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Two contrasting views of the South Korea ferry accident: Lessons learned from using a story-based animation for dissemination of research [Abstract]

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http://www.hf-complexsystems.org.uk/

PUBLISHER

CIEHF and the University of Nottingham

VERSION

AM (Accepted Manuscript)

PUBLISHER STATEMENT

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REPOSITORY RECORD

Jun, Gyuchan Thomas, Man Ki Park, Patrick Waterson, and Roger Haslam. 2019. "Two Contrasting Views of the South Korea Ferry Accident: Lessons Learned from Using a Story-based Animation for Dissemination of Research [abstract]". figshare. https://hdl.handle.net/2134/24052.

Two Contrasting Views of the South Korea Ferry Accident: Lessons Learned from Using a Story-Based Animation for Dissemination of Research

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Abstract

Our understanding of how complex systems fail has made huge progress over the past sixty years from Heinrich's domino model to present-day thinking on resilience engineering. The latest models might be familiar among academics and safety practitioners, but are not widely known among other important stakeholder groups, including policy makers, management leadership, media and general public. The lack of understanding often leads to a counter-productive blame culture, as shown in the aftermath of the South Korea ferry accident and many others. Therefore, there is an urgent need to educate/communicate the latest systems safety thinking to a wider audience. As part of this endeavor, a ten-minute story-based animation, Two Contrasting Views of the South Korea Ferry Accident, was produced through collaboration between a human factors research team and an animator. This paper aims to present the impact of the animation dissemination and share the lessons we learned from the animation production. In terms of the impact, so far (10 months after the official roll-out on 13th July 2015), the animation has been viewed approximately 10,000 times around 70 different countries. The animation received positive comments from various academics, safety practitioners and media personnel including, but not limited to, Richard Cook (Professor of Patient Safety), Don Norman (Professor Emeritus of both Psychology and Cognitive Science), Sidney Dekker (Professor of Human Factors & Safety) and Steve Evans (BBC's Seoul Correspondent). Many commentators declared that they will use the animation for student teaching, professional training and client discussions. Some urged that people at all levels should watch and digest it.

Surprisingly, the responses in Korea were not as enthusiastic as elsewhere. Two possible explanations for this might be a pre-existing hierarchical culture of Korean society and post-traumatic stress at the society level in the aftermath of the accident. First, South Korea has a culture that is characterised by relationships ordered by status and a strong sense of shame. In such a culture, holding people accountable by blaming them is widely-accepted. A more complex, counter-intuitive and paradoxical systems safety concept might have been a challenge to accept. Second, the politicized aftermath with various versions of conspiracy theories on the accident could have made the Korean public weary of listening to another version of explanation about the accident through our story-based animation.

The lessons on the production are twofold. First, the researcher and animator had to play the co-directing role together throughout the production process (fund raising,

script writing, storyboarding, modelling, rigging, mock narrative recording, rendering and sound effect production). It was a painstakingly iterative collaboration. For example, every visual (both static and dynamic) created by the animator had to be carefully validated by the researcher to prevent any misrepresentation of important messages. Consequently, the working relationship between the researcher and animator had to be beyond a business association. It would not have been possible to produce the animation without vision, goodwill and commitment shared by both.

Sponsors / Acknowledgements

The authors acknowledge support for the animation production from Enterprise Office at Loughborough University.