Safety Differently

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~~Safety Differently | Trailer~~ *Book Briefing — Safety Differently Safety Differently | The Movie Safety Differently* ~~Sidney Dekker - Safety I and Safety II and Safety Differently.~~ ~~Sidney Dekker — Safety Differently Lecture~~ ~~Webinar: An Introduction to "New Safety" (HOP, Safety II, and Safety Differently)~~ *Doing Safety Differently* ~~Safety Differently - Sidney Dekker~~ *Safety Differently with Ron Gantt Erik Hollnagel on delivering resilient health care Total's 12 Golden Safety Rules you can Apply in your Workplace A story of Safety II Summit 2014: Plenary Session - Dr Sidney Dekker* Why leaders need to build businesses that 'fail safely' by Dr Todd Conklin - chapter 2 Book Briefing — Field Guide to Understanding 'Human Error' *Eric Hollnagel-Safety 2* ~~Unsafe Acts - Safety Training Video - Safetycare free video preview~~ ~~Safety ll - Chapter 2~~ *A Powerful Message from Sidney Dekker* Is Safety Differently really all that different? Global developments in health and safety thinking. **Traditional Safety v. Safety Differently**

Safety Differently in practice with Kym BancroftSafety II and Safety Differently: A Practical Implementation with Queensland Urban Utilities What is Safety Differently? | Thoughts from Author Professor Erik Hollnagel Approaching safety differently *Safety Differently*
safety differently Learn from the leaders behind innovative and critical safety thinking, and connect with other change makers who are making an impact and doing safety differently. About

Safety Differently – Innovative and critical safety thinking
Safety Differently is the name given to a movement within the industry that challenges organisations to view three key areas of their business differently. Phone: US Free Call : +1 (737) 201-1573 support@myosh.com

What is Safety Differently? | Health and Safety News | myosh
Safety Differently, on the other hand, defines safety more positively. An example Dekker has used in the past defines safety as "a capacity to be successful in varying conditions". The role of workers – traditional health and safety aims to control and change the behaviour of workers, whereas Safety Differently views people as the solution.

An Introduction to Safety Differently | Banyard Solutions Ltd
'Safety differently' is about relying on people's expertise, insights and the dignity of work as actually done to improve safety and efficiency. It is about halting or pushing back on the ever-expanding bureaucratization and compliance of work.

Safety Differently – Sidney Dekker
When thinking about Safety Differently, it's just as important to understand what safety 2.0 isn't, as many critics and detractors hone in on individual aspects of the approach in attempt to discredit the whole. Change is daunting and its requires a sympathetic hand to guide organisations through this difficult transition.

Safety Differently: What it is not - SHP - Health and ...
Work has never been as safe as it seems today. But bureaucracy and compliance demands have mushroomed, including many imposed by organizations on themselves....

Safety Differently | The Movie - YouTube
Safety Differently advocates that rather than looking at where things go wrong, the focus should be on 'normal work'. Where can we find examples of work being done well and emulate those? John is critical of behavioural-based safety (BBS) as he says it provides incentives for people to do things the way the organisation says, and punishes them for doing the opposite.

Is Safety Differently REALLY all that different?
Safety Differently is the name given to a movement within safety to change the perspective of organizations in three key areas – how safety is defined, the role of people, and the focus of the organization. Traditional or "normal" safety management tends to view these three areas in this way:

What Is Safety Differently? An Interview with Ron Gantt ...
First, regarding the newness of safety differently, it is worth pointing out that it is called "safety differently," not "safety new." This is because aspects of the ideas that provide the foundation of safety differently have deep roots in different disciplines and professions.

Is Safety Differently Really Any Different than Safety ...
Art of work is able to adapt initiatives and tools developed by individual organisations to be accredited safety differently® programs. There are numerous claims for safety differently® programs and tools in the commercial domain, however, if they are not approved through Art of Work, they are not authentic. The safety differently® initiative created in 2012 and built by Art of Work is an active supporter of the professional engagement and discussion that exists in networking forums.

Art of Work - safety differently®
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.

Safety Differently: Human Factors for a New Era, Second ...
safety differently is an interesting read, zero harm will never be achieved and it also promotes misrepresentation and under reporting. The human factor is the most important piece of the jigsaw,...

Safety Differently - webcommunities.hse.gov.uk
Safety differently poses the idea that safety should consider people within the organisation as the solution. This is achieved by focusing on successes in an HSE context. This can be through the praise and recognition of activities that are beneficial for health and safety.

What are the fundamental principles behind Safety Differently?
It was time to start doing, and seeing, safety differently. Think of safety outcomes as a hypothetical Gaussian, or normal curve, also known as a bell curve. The curve shows that the number of the things that go wrong – the left side of the curve – is tiny.

Safety Differently - Gliding Australia
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Safety Differently: Human Factors for a New Era, Second ...
That is the premise of Safety differently, an approach developed by Sidney Dekker, founder of the Safety Differently movement, Professor of psychology at Griffith University in Australia and expert on human factors and safety. His proposal is about halting or pushing back on the bureaucratisation and compliance of work.

The case for doing safety differently | British Safety Council
The Safety Differently concept is based around critical thinking, building employees' capabilities to manage safety through enabling them to adapt, rather than trying to reduce accidents to zero by constraining actions through rules and procedures. While Safety Differently is people-oriented, Safety II is more process-oriented.

Safety differently: a leading light | IOSH Magazine
For example, Safety Differently and Safety II are commonly quoted models that, more often than not, overlay and overlap with familiar concepts, whilst introducing new language – they can and have been misinterpreted so that they are 'good' and current safety management practices are 'bad'.

