The Promise and Problems of the "New View" of Safety

MICHAEL R FEARS
BA, MA, ABD PHD, CRSP
Safety Guy, Investigator, Instructor, Speaker, Researcher, Author
mikefears@recoveringacademic.ca
www.recoveringacademic.Ca

The Recovering Academic

22ND Alberta Health & Safety Conference

Calgary, AB, Westin Calgary Airport, Blackfoot A/B, Wednesday, 03 April 2025, 0900-1000 hrs

The George Institute for Global Health

WHO Collaborating Centre for Injury Prevention and Trauma Care

SAFETY 2024

15th World Conference on Injury Prevention & Safety Promotion

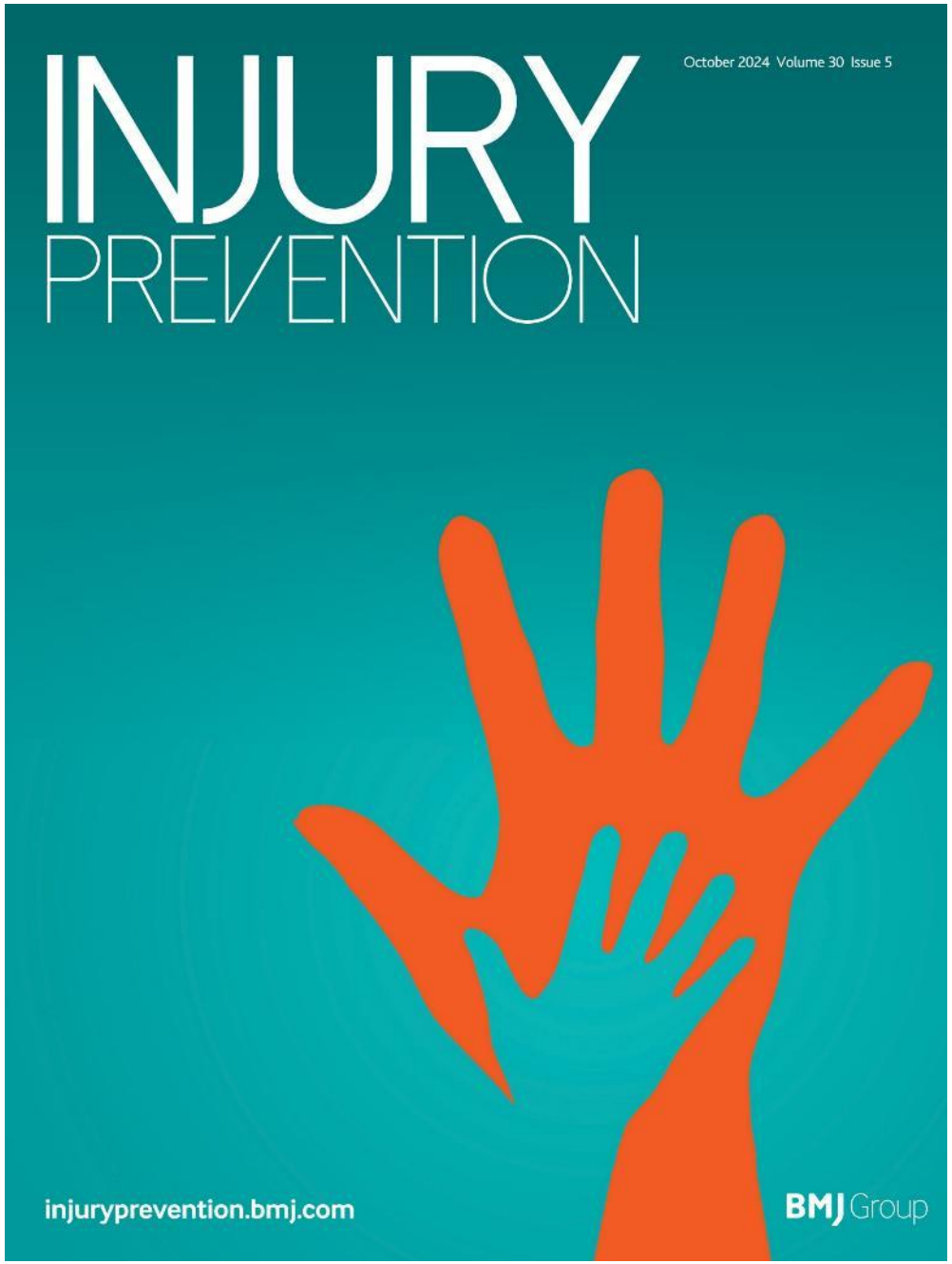
DELHI, INDIA

Building a Safer Future for All: Equitable and Sustainable Strategies for Injury and Violence Prevention

2nd to 4th September 2024

World Health Organization

https://www.worldsafety2024.com/



698 The promise and problems with the "new view" of safety: weaknesses, limitations, and suggestions for further research

Michael Roman Fears

Abstract

Background The "New View" of occupational health and safety (Resilience Engineering, Human and Organization Performance, Safety Differently, Safety-II, etc.), has promised an updated approach to improve safety performance and outcomes. For over a decade it has been the "hot topic" with courses, conferences, and professional practice groups globally. However, safety outcomes remain unchanged.

Objective To determine if application of New View approaches have reduced the rate and severity of unwanted safety events.

Programme Description A literature review was conducted of related texts, case studies, and journal publications. Podcasts, videos, courses, and presentations by its main proponents were included. Reported implementation was assessed against evidence of outcomes.

Outcomes and Learning The New View has not lived up to its promise for several reasons. New View approaches assume, and even rebrand, "old" practices (learning teams). Many definitions, assertions, and arguments are circular and/or internally inconsistent ("safety," systems are the problem and the solution?). The multiple contextual layers that influence how "safety happens" are vaguely understood, dismissed, or missed – peculiar since "context drives behaviour" is the central New View assertion. As a result, New View applications have failed to produce evidence any measurable improvements.

Implications Despite significant issues, the "New View" does contain important insights. One is a renewed focus on context in shaping behaviours and actions. Another is how to ensure responses to unwanted events align with effective corrective action and long-term organizational learning. These should be taken to heart by all safety practitioners within their continual improvement efforts.

