Completing Effective Incident Investigations

BHHC Loss Control

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Madina Ghafar-Porschet

LOSS CONTROL TECHNICAL SPECIALIST

- B.S in Occupational Health and Safety
- Nearly a decade of experience in risk management
- Started my career with a heavy civil GC

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AGENDA

6/16/2026

1. Identify the true root causes of incidents
2. Apply structured investigation techniques and tools
3. Interview witnesses effectively and collect solid evidence
4. Develop corrective actions that prevent recurrence

The Cost of Getting it Wrong

What Happens when investigations miss the mark?

When Investigations Fail

Incidents recur- same hazard, different employee

Root causes aren’t identified- only symptoms are treated

Employees lose trust in the safety process

Legal liability increases when documentation is incomplete or biased

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What you see
vs.
What you Don’t

Most investigations stop at the surface- effective ones go deeper

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The Repeat Injury

Warehouse worker slips on a wet floor and sprains their wrist

Investigation finding: *Employee failed to watch where they were walking*

Corrective Action: *Remind employees to be careful*

Six months Later: Another Employee slips in the same area….

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What an Effective Investigation Would Have Found

- The spill came from a leading pipe fitting
- The area had no wet floor signage
- Housekeeping schedule didn’t cover that aisle

Root Causes: Failed maintenance reporting system, no signage availability, inadequate cleaning schedule

Corrective Actions: Fix the fitting, add signage station, revise cleaning schedule

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Your Role as the Investigating Supervisor

Supervisor’s Investigation Responsibilities

- Secure the scene
- Notify management and safety personnel
- Collect and Preserve evidence
- Interview witnesses
- Complete required documentation
- Recommend and follow up on corrective actions

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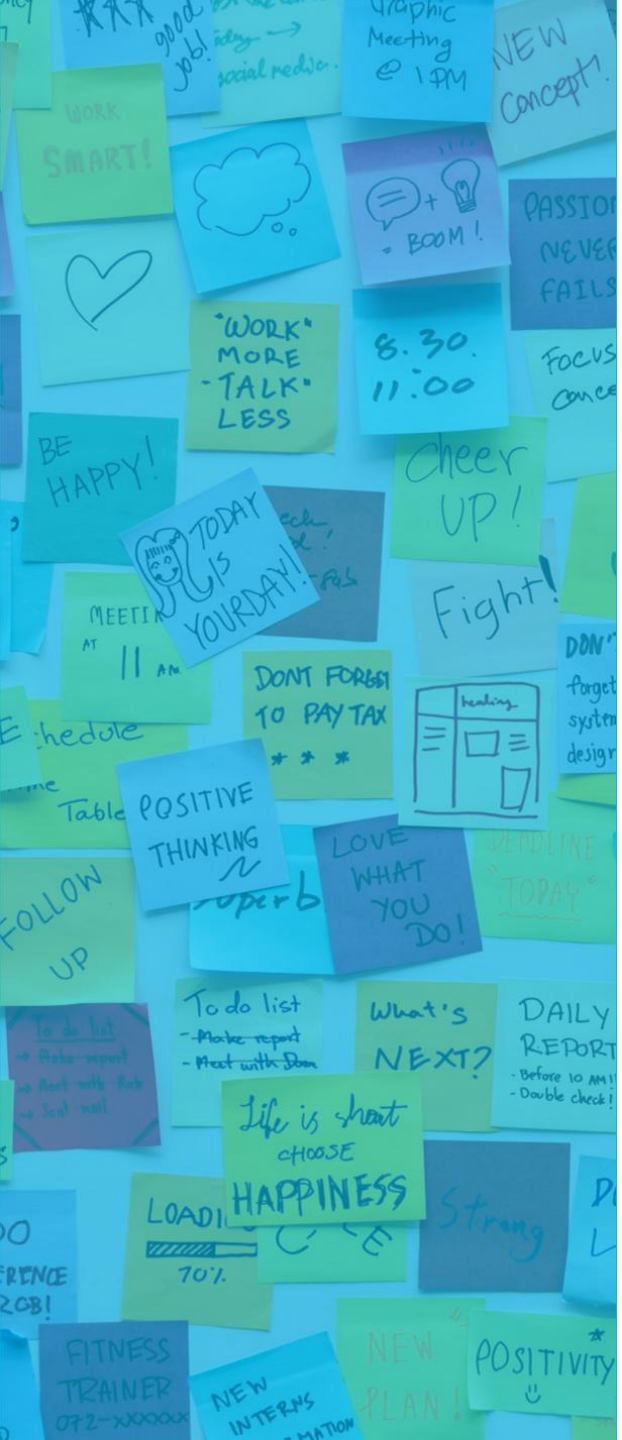

The Timeline

Immediate (0-1 hours): Scene safety, first aid, notifications, scene preservation

