



# The Field Guide to Understanding Human Error

Second Edition

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When faced with a human error problem, you may be tempted to ask 'Why didn't they watch out better? How could they not have noticed?'. You think you can solve your human error problem by telling people to be more careful, by reprimanding the miscreants, by issuing a new rule or procedure. These are all expressions of 'The Bad Apple Theory', where you believe your system is basically safe if it were not for those few unreliable people in it. This old view of human error is increasingly outdated and will lead you nowhere.

The new view, in contrast, understands that a human error problem is actually an organizational problem. Finding a 'human error' by any other name, or by any other human, is only the beginning of your journey, not a convenient conclusion. The new view recognizes that systems are inherent trade-offs between safety and other pressures (for example: production). People need to create safety through practice, at all levels of an organization.

Breaking new ground beyond its successful predecessor, *The Field Guide to Understanding Human Error* guides you through the traps and misconceptions of the old view. It explains how to avoid the hindsight bias, to zoom out from the people closest in time and place to the mishap, and resist the temptation of counterfactual reasoning and judgmental language. But it also helps you look forward. It suggests how to apply the new view in building your safety department, handling questions about accountability, and constructing meaningful countermeasures. It even helps you in getting your organization to adopt the new view and improve its learning from failure.

So if you are faced by a human error problem, abandon the fallacy of a quick fix. Read this book.

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Acknowledgments; Preface; The Bad Apple Theory; The new view; The Hindsight Bias; Put data in context; 'They should have...'; Trade indignation for explanation; Sharp or blunt end?; You can't count errors; Cause is something you construct; What is your accident model?; Human factors data; Build a timeline; Leave a trace; What went wrong?; Look into the organization; Making recommendations; Abandon the Fallacy of a Quick Fix; What about people's own responsibility?; Making your safety department work; How to adopt the New View; Reminders for in the rubble; Index.

## About the Author

Sidney Dekker is Professor and Director of the Key Centre for Ethics, Law, Justice and Governance at Griffith University in Brisbane, Australia. Previously Professor at Lund University, Sweden, and Director of the Leonardo Da Vinci Center for Complexity and Systems Thinking there, he gained his Ph.D. in Cognitive Systems Engineering from The Ohio State University, USA. He has worked in New Zealand, the Netherlands and England, been Senior Fellow at Nanyang Technological University in Singapore, Visiting Academic in the Department of Epidemiology and Preventive Medicine, Monash University in Melbourne, and Professor of Community Health Science at the Faculty of Medicine, University of Manitoba in Canada. Sidney is author of several best-selling books on system failure, human error, ethics and governance. He has been flying the Boeing 737NG part-time as airline pilot for the past few years. The OSU Foundation in the United States awards a yearly Sidney Dekker Critical Thinking Award.

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