

FAILED AUDIT OR FAILING AUDIT SYSTEM?

How Audits Provide Comfort Over Risk Treatment

By Ben Hutchinson

Are your audits effective checks on critical risk systems or merely paperwork exercises that provide comfort? Organizations use audits as pillars of assurance. Safety professionals rely on audits, in part, to reveal critical gaps.

However, what if audits do not reveal these gaps? What if auditing, the process we trust to tell us whether our systems are functional, is instead little more than rustling paper that offers comfort while critical threats remain unaddressed?

Major incident investigations hint at an unsettling reality: audits often fail to warn organizations of emerging danger. For example, the 1988 Piper Alpha disaster, had no shortage of auditing. Yet the audits did not pick up on critical procedural departures, and the absence of critical commentary in the reports “lulled senior management into believing that all was well” (Appleton, 2001, p. 203). This suggests that audits can fail to function as an early warning sign.

This article discusses how audits fail, focusing on two recent studies. There are no silver bullets here, nor a five-point plan for better audits. Rather than one-and-done answers, this article aims to spark better questions to help practitioners critically challenge the assumptions and performance of audits.

Defining Audits & What They Should Achieve

For the purposes of this article, “audit” is defined as a systematic process intended to determine the extent to which safety criteria are fulfilled (Standards Australia/Standards New Zealand, 2019). A core goal of safety audits should be to reduce the degree of decoupling. Decoupling is the misalignment between intentions and reality (i.e., between what our safety system should achieve versus what it actually achieves). For example, decoupling is evident when an audit reports mine ventilation as “working as intended” when in reality mine ventilation processes are critically flawed.

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Unfortunately, the ability of audits to effectively reduce decoupling, or drive risk elimination and mitigation, is challenged by research. Audits may not assess whether safety systems are fit-for-purpose (Hopkins, 1999), may overprioritize the analysis of paperwork at the expense of assessing safety systems (Batalden & Sydnes, 2015; Blewett & O’Keeffe, 2011; Hutchinson et al., 2024a, 2024b), or may contribute to gaming behaviors where audit scores are managed over operational issues (Blewett & O’Keeffe, 2011).

Four Ways Audits Fall Short

The author’s study of 44 major incident reports used counterfactual logic to understand how audits fail (Hutchinson et al., 2024b). Counterfactuals are statements that incident investigators make regarding what an audit should have done, but did not, to prevent a disaster. The research identifies four high-level ways that audits fail to achieve their goals (Hutchinson et al., 2024b):

•**They fail to facilitate an accurate understanding of threats.** Audits often misinterpret the saliency of threats, seeing them as minor issues when they are systemic problems. They may detect symptoms (e.g., trip hazard, missing tag, unsigned permit) but miss the underlying conditions and weak signals that reveal

a much larger issue (e.g., absent confined space atmospheric testing practices).

•**They fail to facilitate timely action against threats.** Instead of pushing for immediate and effective remediation, audits inadequately prevent the deterioration of known issues. They may document a problem but fail to follow up or create a corrective action that leads to a satisfactory fix. Over time, these unaddressed issues can incubate and grow unchecked until a major event occurs.

•**They fail to facilitate effective management of threats.** There is sometimes confusion about an audit’s purpose and scope. Is it for compliance or for learning and improvement? Does it include actual practices or just a desktop review of paperwork? When a major event occurs, it becomes clear that the audit was not effective in managing the issues, and investigators may lament the lack of audit quality even though there were few clear preestablished expectations on what constituted a good quality audit.

•**They fail to facilitate sufficient focus on the most critical threats.** This is perhaps the most insidious failure. Audits often lack focus on critical hazards, choosing instead to prioritize paperwork over operational issues. In some cases, they fail silently by missing or underplaying threats while praising performance. The result is a false sense of safety where an organization is told all is well even as significant dangers accumulate.

These failures are not isolated; some are likely inherent weaknesses in the audit process itself. An audit that simply goes through a checklist may confirm that documents exist and that basic rules are being followed, but it does so at the expense of accurately understanding real, daily operational work and the interaction with major risks.

Militant Paperwork & False Sense of Safety

Another, perhaps more dangerous, aspect of audit failure is the audit masquerade. If audit effectiveness is judged

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STEPS TO ENSURE AUDIT EFFECTIVENESS

- Define the audit's purpose up front.** Clearly distinguish whether an audit is intended to verify compliance, confirm the existence of documentation or test the real-world effectiveness of critical systems, and set success criteria accordingly.

