

# Investigative Processes & Lessons from Tree Fatalities



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# Investigative Purpose

## Significant Incident/Accident Occurred

- People injured/killed
- Significant property damaged
- Events/activities significantly disrupted
- Incident occurred



# Investigative Purpose

## Answers required

- OSH
- Insurance companies
- Employers/managers/supervisors
- Clients
- Victims
- Supervisor



# Investigative Purpose

Investigation initiated



# Investigative Process

1. Discovery of facts
2. Analysis
3. Conclusions/Opinions
4. Recommendations(?)



# What Happened - Overview?

## Incident details



# What Happened?

## Incident process/chronology



# Discovery of Facts

- Comprehensive
- Detailed
- Objective

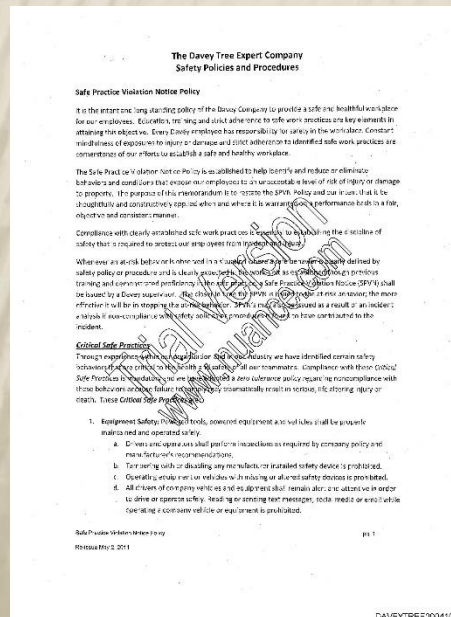




# Investigation

## Documentation

- Policies
- Procedures
- Contracts/specifications
- Photographs and materials (drawings, emails, letters, etc.)



# Investigation

## Tree/tree parts and site conditions

- Defects
- Adverse conditions



# Defects and conditions

Reasonably discoverable prior to incident?



# How?

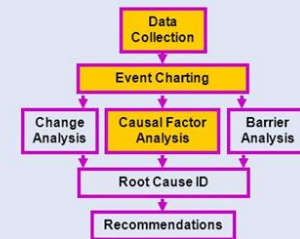
## Direct and proximate causes of incident



### Root Cause Analysis Causal Factor Analysis

#### Casual Factors:

1. **Direct Cause:** Immediate event/ condition that caused accident)
2. **Contributing Cause:** Event/condition that increased probability or severity of the accident
3. **Root Cause:** Event/condition that, if corrected, will prevent recurrence



# Who?

## Directly and indirectly involved in the subject incident?

- Role and responsibility



# Personnel Qualifications

- Education
- Training
- Experience
- Competence.



# Analysis

## Diagnostic Process

- Process facts and evidence
- Order tests if required
- Formulate conclusion/opinion.



# Investigative Principles

## 1. Investigators shall be independent as possible

- In all matters
- In fact and appearance
- Organizationally independent
- Maintain an independent attitude





# Investigator Role - Responsibility

## Overriding duty of expert witness is to investigation

- Not client/supervisor
- Not advocate!



# Investigative Principles

## 2. Investigators highly trained, experienced and skilled



# Investigative Principles

## 3. All potentially relevant issues:

- Identified
- Researched as appropriate



# Investigative Principles

## 4. Investigations adequately resourced

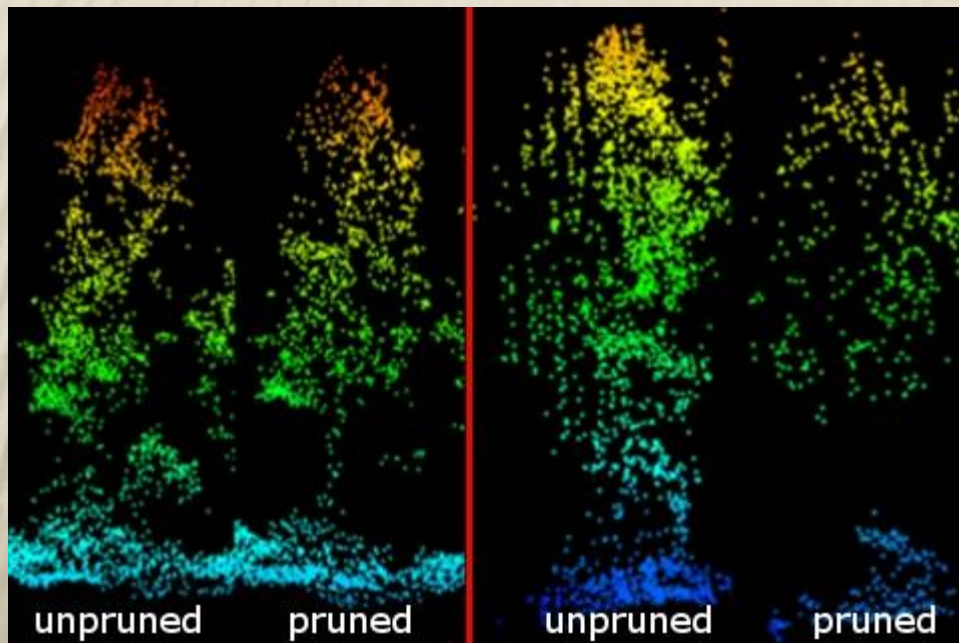
- Financial
- Tools
- Materials
- Access