Conclusion The New View has yet to demonstrate an advantage over the "old view." To prove otherwise, future research will need to directly and rigorously compare implementation of New View approaches to implemented "old" practices, demonstrating if they can achieve better safety outcomes as promised.

https://doi.org/10.1136/injuryprev-2024-SAFETY.347

https://doi.org/10.1136/injuryprev-2024-SAFETY.347

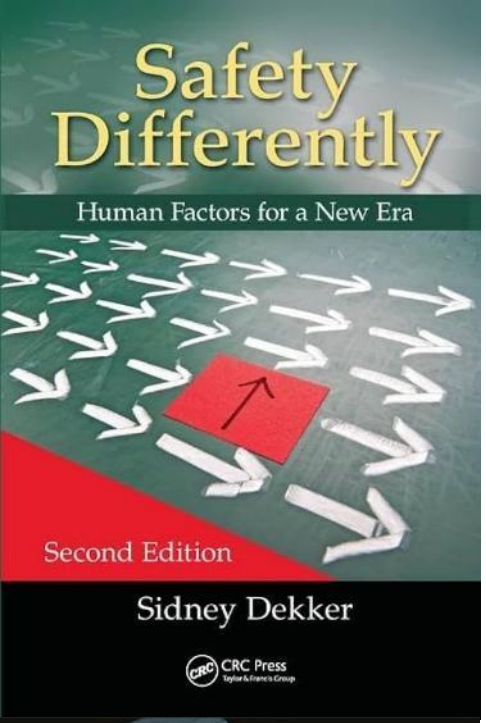
Summary

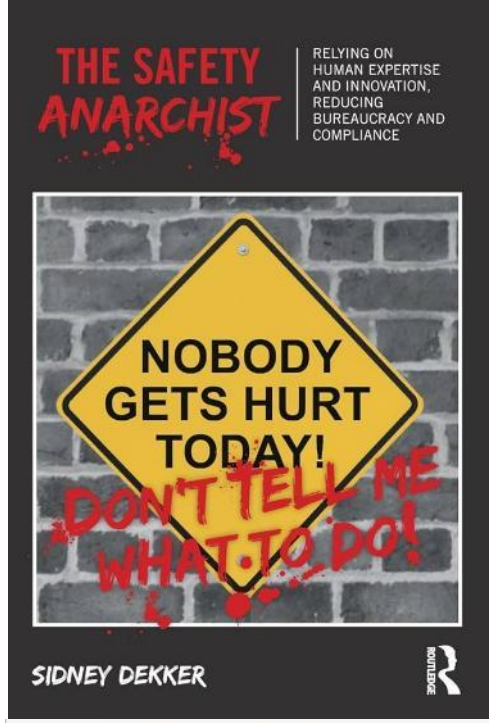
- What is the “New View” of Safety?
- The Big Five Ideas (and 3 little ideas)
- New View good, not-so-good, and BFE*

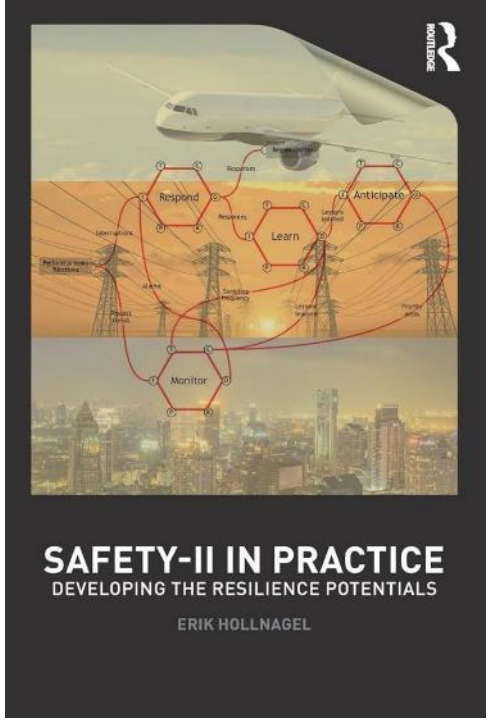
*Bovine Fecal Expostulations

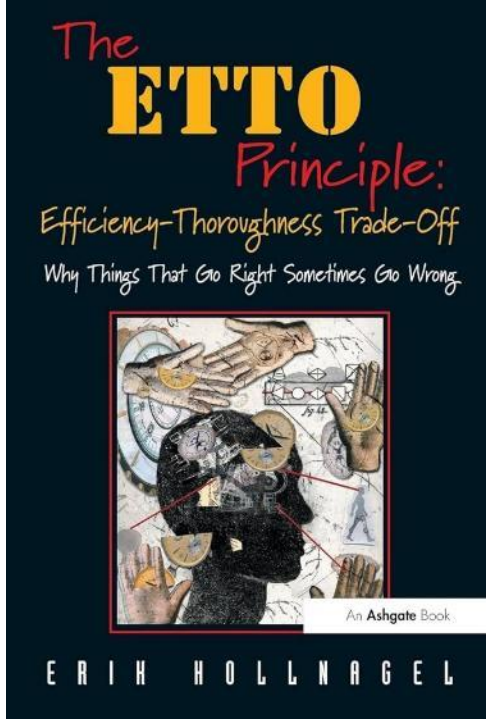
What is the “New View”

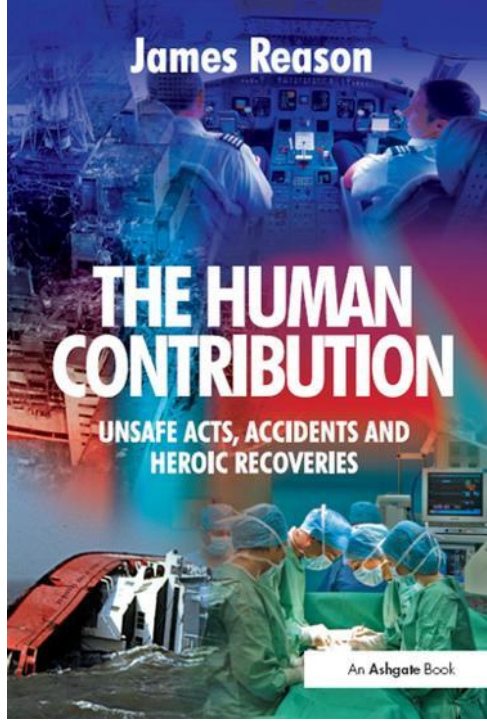
An AI generated image depicting the concept of a “new view” of occupational health and safety (2025, March 15). Image generated using Microsoft Designer.

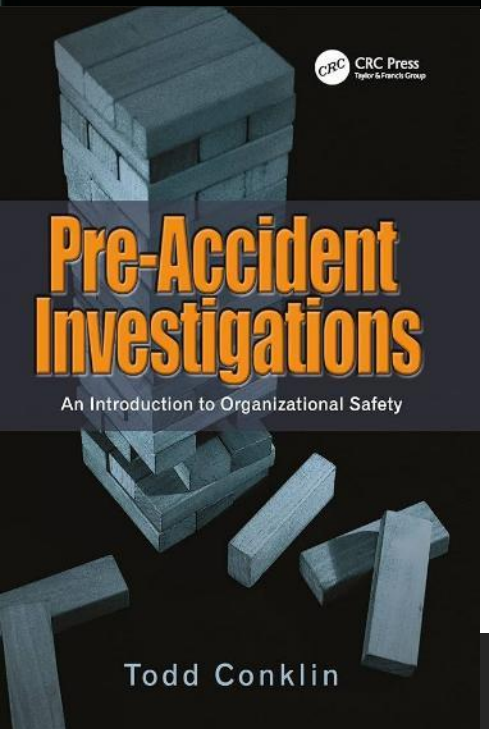

Safety Differently
Human Factors for a New Era
Second Edition
Sidney Dekker
CRC Press

