Procedure

Incident Investigation

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Rev no.	Description	Owner		Approved for issue		
		Position	Signature	Position	Signature	Date
07	Amended Version	Quality Systems Coordinator	Refer to supporting Info in Q-Pulse	GM, Customer, Strategy and Planning	Refer to supporting Info in Q-Pulse	04/02/2020

Contents

1 Purpose

Seqwater is committed to continuous improvement within our business. The purpose of this procedure is to support our “Water for Life” Vision and achieve our “Safe for Life” Promise by guiding each level of the organisation to investigate hazards and incidents in a way that identifies the root cause(s), contributing factors and preventative actions that are appropriate for the level of potential consequence.

When implemented the preventative actions should:

- Eliminate or minimise identified hazards or risks as far as reasonably practicable.
- Prevent the reoccurrence of incidents.
- Imbed Seqwater values and challenge work processes that need improvement.

This procedure supports the requirements of Performance Evaluation as detailed in Corporate Management System Manual (MAN-00004) for all quality systems.

2 Scope

This procedure applies to incidents notified under Emergency Management Manual MAN-00276 work activities within Seqwater. Where deemed relevant, potential or repeated hazards identified may be subject to an incident investigation.

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

3 Definitions

Term	Definitions
Accountable Leader	Person in an Seqwater role with line responsibility for the people, environment or community directly placed at risk or harmed by a hazard, near miss or incident.
Chain of Events & 5 Whys	Chain of Events & 5 Whys is an iterative interrogative technique used to explore the cause-and-effect relationships underlying a particular problem. The primary goal of the technique is to determine the root cause of a defect or problem by repeating the question "Why?". ... Not all problems have a single root cause.
Contributing Factor	A factor that contributed to the causes of the incident.
Corporate Electronic Database	Risk Wizard will be used for all incidents and associated investigations received through OCA as a result of the 2016 Risk Wizard implementation throughout the business.
Emergency	An event that happens as a consequence of an incident and demands immediate action. It is the broader coordination to manage incidents including mitigation and public and stakeholder outcomes.

Term	Definitions
High Potential Incident (HPI)	An incident where the potential consequence is assessed as “Major” or “Catastrophic”. Further expansion on the definition could include HPI - Zero Energy Exchange (proactive reporting) and HPI - Energy Exchange (reactive reporting) Incidents that have been classified as a Near Miss may also be deemed as HPI’s. In determining the potential consequence, consideration should be based on the reasonably foreseeable outcomes given the circumstances, likelihood and controls in place at the time of the event. Confirmation of HPI classification is subject to consultation with the Executive Leadership Team.
Incident	Any occurrence that has resulted in adverse and unplanned consequences to water supply, water quality, people, the environment, property, reputation or a combination of these. This definition of an incident includes near misses.
Incident Cause Analysis Method (ICAM)	The ICAM process is an industrial safety analysis tool that sorts the findings of an investigation into a structured framework. An ICAM analysis clarifies why the incident happened and identifies all the factors that contributed to the event. The contributing factors are classified into four categories of the ICAM Model which are: absent or failed defences, individual or team actions, task or environmental factors, and organisational factors.
Incident Investigation Review	A review of an investigation where the incident meets a certain criteria as defined by the ELT, to determine the effectiveness of the investigation process, including actions, causes and leadership, behavioural and cultural aspects.
Lead Investigator	An appropriately qualified Seqwater Employee (ICAM Trained) appointed to investigate a hazard or incident where the potential consequence is major or above.
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 Incident	An incident that requires notification to a regulator and is determined following consultation between the Functional Manager and the responsible manager in accordance with the Corporate Delegations and Authorisation Manual (MAN-00076).
Potential Consequence	The maximum foreseeable consequence that could have occurred given the controls in place at the time.
Preventive Action	Any action to eliminate the cause of a potential non-conformity or other undesirable potential situation.
Principal Contractor	The person conducting a business or undertaking appointed by Seqwater as the Principal Contractor for a construction project (construction work valued over $250,000), and given the management and control of the workplace at which the construction project will be carried out and who discharges the duties of the Principal Contractor.
Risk – Water Quality (ADWG)	The likelihood of identified hazards causing harm in exposed populations in a specified timeframe, including the consequences.
Root Cause	A root cause is a fundamental, underlying, system-related reason why an incident occurred that identifies one or more correctable system failures, which if corrected would significantly reduce the chance of a reoccurrence of the incident.

