Procedure

Incident Reporting and Investigation

Document number: PRO-00793

Ver No.	Description	Document Owner		Document Approver		
		Position	Approval	Position	Approval	Approval Date
15	Amended Version	Manager Health, Safety & Quality	Refer to supporting Info in REX	Executive General Manager - People, Culture & Safety	Refer to supporting Info in REX	16/06/2025

Contents

1. Purpose

The purpose of this Procedure is to provide an outline of Seqwater's standardised process and approach to how organisational incidents, hazards, and near misses are reported, investigated and responded to in a consistent and effective manner.

The Procedure includes phases and techniques to ensure the immediate, contributory and root causes are identified, and appropriate actions are recommended which, when implemented effectively, will reduce the likelihood and consequences of similar occurrences from reoccurring.

2. Scope

This Procedure applies to all workers unless otherwise stated.

This Procedure does not replace or override the incident and emergency response procedures described by MAN-00276 Emergency Management Manual and required under ERP-00001 Bulk Authority Emergency Response Plan.

2.1. Exclusions

This Procedure does not apply to the following types of incidents -:

- ICT issues (e.g., service desk incidents, cyber security incidents, network issues, hardware failure, software functionality, storage faults, etc.)
- Human Resources issues (e.g., performance management, bullying, harassment, etc.)
- Actual or Suspected Corrupt Conduct or Fraud.

3. Investigation Management Principles

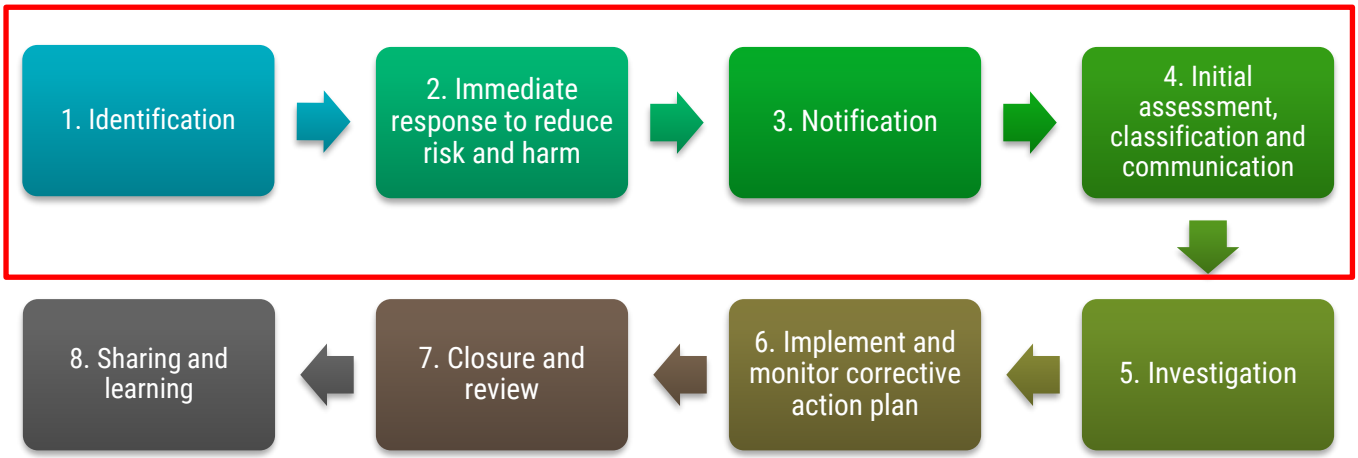
Seqwater is committed to ensuring that this Procedure and its supporting processes adhere to the following seven (7) principles. Application of these principles means that incidents are more likely to be resolved with an effective and acceptable outcome as well as reducing the risk of re-occurrence.

Table 1 Investigation Management Principles

Principle	Description
Accountability	Seqwater must take reasonable care to avoid harm to the workforce, contractors, visitors, the environment, and water consumers. When an incident is raised, Seqwater will undertake associated actions to remedy problems promptly. Everyone involved in the management of an incident understands their roles and responsibilities.
Transparency	All investigation will contain an honest and open explanation of what happened, why it happened, and what actions have been and will be taken, as a result. Conclusions and findings will be based on evidence and facts.
Blame free culture	Seqwater aims to create a culture where the workforce is encouraged and feels safe from reprisals to report incidents. Seqwater supports a 'blame-free' culture, with a focus on understanding, learning, and improvement. All investigations will use a systems-based approach and treat everyone fairly.
Outcome focused	Seqwater's approach to managing incidents focuses on understanding the risk and preventing incidents from occurring, and if they do, we act to prevent recurrence.
Effective risk management	Seqwater has in place effective risk management systems and practices that enable the management of all incidents.
Act in a timely manner	Seqwater will endeavour to resolve all incidents promptly and within statutory timeframes. Investigations and / or corrective actions will be prioritised to address problems and direct resources to the areas of highest risk and where the greatest improvements are possible.
Shared learning	Lessons learned from incidents will be shared to prevent further occurrences and to aid continual improvement.

