The Safety Anarchist Relying On Human Expertise And Innovation Reducing Bureaucracy And Compliance

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The Safety Anarchist Relying On
It is time for Safety Anarchists: people who trust people more than process, who rely on horizontally coordinating experiences and innovations, who push back against petty rules and coercive

compliance, and who help recover the dignity and expertise of human work.

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The Safety Anarchist: Relying on human expertise and ...
The Safety Anarchist: relying on human expertise and innovation, reducing bureaucracy and compliance

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Professor Sidney Dekker has a new book out called “The Safety Anarchist – Relying on human expertise and innovation, reducing bureaucracy and compliance “. Last month Sidney spoke exclusively with SafetyAtWorkBlog about the issues of governance, risk assessment, the safety profession, bureaucracy, centralisation and the cost of compliance.

The Safety Anarchist – SafetyAtWorkBlog
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19, 2017 - Technology & Engineering - 220 pages. 0 Reviews. Work has never been as safe as it seems today. Safety has also never been as bureaucratized as it is today. Over the past two decades, the number of ...

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The Safety Anarchist Relying on human expertise and innovation, reducing bureaucracy and compliance. Author(s) Dekker, Sidney. Griffith University Author(s) Dekker, Sidney. Year published. 2018. Metadata Show full item record. Abstract. Work has never been as safe as it seems today. Safety has also never been as bureaucratized as it is today.

The Safety Anarchist Relying on human expertise and ...
Sidney W. A. Dekker (born 1969, "near Amsterdam"), is a Professor at Griffith University in Brisbane, Australia, where he founded the Safety Science Innovation Lab. He is also Honorary Professor of Psychology at the University of Queensland.. Previously, Dekker was Professor of human factors and system safety at Lund University in Sweden, where he founded the Leonardo da Vinci Laboratory for ...

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It is time for Safety Anarchists: people who trust people more than process, who rely on horizontally coordinating experiences and innovations, who push back against petty rules and coercive compliance, and who help recover the dignity and expertise of human work.

Work has never been as safe as it seems today. Safety has also never been as bureaucratized as it is today. Over the past two decades, the number of safety rules and statutes has exploded, and organizations themselves are creating ever more internal compliance requirements. At the same time, progress on safety has slowed to a crawl. Many incident- and injury rates have flatlined. Worse, excellent safety performance on low-consequence events tends to increase the risk of fatalities and disasters. Bureaucracy and compliance now seem less about managing the safety of the workers we are responsible for, and more about managing the liability of the people they work for. We make workers do a lot that does nothing to improve their success locally. Paradoxically, such tightening of safety bureaucracy robs us

of exactly the source of human insight, creativity and resilience that can tell us how success is actually created, and where the next accident may well happen. It is time for Safety Anarchists: people who trust people more than process, who rely on horizontally coordinating experiences and innovations, who push back against petty rules and coercive compliance, and who help recover the dignity and expertise of human work.

Increased concern for patient safety has put the issue at the top of the agenda of practitioners, hospitals, and even governments. The risks to patients are many and diverse, and the complexity of the healthcare system that delivers them is huge. Yet the discourse is often oversimplified and underdeveloped. Written from a scientific, human factors perspective, Patient Safety: A Human Factors Approach delineates a method that can enlighten and clarify this discourse as well as put us on a better path to correcting the issues. People often think, understandably, that safety lies mainly in the hands through which care ultimately flows to the patient—those who are closest to the patient, whose decisions can mean the difference between life and death, between health and morbidity. The human factors approach refuses to lay the responsibility for safety and risk solely at the feet of people at the sharp end. That is where we should intervene to make things safer, to tighten practice, to focus attention, to remind people to be careful, to impose rules and guidelines. The book defines an approach that looks relentlessly for sources of safety and risk everywhere in the system—the designs of devices; the teamwork and coordination between different practitioners; their communication across hierarchical and gender boundaries; the cognitive processes of individuals; the organization that surrounds, constrains, and empowers them; the economic and human resources offered; the technology available; the political landscape; and even the culture of the place. The breadth of the human factors approach is itself testimony to the realization that there are no easy answers or silver bullets for resolving the issues in patient safety. A user-friendly introduction to the approach, this book takes the complexity of health care seriously and doesn't over simplify the problem. It demonstrates what the approach does do, that is offer the substance and guidance to consider the issues in all their nuance and complexity.

What does the collapse of sub-prime lending have in common with a broken jackscrew in an airliner's tailplane? Or the oil spill disaster in the Gulf of Mexico with the burn-up of Space Shuttle Columbia? These were systems that drifted into failure. While pursuing success in a dynamic, complex environment with limited resources and multiple goal conflicts, a succession of small, everyday decisions eventually produced breakdowns on a massive scale. We have trouble grasping the complexity and normality that gives rise to such large events. We hunt for broken parts, fixable properties, people we can hold accountable. Our analyses of complex system

breakdowns remain depressingly linear, depressingly componential - imprisoned in the space of ideas once defined by Newton and Descartes. The growth of complexity in society has outpaced our understanding of how complex systems work and fail. Our technologies have gotten ahead of our theories. We are able to build things - deep-sea oil rigs, jackscrews, collateralized debt obligations - whose properties we understand in isolation. But in competitive, regulated societies, their connections proliferate, their interactions and interdependencies multiply, their complexities mushroom. This book explores complexity theory and systems thinking to understand better how complex systems drift into failure. It studies sensitive dependence on initial conditions, unruly technology, tipping points, diversity - and finds that failure emerges opportunistically, non-randomly, from the very webs of relationships that breed success and that are supposed to protect organizations from disaster. It develops a vocabulary that allows us to harness complexity and find new ways of managing drift.

