

Drift Into Failure From Hunting Broken Components To Understanding Complex Systems

A newly revised and updated edition of the classic guide to reframing our view of ADHD and embracing its benefits • Explains that people with ADHD are not disordered or dysfunctional, but simply “hunters in a farmer’s world”--possessing a unique mental skill set that would have allowed them to thrive in a hunter-gatherer society • Offers concrete non-drug methods and practices to help hunters--and their parents, teachers, and managers--embrace their differences, nurture creativity, and find success in school, at work, and at home • Reveals how some of the world’s most successful people can be labeled as ADHD hunters, including Benjamin Franklin, Thomas Edison, and Andrew Carnegie With 10 percent of the Western world’s children suspected of having Attention Deficit Disorder, or ADHD, and a growing number of adults self-diagnosing after decades of struggle, the question must be raised: How could Nature make such a “mistake”? In this updated edition of his groundbreaking classic, Thom Hartmann explains that people with ADHD are not abnormal, disordered, or dysfunctional, but simply “hunters in a farmer’s world.” Often highly creative and single-minded in pursuit of a self-chosen goal, those with ADHD symptoms possess a unique mental skill set that would have allowed them to thrive in a hunter-gatherer society. As hunters, they would have been constantly scanning their environment, looking for food or threats

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(distractibility); they'd have to act without hesitation (impulsivity); and they'd have to love the high-stimulation and risk-filled environment of the hunting field. With our structured public schools, office workplaces, and factories those who inherit a surplus of "hunter skills" are often left frustrated in a world that doesn't understand or support them. As Hartmann shows, by reframing our view of ADHD, we can begin to see it not as a disorder, but as simply a difference and, in some ways, an advantage. He reveals how some of the world's most successful people can be labeled as ADHD hunters and offers concrete non-drug methods and practices to help hunters--and their parents, teachers, and managers--embrace their differences, nurture creativity, and find success in school, at work, and at home. Providing a supportive "survival" guide to help fine tune your natural skill set, rather than suppress it, Hartmann shows that each mind--whether hunter, farmer, or somewhere in between--has value and great potential waiting to be tapped.

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

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actions to change accordingly. It shows how to "reverse engineer" human error, which, like any other component, needs to be put back together in a mishap investigation. William Golding's unforgettable classic of boyhood adventure and the savagery of humanity comes to Penguin Classics in a stunning Graphic Deluxe Edition with a new foreword by Lois Lowry As provocative today as when it was first published in 1954, *Lord of the Flies* continues to ignite passionate debate with its startling, brutal portrait of human nature. William Golding's compelling story about a group of very ordinary boys marooned on a coral island has been labeled a parable, an allegory, a myth, a morality tale, a parody, a political treatise, and even a vision of the apocalypse. But above all, it has earned its place as one of the indisputable classics of the twentieth century for readers of any age. This Penguin Classics Graphic Deluxe Edition features an array of special features to supplement the novel, including a foreword by Lois Lowry, an introduction by Stephen King, an essay by E. M. Forster, an essay on teaching and reading the novel and suggestions for further exploration by scholar Jennifer Buehler, and an extended note by E. L. Epstein, the publisher of the first American paperback edition of *Lord of the Flies*. For more than seventy years, Penguin has been the leading publisher of classic literature in the English-speaking world. With more than 1,700 titles, Penguin Classics represents a global bookshelf of the best works throughout history and across genres and disciplines. Readers trust the series to provide authoritative texts enhanced by introductions and notes by distinguished scholars and contemporary

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authors, as well as up-to-date translations by award-winning translators.

When the Space Shuttle Challenger exploded on January 28, 1986, millions of Americans became bound together in a single, historic moment. Many still vividly remember exactly where they were and what they were doing when they heard about the tragedy. Diane Vaughan recreates the steps leading up to that fateful decision, contradicting conventional interpretations to prove that what occurred at NASA was not skullduggery or misconduct but a disastrous mistake. Why did NASA managers, who not only had all the information prior to the launch but also were warned against it, decide to proceed? In retelling how the decision unfolded through the eyes of the managers and the engineers, Vaughan uncovers an incremental descent into poor judgment, supported by a culture of high-risk technology. She reveals how and why NASA insiders, when repeatedly faced with evidence that something was wrong, normalized the deviance so that it became acceptable to them. In a new preface, Vaughan reveals the ramifications for this book and for her when a similar decision-making process brought down NASA's Space Shuttle Columbia in 2003.