4 Roles and Responsibilities

Role	Responsibility
Accountable Leader	• Ensure, so far as is reasonably practicable, where a notifiable incident has occurred, that the incident site is not disturbed until an inspector gives approval for its release and any emergency response taken to control the incident is complete. • Review and approve the classification of potential consequence for all incidents in consultation with relevant stakeholders. • Establish need for EAP, Injury Management and Drug & Alcohol Testing. • Appoint a Lead Investigator for all Major and Catastrophic Potential Incidents and complete the investigation planning checklist (Appendix D) with them. • Contact Legal Counsel for advice to determine if specific records from incidents should come under Legal and Professional Privilege (LPP) and whether a contractor's claim for LPP is valid. • Review findings from the investigation to ensure recommendations adequately identify the root cause(s) of the incident and the preventative actions prevent the root cause and incident from recurring. • Review proposed actions with the Lead Investigator and allocate action owners and time frames for completion. • Approve Incident Flash, Interim Summary, Lessons Learnt Reports and the Incident Investigation Report after appropriate Legal Counsel review. • Monitor and verify the close-out of corrective actions.
Incident Reporter	• Raise the alarm where personal safety is at risk. • Manage immediate response actions. • Assess the potential risk and escalate accordingly. • Notify the Accountable Leader and preserve the scene, subject to the exceptions above, where required. • Report the hazard/observation/incident as per checklist in Appendix D.
Investigation Process Facilitator	• Provide expertise in guiding the Accountable Leader, Lead Investigator and the investigation team to ensure the process delivers a consistent quality and is time efficient.
Investigation Team Member	• Provide expertise in their area of speciality to assist with the investigation and any other role allocated as part of the team.
Lead Investigator	• Develop investigation plan in consultation with the Accountable Leader for Major and Catastrophic Potential Incidents. • Complete the investigation within the set timeframe. • Review documented actions with the Accountable Leader and action owners, to confirm agreement and effectiveness. • Develop proposed actions to address all shortcomings found during the investigation. • Complete the data and records requirements as per Appendix B. • Develop draft Incident Flash Report, Interim Summary and Lessons Learnt Report for Accountable Leader approval.
Seqwater Legal Counsel	• Provide advice on the provision of information to, or investigations by, Workplace Health and Safety Queensland (WHSQ), the Electrical Safety Office (ESO), Department of Environment and Heritage Protection (DEHP) or other external parties. • Assist the business with identifying and managing legal risks for an incident. • Provide advice and guidance for invoking and maintaining Legal Professional Privilege for investigation communications and documentation.

5 Procedure

5.1.1 Incident Reporting

The first person aware of a hazard or an incident must raise the alarm and act, to prevent further harm to people, product quality or supply, the environment, property, reputation and then must:

- Immediately notify the relevant Accountable Leader;
- Follow the relevant Incident and Emergency Response Plan (IERP) if an emergency; and
- Preserve the incident scene where a Notifiable Incident has occurred until Accountable Leader authorises otherwise.

Report the incident details in accordance with Appendix C and section 5.1.2.

5.1.2 Preserve the incident scene

Preserving the incident scene enables the collection of evidence to ensure the outcomes of the investigation are factual and enable the identification of causes.

In the case of a Notifiable Incident, the first person aware or any other workers involved must preserve the incident scene so that equipment, plant, process, machinery or other associated plant connected with the incident are not disturbed without the permission of the Accountable Leader. For the avoidance of doubt, disturbance can occur for the following reasons:

- to assist an injured person;
- to allow an authorised person to remove a deceased person;
- to make the site safe or to minimise the risk of a further Notifiable Incident;
- incidents that are associated with a police investigation
- or which an inspector or the regulator has given permission;
- to preserve environmental protection; and
- to maintain water quality.

Work must be stopped until the risk of harm is removed, so far as reasonably practicable.

5.1.3 Report the incident details

The following details are to be reported:

- Date, time and location of the event
- What happened
- Actual consequences
- Who was involved, and
- Immediate actions taken.

