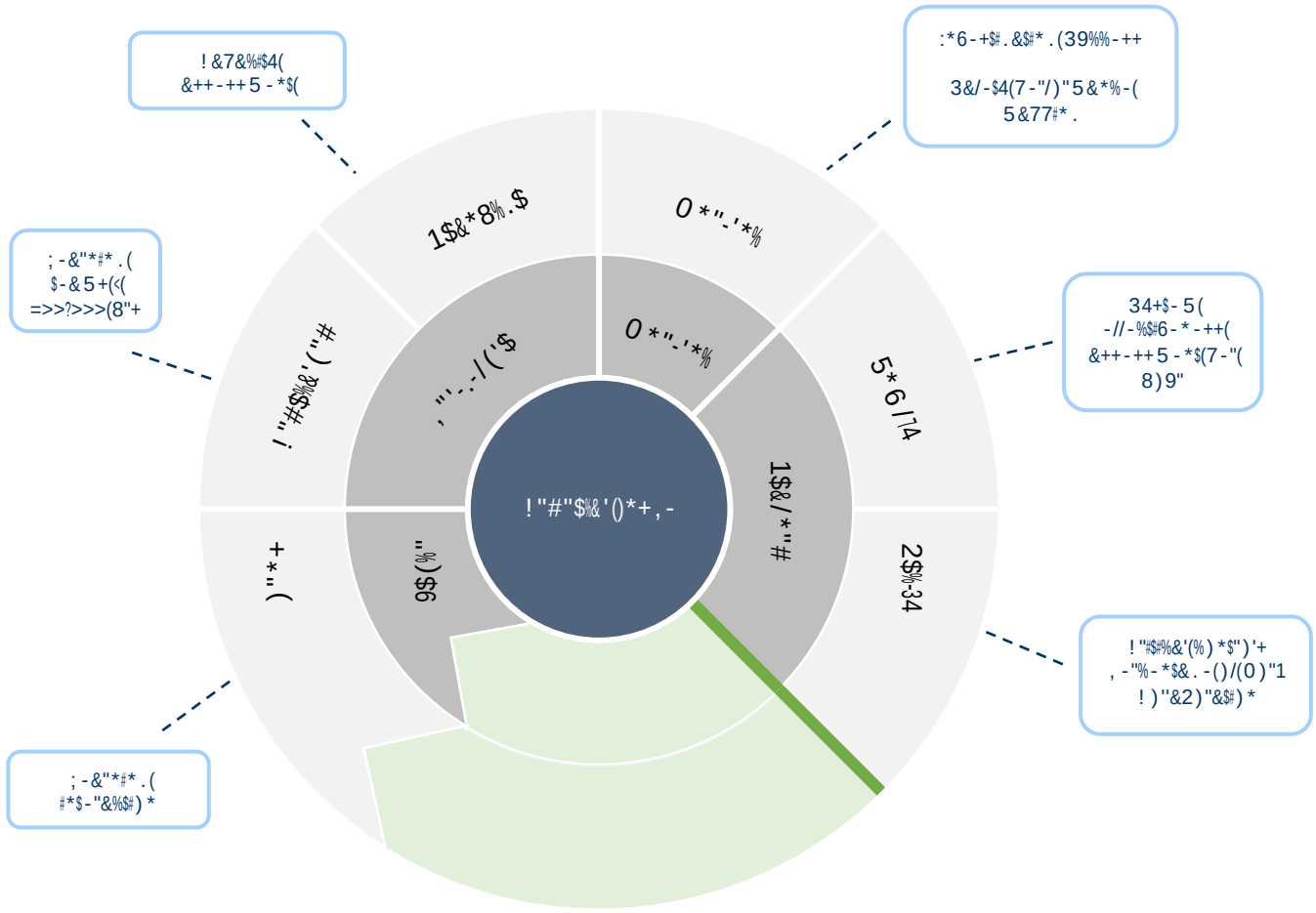
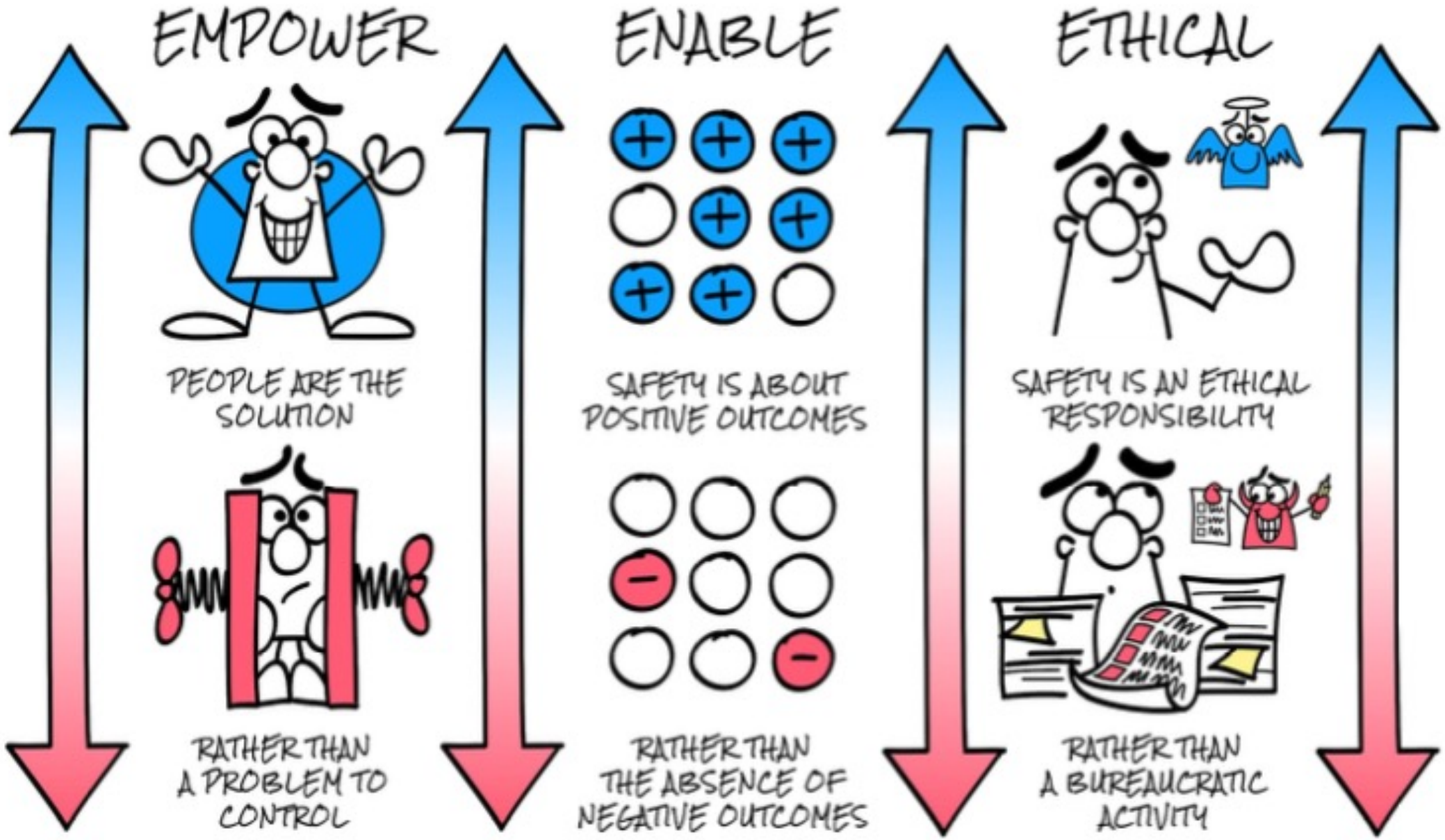
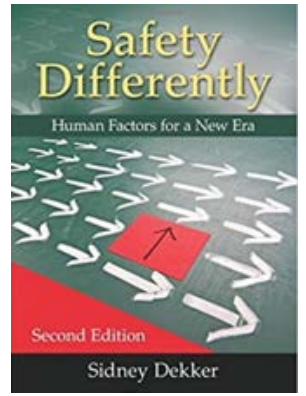



