Process safety practice

The blame culture from a process safety perspective

Adam M Musthafa, Indonesia

Summary

The paper explores how the blame culture undermines process safety by fostering fear, discouraging transparency, and preventing learning from mistakes. When individuals fear punishment, they are less likely to report near misses or admit errors, which erodes trust and perpetuates systemic weaknesses. This culture traps organisations in cycles of incompetence, where failures are repeated and safety risks escalate.

Instead of assigning blame, the paper advocates for a shift toward constructive accountability—where mistakes are treated as opportunities to improve systems rather than punish individuals. This involves clarifying roles, ensuring adequate resources, and encouraging open dialogue. Leaders play a crucial role in modelling this mindset, creating an environment where ownership is rewarded and continuous improvement becomes the norm.

Keywords: Blame culture, process safety

Introduction

To say accidents are due to human failing is like saying falls are due to gravity[1] — it is not helpful and does more damage than it helps the organisation to improve. Trevor Kletz had said this in his book published in 1985. Human performance is one of, if not the key factor, in achieving operational and process safety excellence. However, the damaging effects of blaming people when something bad happens cannot be overstated. It degrades trust and traps the organisation in a cycle of incompetence. This paper aims to remind us why the blame culture can be one of the most damaging cultures an organisation can have in terms of process safety, and the urgent need to address it.

Blame — why it is very damaging?

Before we start, we need to understand that blaming others is a very common human behaviour. We do this often to protect ourselves. By blaming others, we can deflect any consequences of failure away from ourselves or our team to maintain a positive perception of ourselves. Although it is common behaviour, it should not be normalised as the damage it causes is extensive to the process safety culture.

Effective collaboration, problem-solving (including learning from events), the ability to do risk-based decision-making, and strong leadership and accountability are key attributes in an organisation with a strong process safety culture. The culture of blaming people will create fear, and fear kills creativity and prevents problem-solving. Fear, in turn, will also erode trust, which prevents teams from effectively collaborating. Fear will also lead to paralysis, where the organisation will collectively be extremely risk-averse. Figure 1 highlights how fear impacts process safety culture. In such a situation, decision-making will be a very slow and painful process.

An even more dangerous situation caused by fear arising from a blame culture is when an organisation is trapped in the cycle of incompetence, where mistakes are repeated due to failure to learn. Figure 2 – the cycle of incompetence shows how this happens. The problem with this is that in the case of process safety, we are dealing with hazardous material and energy, where a mistake can lead to a higher severity event. In process safety, organisations are even required to learn from others' mistakes because the consequences of errors are often unacceptable.

Another important aspect is that process safety events tend to start with multiple unattended smaller weaknesses and failures. Process safety incidents occur when all barriers fail to prevent harm, while a near miss occurs when one or more barriers fail but are stopped on their path from manifesting into harm[2]. The key to avoiding larger process safety events is to act on and attend the reported minor events and failures (i.e. near misses). Process safety leading indicators and reported near misses can be a very powerful tool to manage process safety if used correctly. However, with the culture of blaming others, people will stop reporting minor failures, hide their mistakes, and censor their concerns. This leads to a lack of transparency, making metrics and data ineffective in reflecting the organisation's true performance.