4. Investigation Management Phases

Seqwater's investigation management process includes the following eight (8) phases which are designed to support the implementation of the investigation management principles. The first four are detailed within MAN-00276 Emergency Management Manual.



4.1. Identification

How do we identify things that have gone wrong?

All workers are responsible for identifying potential incidents requiring an investigation. Incidents can be identified from several functions and sources, including but not limited to:

- Health, safety and wellbeing incidents, hazards or near misses (e.g., injury, vehicle accidents, procedural breaches, etc.)
- Water Quality incidents (e.g., Australian Drinking Water Guideline value exceedance, contamination event, Critical control point limit exceedances, etc.)
- Environmental incidents (e.g., impacts/discharges to environment (air, land, water, noise), impacts to native flora/fauna and their breeding places, loss of containment)
- Cultural Heritage incidents (e.g., damage or disturbance to Aboriginal or European heritage items)
- Biosecurity incidents (e.g., flora/fauna pests and diseases, etc.)
- Asset / Equipment failures, including unplanned Water Treatment Plant shutdowns
- Security incidents (e.g., unauthorised activity/access, vandalism, theft, suspicious activity)
- Incidents involving members of the public (e.g., public safety/reassurance or potential for media interest, recreational activities, acts or threats of violence)
- Any other incidents that may impact on the normal operation of our business (e.g., bush fire, severe wet weather events, heat waves, major project works etc.)
- Non-conformances (e.g., contravention of an environmental and/or planning/development approvals, regulatory breaches, internal and external audits, supplier, etc.)

4.2. Immediate response to reduce risk and harm

How do we control or minimize the immediate risks?

When an incident is identified, immediate action must be taken to minimise the impact and to reduce the risk of harm to people, assets, water quality, environment, Seqwater's reputation, systems, and processes.

The initial response will depend on the nature of the incident (detailed information is in MAN-00276 Emergency Management Manual). Immediate actions may include.

- Notifying emergency services
- Ceasing all related work activities until the risk is removed
- Ensuring no further harm to any person, the environment, property, assets, etc.
- Ensuring continuity of services
- Rectifying the issue (only if possible and safe to do so).
- Collecting information about the incident (i.e., witness/observer statement, photographs, etc.)
- Verbal notification to their Leader as soon as practicable (refer Table 2)
- Preserving the scene.
- For Water Quality CCP Critical limit exceedances, follow the corrective action in the site's HACCP wall chart including shutdown of the process
- Notifying the Health and Wellbeing team to support workers that have responded to the incident.

4.3. Notification

How do we report incidents?

All incidents must be reported verbally to your line leader immediately and entered into Protecht by the end of the next business day. Table 2 summarises reporting methods.

Table 2 Reporting methods

Event type	How reported
Hazard	Telephone Leader to advise of hazard and record in the Protecht. Where required notify SME.
Near miss	Advise Leader and SME, then report the near miss in Protecht. If there is an emergency response required contact the Incident Hotline on (07) 3270 4040 to coordinate the response to the emergency.
Incidents	Advise Leader and SME, then report the incident in Protecht. If there is an emergency response required contact the Incident Hotline on (07) 3270 4040 to coordinate the response to the emergency.

For Water Quality-related incidents (e.g., Critical Limit Exceedances), report as per the site HACCP Wall Chart and PRO-01146 Water Quality Notification and Reporting Procedure. This includes verbal notification to the Operations Supervisor (or on-call Coordinator) and recording in the Protecht (refer PRO-02360 Creating a Water Quality Notification in Protecht Work Instruction).

Reporting of Environment-related incidents are to include verbal notification to the Regional Environment Team (or on-call Environment staff member).