Barbara Kingsolver's acclaimed international bestseller tells the story of an American missionary family in the Congo during a poignant chapter in African history. It spins the tale of the fierce evangelical Baptist, Nathan Price, who takes his wife and four daughters on a missionary journey into the heart of darkness of the Belgian Congo in 1959. They carry with them to Africa all they believe they will need from home, but soon

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find that all of it - from garden seeds to the King James Bible - is calamitously transformed on African soil. Told from the perspective of the five women, this is a compelling exploration of African history, religion, family, and the many paths to redemption. The *Poisonwood Bible* was nominated for the Pulitzer Prize in 1999 and was chosen as the best reading group novel ever at the Penguin/Orange Awards. It continues to be read and adored by millions worldwide.

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

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coercive compliance, and who help recover the dignity and expertise of human work. This cult classic of gonzo journalism is the best chronicle of drug-soaked, addle-brained, rollicking good times ever committed to the printed page. It is also the tale of a long weekend road trip that has gone down in the annals of American pop culture as one of the strangest journeys ever undertaken. Now a major motion picture from Universal, directed by Terry Gilliam and starring Johnny Depp and Benicio del Toro. *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.

Combining captivating storytelling with eye-opening findings, *Inviting Disaster* delves inside some of history's worst catastrophes in order to show how increasingly "smart" systems leave us wide open to human tragedy. Weaving a dramatic narrative that explains how breakdowns in these systems result in such disasters as the chain reaction crash of the Air France Concorde to the meltdown at the Chernobyl Nuclear Power Station, Chiles vividly demonstrates how the battle between man and machine may be escalating beyond manageable limits -- and why we all have a stake in its outcome. Included in this edition is a special introduction providing a behind-the-scenes

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look at the World Trade Center catastrophe. Combining firsthand accounts of employees' escapes with an in-depth look at the structural reasons behind the towers' collapse, Chiles addresses the question, Were the towers "two tall heroes" or structures with a fatal flaw?

The groundbreaking investigative story of how three successive presidents and their military commanders deceived the public year after year about America's longest war, foreshadowing the Taliban's recapture of Afghanistan, by Washington Post reporter and three-time Pulitzer Prize finalist Craig Whitlock. Unlike the wars in Vietnam and Iraq, the US invasion of Afghanistan in 2001 had near-unanimous public support. At first, the goals were straightforward and clear: to defeat al-Qaeda and prevent a repeat of 9/11. Yet soon after the United States and its allies removed the Taliban from power, the mission veered off course and US officials lost sight of their original objectives. Distracted by the war in Iraq, the US military became mired in an unwinnable guerrilla conflict in a country it did not understand. But no president wanted to admit failure, especially in a war that began as a just cause. Instead, the Bush, Obama, and Trump administrations sent more and more troops to Afghanistan and repeatedly said they were making progress, even though they knew there was no realistic prospect for an outright victory. Just as the Pentagon Papers changed the public's understanding of Vietnam, The Afghanistan Papers contains startling revelation after revelation from people who played a direct role in the war, from leaders in the White House and the

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Pentagon to soldiers and aid workers on the front lines. In unvarnished language, they admit that the US government's strategies were a mess, that the nation-building project was a colossal failure, and that drugs and corruption gained a stranglehold over their allies in the Afghan government. All told, the account is based on interviews with more than 1,000 people who knew that the US government was presenting a distorted, and sometimes entirely fabricated, version of the facts on the ground. Documents unearthed by The Washington Post reveal that President Bush didn't know the name of his Afghanistan war commander—and didn't want to make time to meet with him. Secretary of Defense Donald Rumsfeld admitted he had “no visibility into who the bad guys are.” His successor, Robert Gates, said: “We didn't know jack shit about al-Qaeda.” The Afghanistan Papers is a shocking account that will supercharge a long overdue reckoning over what went wrong and forever change the way the conflict is remembered.

City Spies meets Indiana Jones in this second book of the Lola Benko, Treasure Hunter series that follows Lola and her friends as they compete for a spot in top treasure-hunting society. After saving her father and the world, twelve-year-old Lola Benko and her new best friends, Jin and Hannah, are a true treasure-hunting team. But after botching a huge job, they are looking to redeem themselves. They decide to try their luck at Camp Timberwood, where teams will compete to join the legendary Task Force, a group that gets plumb assignments around the globe. When their former nemesis,

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Lipstick, shows up unexpectedly, she makes an offer they can't refuse: help her find the legendary Helm of Darkness and she will help them come out on top in the competition—and be the first team in line for the Task Force. They just have to go to the mysterious Midnight Market, where the Helm is rumored to be. But Lola, Jin, and Hannah still aren't fully back in sync after their recent failure. Can they prove to the Task Force—and themselves—that they still have what it takes?