- Prioritize critical risks over paperwork.** Direct audit efforts toward major hazards, key controls and high-consequence scenarios instead of focusing primarily on signatures, forms and document reviews.

- Test how work is actually performed.** Observe and probe real operational work, including unscheduled site visits and different shifts, rather than relying solely on procedures and planned demonstrations.

- Investigate root causes, not symptoms.** Look beyond isolated findings such as missing tags or incomplete permits to identify the underlying system weaknesses and emerging warning signs that create risk.

- Demand corrective actions that address hazards.** Evaluate whether audit actions directly reduce the operational risk identified. Avoid superficial fixes such as additional signage, documentation or administrative changes when systemic improvements are needed.

- Challenge assumptions about assurance.** Regularly ask how you know critical controls are present, understood, resourced and functioning as intended, and whether the audit would detect a serious deterioration before an incident occurs.

by its ability to reduce decoupling, then observations and corrective actions should directly address the identified issues. If an audit identifies an issue, but the implemented action does not fix the problem, then the audit itself has failed a core goal.

Another of the author's audit studies analyzed 327 corrective actions from a sample of health and safety audits to see if they were aligned with operational issues (Hutchinson et al., 2024a). Findings indicate that only 16% of all corrective actions were strongly connected to the issue or hazard identified by the audit criteria.



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Most actions were only weakly or moderately connected. This shows that some audits do a poor job of focusing on the underlying physical issues and generating effective corrective actions. That is, if the audit criteria related to a mobile plant, only 16% of audit actions directly addressed mobile plant hazards (e.g., the interaction between people and plant). Overall, most corrective actions focused on superficial, localized fixes such as signage and documentation rather than systemic engineering improvements.

This reduces the audit to a superficial exercise, merely a "symbolic activity optimized for surface tweaks" (Hutchinson et al., 2024a). This is the essence of what is referred to as the audit masquerade: The audit appears to address an issue with a corrective action assigned and completed, and the organization feels better. But nothing of substance has been done. The organization has been blinded to the need for more substantial systemic fixes and has been given comfort over risk treatment.

How Audits Can Fail Us

The author's research has found that audits:

- struggle to reveal substantive gaps between operational practice and expectations;

- emphasize surface compliance, or the mere demonstration of compliance with safety rules and procedures, with minimal effort invested in the task (Hu et al., 2020);

- confuse managing the operational issues with managing documents; and

- fail to provide early warning signs of emerging danger or drifting standards.

This is not just that the audits were poorly performed. Some of these issues appear to be inherent aspects of an audit's structure, design, resourcing and execution. Thus, audit paperwork becomes self-reinforcing and falsely comforting.

This masquerade separates efforts to improve the safety of work from those aimed at ensuring it (i.e., the work of safety; Rae & Provan, 2019). Blewett and O'Keeffe (2011, p. 1,018) aptly state that we instead have paperwork that helps us complete an audit versus paperwork that "helps keep us healthy and safe."

Asking the Right Questions

As previously stated, there are no clear, simple answers. But perhaps with better questions and a constructively critical lens, safety professionals can determine whether their auditing is delivering against expectations.

Identify the audit's core goals. Different audits serve different core goals. A desktop audit may confirm that a documented

system exists, whereas an effectiveness audit will test whether it works.

Consider asking leaders what goals they believe the auditing program achieves. If the goal is to ensure that safety documents exist and have been reviewed, signed and uploaded, then the auditing achieves that. If they expect audits to verify the effectiveness of critical systems, then that assumption must be carefully verified, because this may not be happening in practice.

Clearly articulate the goals of different audits and the criteria for success and failure. If audits are expected to verify critical system effectiveness, they must be grounded, at least partly, in actual hazardous work.

Focus on critical risks and system functioning. We must reconnect process with purpose (Smith, 2018, p. 140). That means critically challenging why we do what we do. For example, why do we check for signatures on a permit but not for the manager's, supervisor's or worker's understanding and use of it? Why do we check that the construction safety plan had its 12-month review but not whether a program of continual risk reduction has been achieved? Why do we check work during the day shift (carefully orchestrated just for the day of the audit), but not conduct more spontaneous visits during the night shift?

If auditing is largely to assure the business and other stakeholders about the effectiveness of critical systems, why do we not spend more time critically probing, testing and learning about how systems function in practice? From a legal perspective, Smith (2018, p. 134) challenges some of these safety practices as becoming bureaucratic, reporting on whether an activity or process is completed rather than whether it is effective.