For certain Environment-related incidents there are strict statutory reporting timeframes, those include;

1. Where an event contravenes a condition of an environmental authority or other permit; or
2. Where an event has happened that causes or threatens serious or material environment harm

When reporting, ensure the accuracy, quality, and completeness of the report to support the follow-up initial assessment and classification process. Important considerations for notifiers include:

- Provide as much detail as possible (including witness/observer statements and photographs where practicable)
- Provide objective and factual information (do not suppose what has happened).
- Avoid identifiable details such as names or persons involved
- Provide details of the immediate actions taken.

Supporting Tools

- PRO-01146 Water Quality Notification and Reporting Procedure
- PRO-02360 Creating a Water Quality Notification in Protecht Work Instruction
- Loss of Containment - User Guide
- How to report an incident.

4.4. Initial triage, clarification, and communication

Do we have all the information we need?
How severe is the incident and what type of investigation is required?
How do we communicate reported incidents?

All incidents are to be classified and investigated based on their potential risk consequence. A triage of the incident impacts must be undertaken to determine:

- assignment of the appropriate investigation type and methodology and
- notification requirements.

After being notified of the incident, and as part of the triage, the Leader in consultation with the SME shall:

- Review the accuracy, quality and completeness and update any additional information
- Determine if it is reportable to a Regulator (within 24 hours) and whether further guidance from Legal Counsel is required. Where the incident is determined to be reported to a regulatory body refer to 4.4.3.
- Allocate a risk consequence category in accordance with FRA-00014 Enterprise Risk Management Framework.
- Conduct a risk assessment to allocate a potential maximum credible risk consequence in accordance with Appendix B of FRA-00014 Enterprise Risk Management Framework
- Notification of Incidents must be made as per Table 3 or escalated to the next level if unable to make contact.
- Based on the potential risk consequence, determine the investigation type and recommended method as per Table 3.
- Assign a Lead Investigator (refer to Appendix A for details)
- Consider the development of an Incident Investigation Plan
- Provide an Incident Flash Report as required (refer to Appendix A for details).
- Where applicable, change the status of the incident record in Protecht to “triage”

Note: The applicable Level 3 Manager may use their discretion on which investigation method is applied relevant to the event within their area of operation and responsibility. Refer to Section 6 for further details.

Table 3 shows the recommended investigation methods based on the incident's potential consequence. Further details regarding Leaders, Lead Investigators and investigation timeframes are found in the Incident Investigation and Review Requirements Matrix in Appendix A.

Table 3 Notification, Escalation, Potential Consequence Ratings, Investigation Types and Methodology

Potential Risk Consequences	Investigation Type	Recommended Investigation Method	Reporting and escalation Responsibilities		
			Worker	Leader	General Manager
INSIGNIFICANT [1]	Basic	Protecht fields only	As soon as practical to Supervisor or Leader		
MINOR [2]	Standard	5 Whys			
MODERATE [3]	Standard	5 Whys	Immediately to Supervisor or Leader and SME	Within 24 hours to relevant General Manager	As required within 24 hours to CEO
MAJOR [4]	Detailed	ICAM		Immediately to relevant General Manager	Within 2 hours to CEO
CRITICAL [5]	Detailed	ICAM			

4.4.1. Hazard investigations

There is no requirement for an investigation to be undertaken into hazards with a potential consequence of Moderate or below, however, an investigation may be conducted in these instances at the discretion of the leader (for example if a trend of incidents has been identified, or if meaningful and actionable learnings are thought likely from an investigation). Hazards with a potential consequence of Major or Critical should be investigated in accordance with the requirements of this procedure.

4.4.2. Lead investigator and team

The Leader, together with the Lead Investigator, must consider the following when determining the makeup of the investigation team-:

- The skill sets (experience and knowledge) required to determine the incident's contributory factors and root causes
- Participation of SMEs where applicable. Note: for incidents where the potential risk consequence is Major or Critical or notifiable to a Regulator the team must include an applicable SME.

The Lead investigator, Leader and SME should develop an investigation plan for the investigation. The investigation plan must include key stakeholders and key dates to ensure the investigation is completed within the timeframes set out in Appendix A.

4.4.3. Notifiable events to Regulator

Seqwater will comply with all applicable legislative and regulatory requirements. This includes the reporting of certain types or levels of incidents to the Industry Regulator or respective Government Department.

Where it has been determined that the incident is to be reported to a Regulator, notification must only be made by the relevant approved SME level 3 leader, or their delegate. Reporting and management of the event will be within the required statutory timeframes.