Ten Questions About Human Error asks the type of questions frequently posed in incident and accident investigations, people's own practice, managerial and organizational settings, policymaking, classrooms, Crew Resource Management Training, and error research. It is one installment in a larger transformation that has begun to identify both deep-rooted constraints and new leverage points of views of human factors and system safety. The ten questions about human error are not just questions about human error as a phenomenon, but also about human factors and system safety as disciplines, and where they stand today. In asking these questions and sketching the answers to them, this book attempts to show where current thinking is limited--where vocabulary, models, ideas, and notions are constraining progress. This volume looks critically at the answers human factors would typically provide and compares/contrasts them with current research insights. Each chapter provides directions for new ideas and models that could perhaps better cope with the complexity of the problems facing human error today. As such, this book can be used as a

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supplement for a variety of human factors courses.

"A sophisticated, deeply informed account of real life in the real CIA that adds immeasurably to the public understanding of the espionage culture—the good and the bad." —Bob Woodward

Jack Devine ran Charlie Wilson's War in Afghanistan. It was the largest covert action of the Cold War, and it was Devine who put the brand-new Stinger missile into the hands of the mujahideen during their war with the Soviets, paving the way to a decisive victory against the Russians. He also pushed the CIA's effort to run down the narcotics trafficker Pablo Escobar in Colombia. He tried to warn the director of central intelligence, George Tenet, that there was a bullet coming from Iraq with his name on it. He was in Chile when Allende fell, and he had too much to do with Iran-Contra for his own taste, though he tried to stop it. And he tangled with Rick Ames, the KGB spy inside the CIA, and hunted Robert Hanssen, the mole in the FBI. Good Hunting: An American Spymaster's Story is the spellbinding memoir of Devine's time in the Central Intelligence Agency, where he served for more than thirty years, rising to become the acting deputy director of operations, responsible for all of the CIA's spying operations. This is a story of intrigue and high-stakes maneuvering, all the more gripping when the fate of our geopolitical order hangs in the balance. But this book also sounds a warning to our nation's decision makers: covert operations, not costly and devastating full-scale interventions, are the best safeguard of America's interests worldwide. Part memoir, part historical redress, Good Hunting debunks outright some of

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the myths surrounding the Agency and cautions against its misuses. Beneath the exotic allure—living abroad with his wife and six children, running operations in seven countries, and serving successive presidents from Nixon to Clinton—this is a realist, gimlet-eyed account of the Agency. Now, as Devine sees it, the CIA is trapped within a larger bureaucracy, losing swaths of turf to the military, and, most ominous of all, is becoming overly weighted toward paramilitary operations after a decade of war. Its capacity to do what it does best—spying and covert action—has been seriously degraded. *Good Hunting* sheds light on some of the CIA's deepest secrets and spans an illustrious tenure—and never before has an acting deputy director of operations come forth with such an account. With the historical acumen of Steve Coll's *Ghost Wars* and gripping scenarios that evoke the novels of John le Carré even as they hew closely to the facts on the ground, Devine offers a master class in spycraft.

Pulitzer Prize winner Tracy Kidder memorably records the drama, comedy, and excitement of one company's efforts to bring a new microcomputer to market.

Computers have changed since 1981, when *The Soul of a New Machine* first examined the culture of the computer revolution. What has not changed is the feverish pace of the high-tech industry, the go-for-broke approach to business that has caused so many computer companies to win big (or go belly up), and the cult of pursuing mind-bending technological innovations. *The Soul of a New Machine* is an essential chapter in the history of the machine that revolutionized the world in the twentieth century.

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On April 14, 1994, two U.S. Air Force F-15 fighters accidentally shot down two U.S. Army Black Hawk Helicopters over Northern Iraq, killing all twenty-six peacekeepers onboard. In response to this disaster the complete array of military and civilian investigative and judicial procedures ran their course. After almost two years of investigation with virtually unlimited resources, no culprit emerged, no bad guy showed himself, no smoking gun was found. This book attempts to make sense of this tragedy--a tragedy that on its surface makes no sense at all. With almost twenty years in uniform and a Ph.D. in organizational behavior, Lieutenant Colonel Snook writes from a unique perspective. A victim of friendly fire himself, he develops individual, group, organizational, and cross-level accounts of the accident and applies a rigorous analysis based on behavioral science theory to account for critical links in the causal chain of events. By explaining separate pieces of the puzzle, and analyzing each at a different level, the author removes much of the mystery surrounding the shutdown. Based on a grounded theory analysis, Snook offers a dynamic, cross-level mechanism he calls "practical drift"--the slow, steady uncoupling of practice from written procedure--to complete his explanation. His conclusion is disturbing. This accident happened because, or perhaps in spite of everyone behaving just the way we would expect them to behave, just the way theory would predict. The shutdown was a normal accident in a highly reliable organization.