In this unique book, Sidney Dekker tackles a largely unexplored dilemma. Our scientific age has equipped us ever better to explain why things go wrong. But this increasing sophistication actually makes it harder to explain why we suffer. Accidents and disasters have become technical problems without inherent purpose. When told of a disaster, we easily feel lost in the steely emptiness of technical languages of engineering or medicine. Or, in our drive to pinpoint the source of suffering, we succumb to the hunt for a scapegoat, possibly inflicting even greater suffering on others around us. How can we satisfactorily deal with suffering when the disaster that caused it is no more than the dispassionate sum of utterly mundane, imperfect human decisions and technical failures? Broad in its historical sweep and ambition, The End of Heaven is also Dekker's most personal book to date.

In this book, Sidney Dekker sets out to identify the market mechanisms that explain how less government paradoxically leads to greater compliance burdens. This book gives shape and substance to a suspicion that has become widespread among workers in almost every industry: we have to follow more rules than ever—and still, things can go spectacularly wrong. Much has been privatized and deregulated, giving us what is sometimes known as ‘new public management,’ driven by neoliberal, market-favoring policies. But, paradoxically, we typically have more rules today, not fewer. It’s not the government: it’s us. This book is the first of a three-part series on the effects of ‘neoliberalism,’ which promotes the role of the private sector in the economy. Compliance Capitalism examines what aspects of the compliance economy, what mechanisms of bureaucratization, are directly linked to us having given free markets a greater reign over our political economy. The book steps through them, picking up the evidence and levers for change along the way. Dekker’s work has always challenged readers to embrace more humane, empowering ways to

think about work and its quality and safety. In Compliance Capitalism, Dekker extends his reach once again, writing for all managers, board members, organization leaders, consultants, practitioners, researchers, lecturers, students, and investigators curious to understand the genuine nature of organizational and safety performance.

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.

How are today’s ‘hearts and minds’ programs linked to a late-19th century definition of human factors as people’s moral and mental deficits? What do Heinrich’s ‘unsafe acts’ from the 1930’s have in common with the Swiss cheese model of the early 1990’s? Why was the reinvention of human factors in the 1940’s such an important event in the development of safety thinking? What makes many of our current systems so complex and impervious to Tayloristic safety interventions? ‘Foundations of Safety Science’ covers the origins of major schools of safety thinking, and traces the heritage and interlinkages of the ideas that make up safety science today. Features Offers a comprehensive overview of the theoretical foundations of safety science Provides balanced treatment of approaches since the early 20th century, showing interlinkages and cross-connections Includes an overview and key points at the beginning of each chapter and study questions at the end to support teaching use Uses an accessible style, using technical language where necessary Concentrates on the philosophical and historical traditions and assumptions that underlie all safety approaches

How do people cope with having "caused" a terrible accident? How do they cope when they survive and have to live with the consequences ever after? We tend to blame and forget professionals who cause incidents and accidents, but they are victims too. They are second victims whose experiences of an incident or adverse event can be as traumatic as that of the first victims’. Yet information on second victimhood and its relationship to safety, about what is known and what organizations might need to do, is difficult to find. Thoroughly exploring an emerging topic with great relevance to safety culture, Second Victim: Error, Guilt, Trauma, and Resilience examines the lived experience of second victims. It goes through what we know

about trauma, guilt, forgiveness, and injustice and how these might be felt by the second victim. The author discusses how to conduct investigations of incidents that do not alienate second victims or make them feel even worse. It explores the importance support and resilience and where the responsibilities for creating it may lie. Drawing on his unique background as psychologist, airline pilot, and safety specialist, and his own experiences with helping second victims from a variety of backgrounds, Sidney Dekker has written a powerful, moving account of the experience of the second victim. It forms compelling reading for practitioners, risk managers, human resources managers, safety experts, mental health workers, regulators, the judiciary, and many other professionals. Dekker provides a strong theoretical background to promote understanding of the situation of the second victim and solid practical advice about how to deal with trauma that continues after an event leading to preventable harm or even avoidable death of a patient, consumer, or colleague. Listen to Sidney Dekker speak about his book

The Anarchist Cookbook will shock, it will disturb, it will provoke. It places in historical perspective an era when "Turn on, Burn down, Blow up" are revolutionary slogans of the day. Says the author" "This book... is not written for the members of fringe political groups, such as the Weatherman, or The Minutemen. Those radical groups don't need this book. They already know everything that's in here. If the real people of America, the silent majority, are going to survive, they must educate themselves. That is the purpose of this book." In what the author considers a survival guide, there is explicit information on the uses and effects of drugs, ranging from pot to heroin to peanuts. There i detailed advice concerning electronics, sabotage, and surveillance, with data on everything from bugs to scramblers. There is a comprehensive chapter on natural, non-lethal, and lethal weapons, running the gamut from cattle prods to sub-machine guns to bows and arrows.

The second edition of a bestseller, Safety Differently: Human Factors for a New Era is a complete update of Ten Questions About Human Error: A New View of Human Factors and System Safety. Today, the unrelenting pace of technology change and growth of complexity calls for a different kind of safety thinking. Automation and new technologies have resu