Safety: differently, I vs II, or leading, caring and ...
Helen McKenna sits down with Marvin Rees, the Mayor of Bristol, to explore his approach to place-based leadership, the NHS's role as a 'place-shaper' and the city's experience of Covid-19. The second wave of Covid-19 offers new as well as ongoing challenges for the health and care system ...

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 resulted in new roles, decisions, and vulnerabilities whilst practitioners are also faced with new levels of complexity, adaptation, and constraints. It is becoming increasingly apparent that conventional approaches to safety and human factors are not equipped to cope with these challenges and that a new era in safety is necessary. In addition to new material covering changes in the field during the past decade, the book takes a new approach to discussing safety. The previous edition looked critically at the answers human factors would typically provide and compared/contrasted them with current research and insights at that time. The edition explains how to turn safety from a bureaucratic accountability back into an ethical responsibility for those who do our dangerous work, and how to embrace the human factor not as a problem to control, but as a solution to harness. See What's in the New Edition: New approach reflects changes in the field Updated coverage of system safety and technology changes Latest human factors/ergonomics research applicable to safety Organizations, companies, and industries are faced with new demands and pressures resulting from the dynamics and nature of the modern marketplace and from the development and introduction of new technologies. This new era calls for a different kind of safety thinking, a thinking that sees people as the source of diversity, insight, creativity, and wisdom about safety, not as the source of risk that undermines an otherwise safe system. It calls for a kind of thinking that is quicker to trust people and mistrust bureaucracy, and that is more committed to actually preventing harm than to looking good. This book takes a forward-looking and assertively progressive view that prepares you to resolve current safety issues in any field.

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Safety has traditionally been defined as a condition where the number of adverse outcomes was as low as possible (Safety-I). From a Safety-I perspective, the purpose of safety management is to make sure that the number of accidents and incidents is kept as low as possible, or as low as is reasonably practicable. This means that safety management must start from the manifestations of the absence of safety and that - paradoxically - safety is measured by counting the number of cases where it fails rather than by the number of cases where it succeeds. This unavoidably leads to a reactive approach based on responding to what goes wrong or what is identified as a risk - as something that could go wrong. Focusing on what goes right, rather than on what goes wrong, changes the definition of safety from 'avoiding that something goes wrong' to 'ensuring that everything goes right'. More precisely, Safety-II is the ability to succeed under varying conditions, so that the number of intended and acceptable outcomes is as high as possible. From a Safety-II perspective, the purpose of safety management is to ensure that as much as possible goes right, in the sense that everyday work achieves its objectives. This means that safety is managed by what it achieves (successes, things that go right), and that likewise it is measured by counting the number of cases where things go right. In order to do this, safety management cannot only be reactive, it must also be proactive. But it must be proactive with regard to how actions succeed, to everyday acceptable performance, rather than with regard to how they can fail, as traditional risk analysis does. This book analyses and explains the principles behind both approaches and uses this to consider the past and future of safety management practices. The analysis makes use of common examples and cases from domains such as aviation, nuclear power production, process management and health care. The final chapters explain the theoretical and practical consequences of the new perspective on the level of day-to-day operations as well as on the level of strategic management (safety culture). Safety-I and Safety-II is written for all professionals responsible for their organisation's safety, from strategic planning on the executive level to day-to-day operations in the field. It presents the detailed and tested arguments for a transformation from protective to productive safety management.

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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.

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.

Human error is cited over and over as a cause of incidents and accidents. The result is a widespread perception of a 'human error problem', and solutions are thought to lie in changing the people or their role in the system. For example, we should reduce the human role with more automation, or regiment human behavior by stricter monitoring, rules or procedures. But in practice, things have proved not to be this simple. The label 'human error' is prejudicial and hides much more than it reveals about how a system functions or malfunctions. This book takes you behind the human error label. Divided into five parts, it begins by summarising the most significant research results. Part 2 explores how systems thinking has radically changed our understanding of how accidents occur. Part 3 explains the role of cognitive system factors - bringing knowledge to bear, changing mindset as situations and priorities change, and managing goal conflicts - in operating safely at the sharp end of systems. Part 4 studies how the clumsy use of computer technology can increase the potential for erroneous actions and assessments in many different fields of practice. And Part 5 tells how the hindsight bias always enters into attributions of error, so that what we label human error actually is the result of a social and psychological judgment process by stakeholders in the system in question to focus on only a facet of a set of interacting contributors. If you think you have a human error problem, recognize that the label itself is no explanation and no guide to countermeasures. The potential for constructive change, for progress on safety, lies behind the human error label.

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.

A just culture is a culture of trust, learning and accountability. It is particularly important when an incident has occurred; when something has gone wrong. How do you respond to the people involved? What do you do to minimize the negative impact, and maximize learning? This third edition of Sidney Dekker's extremely successful Just Culture offers new material on restorative justice and ideas about why your people may be breaking rules. Supported by extensive case material, you will learn about safety reporting and honest disclosure, about retributive just culture and about the criminalization of human error. Some suspect a just culture means letting people off the hook. Yet they believe they need to remain able to hold people accountable for undesirable performance. In this new edition, Dekker asks you to look at 'accountability' in different ways. One is by asking which rule was broken, who did it, whether that behavior crossed some line, and what the appropriate consequences should be. In this retributive sense, an 'account' is something you get people to pay, or settle. But who will draw that line? And is the process fair? Another way to approach accountability after an incident is to ask who was hurt. To ask what their needs are. And to explore whose obligation it is to meet those needs. People involved in causing the incident may well want to participate in meeting those needs. In this restorative sense, an 'account' is something you get people to tell, and others to listen to. Learn to look at accountability in different ways and your impact on restoring trust, learning and a sense of humanity in your organization could be enormous.