Short Term (1-24 hours): Witness interviews, evidence collection, preliminary report (Notify internal contact of WC Claim so the claim can be reported)

Within 24-72 hours: Root Cause analysis, corrective action development

Within 1 week: Final report submitted, corrective actions assigned

Ongoing: Track corrective action completion- verify effectiveness

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What Supervisors Often Get Wrong

- Waiting too long to start investigation
- Jumping to conclusions
- Focusing only on the behavior
- Failing to interview all witnesses
- Incomplete/vague documentation
- Not following up on corrective actions

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Objectivity is Non-Negotiable

- Your job is to find facts
- Blame focused investigation miss root causes
- Treat all employees with respect
- Avoid leading questions, assumptions, or conclusions before the evidence is in

Approach every investigation with *what in our system allowed this to happen?*

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Supervisor vs. Safety Professional

Supervisor

- First on scene
- Secures area
- Gather initial facts
- Interview witnesses
- Completes initial report

Safety Professional

- Provides tools and guidance
- Reviews findings
- Assists with root cause analysis
- Ensure regulatory compliance
- Trend Analysis – multiple investigations reviewed for trends

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Immediate Response

What to do in the first hour of an incident

Step 1: Ensure Safety First

- Stop work if necessary
- First aid or medical attention immediately
- Call 9-11 if a life-threatening emergency
- Do not move injured persona
- Notify your manger or safety department immediately

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Step 2: Secure and Preserve the Scene

1. Do not alter the scene
2. Use barrier to keep other out of the area
3. Take photos and videos
4. Note environmental conditions

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Step 3: Identify and Separate Witnesses

- Identify those who saw the incident
- Separate witnesses
- Document names, contact information, and job titles
- Reassure witnesses: this is not about blame it is about prevention

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Step 4:
Begin Your Documentation

Start your incident report form immediately

Record: Date, time location, etc. Follow your company's documentation protocols

Your notes are the foundation of the entire investigation

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Evidence Collection

Building the Factual Foundation of your Investigation

Types of Evidence

- Physical
- Documentary
- Photographic/Video
- Witness Statements
- Data/Records

What's the first type of evidence you typically look for after an incident?

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Reviewing Records and Documentation

Pull training records

Review maintenance logs

Check prior incident reports

Review SOP or work procedure

Look at scheduling and workload data

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Interviewing Witnesses

Getting the full story

Effective Interview Techniques

- Start with open-ended questions
- Follow up with clarifying questions
- Avoid leading questions
- Ask about conditions
- Ask what they think contributed

End with *"Is there anything else you think I should know?"*

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Documenting Interview Findings

Write a summary of each interview immediately

Use of witness's own words where possible

Note the date, time, location, and who was present

Keep notes as part of the investigation file

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Root Cause Analysis

What is a Root cause?

A Root cause is the fundamental reason an incident occurred

- If you fix the root cause, the incident cannot recur in the same way
- Root causes are almost never “employee carelessness” or “not paying attention
- Root causes are typically: system failures, design flaws, inadequate training, missing procedures, poor maintenance, production pressure

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The 5 Why's Technique

Ask "Why?" across multiple areas (people, process, equipment, environment) and explore each path

One Possible Path (Process): Worker burned by hot surface

- Why? → They touched an unguarded pipe
- Why? → The guard had been removed for maintenance and not replaced
- Why? → No procedure required guards to be replaced before returning equipment to service
- Why? → Maintenance procedures had not been updated in 3 years
- Why? → No scheduled review process existed for maintenance procedures

If you only find one root cause, you probably missed something

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Contributing Factors vs. Root Causes

Proximate Cause – The direct cause of the incident or accident, the last cause in the chain of events leading to the accident.

Contributing factors: Conditions or behaviors that contributed to the incident but are not the root cause (e.g., fatigue, distraction, inadequate lighting)

Root cause: The system failure that allowed those contributing factors to exist

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Avoiding the “human error” trap

- Humans make mistakes - systems should be designed to catch and prevent those mistakes
- When you find human error, ask: *"Why did the human error occur? What allowed it?"*
- Was training inadequate? Was the procedure unclear? Was there time pressure?
- Was the hazard visible and recognizable? Were controls in place?
- Blaming the worker without fixing the system guarantees recurrence