5.2 Assess the Potential Consequence

5.2.1 Assess the potential consequence and establish the Accountable Leader

The potential consequence should be assessed considering the controls in place at the time. The potential consequence determines the role level of the Accountable Leader as per Appendix A.

The Accountable Leader must be a Seqwater role with line responsibility for the people, environment or community directly put at risk by the incident.

5.2.2 Establish the level of investigation required

The method used to determine the root cause(s) and data recorded from the investigation will be based on the potential consequence as per Appendix A.

5.2.3 Assess if the incident is a Notifiable Incident

The Accountable Leader should consult with the relevant Functional Manager and Legal Counsel to determine if a Notifiable Incident has occurred and report it as per the related requirements in Section 7.3.

5.2.4 Identify the investigator

For insignificant, minor and moderate potential consequence incidents, the investigator is the Accountable Leader. For Major and Catastrophic Potential Incidents, the Lead Investigator is selected by the Accountable Leader from the trained and approved ICAM Leader list.

5.2.5 Develop the Incident Flash Report

The Lead Investigator and team will draft the Incident Flash Alert TEM-00290 with support from the relevant Functional Advisor for any Major and Catastrophic Potential Incidents. The report should use questions to stimulate thoughts at other sites which could experience a similar event.

5.2.6 Issue the Incident Flash Report

The Accountable Leader will approve the Incident Flash Report and issue to their respective General Manager for communication to all Seqwater personnel via email.

5.3 Plan the investigation

5.3.1 Decide members of investigation team

The Accountable Leader, with the Lead Investigator where appointed, and supported by a process facilitator shall consider:

- The skillsets of the investigation team members required to determine root causes and contributing factors.
- Diversity of experience and knowledge of team members.
- Participation of Workplace Health and Safety Representatives where applicable.

5.3.2 Establish the scope

Consult Legal Counsel to consider whether any material generated as part of an investigation should be made under the protection of Legal Professional Privilege.

In consultation with the investigation team the Accountable Leader will establish the scope of the investigation to match investigation effort with the potential consequence and root cause analysis method required. The scope should consider the following key elements:

- The purpose of the investigation;
- Schedule of steps required to complete the investigation;
- Stakeholders, confidentiality, team jurisdiction and authority
- What are the boundaries and limits of the investigation; and
- Physical resources required and timing expected to complete the analysis and reporting process.

A simple investigation planning checklist is listed in Appendix D, with further detailed information in the Chain of Events and 5 Whys and ICAM Chart Template (TEM-00294).

5.4 Conduct the investigation

5.4.1 Use the appropriate root cause analysis method

Follow the root cause analysis method of the investigation as per Appendix A. Refer to the 5 Whys and ICAM work instructions for specific guidance on how to use those methods.

5.4.2 Develop Actions

Consult with relevant stakeholders to gain consensus that actions will prevent a recurrence of the incident or significantly reduce the likelihood.

Actions must:

- Utilise the hierarchy of control
- Be specific, measurable, actionable and timely in their effectiveness, and
- Be designed to give value to all Seqwater operations where practicable.

5.4.3 Record relevant information in Risk Wizard and REX

The investigator must populate the mandatory data fields in Risk Wizard using the published user guide.

The investigator must store all evidence in accordance with section 8 of this Procedure.

Appendix B outlines different levels of data and records to be populated for each type of investigation.

5.5 Share key learnings

The Accountable Leader must share the key learnings for Major and Catastrophic Potential Incidents in a way that can be easily adopted in other areas of the business using the Lessons Learnt Report. When an investigation will not meet the target of 28 days for completion, an Interim Summary should be communicated to the business, followed by a Lessons Learnt Report once the investigation is complete. The General Manager of the Accountable Leader will issue the Incident Flash report to all Seqwater personnel. The Lesson Learnt Report should be reviewed by Legal Counsel prior to release.

5.5.1 Interim Summary Report

The Interim Summary Report should use template (TEM-00291) and as a minimum should include the following:

- When and where the incident occurred, what actually happened and initial actions to remedy the incident.
- Possible root causes requiring further investigation.