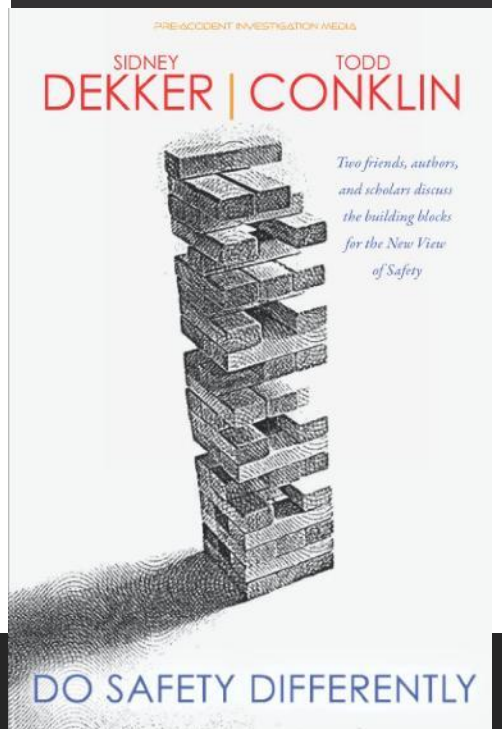

THE SAFETY ANARCHIST
RELYING ON HUMAN EXPERTISE AND INNOVATION, REDUCING BUREAUCRACY AND COMPLIANCE
NOBODY GETS HURT TODAY!
DON'T TELL ME WHAT TO DO!
SIDNEY DEKKER

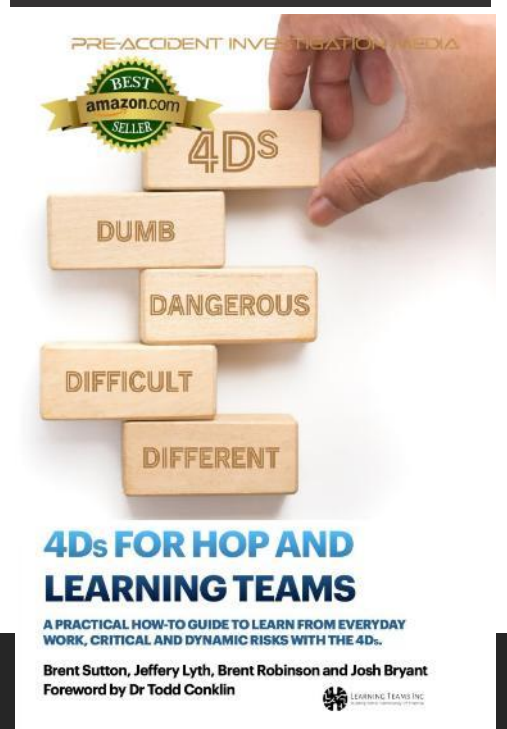

Respond
Anticipate
Learn
Monitor
SAFETY-II IN PRACTICE
DEVELOPING THE RESILIENCE POTENTIALS
ERIK HOLLNAGEL

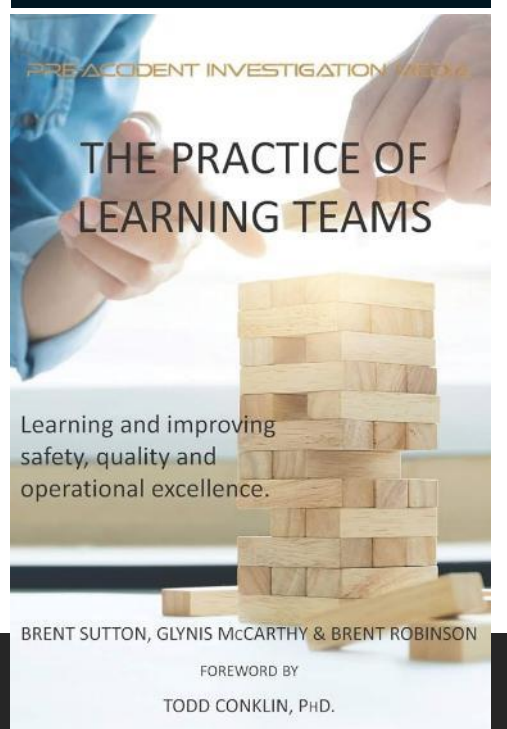

The ETTO Principle:
Efficiency-Thoroughness Trade-Off
Why Things That Go Right Sometimes Go Wrong
An Ashgate Book
ERIK HOLLNAGEL

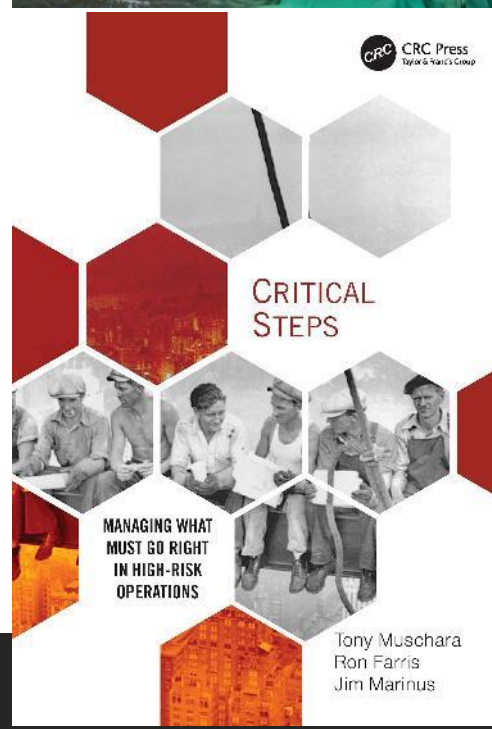

James Reason
THE HUMAN CONTRIBUTION
UNSAFE ACTS, ACCIDENTS AND HEROIC RECOVERIES
An Ashgate Book


CRC Press
Pre-Accident Investigations
An Introduction to Organizational Safety
Todd Conklin


SIDNEY DEKKER | TODD CONKLIN
Two friends, authors, and scholars discuss the building blocks for the New View of Safety
DO SAFETY DIFFERENTLY


BEST amazon.com SELLER
4Ds
DUMB
DANGEROUS
DIFFICULT
DIFFERENT
4Ds FOR HOP AND LEARNING TEAMS
A PRACTICAL HOW-TO GUIDE TO LEARN FROM EVERYDAY WORK, CRITICAL AND DYNAMIC RISKS WITH THE 4Ds.
Brent Sutton, Jeffery Lyth, Brent Robinson and Josh Bryant
Foreword by Dr Todd Conklin


THE PRACTICE OF LEARNING TEAMS
Learning and improving safety, quality and operational excellence.
BRENT SUTTON, GLYNIS McCARTHY & BRENT ROBINSON
FOREWORD BY
TODD CONKLIN, PhD.