# Investigative Principles

## 5. All relevant physical and digital evidence

- Identified
- Preserved
- Collected
- Examined as necessary



# Investigative Principles

## 6. All relevant documentation:

- Secured
- Reviewed



Honolulu Police Department Page 4 of 5  
12-471239

Continuation Page

Incident Type UNATTENDED DEATH	Code 442	Reclassify <input type="checkbox"/>	Key Rpt <input checked="" type="checkbox"/>	FIU <input type="checkbox"/>	Status Open	File # N/A	HCS Section No
Complainant (Last, First, Middle Name) DOMINGCIL, VENASCIO						Date of Occurrence 12-20-2012	
Location of Offense 87-1420 PAAKEA ROAD							

**MEDICAL EXAMINER NOTIFIED**  
I notified Joan WELLS at about 1224 hours.

**MEDICAL EXAMINER ON SCENE**  
At about 1330 hrs, Medical Examiner Joan WELLS arrived on scene.

**CRIMINAL INVESTIGATION DIVISION NOTIFIED**  
Detective PHILLIPS was notified of the fact and circumstances at about 1205 hours and related that she would not be responding to the scene.

**PRONOUNCEMENT**  
The pronouncement of death was made at 1135 hours, by Waiānae Coast Comprehensive Center emergency Room DR. PRICE.

**ADDITIONAL FACTS AND CIRCUMSTANCES**  
Due to the fact that the only reporting person's statement was related verbally through broken english, reporting person, [REDACTED] came to the hospital to check on the condition of his cousin, the late Venacio DOMINGCIL. At this time, first son of the deceased, identified as [REDACTED], verbally translated the following statement of [REDACTED].

[REDACTED] related through [REDACTED] that [REDACTED] hired DOMINGCIL to cut down a tree on his property (87-1420 Paakea Road). [REDACTED] further related through [REDACTED] that DOMINGCIL put on a safety harness to climb the tree but was first lifted up in the bucket of a back hoe, so the branches that needed to be cut. [REDACTED] said through [REDACTED] that DOMINGCIL did not tie off his safety harness to the tree and began cutting the two branches that needed to be trimmed, one at a time. At that time [REDACTED] used the back hoe to grab onto those branches being cut.

[REDACTED] stated through [REDACTED] that after DOMINGCIL cut through the first branch [REDACTED] then operated the back hoe in a way to pull the branches away from the tree, subsequently shaking the whole tree violently, because one branch was still attached. [REDACTED] recalled through [REDACTED] that DOMINGCIL was unable to hold on and fell face first to the ground at which time he was observed as being unresponsive and bleeding heavily. Due to the emotional state of [REDACTED] and [REDACTED] only a verbal statement was taken at the hospital.

**POSSIBLE WITNESS INFO**  
[REDACTED] was named as a possible witness due to fact that [REDACTED] verbally related different facts and circumstances to Officer F.FLORES. Refer to Officer F.FLORES' follow up for further info.

NAME: [REDACTED]  
SSN: [REDACTED]  
ADDRESS: [REDACTED]

Submitted By: [REDACTED], LInubo 3	Rank: MPD	Date/Time: 12/30/2012 / 1029	Approved By: LOUGERMILK BRYAN
ID Number: [REDACTED]	Rank: Sgt	Date/Time: 12/30/2012 / 1003	Officer No: 528242

This report was prepared, printed, reviewed, submitted, and filed electronically via secure network in accord with Honolulu Police Department policy.