Seqwater Legal Team should also be consulted to ascertain if the investigation into the notifiable event should be undertaken under Legal Professional Privilege.

Appendix B details those Regulators that Seqwater may need to notify depending on the incident.

Supporting Tools

- Incident Communication Data Capture Form
- PRO-00707 Drinking Water Incident Reporting to Water Supply Regulation Procedure
- PRO-01146 Water Quality Notification and Reporting Procedure
- FRM-01312 Investigation Plan

4.5. Completing the investigation

What, how and why did the event happen?
What can we do to prevent recurrence or similar incidents?

All incidents will be investigated and reported in a method that clearly identifies what happened, why it occurred, and recommendations to prevent a recurrence. All incidents with a Major or Critical rating must undergo an in-depth and detailed investigation.

The investigation is to identify why the incident happened and its contributing factors (including technical, organisational, and human), its root cause and to determine what corrective actions are required to prevent a recurrence.

The Leader Investigator should update the Protecht record of the incident to “Under Investigation” and keep the record updated of any progress.

The investigation should:

- Be conducted using the appropriate methodology (the process built in Protecht or as determined by the relevant level 3 manager)
- Determine the scope (boundaries, limits, and resources required)
- For HSW incidents – include a review of the HSW Risk Assessment / Bow-tie analysis whenever a Critical control is deemed not in place or effective,
- Seek to identify the immediate cause(s), the contributing factors and finally the root cause(s).
- Be conducted as a fact-finding exercise, not a fault-finding mission, i.e., free of value judgments, speculation, or opinion
- Check to see if any similar incidents have previously occurred and if so, what corrective actions were taken
- Be completed promptly (refer to Appendix A for timeframes)
- Record all evidence gathered to support the facts found
- Result in recommendations and corrective actions for approval and actioning

- Be documented in accordance with this Procedure
- Be reviewed and signed off by the Leader.

Refer to the Incident Investigation and Review Requirements Matrix in Appendix A for further information.

Note: for ICAM investigations must complete the investigation using: TEM-00025 Incident Investigation Report Template, with the findings and associated actions entered into Protecht. All supporting evidence captured to complete the ICAM must be saved in Protecht.

Supporting Tools

- Incident Communication Data Capture
- TEM-00025 Incident Investigation Report Template

Supporting Tools

- PRO-00003 Corrective and Preventative Action Management Procedure

4.6. Investigation Report Review

How do we review investigation reports?

Once the incident investigation is complete, the Lead Investigator will notify the Leader for review. The Leader should then change the status of the incident record in Protecht from "Under Investigation" to "Investigation Under Review." Note that this status change will affect the notification of overdue emails.

If an ICAM has been completed, the Lead Investigator must attach a copy of the report to the incident record in Protecht. Once the Leader has reviewed and confirmed that the investigation has identified the root cause of the incident, the Leader can close the incident. Refer to Section 4.7 for further details.

4.6.1. Implement and monitor corrective action plan

What did we do to improve and prevent recurrence of incidents?

All investigations shall identify corrective and improvement actions including control measures to eliminate or mitigate the root cause(s) of the incident and reduce the likelihood of reoccurrence.

All approved corrective actions relating to an incident will be raised in Protecht. Corrective Actions should:

- Reflect the magnitude of the event and associated risk
- Address the contributing factors and root cause(s) identified in the investigation
- Be developed in consultation with relevant persons
- Clearly describe what is required to prevent the event from reoccurring
- Be written in a SMART (Specific, Measurable, Achievable, Realistic, Time-bound) format
- Be assigned to a person who has authority for the implementation
- Be designed to give value to Seqwater processes, procedures, systems, and operations where practicable.

The progress of implementing the corrective actions must be regularly monitored by the Leader to ensure timely completion and positive change.

4.7. Incident Closure and 12-month review

How do we close out incidents?
How we know if we have improved?

Once the investigation is complete and all the details are documented and recorded and all actions are raised, the incident can be closed. Consideration should be given to the review of the identified risks and any updates to relevant risk registers.

Actions do not have to be completed before the incident is formally closed out.

A post-event review must be conducted for all Major and Critical incidents by the Leader with support from the SME, 12 months after the date of the event. The purpose of the review is to ensure that all appropriate controls or corrective actions have been considered and have had the intended results to provide confidence that the risk of reoccurrence has been appropriately mitigated.

The review may include an investigation team debrief relating to the overall management of the event and to record learnings.

