



Innovative Strategies for the Road Ahead

Fleet Forum Toolkit Managing Crash Reporting & Analysis



Part III

How to Analyse Crash Data

What's inside:

3.1: Investigate the Crash

3.1.1: Who should do the investigation?

3.1.2. Completing the Post-Crash Investigation Form

3.1.3. Conducting driver and passenger interviews

3.1.4. In-house investigations

3.1.5. Interview techniques

3.1.6. Vehicle checks

3.1.7. Operational practices

3.2: Data analysis to establish trends and lessons learned

3.2.1. Root Cause Analysis

3.2.2. Dealing with investigation findings and implementing remedial action

3.3. 'Near Miss' reporting

3.4. Trend analysis

3.5. Learning from Crashes

3.6. Selecting which recommendation to implement



3.1. Investigate the crash

After a road crash, an organisation should [investigate the causes](#). The emphasis should be on finding [the root cause of the crash](#) in order to prevent future crashes. The purpose is to find facts that can lead to corrective actions, not to find fault. The investigative team should search for root causes and not simply record the steps of the event.

This section provides guidance for those responsible for undertaking a crash investigation and analysing results to develop remedial actions and lessons learned.

Reasons to investigate a road traffic crash are to:

- Identify the [cause of the crash](#) and prevent a future crash.
- Fulfil any legal requirements.
- Determine the [cost of the crash](#).
- Ensure compliance with applicable regulations (i.e., occupational health and safety, criminal, etc.).
- Process staff or third-party compensation claims.

The same principles apply to an inquiry of a minor incident and the formal investigation of a serious event. These steps can also be used to investigate any situation as a way to prevent a crash.

3.1.1. Who should do the investigation?

An investigation should, ideally, be conducted by someone (or a group of people) who is:

- Experienced in incident causation models.
- Experienced in investigative techniques.
- Knowledgeable about legal or organisational requirements.
- Knowledgeable about occupational health and safety issues
- Knowledgeable about the work processes, procedures and persons for the particular situation.
- Able to effectively use interview and other person-to-person techniques (such as mediation or conflict resolution).
- Knowledgeable about requirements for documents, records, and data collection.
- Able to analyse the data gathered to determine findings and reach recommendations.

Some jurisdictions require that a crash investigation be conducted with both management and labour (such as a staff council representative), or that the investigators be knowledgeable about the work processes involved.

Members of the team can include:

- Employees with knowledge of the work
- Supervisor of the area or work
- Safety officer
- Health and safety committee
- Union representative, if applicable
- Employees with experience in investigations
- External experts
- A representative from local government or police

3.1.2. Completing the Post-Crash Investigation Form

The [Post-Crash Investigation Form](#) should be completed by the road safety manager (or team) during a debriefing with the driver, the driver's supervisor and, if applicable, any passengers. The post-crash form aims to identify the causes of the crash and verify the facts as reported in the driver and manager post-crash forms. All evidence available should be present for the investigation.

The [Post-Crash Investigation Form](#) assists the road safety manager (or safety team) in determining the root cause of the crash, and identifying actions to be taken. All relevant information should be extracted from the data sources, including the following:

- [Interviews](#) with the driver, passengers and supervisors.
- Vehicle daily defect reports.
- Data downloads from on-board telematics systems.
- Mobile phone records (to verify if any distraction took place before the crash).
- Digital 'witness' data, such as on-board camera systems.
- Witness statements.
- Photos and videos taken at the scene.
- Police reports.

The [investigation process](#) should be guided by four key principles:

- **Swift response:** The incident should be investigated as soon as possible, while details are fresh and evidence is clear and available.
- **Comprehensive analysis:** The information gathered should provide a detailed and wide-ranging pool of data to analyse and draw conclusions.
- **Accurate data:** The information gathered should be high quality and accurate to ensure that weight can be placed on the conclusions drawn.
- **Robust analysis:** Effective collection of information and a focused investigation will allow for a reliable and comprehensive examination of individual incidents and broader trends over time.

3.1.3. Conducting driver and passenger interviews

During a crash investigation, a key source of information is [interviews](#) with the driver, any passenger(s) and the supervisor of the vehicle involved. It is important to balance the need to discuss the crash as soon as possible, while also recognising that the driver (or passenger) may be distressed and in need of support or professional counselling.

It is important to avoid placing blame for the crash. Rather than asking 'What did you do wrong?' or 'What went wrong here?', ask instead 'What happened?' The way the answer is framed can provide information: "All of a sudden..." may indicate that the driver was not paying full attention at the time of the crash.