EMPOWER
PEOPLE ARE THE SOLUTION
RATHER THAN A PROBLEM TO CONTROL
ENABLE
SAFETY IS ABOUT POSITIVE OUTCOMES
RATHER THAN THE ABSENCE OF NEGATIVE OUTCOMES
ETHICAL
SAFETY IS AN ETHICAL RESPONSIBILITY
RATHER THAN A BUREAUCRATIC ACTIVITY


Safety Differently
Human Factors for a New Era
Second Edition
Sidney Dekker

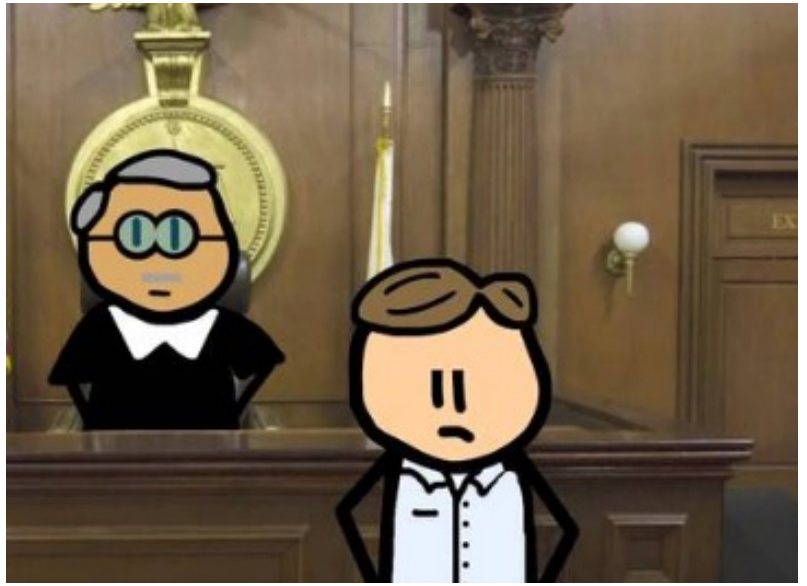

30
50
30
GIVE
WAY

# When things go wrong…

What rule is broken

How bad is the breach

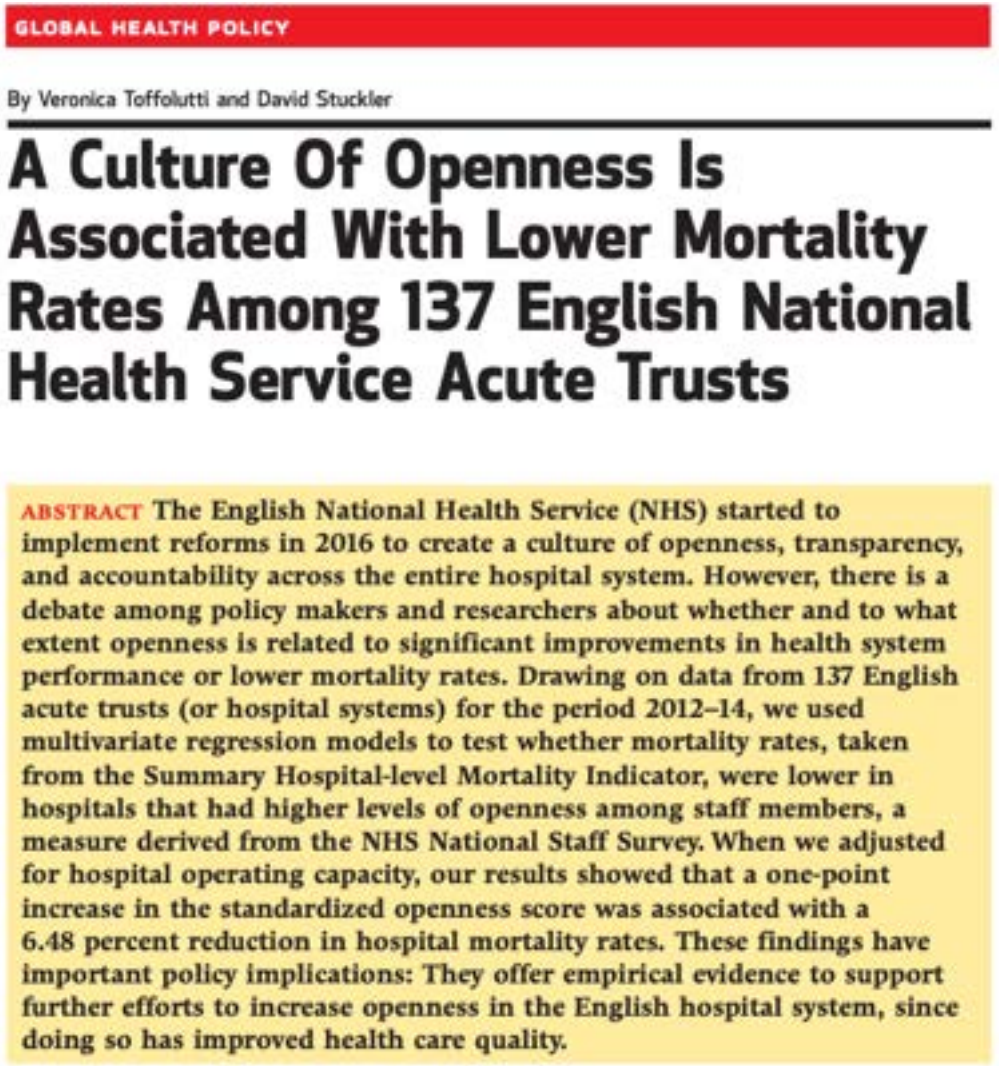
What should the consequences be



# Retribution effects

Risk secrecy

Organizational learning disabilities



GLOBAL HEALTH POLICY

By Veronica Toffolutti and David Stuckler

## A Culture Of Openness Is Associated With Lower Mortality Rates Among 137 English National Health Service Acute Trusts

ABSTRACT The English National Health Service (NHS) started to implement reforms in 2016 to create a culture of openness, transparency, and accountability across the entire hospital system. However, there is a debate among policy makers and researchers about whether and to what extent openness is related to significant improvements in health system performance or lower mortality rates. Drawing on data from 137 English acute trusts (or hospital systems) for the period 2012–14, we used multivariate regression models to test whether mortality rates, taken from the Summary Hospital-level Mortality Indicator, were lower in hospitals that had higher levels of openness among staff members, a measure derived from the NHS National Staff Survey. When we adjusted for hospital operating capacity, our results showed that a one-point increase in the standardized openness score was associated with a 6.48 percent reduction in hospital mortality rates. These findings have important policy implications: They offer empirical evidence to support further efforts to increase openness in the English hospital system, since doing so has improved health care quality.