Supporting Tools

- Incident Communication Data Capture Form

4.8. Sharing and learning

How we share what happened and what we did to improve and prevent recurrence?
How do we learn from incidents?

Once the incident investigation has been formally closed, the Lessons Learnt must be formally communicated as appropriate. For complex or protracted investigations, interim lessons learnt may also be shared.

Outcomes resulting from incidents will be communicated so that the learnings can help others also to prevent similar incidents and encourage the workforce to report future concerns. Information should be factual and presented in a manner that is appropriate for the audience, i.e., meetings, toolbox talks, emails, reports, Waternet article, etc. Refer to Appendix A for details on when a Lessons Learnt report is to be communicated.

Learnings include several different activities including implementing recommendations, monitoring their effectiveness, and providing feedback to the organisation. Lessons Learnt should as a minimum include the following:

- Facts pertaining to the event and findings, including root causes, and contributing factors
- Agreed recommendations and associated corrective actions to prevent recurrence of the incident
- Key learnings.

Considerations should be given when sharing lesson learnt reports with the business to ensure adequate debriefs are occurring and consistency of key learnings.

Supporting Tools

- Incident Communication Data Capture Form

5. Contractors

5.1. Principal Contractors

The Principal Contractor must adequately investigate all incidents as per their contract, management plan and the Principal Contractor Minimum Health, Safety and Environmental Requirements (GDE-00368). Seqwater requires:

- The Incident Investigation must be led by an Incident Investigator with a suitable level of independence from the Project.
- Any breach of a Seqwater Critical control and/or licence/approval condition must be investigated.

The Contractor must fully cooperate with Seqwater in the event of an investigation and make the incident investigation report and all relevant documents available in full to the Seqwater without exercising any legal privilege.

The Leader (e.g. Project Manager), with support from the SME is to review the Contractor's incident investigation report. Note: once the report is received from the PC, the incident record can be changed to "Investigation Under Review", this stops any escalation emails. If Seqwater considers that the incident investigation corrective actions are insufficient, Seqwater may:

- Issue the Contractor with a Corrective Action Request, and / or
- Impose a Hold Point on the particular work process and / or
- Stop work in accordance with contractual arrangements

The Contractor's initial Investigation report (and supporting documents) must be completed and provided to Seqwater within statutory and reasonable time frames given the nature and circumstances of the incident. The following timeframes are in line with Seqwater's internal requirements and are provided as a guide in Appendix A.

Notwithstanding these timeframes the Contractor may request an extension and, where requested by Seqwater shall provide periodic updates (including briefings) relating to the incident until their final incident investigation report is completed

The Contractor's investigation report is to include 'lessons learnt' (or equivalent). Seqwater may choose to participate in the Contractors Incident Investigation Team or Investigation process or to investigate independently any near miss/incident/injury or illness. Any investigations by Seqwater may be conducted for the purpose of obtaining legal advice and subject to legal professional privilege.

5.2. All other Contractors

The Contractor must adequately investigate all incidents as per their contract or relevant agreement in accordance with their management systems to the satisfaction of Seqwater. Seqwater expects:

- The Incident Investigation to be led by an Incident Investigator with a suitable level of competence and independence from the works.
- Breaches of a Seqwater Critical control and/or licence/approval condition to be investigated.

The Contractor must fully cooperate with Seqwater in the event of an investigation and make the incident investigation report and all relevant documents available in full to Seqwater without exercising any legal privilege.

The Leader (e.g. Project Manager or Site Owner), with support from the SME is to review the Contractor's incident investigation report. Note: once the report is received from the Contractor, the incident record can be changed to

"Investigation Under Review", this stops any escalation emails. If Seqwater considers that the incident investigation corrective actions are insufficient, Seqwater may:

- Issue the Contractor with a Corrective Action Request, and / or
- Impose a Hold Point on the particular work process and / or
- Stop the current and pending work

The Contractor's initial Investigation report (and supporting documents) must be completed and provided to Seqwater within statutory and reasonable time frames given the nature and circumstances of the incident. The following timeframes are in line with Seqwater's internal requirements and are provided as a guide in Appendix A.

Notwithstanding these timeframes the Contractor may request an extension and, where requested by Seqwater shall provide periodic updates (including briefings) relating to the incident until their final incident investigation report is completed

The Contractor's investigation report is to include 'lessons learnt' (or equivalent). Seqwater may choose to participate in the Contractors Incident Investigation Team or Investigation process or to investigate independently any near miss/incident/injury or illness. Any investigations by Seqwater may be conducted for the purpose of obtaining legal advice and subject to legal professional privilege.