5.5.2 Lessons Learnt Report

The Lessons Learnt Report should use template TEM-00292 and as a minimum should include the following:

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

5.5.3 ICAM Report

The Final Report must be compiled using the Incident Investigation Report Template (TEM-00025).

5.6 Complete Actions

The Accountable Leader should regularly review identified actions to encourage timely completion.

5.7 Verify Major & Catastrophic Potential Incident Investigation Effectiveness

The Accountable Leader must conduct a field verification to ensure actions are checked 12 months after investigation completion to ensure that they have been completed, still effective and will prevent incident recurrence. Findings should be communicated to the business using the Action Close Out Review Report Template (TEM-00293). If actions are found to be ineffective, remediation actions should be raised in Risk Wizard and implemented urgently.

6 Training requirements

6.1 Potential Insignificant Consequence

No training is required for informal investigations. Accountable Leaders can use the checklist in Appendix E.

6.2 Potential Minor and Moderate Consequences

Accountable Leaders are required to complete the approved training course for 5 Whys investigations.

6.3 Potential Major and Catastrophic Consequence

Accountable Leaders for ICAM investigations are required to complete the approved ICAM training course, and Lead Investigators are required to complete the approved ICAM Leader training course.

7 References

7.1 Legislation and other requirements

Description	Status	Location
Electrical Safety Act 2002 (Qld)	Active	www.legislation.qld.gov.au
Electrical Safety Regulation 2013 (Qld)	Active	www.legislation.qld.gov.au
Work Health and Safety Act 2011 (Qld)	Active	www.legislation.qld.gov.au
Work Health and Safety Regulation 2011 (Qld)	Active	www.legislation.qld.gov.au
Environmental Protection Act 1994 (Qld)	Active	www.legislation.qld.gov.au
Environmental Protection Regulation 2008 (*Qld)*	Active	www.legislation.qld.gov.au
Water Supply (Safety and Reliability) Act 2008 (Qld)	Active	www.legislation.qld.gov.au
WHS Standard AS/NZS 4801	Active	www.saiglobaliso.com/online
Environmental Standard ISO 14001	Active	www.saiglobaliso.com/online
Quality Standard ISO 9001	Active	www.saiglobaliso.com/online
Drinking Water Quality Standard ISO 22000	Active	www.saiglobaliso.com/online

7.2 Supporting Procedures, documents, forms and templates

Description	Status	Location
Emergency Management Manual MAN-00276	Active	Q-Pulse & Waternet
Non-conformance, Corrective Action and Continual Improvement Procedure PRO-00003	Active	Q-Pulse & Waternet
Seqwater Retention and Disposal Schedule – QDAN 717	Active	Q-Pulse external document
Seqwater Retention and Disposal Schedule – QDAN 717	Active	Q-Pulse external document
Chain of Events and 5 Whys Template TEM-00294	Active	Q-Pulse & Waternet
Chain of Events _ 5 Whys Work Instruction PRO-02440	Active	Q-Pulse & Waternet
ICAM Investigation Work Instruction PRO-02439	Active	Q-Pulse & Waternet
Incident Flash Report Template TEM-00290	Active	Q-Pulse & Waternet
Incident Interim Summary Report Template TEM-00291	Active	Q-Pulse & Waternet
Lessons Learnt Report Template TEM-00292	Active	Q-Pulse & Waternet
Action Close out Review Template TEM-00293	Active	Q-Pulse & Waternet
Incident Investigation Report TEM-00025	Active	Q-Pulse & Waternet
Incident Witness Statement FRM-00480	Active	Q-Pulse & Waternet

7.3 Notifiable Incident definition references

The need for notification to external parties will be determined by the relevant Subject Matter Expert (SME) Manager in consultation with the Accountable Leader. The notification will be completed in accordance with the Corporate Delegations and Authorisation Manual (MAN-00076)

7.3.1 WHS

Notifiable Incident - WHS Act 2011 Section 35.

Dangerous Incident - WHS Act 2011 Section 37.

7.3.2 ESO

Serious Electrical Incident - ESA 2002 Section 11.

Dangerous Electrical Event - ESA 2002 Section 12.

7.3.3 EPA – Environmental Breaches

General Environmental Duty – EPA 1994 Section 319.

