

1. Pursue second stories beneath the surface to discover multiple contributors to a safety hazard
2. Escape hindsight bias
3. Understand work as performed at the sharp end of the system (and not depend on being told how it is intended to be)
4. Search for systemic safety vulnerabilities
5. Study how practice creates safety
6. Search for underlying patterns
7. Examine how change to the care pathway will produce new vulnerabilities and paths to failure
8. Use new technology to support and enhance human expertise
9. Tame complexity with new forms of feedback