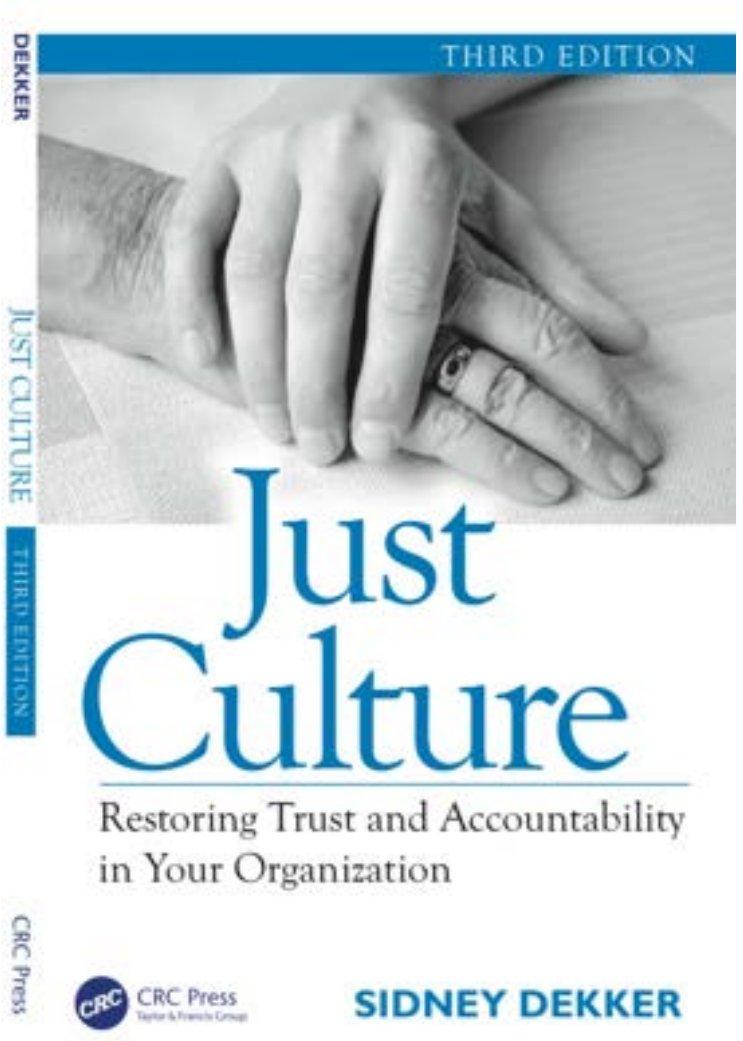
# Restoration

Who is impacted

What are their needs

Whose obligation is it to meet those needs

And how do we involve the community



# Accountability (retributive versus restorative)

You *pay* or *settle* an account

*Who* is responsible

Backward-looking accountability