Due to the complexity of environmental regulation the decision to notify Environmental Regulators will be made by the Functional Manager and Functional Principal in consultation with Legal Counsel where required.

7.3.4 DWQ - Water Quality Incident Notifications

Qld Government Department of Natural Resources Mines and Energy (DNRME) specify in the water quality and reporting guidelines that providers must report any incident that will or is likely to adversely affect water quality. This process is outlined in DWQ Incident Reporting PRO-00707 to the Department of Natural Resources Mines and Energy (DNRME). The requirement to report incidents to the regulator ensures action is taken by the provider to manage these incidents and reduce risks to public health.

8 Record keeping

All 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. All incident investigation reports, including supporting documentation must be saved in REX, with appropriate security that limits access to the record to:

- the incident investigation team and investigation process facilitator.
- the SMEs coordinator and manager.
- the Manager, Supervisor and Team Leader for the area in which the incident occurred.
- Legal Counsel.

9 Monitoring and Auditing

The requirements of this procedure may be audited in accordance with the Integrated Management System Internal Audit Procedure (PRO-00002).

Monitoring of investigation findings, actions and learnings will be undertaken for each Major and Catastrophic Potential Incident as part of monthly reviews to prevent repeat incidents, reduce risk exposure and determine risk themes.

Appendix A – Investigation Matrix

Incident category/ level	WHS Category Description	Environment Category Description	Water Quality Category Description	Water Supply Category Description	Accountable Leader	Investigation Method	Lead Investigator	Investigation Process Facilitator	Reports and Timeframes
Catastrophic	Single or multiple fatalities	Actual or potential widespread environmental harm/Impacts to the ecosystem, flora, fauna requiring extensive resources to mitigate (>6 months).	Complete HACCP Critical Control Point failure - WQ product safety cannot be determined. Potential for acute health impacts (potential for declared outbreak). EMT stood up.	Unplanned loss of water supply from any bulk water supply point to any non-network or network connected supply zones for > 24 hours.	Manager	ICAM	Approved ICAM Leader	WHS, E, WQ Functional Advisors	**General Manager to issue: Incident Flash Report sent within 24 hrs. Lessons Learnt Report within 28[1] working days[2]
Major	Permanent injury or impairment	Localised on/off site actual or potential serious harm/Impacts to the ecosystem, flora, fauna (including declared and rare threatened and vulnerable species) requiring substantial resources to mitigate (>3 &<6 months).	Complete HACCP Critical Control Point failure - WQ product safety cannot be determined. Potential for acute health impacts (no declared outbreak expected). EMT stood up.	Unplanned loss of water supply from any bulk water supply point to any non-network or connected customers supply zones for up to 24 hours	Manager	ICAM	Approved ICAM Leader	WHS, E, WQ Functional Advisors	General Manager to issue: Incident Flash Report sent within 24 hrs Lessons Learnt Report within 28[1] working days
Moderate	Moderate injury or temporary impairment. One or more entire shift missed as a result	Localised on/off site actual or potential environmental harm/impact to the ecosystem, flora, fauna (excluding declared and rare threatened and vulnerable species) requiring limited resources to mitigate (>1 - <3 months).	Repeated or elevated result above ADWG value / specification for chronic health parameters. Repeated HACCP Critical or Action Limit exceedance - WQ product still in specification but extensive corrective action taken place. Exceedance of Bulk Water Supply Agreement or ADWG aesthetic level with potential for or actual widespread customer impact.	Reservoir levels below communication trigger levels > 8 hours. Reduced operating volumes due to treatment plant capability for a short duration resulting in retailer network configuration changes.	Coordinator	5 Whys or RCA	Not Required	WHS, E, WQ Functional Advisors	5 Whys/RCA attached in Risk Wizard. Completed and data recorded within 14 days
Minor	Minor temporary injury or illness requiring medical treatment. Inability to complete rest of shift or modified duties.	Localised on/off site environmental nuisance. Routine short-term remediation (<1 month).	Isolated result above ADWG value / specification for chronic health parameters. Repeated HACCP Critical or Action Limit exceedance - WQ product still in specification & process controlled as per HACCP Plan. Exceedance of Bulk Water Supply Agreement or ADWG aesthetic level with potential for or actual customer impact.	Reservoirs approaching agreed communication trigger levels. Treatment plant at restricted output requiring supply reconfiguration. No loss of supply from any bulk water supply point.	Coordinator	5 Whys or RCA	Not Required	WHS, E, WQ Functional Advisors	5 Whys/RCA attached in Risk Wizard. Completed and data recorded within 14 days
Insignificant	Symptoms requiring no treatment or first aid treatment only. Returned to full duties	Localised, on site, actual or potential nuisance. Routine short-term remediation.	HACCP Critical Limit or repeated Action Limit exceedance - WQ product still in specification & process controlled as per HACCP Plan. Exceedance of Bulk Water Supply Agreement level without customer impact.	Reservoirs lower than agreed normal operating levels for <4 hours or restricted output from treatment plant. No loss of supply from any bulk water supply point. Little or no disruption to normal operations.	Supervisor	Informal Investigation Checklist (Appendix E)	Not Required	Not Required	Direct Risk Wizard Fields only. Completed and data recorded within 7 days