6. Deviations

Deviations from the requirements of this procedure may only be considered when:

- regulatory obligations dictate otherwise
- implementation of the requirement is not technically feasible or has time constraints placed on it
- the cost of implementing the requirements substantially exceeds the benefits.

To deviate from the requirements of this procedure you must:

- specify the risks implications of not implementing the requirement and document the identified control measures to be put in place
- have the deviation authorised by obtaining documented approval from the applicable Level 3 Manager (or higher) and recorded in Protecht.

7. Training and Competency

Training will be provided as follows-:

Table 4 Training and Competency Requirements

Requirement	Description	Refresher Timeframe	Target Audience
General awareness	General awareness of the incident management process as part of the induction process.	Nil	Workers
5 Whys	Training to learn how to assist in investigations under the leadership of a trained ICAM facilitator. Workers will also acquire the skills to independently investigate low-consequence equipment damage, injuries and production loss events.	Where required/requested by employee or required by leader	• Lead Investigators • Subject Matter Experts (functions)
ICAM Lead Investigator	Face-to-face course to provide a comprehensive education in best-practice ICAM methods. Participants will receive the qualifications to supervise incident investigations at work and access to the tools needed to manage an investigation	Where requested by employee or required by leader	• Lead Investigators • Subject Matter Experts (functions)

8. Record keeping

All incident investigation reports, including supporting documentation will be saved in Protecht, with the appropriate security limits as determined by the SMEs.

All incident records are to be retained, archived, and disposed of in accordance with the Queensland State Archives General Retention and Disposal Schedule for Administrative Records and the Seqwater Retention and Disposal Schedule QDAN717.

Additional guidance regarding mandatory record keeping requirements is provided in PRO-01766 Record Retention and Disposal Procedure.

9. Compliance, Assurance, and Monitoring

Compliance with the requirements of this Procedure will be periodically monitored as part of the audit and assurance cycle and in accordance with PRO-00002 Management System Audit and Assurance Procedure.

Monitoring of reporting of incidents, investigation findings, actions and learnings will also be undertaken as part of business unit reviews and performance reporting requirements to prevent future incidents, reduce risk exposure

and determine risk themes and trends. The applicable Leader or Senior Management may use their discretion on what is to be monitored.

The above monitoring should also assess the quality of the information collected, generated and presented in Protecht and where required reported on through IMS Management Review.

10. References and Related Materials

Description	Location
Drinking Water Quality Management Systems Standard ISO 22000	i2i
Environmental Management Systems Standard ISO 14001	i2i
ERP-00001 Bulk Authority Emergency Response Plan	REX
FRA-00014 Enterprise Risk Management Framework	REX
FRM-00480 Incident Observer Form	REX
FRM-01312 Investigation Plan	REX
GDE-00368 Principal Contractor Minimum Health, Safety and Environmental Requirements Guideline	REX
HSW Management Systems Standard ISO 45001	i2i
MAN-00276 Emergency Management Manual	REX
PRO-00002 Management System Audit and Assurance Procedure	REX
PRO-00003 Corrective and Preventative Action Management Procedure	REX
PRO-00656 WTPs - Water Quality Notification Procedure	REX
PRO-00707 Drinking Water Incident Reporting to Water Supply Regulation Procedure	REX
PRO-01146 Water Quality Notification and Reporting Procedure	REX
PRO-01766 Record Retention and Disposal Procedure	REX
PRO-02360 Creating a Water Quality Notification in Protecht Work Instruction	REX
PRO-02439 Incident Cause Analysis Method (ICAM) Work Instruction	REX
Quality Management Systems Standard ISO 9001	i2i
TEM-00025 Incident Investigation Report Template	REX
WIS-00025 Incident Cause Analysis Method (ICAM) Work Instruction	REX