Try to confirm the driver's version of events through a discussion with passengers or any witnesses to the crash. In the case of witnesses, this should be done quickly as they often disperse rapidly from the scene. Even if they are unwilling to offer their name, they may still provide information.

It is important to investigate all crashes to ensure that full and accurate information is presented to the insurer.

In addition to the interviews, it is key to inspect the vehicle and the road for any sign of damage or defect which may have caused or contributed to the crash. Recovery of the vehicle may destroy some evidence so it should be captured before recovery begins.

The vehicle telematics can play a key role in providing an 'unbiased witness' to any incident or claim. Telematics data can help to determine:

- Low impact and low severity crash claims (to determine the change in velocity for crash severity and injury causation).
- Failure to stop or yield at a junction.
- Potential mechanical failures, i.e., brakes, airbags, seatbelts, steering, tyres, etc.
- If a driver was driving in 'normal' fashion and/ or in line with the organisation driving policy
- If the driver was adhering to the 'drivers' hours' rules.

3.1.4. In-house investigations

The [investigation to establish cause](#) should not be conducted by people who are directly linked to the crash events in order to prevent bias or 'covering up' of deficiencies. The driver of the vehicle, for example, would not make a suitable investigator. Instead, someone who has a good grasp of the organisation's processes and policies should be involved to determine if these were followed or if they influenced the crash. The individual should have had training in crash investigation techniques and root cause analysis.

Assessing the causes behind your vehicle crash record and any apparent trends will make identifying and planning interventions more effective. In-house investigations also ensure that information stays in the organisation and interviews can be conducted discreetly and to suit the needs of individuals.

The [insurance company](#) may wish to conduct its own investigation. This decision will depend on your previous record with the insurer, the insurer's policy and the severity of the crash.

If the police are involved in investigating a crash, certain key guidelines should be followed:

- The policy should indicate who is responsible for liaising with the police and insurance investigations.
- All relevant records and files should be easily accessible for the investigation.
- An organisation should comply with all police and insurer information requests.
- The vehicle and load may be impounded for the duration of the investigation.

In the course of the organisation's investigation, the following roles could be consulted:

- Driver/ passengers involved
- Witnesses to the crash
- Vehicle technician who last inspected the vehicle
- Transport manager/ planner
- Supervisor of the passengers
- Emergency service personnel who attended the scene

In some instances, it may be suitable for the investigator to ask these individuals how they felt the crash occurred.

3.1.5. Interview techniques

An interviewer should be calm and ask unambiguous questions. This is not a blame-finding mission. All parties should be asked if there were clear warning signs or opportunities to avoid the crash. Throughout the investigation, all parties should be treated with suitable respect. In particular, it is important to consider the driver's own legal and human rights, as well as any additional processes involved as a result of union membership and organisation disciplinary processes.

Included in this toolkit are:

- [A set of Crash Investigation Interview Questions](#) to interview key people involved in the crash.

3.1.6. Vehicle checks

It is important to look at the vehicle and the operational practices that were in place at the time of the crash to assess whether these may have contributed to the crash. When investigating the vehicle, it is important to use all sources of information. Daily vehicle checks and servicing reports can provide information on a range of essential features such as tyres, lights, brakes, wheels and mirrors. It may also be worth considering in-vehicle diagnostics and telematics systems (if fitted) to gather a complete picture of the vehicle at the time of the crash.

3.1.7. Operational practices

The third important area is to understand the operational practices that may have contributed to the crash. Examples would include:

- Was the driver rushing under time pressure to meet an unreasonable deadline?
- Was suitable time allowed for maintenance and vehicle checking?
- Was the driver recently trained/ assessed for medical or training needs?
- Did the supervisor or manager brief the driver about the trip?

The analysis should focus on four areas:

- Procedures: Was there any deviation from procedures that might have led to the crash?
- Processes and practices: Which part of the overall work process led to the crash? Practices are things that are done but not documented.
- Decisions, behaviours and attitudes: What decisions, behaviours and attitudes might have contributed to the crash?
- Information and communication: What information was not available or ignored (from people or from other resources) that could have prevented the crash?

The outcomes of this investigation should be recorded.

3.2. Data analysis to establish trends and lessons learned

Analysis of data is important to help determine trends and issues and develop appropriate remedial actions to reduce future crashes. Road traffic crashes have many causes; what may appear to be bad luck can, on analysis, be seen as a chain of failures and errors that led to the road crash. This is known as the Domino effect.