# Investigative Principles

## 7. All relevant witnesses:

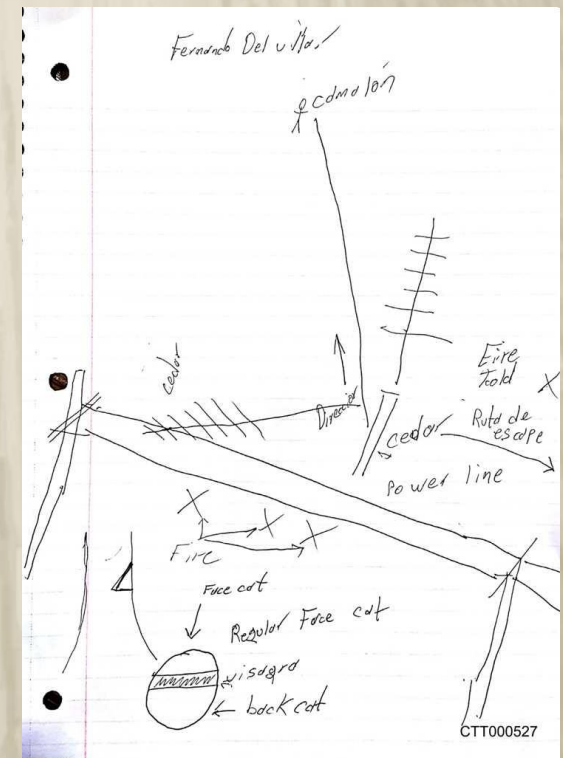
- Identified
- Segregated
- Thoroughly interviewed



# Investigative Principles

## 8. Analysis of all material gathered during investigation

- Objective and based solely on the facts
- Reliable methods to generate opinion.



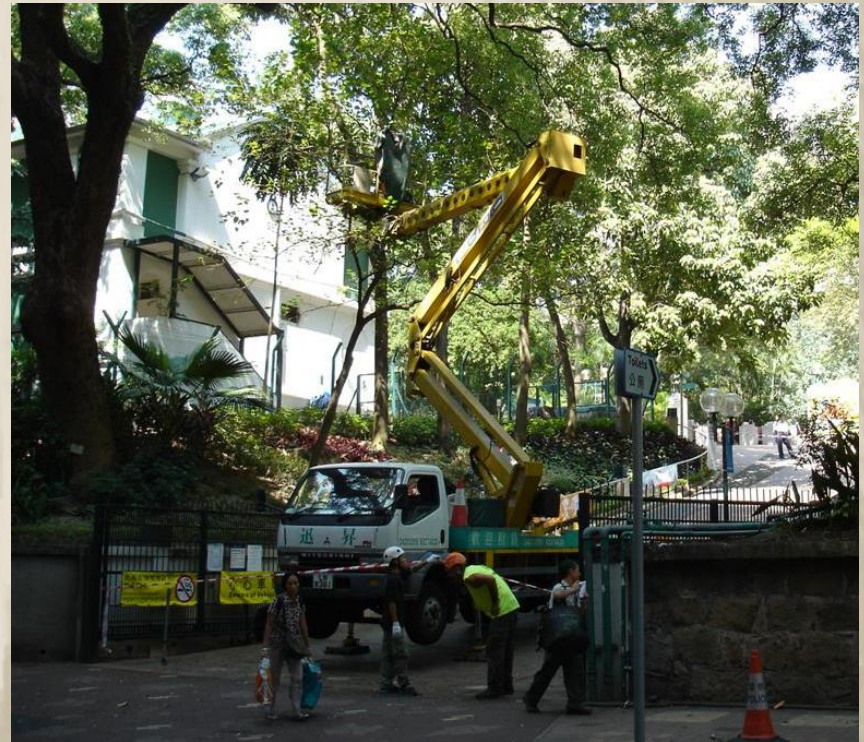


# Guiding Question

## Responsible personnel conform to Duty of Care?

Legal obligation for people and entities to act reasonably when performing tasks.

- Acts of commission
- Acts of omission  
(includes investigator)



# Duty of Care

- **Consistently apply generally accepted practices and standard of care**
  - Tools and equipment
  - Processes and procedures
- **Use common sense/good judgement.**



# Level of Responsibility

## Standard of Care

Level degree of care that a specific person or corporation should exercise within general duty of care

- Level of knowledge and ability?
  - Training
  - Education
  - Experience



# Ultimate Question

**Negligence/Liability:** Should person have known better?

- Do or not do something obvious/reasonable?
- Violate a standard or practice?
- Violate laws, regulations or contracts?.



# Conclusions/Opinions

## Defensible!

- Material evidence
- Logical processing
- Clear metrics whenever possible

**At least 3 factual supports for each opinion.**



# Recommendations(?)

**Not usually required, but sometimes requested**

- Minimize future risk
- Reduce penalties.