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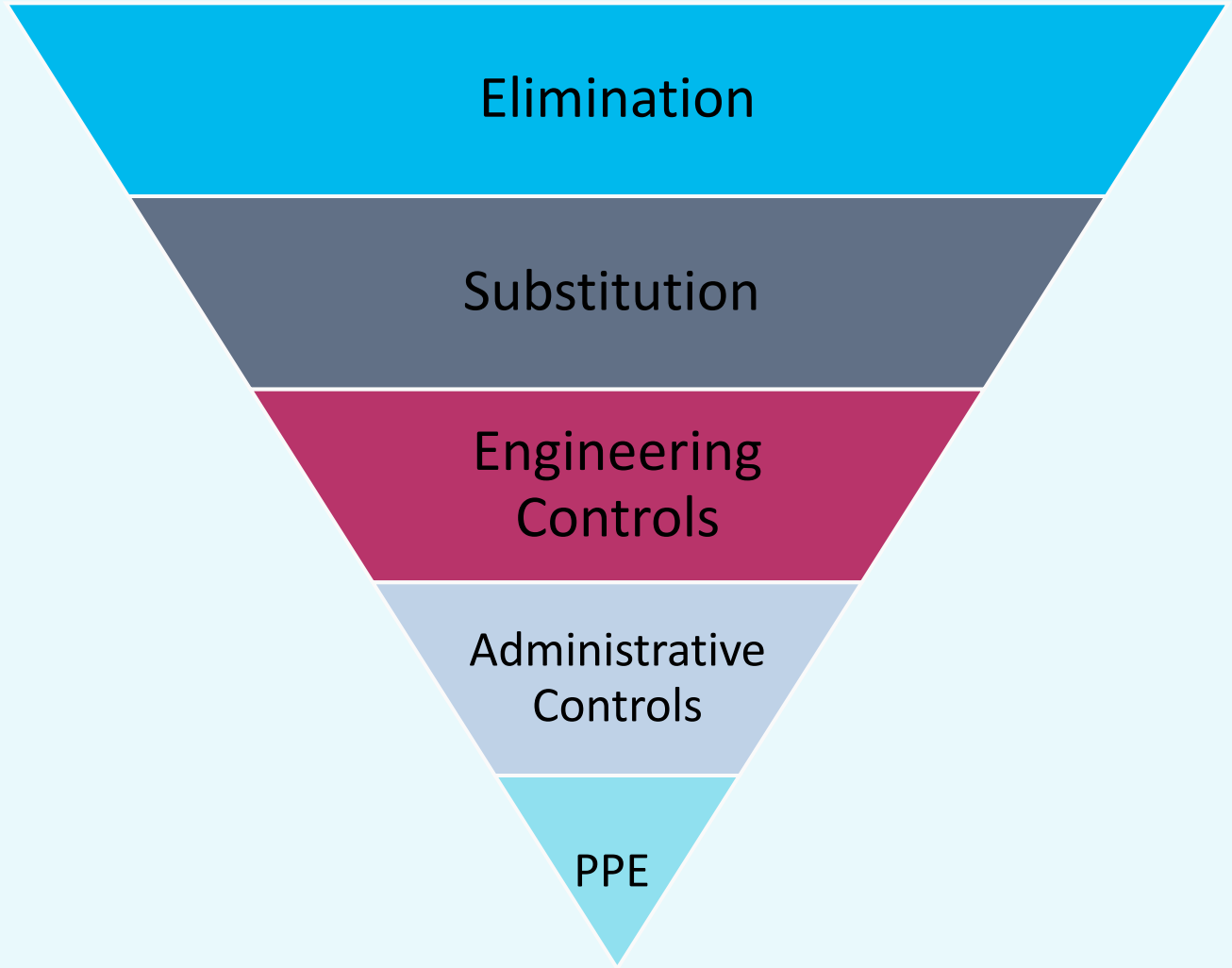
Corrective Actions That Stick

The Hierarchy of Controls



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Writing Corrective Actions

Each corrective action must be SMART:

- Specific: Exactly what will be done, where, and how
- Measurable: How will you know it's complete? What does "done" look like?
- Assigned: One named person is responsible - not "the team" or "everyone"
- Realistic: Achievable with available resources and authority
- Time-bound: A clear due date

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Addressing Root Cause vs Symptom

- Every root cause identified must have a corresponding corrective action
  - **Symptom fix:** *"Replace the broken guard"* - necessary but not sufficient
  - **Root cause fix:** *"Implement a pre-use equipment inspection checklist and assign daily inspection responsibility to shift leads"*

What's one corrective action from a past investigation that you now think only addressed the symptom, not the root cause?

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Following Up

Assigning a corrective action is not the end of your job

You are responsible for verifying that corrective actions are completed on time

Check in with the responsible person before the due date

Document completion with evidence (photos, updated procedures, training records)

Verify effectiveness: Did the corrective action actually eliminate or reduce the hazard?

Report status to management and safety at regular intervals

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Sharing Lessons Learned

Every investigation is an opportunity to improve

Share findings (without blame) with your team in a safety meeting

Alert other departments if the same hazard could exist in their area

Contribute to your organization's incident trend data

A culture of learning, not blame is built one investigation at a time

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Takeaways

1. Identify the true root causes of incidents
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Questions?

Please email additional questions to losscontrol@bhhc.com