These causes can be classified at 3 levels:

- Immediate cause: Factor(s) that obviously led to the problem (i.e., the iceberg that struck the Titanic)
- Underlying cause: These 'set the stage' for the problem to occur (i.e., the northerly route taken by the Titanic, close to an icepack, the speed of the ship, the inadequate look-out arrangements, etc.)
- Root causes: The causal factors that caused, or could cause, numerous issues to arise, not just the individual problem that occurred (in the case of the Titanic, there were multiple root causes, including insufficient lifeboats, flaws in the bulkhead design and an underestimation of the risks).

3.2.1. Root Cause Analysis

A [root cause analysis](#) allows an organisation to discover the underlying or systemic (rather than the generalised or immediate) causes of an incident. Correcting only an immediate cause may eliminate a symptom of a problem, but not the problem itself.

The importance of What, How and Why

Consider the following situation: A vehicle rolls over and ends up in a ditch. Two staff members are injured. A traditional investigation might conclude that the crash was the result of driver speeding. The driver might be issued a warning not to speed again and that is it.

An organisation conducting root cause analysis would learn that the speeding is a symptom of a larger problem. To determine if there are systemic reasons for crashes, the organisation should ask questions such as:

- Why was the driver speeding?
- Were there changes in conditions, processes, or the operating environment?
- What control mechanisms were in place to avoid the speeding?
- Why did these mechanisms not work?
- What tasks were underway?
- Has the organisation seen similar crashes or incidents in the past?
- What measures did the organisation take at that time?

It is important to consider all possible “what,” “why,” and “how” questions to discover the root causes of an incident. In this case, a root cause analysis may have revealed that the root cause of the speeding was a failure to have an effective time management program that would prevent late departures.

To prevent crashes from happening in the future, organisations need to put measures and controls in place at the underlying, root causes. Looking at the above example, if no measures are taken to improve time management, the driver will continue to work under stress and speeding will likely continue.

AN EXAMPLE - of the '5 Why' technique

The problem: A vehicle almost rolls over but the driver gains back control and nothing happens.

1st Why: The driver was speeding

2nd Why: The mission departed too late

3rd Why: Programme staff were not ready at the departure time

4th Why: Programme staff do not respect the agreed departure time

5th Why: The organisation does not correct mismanagement of time

In theory it takes five "whys" to get to the root causes, but in practice there will be cases where you may use more or fewer than five "whys". Keep in mind that also with this technique you can find multiple root causes.

Benefits of using the '5 Why method'

- **Simplicity:** Easy to use and requires no advanced mathematics or tools.
- **Effectiveness:** Helps to quickly separate symptoms from causes and identify the root causes.
- **Comprehensiveness:** Helps to determine relationships between various problem causes.
- **Flexibility:** Works well alone and when combined with other methods.
- **Engaging:** Fosters teamwork.
- **Inexpensive:** A guided, team-focused exercise with no additional costs.

Root Cause Analysis is not a blame game

Individual persons who are involved in a problem should not be regarded as a root cause. Even if a person made a mistake, a proper root cause analysis will invariably reveal problems with the training, coaching and monitoring of the person who made the mistake. The 'Just Culture' Framework (set out in table 2.1) outlines how to consider individual errors or behaviours. Being too quick to appoint blame is symptomatic of a 'scapegoat' culture that will inhibit the ability to find genuine root causes.

Table 2.1: 'Just culture' framework

Type of root cause:	Human Error	At-Risk Behaviour	Reckless Behaviour
Portrayed as:	Inadvertent action: Slip, lapse, mistake	A choice: Risk not recognized or believed justified	Conscious disregard of excessive risk/issues
How to manage?	Manage through changes in: <ul style="list-style-type: none"> - Processes - Procedures - Training - Design - Environment 	Managed through: <ul style="list-style-type: none"> - Remove incentives for at-risk behaviours - Create incentives for safe behaviours - Increase situational awareness 	Managed through: <ul style="list-style-type: none"> - Remedial action - Punitive action
What do you do as manager?	Console	Coach	Discipline / Sanction

Methods to identify causes of crashes

No crash happens for a single reason. There are often multiple gaps in an organisation’s safety approach that lead to crashes or near-misses. Table 2.2 shows the various data analysis methods that you can use to identify the cause of a crash.

Table 2.2: Data analysis methods

Level of Cause	Investigation and analysis method
Immediate	<ul style="list-style-type: none"> - Crash / Incident Reports: <ul style="list-style-type: none"> o At Scene Crash Report o Driver Post Crash Form o Manager Post Crash Form o Police Reports - Technical investigation at the crash scene
Underlying	<ul style="list-style-type: none"> - Interviews with the staff members involved - Interviews with managers / supervisors to identify why the unsafe act or condition could happen - Observation of adherence to policies and procedures - Observation of technical state of vehicle - Data analysis from systems (such as vehicle tracking systems) - Assessment of the level of implementation of the Safe Systems Elements or Fleet Safety Management System
Root	<ul style="list-style-type: none"> - Analysis of job, personal or organisational factors that contributed to the crash (through observation and interviews) - Analysis of culture in the organisation (through observation and interviews)

3.2.2. Dealing with investigation findings and implementing remedial action

The importance of remedial action and learning lessons from crash analysis is critical to ensuring crashes do not reoccur. Once the root causes have been identified, the road safety manager (or team) needs to identify potential solutions.