# Expert Witness Requirements

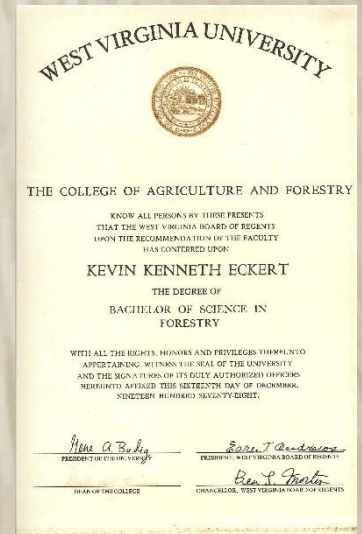
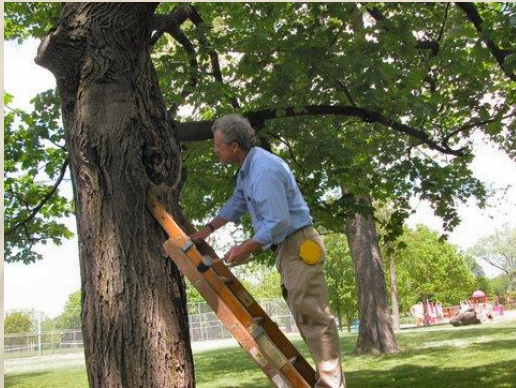
**Possess scientific, technical, specialized knowledge and proficiency**

- Education/training
- Experience/Occupation
- Mastery of Knowledge/Skill



# Education/Training

- University degree
- Hands-on Training
- Research





# Experience/Occupation

## Profession or Job

- Repetitive experience



**ARBOR GLOBAL**  
Arboriculture & Vegetation Management Consulting



# Mastery of Knowledge/Skill

## Recognized Subject Matter Expert

- Practices
- Tools/equipment
- Environment
- Injury/Damage
- Key aspect of case



International Society of Arboriculture™  
Tree Risk Assessment Qualification

# Expert Witness Requirements

## High-Level Communication Skills

- Know audience
- Why
- What
- When
- How
- How much



# High-Level Communication Skills

- Voice modulation
- Body language
  - Facial expressions
  - Body movements





# How to Become an Expert

## Step 1: Study

- Read
- High-level education
- Training

Ensure learning from right people

Unqualified sources will actually stunt your development.



# How to Become an Expert

## Step 2: Practice

- Hands-on application of knowledge and skills
- Master the topic
- Requires time, no shortcuts



# How to Become an Expert

## Step 2: Practice

- Can't become an expert just by reading
- Experience deepens understanding
- Fill in inevitable gaps in world's best books or training programs.