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

[2] The CEO has the responsibility on making the decision to notify the board.

Appendix B – Risk Wizard Data and REX records

	Potential Insignificant Consequence	Potential Minor or Moderate Consequence	Potential Major or Catastrophic Consequence
Information in Risk Wizard	What happened? Who was involved & where? Why did it happen? Describe immediate actions taken	What happened? Who was involved & where? Root Cause? Enter Immediate & Preventative actions Key Learning	What happened? Who was involved & where? Root Cause? Contributing Factors? Enter Immediate & Preventative actions Key Learnings
Records to be kept	No further records	Record photo or word/excel template of 5 Whys	Record investigation scope, Chain of Events and 5 whys and ICAM chart, photos and other evidence collected.
Report Outputs	Risk Wizard Reports H&S Weekly Report	Leaders Dashboard H&S Monthly Report	Leaders Dashboard Flash Report and Lessons Learnt Report H&S Monthly Report, Investigation Verification

Appendix C – Incident Reporting Checklist

- Where the potential consequence of the hazard or incident is insignificant, report in order of preference – Enter hazard directly into Risk Wizard or email details to the Incident Hotline or as a last resort ring 4040.
- Where the potential consequence of the hazard or incident is major or catastrophic then ring Seqwater's Incident Hotline (07) 3270 4040 immediately.
- The first person aware or any other workers involved must facilitate events at the incident scene so that equipment, plant, process, machinery or other associated plant connected with the incident are not disturbed without the permission of the manager or regulator (WHS/Environment). This does not prevent any action:
  - to assist an injured person;
  - to make the site safe or to minimise the risk of a further Notifiable Incident;
  - for which an inspector or the regulator has given permission;
  - to preserve environmental protection; and
  - to maintain water quality.
- Advise team to stop work until the hazards and risk of another or further incident is minimised.

Appendix D – Investigation Planning Checklist

- Select and appoint persons to the investigation team to contribute to the investigation process.
- Allocate appropriate resources to assist the investigation team in meeting the designated timeframes.
- Identify investigations where the Lead Investigator should have no conflict of interest.
- Consult with the relevant Functional Manager for legislation compliance and external notification requirements.
- Prior to generating any material, reports or communications, consult Legal Counsel to consider whether any material generated as part of an investigation is suitable for distribution or should be placed under the protection of Legal Professional Privilege (LPP).
- Utilise the Chain of Events and 5 Whys and ICAM Chart Template (TEM-00294) for identifying and recording information.

Appendix E – Informal Investigation Checklist

Checklist to ensure an informal investigation for insignificant consequence incidents are done well.

- Determine **what** happened?
- Identify **who** was involved and review **where** the incident occurred?
- Think through different **factors** that may have contributed to the incident
    - Workplace conditions including lighting, surface, noise, workgroup interactions
    - Procedures including hazard identification, SWMS, training
    - Equipment factors including design, guarding, maintenance, condition
    - People factors including fatigue, changed routines, time pressures and distractions
- Agree on what the main basic cause of the incident is? **Why** did it happen?
- Agree on what **immediate actions** can be taken to prevent the incident from occurring again?