This book explores complexity theory and systems thinking to better understand how

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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.

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,

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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.

Deep learning systems have gotten really great at identifying patterns in text, images, and video. But applications that create realistic images, natural sentences and paragraphs, or native-quality translations have proven elusive. Generative Adversarial Networks, or GANs, offer a promising solution to these challenges by pairing two competing neural networks' one that generates content and the other that rejects samples that are of poor quality. GANs in Action: Deep learning with Generative Adversarial Networks teaches you how to build and train your own generative adversarial networks. First, you'll get an introduction to generative modelling and how GANs work, along with an overview of their potential uses. Then, you'll start building your own simple adversarial system, as you explore the foundation of GAN architecture: the generator and discriminator networks. Purchase of the print book includes a free eBook in PDF, Kindle, and ePub formats from Manning Publications.

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

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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.

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

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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. 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

The second edition of a bestseller, *Safety Differently: Human Factors for a New Era* is a

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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 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. A new approach to safety, based on systems thinking, that is more effective, less costly, and easier to use than current techniques. Engineering has experienced a technological revolution, but the basic engineering techniques applied in safety and reliability engineering, created in a simpler, analog world, have changed very little over the years. In this groundbreaking book, Nancy Leveson proposes a new approach to safety—more suited to today's complex, sociotechnical, software-intensive world—based on modern systems thinking and systems theory. Revisiting and updating ideas pioneered by 1950s aerospace engineers in their System

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Safety concept, and testing her new model extensively on real-world examples, Leveson has created a new approach to safety that is more effective, less expensive, and easier to use than current techniques. Arguing that traditional models of causality are inadequate, Leveson presents a new, extended model of causation (Systems-Theoretic Accident Model and Processes, or STAMP), then shows how the new model can be used to create techniques for system safety engineering, including accident analysis, hazard analysis, system design, safety in operations, and management of safety-critical systems. She applies the new techniques to real-world events including the friendly-fire loss of a U.S. Blackhawk helicopter in the first Gulf War; the Vioxx recall; the U.S. Navy SUBSAFE program; and the bacterial contamination of a public water supply in a Canadian town. Leveson's approach is relevant even beyond safety engineering, offering techniques for “reengineering” any large sociotechnical system to improve safety and manage risk.

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,

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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. An accessible history of alchemy by a leading world authority explores its development and relationship with myriad disciplines and pursuits, tracing its heyday in early modern Europe while profiling some of history's most colorful alchemists and describing the author's recreation of famous alchemy recipes.

Charles Perrow is famous worldwide for his ideas about normal accidents, the notion that multiple and unexpected failures--catastrophes waiting to happen--are built into our society's complex systems. In *The Next Catastrophe*, he offers crucial insights into how to make us safer, proposing a bold new way of thinking about disaster preparedness. Perrow argues that rather than laying exclusive emphasis on protecting targets, we should reduce their size to minimize damage and diminish their attractiveness to terrorists. He focuses on three causes of disaster--natural, organizational, and deliberate--and shows that our best hope lies in the deconcentration of high-risk populations, corporate power, and critical infrastructures such as electric energy, computer systems, and the chemical and food industries. Perrow reveals how the threat of catastrophe is on the rise, whether from terrorism, natural disasters, or industrial

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accidents. Along the way, he gives us the first comprehensive history of FEMA and the Department of Homeland Security and examines why these agencies are so ill equipped to protect us. The Next Catastrophe is a penetrating reassessment of the very real dangers we face today and what we must do to confront them. Written in a highly accessible style by a renowned systems-behavior expert, this book is essential reading for the twenty-first century. The events of September 11 and Hurricane Katrina--and the devastating human toll they wrought--were only the beginning. When the next big disaster comes, will we be ready? In a new preface to the paperback edition, Perrow examines the recent (and ongoing) catastrophes of the financial crisis, the BP oil spill, and global warming.

This edited book concerns the real practice of human factors and ergonomics (HF/E), conveying the perspectives and experiences of practitioners and other stakeholders in a variety of industrial sectors, organisational settings and working contexts. The book blends literature on the nature of practice with diverse and eclectic reflections from experience in a range of contexts, from healthcare to agriculture. It explores what helps and what hinders the achievement of the core goals of HF/E: improved system performance and human wellbeing. The book should be of interest to current HF/E practitioners, future HF/E practitioners, allied practitioners, HF/E advocates and ambassadors, researchers, policy makers and regulators, and clients of HF/E services and products.

