Safety Snapshot: EHS Essentials



Fast, focused safety insights to help your team prevent incidents before they happen

Why Your Incident Investigation Isn't Preventing the Next Accident

What's Really Causing Your Incidents?

When a serious incident occurs, everyone wants answers fast. But speed often comes at the cost of depth, and most investigations never get to the heart of the problem.

In one cross-industry review, DEKRA found that over 70% of incident investigations* stopped at the worker level, citing causes like "didn't follow procedure" or "poor judgment."

But rarely do those investigations examine the conditions that shaped those decisions: fatigue, workload, unclear expectations, or flawed systems.

The result? You fix the symptom, not the source. And the risk remains.

Surface-Level Investigations = Repeat Incidents

If your reports keep ending in "human error," your team is stuck in a cycle.

Here's why that's dangerous:

- It misidentifies the problem. Humans operate within systems. When systems fail, people do too.
- It stunts improvement. Blame-based reports don't spark innovation; they create fear and silence.
- It wastes resources. Corrective actions are applied in the wrong place, allowing the true cause to fester.

To break the cycle, your investigations need to do more than check a box. They must expose systemic weaknesses, not just behavioral missteps.

What Good Investigations Actually Look Like

Here's how high-performing organizations investigate differently:

They dig for why, not who

Instead of pointing fingers, they use tools like the 5 Whys to uncover contributing factors at multiple levels—people, process, environment, and design.

They challenge assumptions

Investigators are trained to recognize confirmation bias, the tendency to search for evidence that supports what you already believe.

They look at internal hazards

Using tools like Brain-Centered Hazard™ analysis, they examine how factors such as mental load, distraction, and cognitive strain impact decision-making and increase the risk of error.

They focus on learning, not punishment

A blame-free culture encourages people to speak up, provide critical context, and help identify risks before someone gets hurt again.

*Source: DEKRA analysis of over 1,000 incident investigations conducted across multiple high-risk industries. 2020–2024.

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Real-World Example: "He Was Just Rushing"

A maintenance technician skipped a step in the lockout/tagout (LOTO) process and suffered a serious injury. The initial investigation quickly cited "failure to follow procedure." The corrective action? Retraining the worker. Case closed.

But a more thorough review by the company's internal team uncovered a deeper set of issues:

- The technician was behind schedule due to earlier delays in the production line.
- The critical LOTO step was not clearly marked and lacked any visual job aid.
- Supervisors, under pressure to meet aggressive output targets, were unintentionally signaling that speed mattered more than safety.
- The technician was working a 10-hour shift with no formal breaks and reported being mentally exhausted.

This wasn't a simple mistake. It was a predictable outcome of system strain and organizational oversight.

The root causes weren't about the individual, they were embedded in the environment.
The organization responded by:

- Adding visual LOTO checklists and reminders at the point of work
- Revising performance expectations to reward safe work practices
- Coaching frontline leaders on how to balance production and protection
- Launching awareness training around cognitive fatigue and human limitations

The result was a safer process, stronger accountability at all levels, and a team that felt supported, not blamed.

Incident Investigations That Drive Real Change Webinar

If your investigations aren't translating into safer systems, this 30-minute session is a must-watch. We show you how to improve your approach, from better questions to better outcomes.

You'll learn:

- How to ask the "5 Whys" without chasing your tail
- What confirmation bias looks like in action
- How to spot system failures behind "employee error"
- How to use Fishbone Diagrams and Brain-Centered Hazard™ tools
- Immediate upgrades you can make to your process

How DEKRA Can Help

Struggling to get real insights from your incident investigations? Our EHS Consulting team partners with you to move beyond surface-level analysis and uncover **the true root causes** so you can implement changes that actually prevent recurrence.

From investigation coaching and systemic reviews to customized tools and training, DEKRA helps you build a stronger, learning-focused safety culture.

Request our capability sheet or schedule a quick consult.

Questions? We're here to help.

Email: osr.info.us@dekra.com
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