CRC Press
CRITICAL STEPS
MANAGING WHAT MUST GO RIGHT IN HIGH-RISK OPERATIONS
Tony Muschara
Ron Farris
Jim Marinus

2 approaches – Systems & Human Factors

- Resilience engineering, high-risk & high-impact industries
  - Hollnagel, Woods, Le Coze

- Psychological & “human factor” approaches
  - Reason, Dekker, Conklin, Provan, Sutton, Muschara

Old Safety	New Safety
System Focus	Worker Focus
Blame Workers	Learning Organization
Safety = Outcomes	Safety = Capacity
Control of Work	Freedom to Work

Critical views

Cooper, M. (2022). The emperor has no clothes: A critique of Safety-II. *Safety Science*, 152, 105047. https://doi.org/10.1016/j.ssci.2020.105047

Le Coze, J. C. (2022). The 'new view' of human error. Origins, ambiguities, successes and critiques. *Safety Science*, 154, 105853. https://doi.org/10.1016/j.ssci.2022.105853

Verhagen, M. J., De Vos, M. S., Sujan, M., & Hamming, J. F. (2022). The problem with making Safety-II work in healthcare. *BMJ Quality & Safety*, 31(5), 402-408. https://doi.org/10.1136/bmjqs-2021-014396

The real (non-academic) question

Can implementing the New View ideas improve safety outcomes?

The Big Five Ideas

1. Error is normal
2. Blame fixes nothing
3. Context drives behaviour
4. Learning and improving are vital
5. Management response matters

Modified version of original list at: Energy Safety Canada. (2022). *Human and Organizational Performance*. Retrieved October 1, 2023, from https://www.energysafetycanada.com/Standards/Programs/Human-and-Organizational-Performance

#1
Error is normal

#8 Sure Boss, The Bus Has All The Seats In Place [Photograph]. (2023, January 16). Bored Panda. https://www.boredpanda.com/most-pointless-useless-things/?media_id=595184&utm_source=newsletter&utm_medium=link&utm_campaign=Newsletter

Error and the New View

- People and systems aren’t perfect
- Error is a feature of every operation
- Systems are a (major) source of error

It's a system problem

- More complex, unclear expectations
- Technical jargon, incomplete or contradictory instructions
- Competing "incentives"
  - Bonus for no (reported) injuries

What is error?

"Error in an unexpected deviation from an expected outcome. Error is an unintentional event. Error is doing something that you didn't intend to do."(p.8)

"Error is simply the unintentional deviation from an expected behavior."(p.8)

"Error is never intentional… unintentional deviations from expected behaviors." (p10)

Conklin T. *5 principles of human performance: A contemporary update of the building blocks of human performance for the new view of safety*. Santa Fe, NM: Pre-Accident Investigation Media; 2019

Don't check your fuel level with a lighter at this gas station [Photograph]. (2017). reddit. https://www.reddit.com/r/OSHA/comments/5nbn4t/dont_check_your_fuel_level_with_a_lighter_at_this/?rdt=63657

Concerns

- Error may be normal, but not every error is “normal”
- “Honest” and “not-so-honest” mistakes
- If there is no incident, are we good?

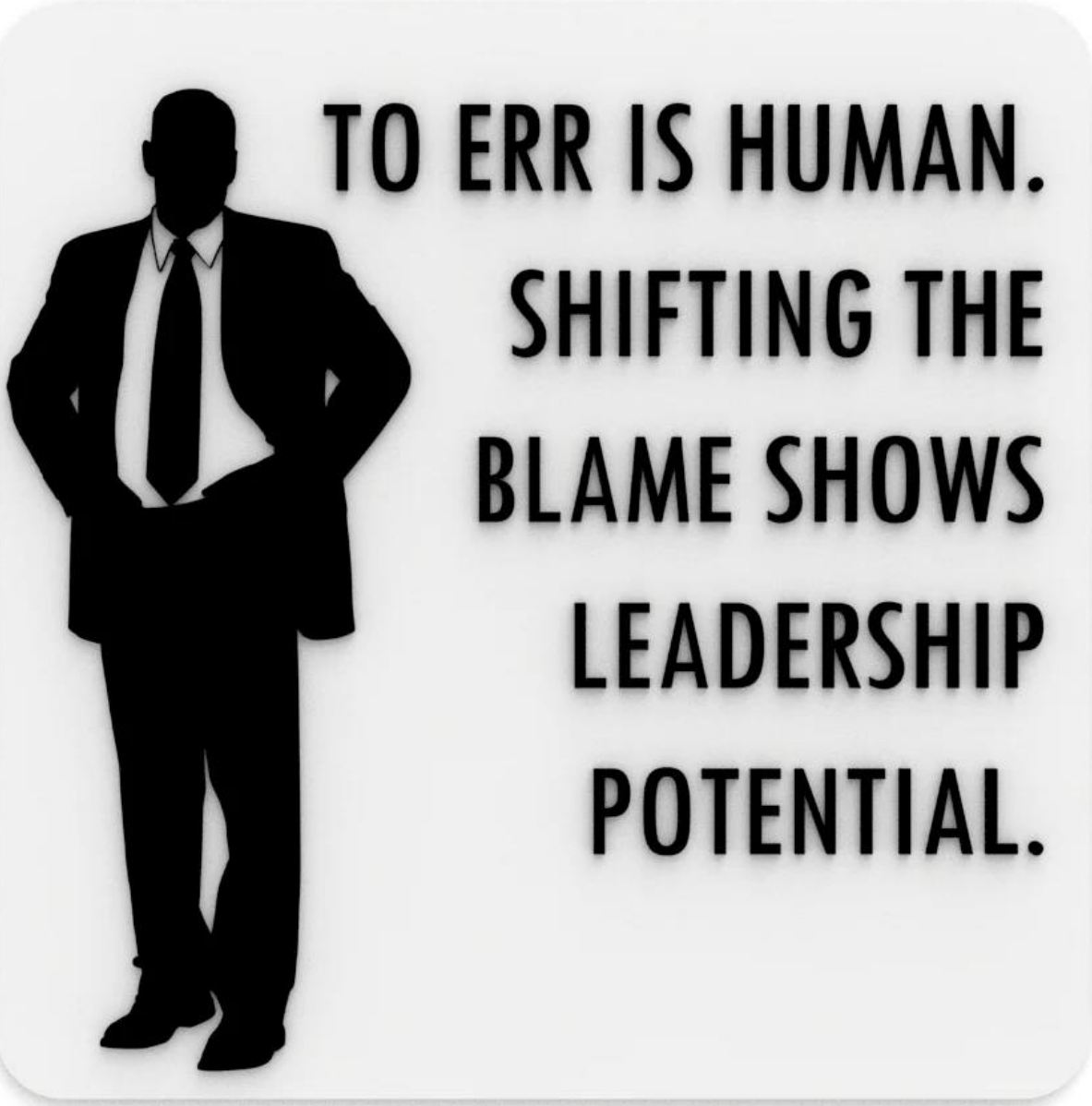
All good?