*Whom do we blame?*

You *tell* an account

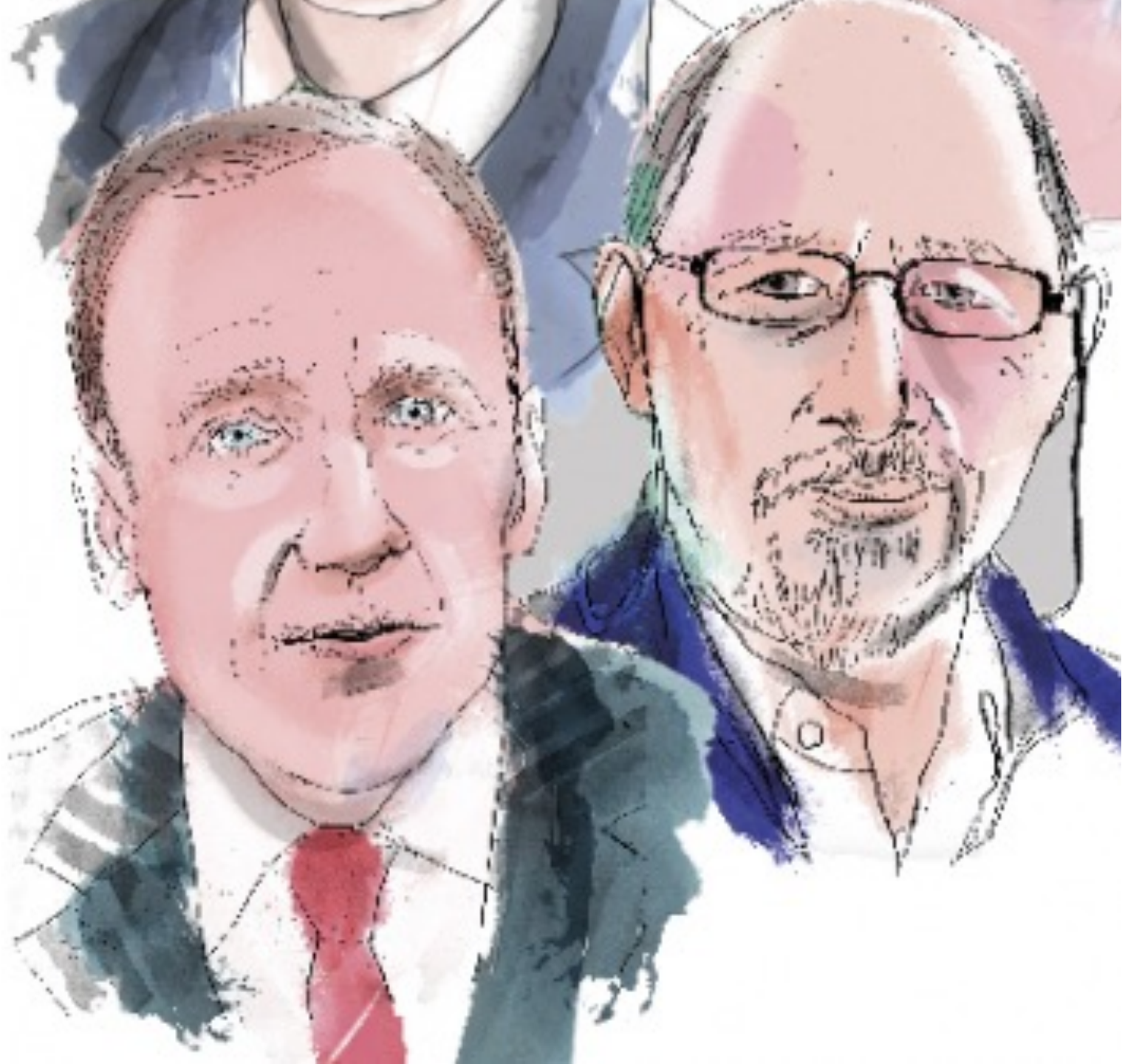
*What* is responsible

Forward-looking accountability

*What do we need to set people up for success?*


I was informed that there was
allegations made against me.

# Människor och möten

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