Reconnect at least some audits with a focus on the few critical systems that are essential for business and safety objectives. This should include probing the expected and actual risk controls (e.g., barriers and safeguards), incident scenarios, goal-directed safety efforts and justifications for whether risks have been eliminated or mitigated so far as is reasonably practicable (or whatever legal, ethical or industrial requirements exist in the relevant region).

And, importantly, an audit must include a focus on real operational work. We find a litany of criticisms from major incident inquiries and legal prosecutions

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on how audits and safety efforts became disconnected from real work, toward rustling paperwork. These different focus areas have been called "work as imagined," which is the idealized or prescribed ways of work, and "work as done," which is what actually occurs in practice (Hollnagel et al., 2015).

Consider the following examples:

- In the 1994 Moura No. 2 mine disaster, management assumed procedures were aligned with practice, yet the manager in charge had never seen the documents (Hopkins, 1999, p. 76). This was a clear case of work as imagined masquerading as reality.

- Similar failures occurred with the DPC Enterprises chlorine release (U.S. Chemical Safety and Hazard Investigation Board, 2007), where safety efforts prioritized the existence of documented systems over their actual operational functioning.

- The 2024 Port of Auckland prosecution underscores this. Prior audits were criticized for focusing on the paper trail and providing only limited assurance because they failed to obtain insight into the critical risks and work as done (*Maritime New Zealand v. Anthony Michael Gibson*, 2024, p. 52).

Safety professionals should ask themselves how they would know if their audits have or have not successfully evaluated system effectiveness. How do you know if the expected risk controls are in place, known, resourced and used as prescribed (or assumed)? The ability to answer these questions may give safety professionals some of the necessary insight to avoid silent audit failures.

Conclusion

Ultimately, audits must do more than rustle paper; they must pull the triggers (Hopkins, 1999) to test how systems actually function in reality, when needed. As shown by a litany of incident inquiries, safety is not found in the demonstration of compliance, but in the intentional probing of critical risk systems and their useability in real work. To avoid the masquerade, we must prioritize asking the difficult questions over the easy comfort of a signed permit.

References

- Appleton, B. (2001). Piper Alpha. In T. Kletz, *Learning from accidents* (3rd edition). Routledge.
- Batalden, B.-M. & Sydnese, A.K. (2015). Auditing in the maritime industry: A case study of the offshore support vessel segment. *Safety Science Monitor*, 19(1), 3.
- Blewett, V. & O'Keeffe, V. (2011). Weighing the pig never made it heavier: Auditing OHS, social auditing as verification of process in Australia. *Safety Science*, 49(7), 1014-1021. <https://doi.org/10.1016/j.ssci.2010.12.010>
- Hollnagel, E., Wears, R.L. & Braithwaite, J. (2015). From Safety-I to Safety-II: A white paper. <https://doi.org/10.13140/RG.2.1.4051.5282>
- Hopkins, A. (1999). *Managing major hazards: The lessons of the Moura Mine disaster*. Allen & Unwin.
- Hu, X., Yeo, G. & Griffin, M. (2020). More to safety compliance than meets the eye: Differentiating deep compliance from surface compliance. *Safety Science*, 130, 104852. <https://doi.org/10.1016/j.ssci.2020.104852>
- Hutchinson, B., Dekker, S. & Rae, A. (2024a). Audit masquerade: How audits provide comfort rather than treatment for serious safety problems. *Safety Science*, 169, 106348. <https://doi.org/10.1016/j.ssci.2023.106348>
- Hutchinson, B., Dekker, S. & Rae, A. (2024b). How audits fail according to accident investigations: A counterfactual logic analysis. *Process Safety Progress*, 43(3), 441-454. <https://doi.org/10.1002/prs.12579>
- Maritime New Zealand v. Anthony Michael Gibson, N.Z.D.C. 27975 (2024).
- Rae, A. & Provan, D. (2019). Safety work versus the safety of work. *Safety Science*, 111, 119-127. <https://doi.org/10.1016/j.ssci.2018.07.001>
- Smith, G. (2018). Paper safe: The triumph of bureaucracy in safety management. Wayland Legal.
- Standards Australia/Standards New Zealand. (2019). Guidelines for auditing management systems (AS/NZS ISO 19011:2019).
- U.S. Chemical Safety and Hazard Investigation Board. (2007). DPC Enterprises Glendale chlorine release. www.csb.gov/dpc-enterprises-glendale-chlorine-release
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