#43, #16, #7 [Photographs]. (2024, January 30). Bored Panda. https://www.boredpanda.com/stupid-people-work/?utm_source=newsletter&utm_medium=email&utm_campaign=Newsletter

Positive takeaways

- Some “errors” are really part of a “system”
- Put a speed bump (or 2) before the blame game
- Ultimate responsibility for safety belongs to those who direct work and control resources

#2
Blame fixes nothing



Funny Sign | To Err Is Human. To Blame it On Someone Shows Management Potential [Photograph]. (2025). Clever Contraptions. https://clevercontraptions.com/en-ca/products/funny-sign-to-err-is-human-management

Old Safety

Worker = problem

Worker's fault

Corrective actions focus on punishment

New Safety

System = problem

Workers are experts

Focus on success – not failures

What the New View says

- Systems are too complicated
- Reduce, declutter, and cut paperwork
- Focus on relationships, not bureaucracy
- Simply systems to “free” workers

Important observations

- Due diligence increasingly “paper chases”
- Lack of paperwork is path to blaming workers
- We do things that people believe are unnecessary (even if they don’t say it out loud)

Little Idea #1

Workers should decide how work is done

#35 [Photograph]. (2024, January 30). Bored Panda. https://www.boredpanda.com/stupid-people-work/?utm_source=newsletter&utm_medium=email&utm_campaign=Newsletter

What the New View says

- Workers are the experts at what they do – get out of their way (less systems)
- Focus on what goes right, don't prioritize what goes "wrong" (don't blame)
- Work-as-Done vs. Work-as-Imagined

Are we happy with this?

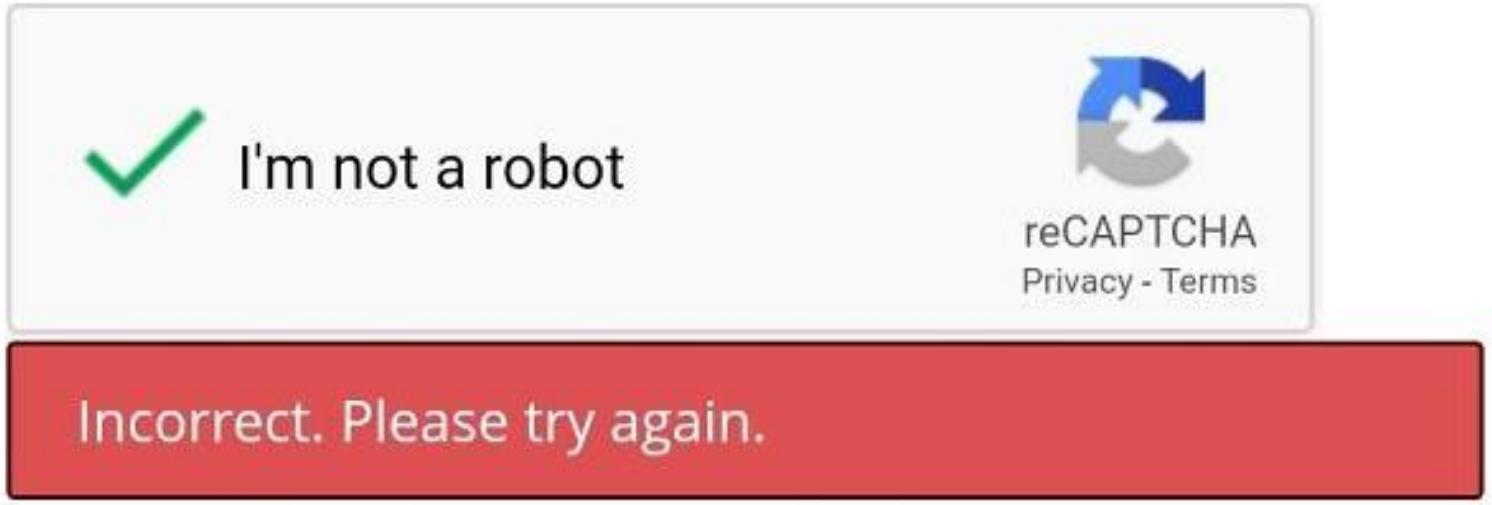
#27, #6, #49 [Photographs]. (2024, January 30). Bored Panda. https://www.boredpanda.com/stupid-people-work/?utm_source=newsletter&utm_medium=email&utm_campaign=Newsletter

Serious concerns

- Overstates the “blame game”
- Sometimes blame is appropriate
  - Boeing & Homer Simpsons exist in real life
- How about: *“Blame is not a corrective action”?*

Little Idea #2

Minimal systems, more freedom



#25 Damn Robots [Photograph]. (2020, July 3). Bored Panda. https://www.boredpanda.com/funny-computer-errors-software-glitches/

The actual logical extension

- Let workers do “their thing”
- “Let my people go” – no safety manuals, instructions, etc.
- No investigations – have discussions and “learning sessions”

Charlton Heston in Ten Commandments [Photograph]. (2012, January 26). The Cineastes Lament. https://thecineasteslament.com/2012/01/26/spielberg-to-get-his-moses-on-with-gods-and-kings/