A Los Angeles Times Best Non-Fiction Book of 2007
A Boston Globe Best Non-Fiction Book of 2007
Amazon.com Editors pick as one of the 10 best history books of 2007
Winner of the 2007 John Lyman Award for U. S. Maritime History, given by the North American Society for Oceanic History "The best history of American whaling to come along in a generation."

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—Nathaniel Philbrick The epic history of the "iron men in wooden boats" who built an industrial empire through the pursuit of whales. "To produce a mighty book, you must choose a mighty theme," Herman Melville proclaimed, and this absorbing history demonstrates that few things can capture the sheer danger and desperation of men on the deep sea as dramatically as whaling. Eric Jay Dolin begins his vivid narrative with Captain John Smith's botched whaling expedition to the New World in 1614. He then chronicles the rise of a burgeoning industry—from its brutal struggles during the Revolutionary period to its golden age in the mid-1800s when a fleet of more than 700 ships hunted the seas and American whale oil lit the world, to its decline as the twentieth century dawned. This sweeping social and economic history provides rich and often fantastic accounts of the men themselves, who mutinied, murdered, rioted, deserted, drank, scrimshawed, and recorded their experiences in journals and memoirs. Containing a wealth of naturalistic detail on whales, Leviathan is the most original and stirring history of American whaling in many decades.

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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

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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.

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

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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

Offers a bold new argument about how Irish, American and Caribbean modernisms helped remake the twentieth-century world literary system.

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

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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.

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.

A National Book Award Finalist, a New York Times bestseller and one of the most highly-acclaimed books of the year, *A Hologram for the King* is a sprawling novel about the decline of American industry from one of the most important, socially-aware novelists of our time. In a rising Saudi Arabian city, far from weary, recession-scarred America, a struggling businessman named Alan Clay pursues a last-ditch attempt to stave off foreclosure, pay his daughter's college tuition, and finally do something great. In *A Hologram for the King*, Dave Eggers takes us around the world to show how one man fights to hold himself and his splintering family together in the face of the global economy's gale-force winds. This taut, richly layered, and elegiac novel is a powerful evocation of our contemporary moment--and a moving story of how we got here.

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For Resilience Engineering, 'failure' is the result of the adaptations necessary to cope with the complexity of the real world, rather than a breakdown or malfunction. The performance of individuals and organizations must continually adjust to current conditions and, because resources and time are finite, such adjustments are always approximate. This definitive new book explores this groundbreaking new development in safety and risk management, where 'success' is based on the ability of organizations, groups and individuals to anticipate the changing shape of risk before failures and harm occur. Featuring contributions from many of the worlds leading figures in the fields of human factors and safety, Resilience Engineering provides thought-provoking insights into system safety as an aggregate of its various components, subsystems, software, organizations, human behaviours, and the way in which they interact. The book provides an introduction to Resilience Engineering of systems, covering both the theoretical and practical aspects. It is written for those responsible for system safety on managerial or operational levels alike, including safety managers and engineers (line and maintenance), security experts, risk and safety consultants, human factors professionals and accident investigators.

Many organizations tell us that work has never been as safe as it is today. They will show the lowest injury figures ever, and the rosiest incident counts in years. They want to be proud of these accomplishments, and perhaps they should be. But behind these results hides complexity and contradiction-a messiness that Todd Conklin takes us into

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with this book. For one, it is pretty obvious by now that trying to lower our incident and injury rates leaves the risk of process safety disasters and fatalities pretty much unaffected. Getting better at managing injuries and incidents doesn't help us prevent fatalities and accidents-we've known that for a long time (Salminen, Saari, Saarela, & Rasanen, 1992). The number of fatalities in, say, construction, or the energy industry, has remained relatively stable over the past decades (Amalberti, 2013; National-Safety-Council, 2004), even when many organizations proudly report entire years (or more) without injury. Lowering the injury or non-serious incident rate can actually put an organization at greater risk of accidents and fatalities. In shipping, for example, injury counts were halved over a recent decade, but the number of shipping accidents tripled (Storkersen, Antonsen, & Kongsvik, 2016). In construction, most workers lost their lives precisely in the years with the lowest injury counts (Saloniemi & Oksanen, 1998). And in aviation, airlines with the fewest incidents have the highest passenger mortality risk (Barnett & Wang, 2000). What lies behind these fatalities? Do they really happen because some people don't wear their personal protective equipment; that some don't wear gloves when rules say they should? *WorkPlace Fatalities: Failure to Predict* is the first book for the industry professional that speaks directly to this important challenge: If your organization is so safe - Why do we have fatal and serious events?

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