

## Preface

I began my adventure in system safety after completing graduate studies in computer science and joining the faculty of a computer science department. In the first week at my new job, I received a phone call from Marion Moon, a system safety engineer at what was then the Ground Systems Division of Hughes Aircraft Company. Apparently he had been passed between several faculty members, and I was his last hope. He told me about a new problem they were struggling with on a torpedo project, something he called “software safety.” I told him I didn’t know anything about it and that I worked in a completely unrelated field. I added that I was willing to look into the problem. That began what has been a thirty-year search for a solution and to the more general question of how to build safer systems.

Around the year 2000, I became very discouraged. Although many bright people had been working on the problem of safety for a long time, progress seemed to be stalled. Engineers were diligently performing safety analyses that did not seem to have much impact on accidents. The reason for the lack of progress, I decided, was that the technical foundations and assumptions on which traditional safety engineering efforts are based are inadequate for the complex systems we are building today.

The world of engineering has experienced a technological revolution, while the basic engineering techniques applied in safety and reliability engineering, such as fault tree analysis (FTA) and failure modes and effects analysis (FMEA), have changed very little. Few systems are built without digital components, which operate very differently than the purely analog systems they replace. At the same time, the complexity of our systems and the world in which they operate has also increased enormously. The old safety engineering techniques, which were based on a much simpler, analog world, are diminishing in their effectiveness as the cause of accidents changes.

For twenty years I watched engineers in industry struggling to apply the old techniques to new software-intensive systems—expending much energy and having little success. At the same time, engineers can no longer focus only on technical issues and ignore the social, managerial, and even political factors that impact safety

if we are to significantly reduce losses. I decided to search for something new. This book describes the results of that search and the new model of accident causation and system safety techniques that resulted.

The solution, I believe, lies in creating approaches to safety based on modern systems thinking and systems theory. While these approaches may seem new or paradigm changing, they are rooted in system engineering ideas developed after World War II. They also build on the unique approach to engineering for safety, called System Safety, that was pioneered in the 1950s by aerospace engineers such as C. O. Miller, Jerome Lederer, and Willie Hammer, among others. This systems approach to safety was created originally to cope with the increased level of complexity in aerospace systems, particularly military aircraft and ballistic missile systems. Many of these ideas have been lost over the years or have been displaced by the influence of more mainstream engineering practices, particularly reliability engineering.

This book returns to these early ideas and updates them for today's technology. It also builds on the pioneering work in Europe of Jens Rasmussen and his followers in applying systems thinking to safety and human factors engineering.

Our experience to date is that the new approach described in this book is more effective, less expensive, and easier to use than current techniques. I hope you find it useful.

## Relationship to *Safeware*

My first book, *Safeware*, presents a broad overview of what is known and practiced in System Safety today and provides a reference for understanding the state of the art. To avoid redundancy, information about basic concepts in safety engineering that appear in *Safeware* is not, in general, repeated. To make this book coherent in itself, however, there is some repetition, particularly on topics for which my understanding has advanced since writing *Safeware*.

## Audience

This book is written for the sophisticated practitioner rather than the academic researcher or the general public. Therefore, although references are provided, an attempt is not made to cite or describe everything ever written on the topics or to provide a scholarly analysis of the state of research in this area. The goal is to provide engineers and others concerned about safety with some tools they can use when attempting to reduce accidents and make systems and sophisticated products safer.

It is also written for those who are not safety engineers and those who are not even engineers. The approach described can be applied to any complex,

sociotechnical system such as health care and even finance. This book shows you how to “reengineer” your system to improve safety and better manage risk. If preventing potential losses in your field is important, then the answer to your problems may lie in this book.

## Contents

The basic premise underlying this new approach to safety is that traditional models of causality need to be extended to handle today’s engineered systems. The most common accident causality models assume that accidents are caused by component failure and that making system components highly reliable or planning for their failure will prevent accidents. While this assumption is true in the relatively simple electromechanical systems of the past, it is no longer true for the types of complex sociotechnical systems we are building today. A new, extended model of accident causation is needed to underlie more effective engineering approaches to improving safety and better managing risk.

The book is divided into three sections. The first part explains why a new approach is needed, including the limitations of traditional accident models, the goals for a new model, and the fundamental ideas in system theory upon which the new model is based. The second part presents the new, extended causality model. The final part shows how the new model can be used to create new techniques for system safety engineering, including accident investigation and analysis, hazard analysis, design for safety, operations, and management.

This book has been a long time in preparation because I wanted to try the new techniques myself on real systems to make sure they work and are effective. In order not to delay publication further, I will create exercises, more examples, and other teaching and learning aids and provide them for download from a website in the future.

Chapters 6–10, on system safety engineering and hazard analysis, are purposely written to be stand-alone and therefore usable in undergraduate and graduate system engineering classes where safety is just one part of the class contents and the practical design aspects of safety are the most relevant.

## Acknowledgments

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I also am indebted to all my students and colleagues who have helped develop these ideas over the years. There are too many to list, but I have tried to give them

credit throughout the book for the ideas they came up with or we worked on together. I apologize in advance if I have inadvertently not given credit where it is due. My students, colleagues, and I engage in frequent discussions and sharing of ideas, and it is sometimes difficult to determine where the ideas originated. Usually the creation involves a process where we each build on what the other has done. Determining who is responsible for what becomes impossible. Needless to say, they provided invaluable input and contributed greatly to my thinking.

I am particularly indebted to the students who were at MIT while I was writing this book and played an important role in developing the ideas: Nicolas Dulac, Margaret Stringfellow, Brandon Owens, Matthieu Couturier, and John Thomas. Several of them assisted with the examples used in this book.

Other former students who provided important input to the ideas in this book are Matt Jaffe, Elwin Ong, Natasha Neogi, Karen Marais, Kathryn Weiss, David Zipkin, Stephen Friedenthal, Michael Moore, Mirna Daouk, John Stealey, Stephanie Chiesi, Brian Wong, Mal Atherton, Shuichiro Daniel Ota, and Polly Allen.

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# Engineering a Safer World

## Systems Thinking Applied to Safety

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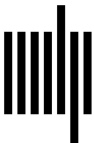
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