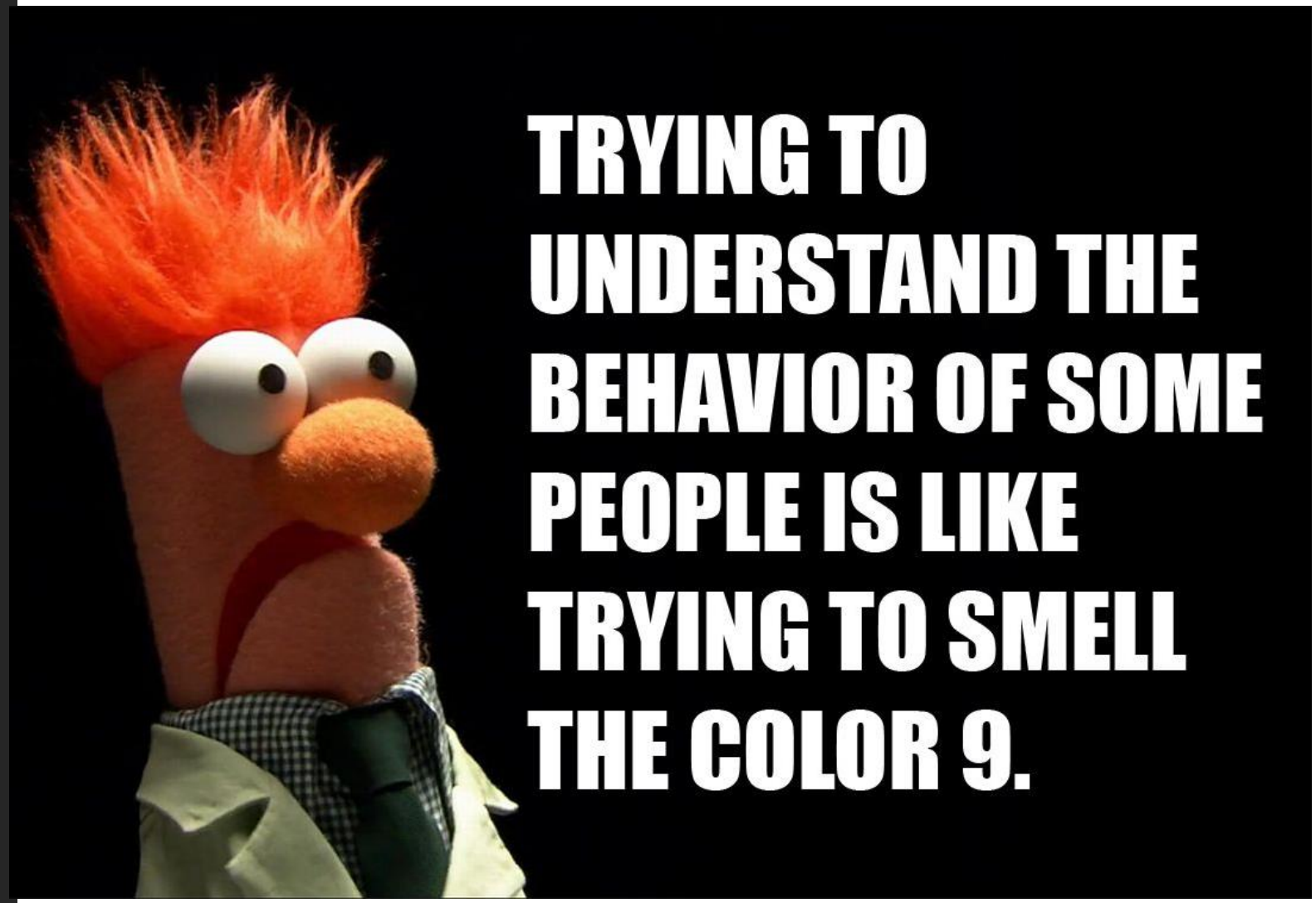
Do we ignore the people “problem”?

- People are people & make mistakes
- They often take shortcuts and risks
- Their behaviour is often a mystery – even to themselves

Reality bites

- Context matters – liability, laws, clients, etc.
- More complicated work = more complicated systems?
- Letting workers decide likely requires more oversight, not less
- Systems are required – for good or bad

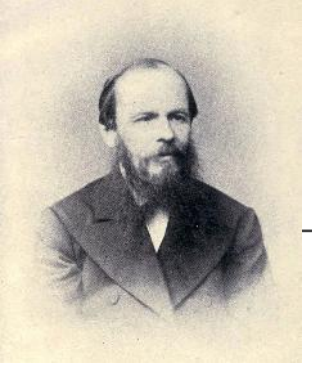
#3 Context Drives Behaviour



Goodwin, D. (n.d.). [Photograph]. Pinterest. https://ca.pinterest.com/pin/194077065166465297/

Context DOES drives behaviour

This is the most important “rediscovery” in the New View approach



Remember this

The nature and causes of human actions are usually immeasurably more complex and varied than our subsequent explanations of them.

F. Dostoyevksky, *The Idiot*

Fyodor Dostoyevsky 1876 [Photograph]. (2025, February 5). Britannica. https://www.britannica.com/biography/Fyodor-Dostoyevsky

Context matters

- Work does not happen in a vacuum
- The context can have massive impact on efficiency and outcomes
- It is complex and is always changing

Where the New View errs

- Focused only on internal context
  - Often just supervisor / crew / worker
- Ignores layered and external influences
  - Budgets, time pressures, changing laws, client demands, economy, etc.

Modular Switchgear Enclosures [Photograph]. (2023, July 19). Porta-King Building Systems. https://www.portaking.com/equipment-enclosures/switchgear-enclosures/

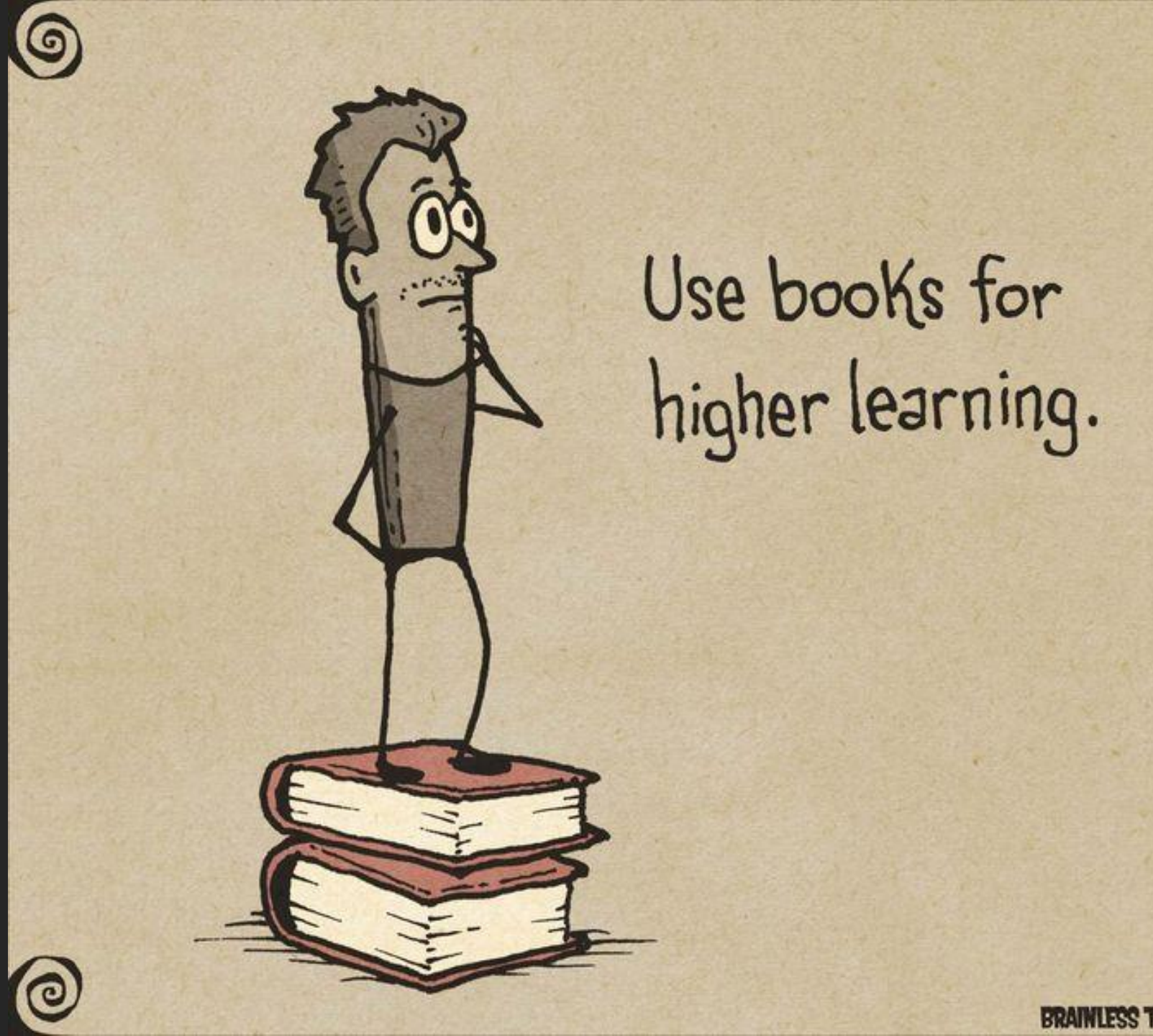
Incident

- Techs installed part in switchgear
- Turned on switchgear
- Caused blackout
- Management: it’s worker error

Maybe some context?