11. Definitions

Term	Definitions
5 Whys	Seqwater's recommended investigation methodology for MINOR and MODERATE rated incidents. 5 Whys is a tool that requires the Investigator to ask "why?" up to five or more consecutive times until the root cause of the incident is clearly identified.
Contributing factor	Any behaviour, omission or deficiency that contributed to the cause of the incident.
Corrective action	Any planned action or control measure to eliminate, minimise or resolve the cause(s) of an incident and prevent recurrence.
Protecht	Seqwater's electronic risk management system. Its functions include risk, incident, compliance, audit, and action management.
Hazard	A situation that has the ***potential to harm*** a person and/or the environment and/or damage property
High Potential Incident	Any incident with a potential consequence rating of MAJOR or CRITICAL.
ICAM (Incident Cause Analysis Method)	Seqwater's recommended investigation methodology for MAJOR and CRITICAL rated incidents. ICAM clarifies why the incident happened and identifies all the factors that contributed to the incident. The contributing factors are classified into four categories: • absent or failed defences, • individual or team actions, • task or environmental factors, • and organisational factors.
Incident	Any occurrence that has resulted in adverse and unplanned consequences to water supply, water quality, people, the environment, property, reputation, compliance or a combination of these. For the purposes of this procedure, incidents include hazards and near misses.
Incident management	The entire lifecycle of an incident from its detection until its resolution and closure.
Incident risk categories	Grouping of categories that enable a more structured and systematic approach for identifying, analysing, assessing, and reporting on incidents.
Investigation	The process of gathering the facts surrounding an incident in an unbiased, systematic, and comprehensive manner to identify all contributing factors and root causes.
Lead investigator	An appropriately qualified Seqwater employee appointed to investigate an incident.
Leader	Means any Level 1, 2, 3 and 4 Leader with responsibility for managing a functional area of the business, including people management responsibilities within their functional area.

Term	Definitions
Maximum credible risk	The most likely maximum risk scenario/outcome of a particular incident.
Near miss	Any unplanned incident that occurred at the workplace which, although not resulting in any damage, disturbance, injury or illness, had the potential to do so. Note – A near miss may also be a notifiable incident in accordance with the definition of the term.
Notifiable event	Any incident that is required to be reported to the relevant Regulator or other external body.
Potential consequence	The maximum foreseeable impact that could have occurred given the circumstances and controls in place at the time of the incident (this is not a worst-case scenario, but maximum realistic outcome).
Principal Contractor	Has the same meaning given to that term under the WHS Act and the WHS Regulation.
Risk	The effect of uncertainty on Seqwater's objectives.
Root cause	A root cause is a fundamental, underlying, system-related reason an incident occurred, which if corrected would significantly reduce the chance of recurrence of the incident and its consequences.
Subject matter expert (SME) / Process Owner	Representative of the business that has an in-depth knowledge of the functional, system and business processes affected by the incident. This role helps provide valuable information that may help with investigating the root causes of the incident and developing corrective actions.
Worker(s)	Includes all permanent, temporary, and casual employees of Seqwater, and: • vocational and work experience placements • volunteers/visitors • contractors and consultants employed by another entity but temporarily assigned to do work for or on behalf of Seqwater.

12. Roles and Responsibilities

Role	Responsibility
Executive Leadership Team (ELT)	• Review all MAJOR and CRITICAL investigation findings, recommendations, corrective actions, and key learnings. • Ensure that resources are made available to meet the requirements of this Procedure.
Investigation team	• Assist with the investigation and any other role allocated as part of the team.
Lead investigator	• Develop investigation plan in consultation with the Leader and SME. • Identifies and appoints Investigation Team Members and SMEs to participate in the investigation • Updates the status of the incident record in Protecht when required • Complete the investigation within the set timeframe. • Develop proposed actions to address all shortcomings found during the investigation. • Review documented actions with the Leader and action owners, to confirm agreement and effectiveness. • Complete all data and records requirements. • Develop draft Lessons Learnt Report for Leader approval.
Leader	In addition to the responsibilities of a worker: • Ensure staff compliance with this Procedure. • Ensure that incidents are managed as per this Procedure for activities within their area of their responsibility. • Actively engage and participate in the investigation process. • Appoint a suitably qualified and trained Lead Investigator • Communicate investigation plan, findings, corrective actions, and key learnings to their team and or business. • Updates the status of the incident record in Protecht when required • Implement and monitor the effectiveness of corrective actions and provide feedback. • Issue Lessons Learnt reports as required in consultation with investigation team.
Legal Counsel	Where required, • provide advice and guidance on what type of incidents are reported to a regulator. • Assist the business with identifying and managing legal risks for an incident. • Participating in investigations as required.

