# **APS1034H – Making Sense of Accidents**

## Outline

Despite the best engineering practices that rely on reliability, human factors, and continuous quality improvement, severe accidents involving complex technological systems occur regularly: bridges collapse, chemical plants catch fire and explode, airplanes crash, and nuclear reactors melt down. The most comprehensive approach to understanding the causes of such disasters is based on a systems-thinking perspective that highlights the limits of traditional event-chain causation models. The course focuses on this approach using a group project but also provides an overview of various sociological theories that have attempted to elucidate the organizational and psychological factors underlying the failure of sociotechnical systems.

## <u>Syllabus</u>

## TOPIC

## Accidents as Sociotechnical Events

Accidents cannot be considered strictly technical events and must be viewed within a social context. Review of traditional approaches to accident analysis.

## **Systems Thinking**

Shortcomings of chain-of-events accident causal analyses. The Rasmussen (AcciMap) "soft" systems engineering approach for understanding and preventing accidents.

Case Study 1: The ferry capsizing accident at Zeebrügge, Belgium.

## Systems-Theoretic Accident Modeling and Processes (STAMP)

A significant enhancement of the Rasmussen systems methodology based on control theory and system dynamics modeling was formulated by Nancy Leveson (MIT).

## Causal Analysis based on Systems Theory (CAST)

The methodology used to perform a STAMP-based analysis of an accident with the goal of identifying the related accident causal factors.

Case Study 2: The Walkerton (Ontario) water contamination disaster.

## Joint Cognitive System (JCS)

The human and machine are considered together as a basic construct, and the focus is on what the JCS does, *i.e.*, its functions, and not on how it does it.

## Functional Resonance Accident Model (FRAM)

In FRAM, the systemic accident model describes the characteristic performance of the JCS rather than focusing on specific cause-and-effect mechanisms. It achieves this by extending the concept of stochastic resonance to normal system functions.

Case Study 3: The RNAV flight area navigation for aircraft operation.

# **Turner's Man-Made Disasters**

Disasters arise from error accumulation resulting from a lack of information and the misinterpretation of warning signals by organizations managing technical systems. *Case Study 4*: Israeli intelligence failure in the 1973 October war.

## **Psychology of Decision-Making**

Our mental machinery underlies strategic surprise, human error, and faulty decisionmaking. This topic discusses how people process information to judge incomplete and ambiguous information.

## Normal Accident Theory (NAT)

This theory, formulated by Charles Perrow (Yale), claims that accidents in interactively complex and tightly coupled technological systems are inevitable.

Case Study 5: Three Mile Island nuclear power reactor accident.

## High Reliability Organizations (HRO)

A discussion of high-risk organizations that succeed in avoiding accidents.

Case Study 6: Aircraft carrier flight operations.

## **Mindfulness in Organizations**

An examination of the processes used by HROs to promote anticipation and resilience, thus achieving operational reliability. Includes a discussion of organizational culture. *Case Study 7*: Refueling at the Diablo Canyon Nuclear Power Plant.

# **Critique of NAT and HRO Frameworks**

Studies supporting and rejecting Normal Accident Theory. Limitations of High Reliability Organizations.

## Textbook

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

E. Hollnagel, *FRAM: the Functional Resonance Analysis Method – Modelling Complex Socio-Technical Systems*, Ashgate, Burlington, VT, 2012.

(Both monographs are available in digital form through the U of T Library system.)

## References

The following books provide a sociological perspective of disaster causation and risk management:

[1] C. Perrow, *Normal Accidents: Living with High-Risk Technologies*, 2<sup>nd</sup> Edition, Princeton University Press, Princeton, NJ, 1999.

[2] K.E. Weick and K.M. Sutcliffe, *Managing the Unexpected: Resilient Performance in an Age of Uncertainty*, 2<sup>nd</sup> Edition, Jossey-Bass, San Francisco, 2007.

Other reading material consisting of journal articles covering various topics will be made available during the course.

#### **Evaluation**

Term paper40%Team project presentation and report60%

#### Team Project

The project will consist of an analysis by competing teams of the 1987 Zeebrügge car ferry disaster using the STAMP or FRAM accident causation models.

#### **Prerequisites**

English-language proficiency, including writing and communication skills, is required. The course is aimed at graduate students enrolled in the ELITE Program but is open to other disciplines.

#### Schedule and Important Dates

Sessions:	Monday, Tuesday, and Thur	sday	5 – 7 pm	MY370
Duration:	Monday, May 1 – Thursday, June 15			
Drop:	Friday, May 26			
Instructor				
(Dr.) Julia	1 Lebenhaft, P.Eng.	julian.lebenhaft@utoronto.ca		