- COVID – vaccine policy, illnesses, job losses
- Union / management tension
- New equipment – unfamiliar, very different
- Original part broken during installation
- New part arrived months later
- Control panel wasn’t programmed

#4 Learning & Improving are Vital



Higher learning [Web image]. (2016, January 26). Brainless tales. https://www.brainlesstales.com/2016-01-26/higher-learning

No disagreement

- Continual improvement
- Identify and fix system issues
- Learning should be wide and broad

New View's odd approach

- Stop root cause analysis – doesn't work
  - Same issues, organizations aren't learning
- Use Learning Teams or 4Ds
  - 4Ds – Dumb, Dangerous, Different, Difficult
- Deeper learning, better engagement

Interesting, but…

- Learning Teams are designed only for general information gathering
- 4Ds are type of “stop and think”

No evidence that 4Ds or Learning Teams can complete effective investigations

Root cause analysis in context

- Regulators – AB OHS, WCB
- Clients – investigation in 48 hrs
- Certificate of Recognition (COR) audits
- Good investigators using decent systems can be very effective (TapRooT®)*

What is the real issue?

- Bad root cause investigations
- Poor corrective actions
- Not implementing corrective actions
- All or some of the above?

Good reminders

- Investigations up to snuff?
- Real corrective actions or more BFE*?
- A “management problem”?
- Following up like we should?
- Fixing things, or just closing the file?

*Bovine Fecal Expostulations

Modular Switchgear Enclosures [Photograph]. (2023, July 19). Porta-King Building Systems. https://www.portaking.com/equipment-enclosures/switchgear-enclosures/

Incident

- Techs installed part in switchgear
- Turned on switchgear
- Caused blackout
- Management: it’s worker error

Investigation

- COVID – everyone distracted, worker “demotions”, labour tension, many personal issues
- Poor communications and paperwork – forgot control panel was not programmed
- No change management program
- No real lockout / tagout process

Little Idea #3

Safety is a capacity, not an outcome

An AI generated image of a maintenance worker missing a right leg and left arm. (2025, February 23). Image generated using Microsoft Designer.

What the New View says

- You can have no/low incidents and be “unsafe”
- Safety is about how “resilient” an organization is
- Learn from what works, don’t focus on outcomes (i.e., injury stats)
- The answer to error is “better” systems (?)

Concerns

- What is “capacity for safety”?
  - Organizational rebound? Worker rebound?
- Is it okay to lose an arm or a leg if down time is minimized?

[Web image]. (2020, July 11). Medium. https://medium.com/swlh/the-ten-most-ridiculous-error-messages-in-the-history-of-software-4198d710ea8e

Same old, same old?

Is “capacity for safety” just a strange rebranding of “***failing safely***” and “***ability to recover from error***”?

See HAZOP and TapRooT®

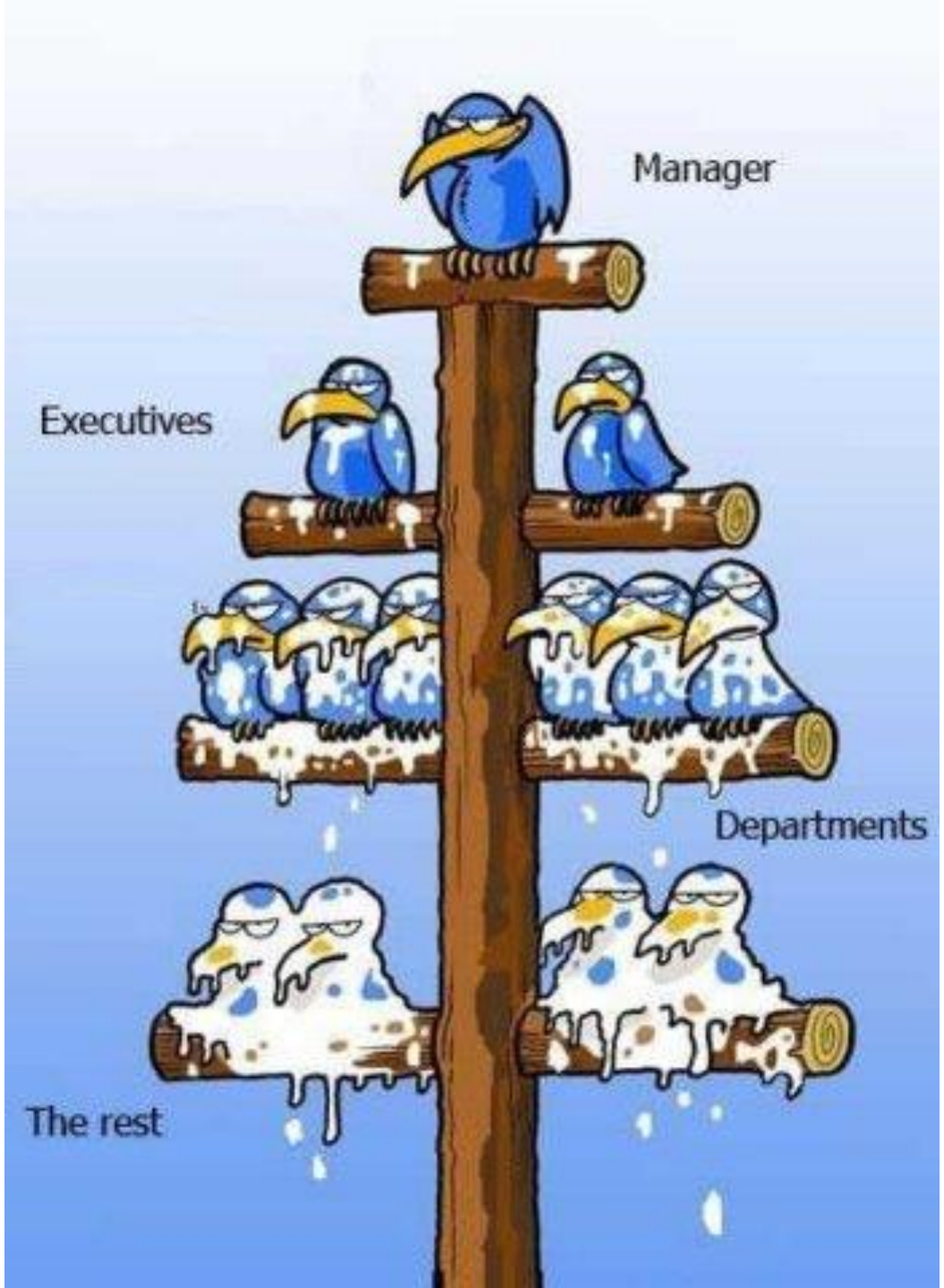
Outcomes

Capacity

Someone ill, injured, disabled, or killed on the job is more important than “capacity”.