Role	Responsibility
Notifier	• Report all incidents as soon as practicable • Conduct immediate response actions • Seek and follow direction from the SME and Leader • Participating in investigations as required.
Subject Matter Experts (SME)	• Perform the initial assessment of the incident to determine the investigation plan, the appropriate investigation methodology and notification requirements • Develop and issue an Incident Flash Report as required. • Ensure the appropriate notifications are made to external regulatory authorities • Lead and participate in investigations as requested • Provide support in all aspects of the incident management process, including entry of supporting information into Protecht • Assist with conducting 5 Whys and ICAM investigations as required. • Issue Lessons Learnt reports as required. • Level 3 line leader SME – Report incidents to regulatory bodies where required
Workers	• Be aware of and comply with this Procedure. • Complete any mandatory training. • Actively engage and participate in the incident management process (as required).

Appendix A – Incident Investigation and Review Requirements Matrix

Potential Risk Consequence	Recommended Investigation Method	Reported in Protecht	Risk Assessment / Bow Tie Review (where HSW Critical Control not in place or effective)	Investigation Due (from date reported)	Leader	Lead Investigator	Incident Flash Report	Lessons Learnt Report	Post Incident Review
CRITICAL [5]	ICAM	by the end of the next business day	Yes	28 Calendar Days [1]	Level 3 Manager	Approved ICAM Investigator or equivalent	Yes – within 5 Calendar Days	Yes – within 5 days of the incident being closed	Required – within 12 months after Incident date
MAJOR [4]	ICAM	by the end of the next business day	Yes	28 Calendar Days [1]	Level 3 Manager	Approved ICAM Investigator or equivalent	Yes – within 5 Calendar Days	Yes – within 5 days of the incident being closed	Required – within 12 months after Incident date
MODERATE [3]	5 Whys	by the end of the next business day	Yes	14 Calendar Days [1]	Level 4 Co-ordinator / Principal	Level 4 Co-ordinator / Principal or appointed	Yes – within 5 Calendar Days	Yes – within 5 days of the incident being closed	Where applicable at the discretion of Level 4 SME
MINOR [2]	5 Whys	by the end of the next business day	No	14 Calendar Days [1]	Level 4 Co-ordinator / Principal	Level 4 Co-ordinator / Principal or appointed	Where applicable at the discretion of Level 4 SME	Where applicable at the discretion of Level 4 SME	Not Required
INSIGNIFICANT [1]	Basic	by the end of the next business day	No	7 Calendar Days	Level 5 Supervisor	Level 5 Supervisor or appointed Senior DWQ Advisor or Environmental Advisor	Not Required	Not Required	Not Required

[1] This timeframe is not applicable where incidents have Regulator or External Stakeholder involvement that delays access to site or the investigation process.

Appendix B - Notifiable Regulators

Regulators that Seqwater may be required to notify are detailed below (not an exhaustive list).

Regulator	Notification requirement / Event
Dam Safety Regulator	• Event in relation to Seqwater's referable dams
Department of Agriculture and Fisheries (DAF)	• Fish kills • Compliance matters pertaining to development approvals
Department of Environment Science and Innovation (DESI)	• Where an event has happened that causes or threatens serious or material environment harm (*Environmental Protection Act 1994, Section 320*), and • Where an event contravenes the condition of an environmental authority (*Environmental Protection Act 1994, Section 430).*
Electrical Safety Office (ESO)	• Serious Electrical Incident (*Electrical Safety Act 2002 Section 11)* • Dangerous Electrical Event (*Electrical Safety Act 2002 Section 12)*
State or Federal Environmental or Planning Regulators	• Other offences under the *Environmental Protections Act 1994*, *Fisheries Act 1994*, *Environmental Protection and Biodiversity Conservation Act 1999*, *Planning Act 2016* or other environmental legislation/approvals may occur that are not 'notifiable events'. "Advisory notifications" may be provided to the relevant State or Federal regulators to manage regulatory risk from these events on a case-by-case basis.
Water Supply Regulation (WSR)	• Detection of E. coli or another parameter greater than the ADWG health guideline value. • [Onward reporting to the Public Health Unit *(Public Health Regulation 2018)* is undertaken by WSR] Event that could not be controlled and Seqwater believes or is concerned that public health may be adversely impacted as a result. • Detection of a parameter with no water quality criteria. • Any of the above occurring during research activities. • Failure to take treated water samples in accordance with the approved Verification Monitoring Plan
Work Health and Safety Queensland (WHSQ)	• Notifiable Incident (*WHS Act 2011 Section 35*) • Dangerous Incident (*WHS Act 2011 Section 37*)