## **APS1034H - Understanding Technological Catastrophes**

#### Outline

Despite the best of engineering practices which include a focus on reliability, human factors and quality improvement, spectacular failures of complex technological systems occur regularly: bridges collapse, chemical plants catch fire and explode, airplanes crash and nuclear reactors melt down. Various theories have been proposed to explain this behavior. At two extremes are Normal Accident Theory which claims accidents are inevitable in highly complex and tightly coupled systems, and High Reliability Theory according to which such failures can be avoided by organizations that use appropriate management processes. This course describes these theories, highlights the limits of traditional event-chain models of causation in preventing disasters, and suggests that the safety of large sociotechnical systems can be enhanced using systems thinking and practice. The course comprises the following: (a) seminars that present and integrate the various theoretical approaches to understanding engineering accidents; (b) a demonstration of these concepts using case studies drawn from a range of industries and organizations; and (c) individual and/or group presentations by students analyzing specific disasters.

#### **Syllabus**

SESSION a	TOPIC
1	Disasters as Sociotechnical Events Introduction to the main elements of the course, examples of some recent disasters, and the importance of a system-oriented approach to risk.
	Case 1(a): Herald of Free Enterprise Disaster (introduction)
2	Man-Made Disasters Disasters arise from an interaction between the human and organizational arrangements of sociotechnical systems set up to manage complex and ill-structured risk problems.  Case Study 2: Israeli Intelligence Failure in 1973 October War
3	Normal Accident Theory (NAT)  Claims that accidents in highly complex and tightly-coupled technological systems are inevitable.  Case Study 3: Three Mile Island
4	Epistemic Accidents  System accidents caused by technologies built around fallible theories, judgments and assumptions. Limits of regulation.  Case Study 4: Aloha Flight 243
5	High Reliability Organizations (HRO) High-risk organizations that succeed in avoiding accidents.  Case Study 5: Aircraft Carrier Flight Operations

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	Reliability, Conceptual Slack and Mindfulness of Organizations
6	Defining organizational reliability, and the importance of maintaining sufficient mindfulness and operational slack.
	Case Study 6: The Diablo Canyon Nuclear Power Plant
7	Critique of NAT and HRO Frameworks
	Studies supporting and rejecting Normal Accident Theory. Limitations of High Reliability Organizations.
8	Resolution of the HRT versus NAT Debate
	Summarizes a proposed resolution of the debate via incorporation of a temporal dimension and Practical Drift Theory. Reframing of NAT using open systems concepts such as negentropy and requisite variety.
9	Traditional Safety Engineering versus Systems Thinking
	Reviews the use of traditional event-chain models of causality in accident modelling and highlights the advantages of systems theory as formulated by Jens Rasmussen (Risø) and Nancy Leveson (MIT).
	Case 1(b): Herald of Free Enterprise Disaster (continued)
10	Systems Theoretic Approach to Accident Modelling
	Applying systems theory concepts to accident analysis and prevention requires inclusion of the social system overlying the technical system.
	Case Study 7: Walkerton (Ontario) Water Contamination Accident
11	Student Presentations 1 <sup>b</sup>
	30 min individual/group accident case-study presentations
12	Student Presentations 2 <sup>b</sup>
	30 min individual/group accident case-study presentations

<sup>&</sup>lt;sup>a</sup> Each session is of 2-3 hour duration.

# References

The following books provide a sociological perspective of disaster causation and management. Optional reading if time permits.

- [1] C. Perrow, <u>Normal Accidents:</u> <u>Living with High-Risk Technologies</u>, 2<sup>nd</sup> Edition, Princeton University Press, Princeton, NJ, 1999.
- [2] K.E. Weick and K.M. Sutcliffe, <u>Managing the Unexpected: Resilient Performance in an Age of Uncertainty</u>, 2<sup>nd</sup> Edition, Jossey-Bass, San Francisco, 2007.

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<sup>&</sup>lt;sup>b</sup> Additional sessions may be allocated depending on class size. Peer critique.

#### Textbook

Specific reading material (in the form of available extracts from books and journal articles) covering each topic will be assigned during the course. This will include the systems approach needed for the group project, although an excellent resource is the following book:

N.G. Leveson, *Engineering a Safer World: Systems Thinking Applied to Safety*, MIT Press, Cambridge, MA, 2001.

(Available for short-term loan at the Eng. & Comp. Sci. Library.)

## **Evaluation**

Participation 10%
Term Papers<sup>1</sup> 40%
Team Project Presentation and Report<sup>2</sup> 50%

### Prerequisites

There are no prerequisites other than English-language proficiency. The course is aimed at engineering students enrolled in the ELITE Program, but is open to graduate students from all disciplines including the social sciences and Business Administration.

Schedule (January 12 – April 5)

Tuesdays 6 PM – 9 PM WB219

#### Instructor

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<sup>&</sup>lt;sup>1</sup> Two term papers on the application of Man-Made Disaster framework and Epistemic Accident theory to a severe accident (20% each).

<sup>&</sup>lt;sup>2</sup> Application of the systems approach to the understanding of some technological catastrophe. Team members will be expected to contribute and present sections of the report, and formal critique will be provided by selected class members. Team size: 2-4 (ideally 3).