Nikiforov, O. (2017, April 5). [Donald Trump emoticon]. fineartamerica.com. https://fineartamerica.com/featured/donald-trump-emoticons-oleg-nikiforov.html

#5 Management Response Matters



Management levels [Web image]. (2019, January 30). Mike's Blog. https://mikesblog.com/funny-idea-of-management-structure-but-i-disagree/

New View management must:

- Accept the inevitability of error
- Avoid blame
- Set the proper context
- Focus on learning

This makes sense

- Management leads (not safety guy / gal)
- Blame, learning, improvement, and some context are management outcomes
- Organizational culture is “safety culture”

Limited view

- The New View focuses on “leadership” (executives), not managers
- Work as Done vs. Work as Imagined is often a response to conflicting priorities
  - Often the gap is found in the “frozen middle”
  - Ignores layers of context (including “real” messages)

Vacuum Truck Explosion Injures Worker

WorkSafeBC. (2016, November 7). *Incident investigation: Vacuum truck explosion injures worker* | *WorkSafeBC* [Video]. YouTube. https://youtu.be/AiW104jHw4U?si=ZlECXtImcS2YclAG

The Incident

- Fire lasted 3 days
  - 1 heart attack, driver permanently disfigured
  - Staff significantly psychologically impacted
- About 60 million in repairs
- 35 orders from regulator - $200,000 fine
- Major hit to revenue

Background

- Same task 100,000 times a year – 11 years since last incident (no loss to company)
- Ignored several significant near misses – so staff stopped reporting
- They just designed and built a facility down the road where this could not have happened

No change because…

- Insurance wouldn’t cover the cost
- New design raises efficiency “concerns”
- Competitors don’t do it
- Cost “impractical” given potential benefits
  - Event thought to be an “outlier” (1 in 1.1 mill)

Things to consider

- Changing response means changing corporate culture (not just safety)
- Complexity also impacts management
- Management response can be improved, but it is constrained by its own context

Conclusions?

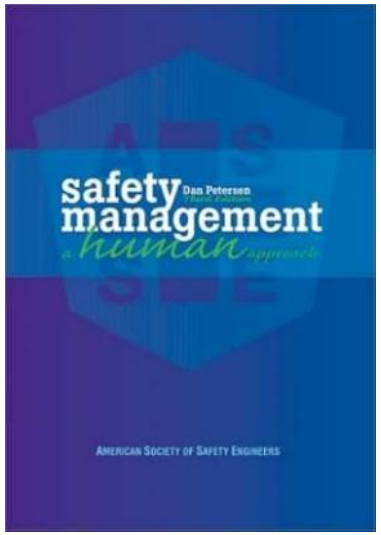
Old Safety vs. “New View”

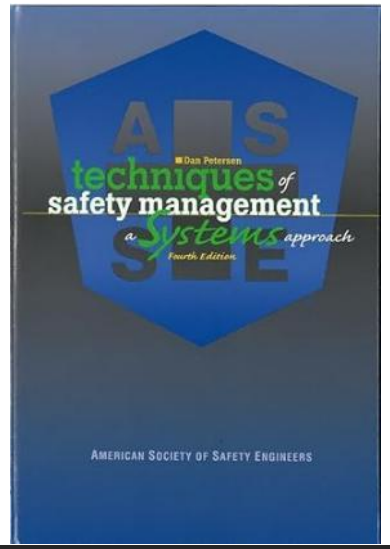
- The new needs to build upon the old, not toss it out
- Must recognize key realities in safety
  - Laws, due diligence, WCB, outcomes, client demands, social responsibility, etc.

No evidence of better safety outcomes

“Old Safety” rebranded?

- Human factors vs. systems is “old news”
- Dan Peterson
  - *Safety Management: A Human Approach (1975)*
  - *Techniques of Safety Management: A Systems Approach (1978)*





Safety Management: A Human Approach and *Techniques of Safety Management: A Systems Approach* [Photographs]. (n.d.). Amazon. https://www.amazon.ca/Techniques-Safety-Management-Systems-Approach-dp-1885581394/dp/1885581394/ref=dp_ob_image_bk

New View – Disunified Theory

- Prescribes “more systems” but demands “more freedom”
- Confusion over concepts (safety, error) or repackages old ideas as “new”
- Narrow field of vision – context and real-world application

Out of the jaws of victory?

- Safety isn’t perfect, but it’s not broken
- Flat or inconsistent numbers may indicate a limit, statistical noise, or “reasonable” balance
- “Failure to learn” – root cause, context, management, or a mix?

Parting thoughts

- Understand the **total context** if you want to improve safety outcomes
- There are some positive takeaways, but many dead ends
- New View looks a lot like the emperor's new clothes


The Recovering
Academic

Recommended “New View” Reading

Bryant, J., Lyth, J., Robinson, B., & Sutton, B. (2023), *4Ds for HOP and learning teams*. Learning Teams Inc.

Conklin, T. (2019). *Pre-accident investigations: An introduction to organizational safety*. CRC Press.

Conklin, T. E. (2019). *The 5 principles of human performance: A contemporary update of the building blocks of human performance for the new view of safety*. Independently Published.

Dekker, S. (2014). *Safety differently: Human factors for a new era* (2nd ed.). CRC Press.

Dekker, S. (2017). *The Field guide to understanding 'Human error'*. CRC Press.

Dekker, S., & Conklin, T. (2022). *Do safety differently*.

Hollnagel, E. (2017). *The ETTO principle: Efficiency-thoroughness trade-off: Why things that go right sometimes go wrong*. CRC Press.

Hollnagel, E. (2017). *Safety-II in practice: Developing the resilience potentials*. Routledge.

Hollnagel, E. (2022). *Synesis: The unification of productivity, quality, safety and reliability*. Routledge.

McCarthy, G., Robinson, B. M., & Sutton, B. (2020). *The practice of learning teams: Learning and improving safety, quality and operational excellence*.

Muschara, T., Farris, R., & Marinus, J. (2021). *Critical steps: Managing what must go right in high-risk operations*. CRC Press.

Reason, J. (1990). *Human error*. Cambridge University Press.

Schein, E. H. (2013). *Humble inquiry: The gentle art of asking instead of telling*. Berrett-Koehler Publishers.