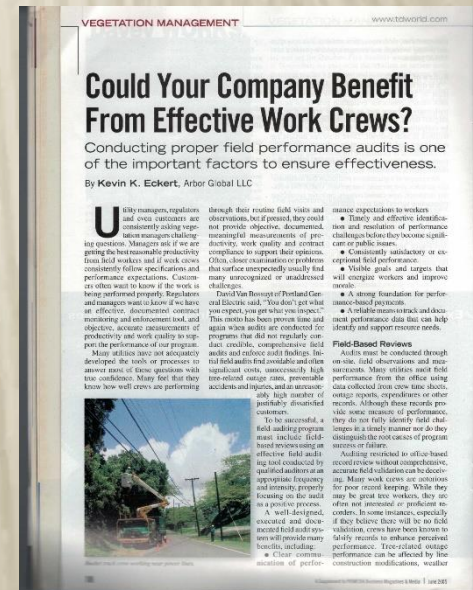




# How to Become an Expert

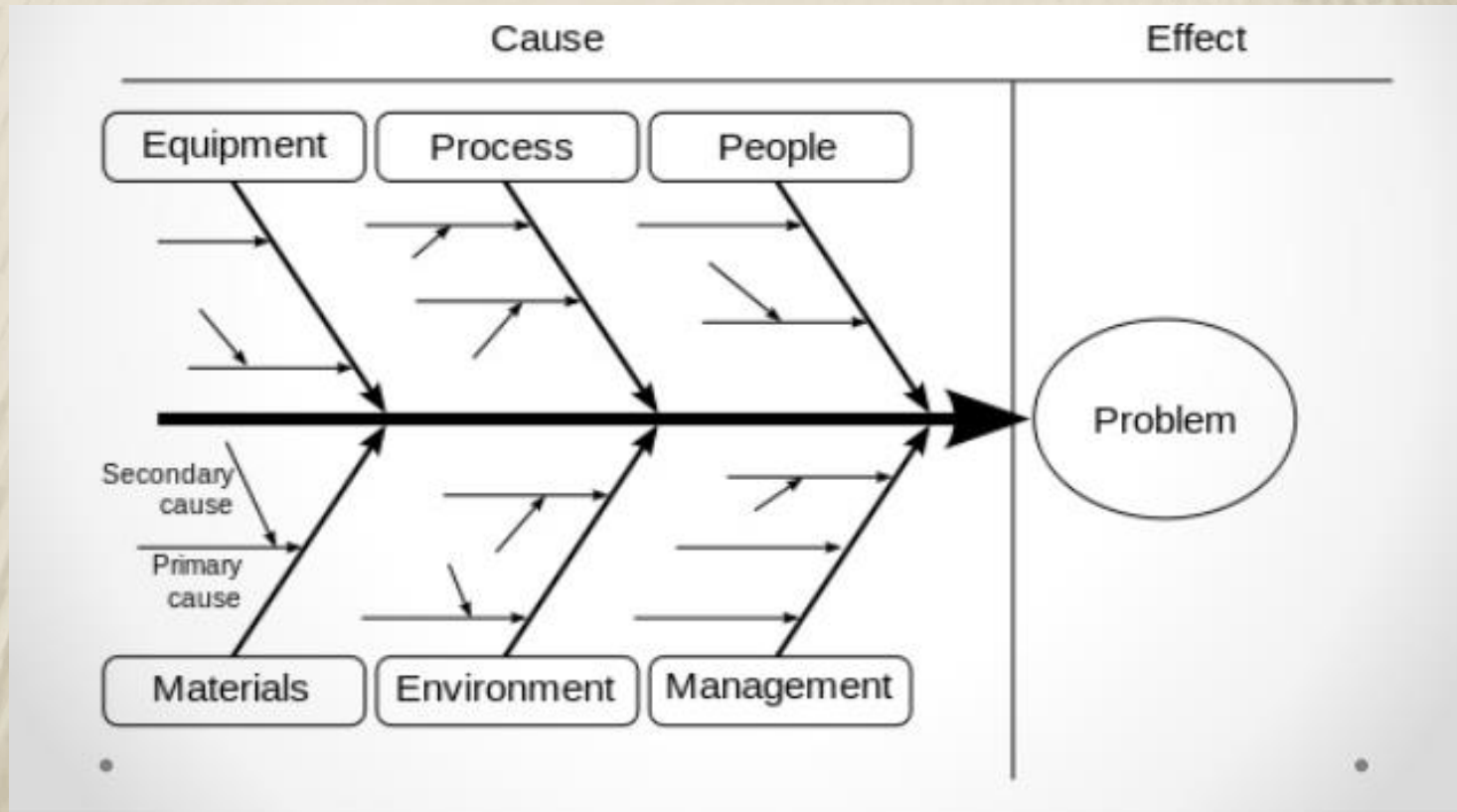
## Step 3: Teach

- Requires a deep understanding of foundation of topics and practices
- Challenges you to expand and view from different perspectives
- Provides opportunities to improve communication skills
  - Write articles
  - Conduct training
  - Provide presentations
  - Formal or informal



# Conclusions

Root accident causes:



# Most Common Conclusion

## Never 1 or 2 - Multiple Errors:

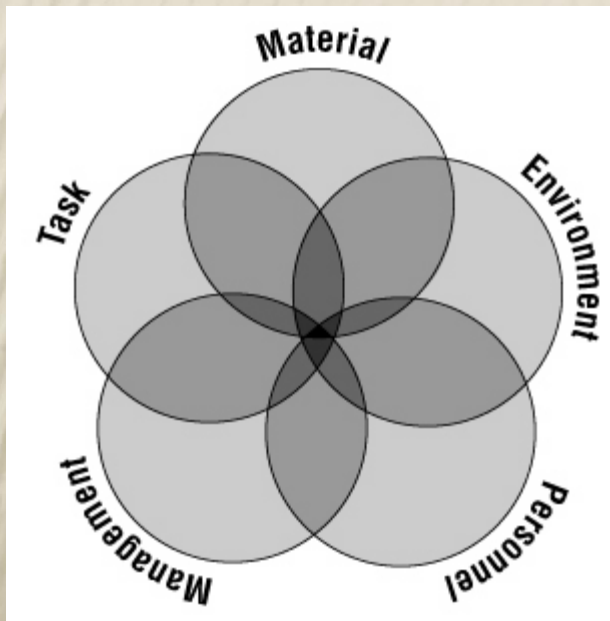
- 6 to 8 + errors
- Cumulative



# Most Common Root Cause

## People

- Nonconformance with known standards/practices
- Inadequate qualification
- Incompetent supervision.



# Questions?



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