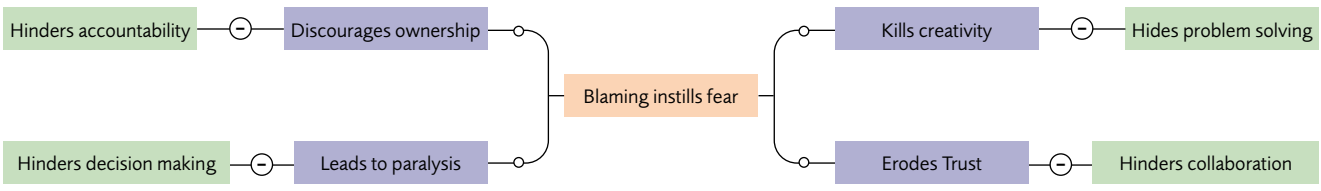

Figure 1 – How fear impacts process safety culture

0260-9576/25/$17.63 + 0.00

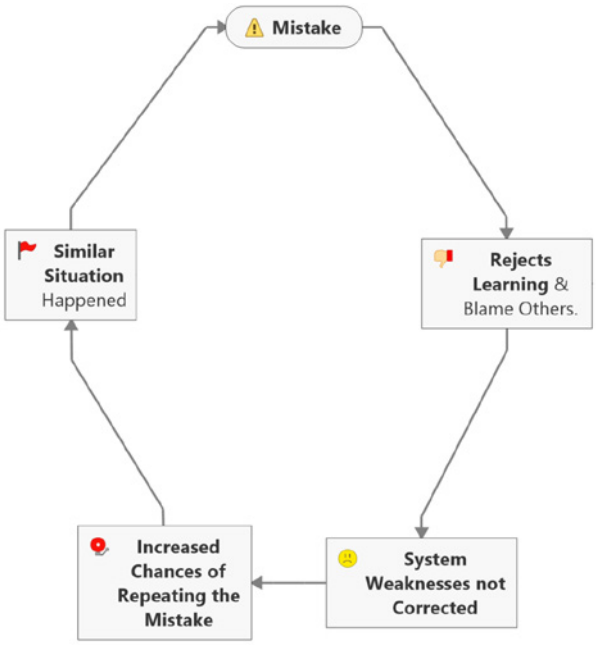

Figure 2 – The cycle of incompetence

The behaviour of blaming others can happen in any organisation. We may think that this will not happen in a big organisation consisting of intelligent and 'the best people' in the industry. However, a study by Chris Argyris from Harvard University found that top management consultants often do not admit their mistakes, even to themselves. This is because they feel uncomfortable and upset when reflecting on their errors. These individuals have strong intellectual skills, achieve high success at work, and set difficult standards for themselves. The thought of failing is very painful for them[3]. The more success the organisation has, such as years of operations without a recordable process safety event or getting a good assessment of recent process safety audits, the more difficult it may be for the management to admit there are weaknesses in their process safety management system.

How to move from blaming to accountability?

Accountability is critical in human performance management and underpins the concept of operational discipline[4]. No management system can operate effectively without personal accountability. When something bad happens, we tend to ask ourselves: "whose fault is it?". On the other hand, when we are accountable as a leader, we own the process and verify the implementation and result. We tend to ask ourselves: "Does the system work? What can we improve further?". Being accountable means owning the result of an activity. Blaming means declaring someone is responsible for a fault or wrong. They are the opposite of each other. Blaming will, in fact, discourage people from being accountable and should be avoided.

How do we hold personnel accountable is the key. First, we need to ensure that the person does have control over the mistake or problem being faced. There should be a clear contract on what to achieve, along with clear roles and responsibilities. The person should also be provided with adequate resources and time to achieve the goal. Without all of these, holding a person accountable will only result in frustration, resentment, and poor process safety performance[4]. Once ownership, roles and responsibilities are clear, required resources are provided and delegation is done properly, accountability will be established.

One common example is when a HAZOP team is given a very limited time to complete the workshop, so that the team members can return to their day-to-day activities as quickly as possible. Time is one of the most valuable resources in business. However, it is not fair to ask the HAZOP team to produce a complete and high-quality HAZOP when their management has not released the necessary resources to complete the task within the required time. The team will be demotivated and execute the task with a 'check the box' mentality. They will aim to complete the discussion as quickly as possible, take shortcuts, and assume things instead of properly verifying the information. The HAZOP will lose its value, and no one will own the result, with management being blamed for not providing adequate time and resources to complete the HAZOP. On the other hand, when enough resource and time are given and the team can deliver the HAZOP effectively, they will own the result and implement the recommendation more willingly.

Secondly, we need to understand that even the best can sometimes fail. Thus, more focus should be given to the system improvement so that it is easy for people to do the correct thing and make it hard for them to do the wrong thing. This should start by asking why the error/mistake happened. By identifying why an error or mistake happened in a task or activity, we can determine what kind of support and controls should have been provided to prevent or mitigate them. Missing support and control such as training, clearly written working procedures or guidelines, or adequate supervision are the key to avoiding similar mistakes or failures in the future. On the other hand, when procedures are clear, training is given, and adequate tools and resources are provided to correctly follow them, any violation to the procedure should lead to consequence management.

It is also worth seeing the bigger picture by remembering that organisations are sometimes complex and come with conflicting priorities. When organisational goals, strategies, and values are unclear, groups may pursue different objectives, which may also contribute to performance issues[5]. This is especially important when there is a perception that process safety priorities are conflicting with production or business priorities.

The techniques for incident or nonconformance root cause analysis are outside the scope of this paper. However, once the root causes are identified, it is important to conduct a constructive discussion with the accountable person. This is the third and last step to shift the blame to accountability. In this discussion, it is very important to use neutral language and frame the mistake as an opportunity to learn.

The language we use when discussing mistakes or failure really matters. Admitting weaknesses or mistakes is already a daunting task. Using negative words makes people feel even more threatened[6]. Instead of saying "what are the gaps in our system?", we can say "what can we improve to avoid similar events?". Some reference events suggest avoiding the use of "errors, slips, lapses, or mistakes" in the conversation. While to some, these are the correct technical terminology in human

0260-9576/25/$17.63 + 0.00

performance, they may sound negative to others. The use of "opportunities for learning, area of improvement, valuable lessons, experience, or events" should be used instead.

Shifting from blame to accountability is challenging and may take time. It takes the organisation's collective willingness to change the way they act, talk, and think. Let's start by framing mistakes or failures as learning opportunities. Bill Gates argues that people who have made mistakes in the past and (most importantly) learned from them, create more successful leaders in times of rapid change. It is more productive to learn and gain from the mistake and improve the existing system than to find who is at fault.

Make it systematic

The last part of this paper outlines how to make the process of avoiding blame and promoting ownership and accountability systematic. The first step is to have a clear policy and expectations. It should be clear that a reported honest mistake will be fairly investigated. There should be a clear definition of what constitutes a violation and what does not. This will allow the organisation to understand and categorise mistakes properly and act on them. The procedure of root cause analysis and/or incident investigation should also clearly ask for the investigation team to focus on the problem and the system, to avoid reoccurrence in the future.

Senior leaders should lead by example by owning the process and improving it whenever weaknesses are identified. Whenever a failure of the system happens, leaders should use this opportunity to correct their existing assumptions about how the system works. They should openly start a self-assessment and verification on how the system works at the implementation level. Second-party audit, where different owners of different systems assess, audit, and learn from each other, is another way to increase the perception of accountability.

It is also a good practice to recognise and reward accountability. When a worker steps up to own his mistake and correct it, this should be seen as a positive act and rewarded. We tend to focus on rewarding positive performance but neglect those who bounce back from failure or mistake with the right attitude.

Empowering the team to continuously improve the system is also a good practice to encourage ownership. Periodically, let the system's administrator or coordinator do self-verification and metrics measurement. Then, give the autonomy to the team to improve the existing system. Let them present the result of this self-assessment to senior leaders and the rest of the organisation.

The key to systematically eliminating blame culture is to promote and encourage ownership and responsibility. Responsibility comes from within and involves taking ownership. Effective leaders encourage shared responsibility among the team. When everyone shares responsibility, they are more likely to hold themselves accountable and honestly address future mistakes and failures[7].

Conclusion

Addressing the blame culture within organisations is critical for enhancing process safety. While blame is a common response to failure, it ultimately prevents learning, discourages ownership, and erodes trust, which is key to a good process safety culture. Instead of blaming, organisations should invest in resources to allow them to understand mistakes, promote constructive discussions, and establish a supportive environment. By adopting these practices, organisations can empower their teams to break the cycle of incompetence and move towards a safer and more effective workplace.

Reference

1. *T. Kletz, An Engineer's View of Human Error, Rugby, Warwickshire: Institution of Chemical Engineers (IChemE), 2001.*
2. *Center for Chemical Process Safety, Recognizing and Responding to Normalization of Deviance, Hoboken, New Jersey: John Wiley & Sons, Inc, 2018.*
3. *C. Argyris, Overcoming Organisational Defences, New York: Allyn and Bacon, 1990.*
4. *Center for Chemical Process Safety, Conduct Of Operations And Operational Discipline for Improving Process Safety in Industry, Hoboken, New Jersey: John Wiley & Sons, Inc. , 2011.*
5. *M. Paul, "thesystemsthinker.com," [Online]. Available: https://thesystemsthinker.com/moving-from-blame-to-accountability/. [Accessed 5 13 2025].*
6. *C. M. T. P. Michael Peam, Ending the Blame Culture, New York: Routledge, 2017.*
7. *T. B. Diana Larsen, Lead Without Blame: Building Resilient Learning Teams, Oakland, California: Berrett-Koehler Publishers, Inc., 2022.*

0260-9576/25/$17.63 + 0.00