Remedial actions may include, but are not limited to, the following:

- Management awareness of risks associated with road travel
- Safety culture programmes for management
- Implementation of staff road travel awareness training
- Staff empowerment to stop unsafe situations
- Hazard recognition training
- Driver advice and counselling
- Driver assessment and/ or training or retraining
- Disciplinary action
- Improved operating procedures
- Revised routing considerations/ improved journey planning
- Improved vehicle inspection and maintenance regimes
- Revised vehicle and/ or vehicle equipment specification

3.3. 'Near Miss' reporting

Organisations with a generative safety culture see [near misses](#) or near crashes as high-value and low-cost learning opportunities. As a result, they are making efforts to report, collect data, and investigate near misses and near crashes. Near-miss and near-crash investigations are considered to be an essential tool for effective risk management.

Why Focus on Near-Miss Events?

A near miss, by definition, means no crash occurred. So why report or focus on it? The reason is that even if a near-miss event did not cause injury or damage, it had the potential to do so. Near misses are only near misses due to a fortunate interruption in the chain of events that could have otherwise gone terribly wrong.

Some organisations have implemented 'Good Catch' programmes. Although Good Catch and Near Miss reporting serve the same purpose, which is to prevent future crashes or incidents from happening, they are not the same.

Spot the difference	
<u>A Good Catch</u>	<u>A Near Miss</u>
Proactive	Reactive
The results of vigilance and intentional action; mitigates or eliminates exposure to hazards.	The result of negligence, poor judgement, or chance, and exposes workers to hazards
“Through my engagement and proactive action, I recognised an unsafe condition, I acted upon it and prevented bad results from occurring.”	“That was a close call. Something already happened that could have been very bad but it didn’t happen and I am reporting it.”

A Good Catch is when someone recognises an unsafe condition or poor-quality work, and proactively acts to prevent something bad from happening. This may involve pausing the work, correcting the unsafe situation or poor-quality work and coaching employees.

According to safety culture experts, the best indicator of an organisation’s safety culture is the quality of the good catches submitted.

Included in this toolkit are:

- [Best practices for establishing Good Catch or Near Miss Reporting](#)
- Templates for [reporting Good Catch](#) or [Near Miss incidents](#)
- Toolbox Talks for explaining the importance of [Near Miss reporting](#)

3.4. Trend analysis

To effectively analyse if there are underlying similarities between multiple incidents, it is important that all crashes and near misses are recorded centrally within the organisation and checked regularly for emerging trends. One person should be tasked with overseeing the database for the organisation and offering the best assessment. Smaller chunks of the data (for example, by region or by load type) may not present the same overall picture.

When assessing the data, a number of potential similarities should be checked:

- Are there common crash types? (i.e., when reversing or with urban driving?)
- Are certain drivers or staff members overly represented in the statistics?
- Are there location hot spots or routes for crashes?
- Are there trends in terms of the time of day or night or light levels?
- Is the weather a factor in a large proportion of crashes?
- Are there similarities in specific programmes?
- Are there similarities in the age group or job role of drivers involved?

Careful record keeping, such as this, is indicative that the organisation has embraced a safety-led culture, and allows clear analysis and assessment of crash trends. For example, your analysis may demonstrate that a high number of crashes in the sector are linked to low-speed manoeuvres, such as turning and reversing in the compound. Taking all of the information gathered after each crash and aggregating it allows certain trends to be established:

- Do most drivers consistently drive well without any problems?
- Is one make of vehicle involved more often?

The answer to these questions may point to insufficient driver training or to a vehicle that is unsuitable for the role to which it is currently being applied. Alternatively, it might be an operational issue:

- Is it the layout of the compound that is causing these issues?
Perhaps vehicle size has increased since the compound was set out, resulting in obstructions that were not originally envisaged?

Having identified the key issues, it is important to then develop some remedial options:

- Manoeuvring training for drivers?
- Re-adjustment of vehicle operations, either alternative vehicles or fitting of extra features to vehicles (such as mirrors/ sensors) to mitigate the problem?
- Could the compound be adjusted to ease the use of vehicles, such as being made one way?

This approach can be replicated in relation to crashes that occur due to a particular location, weather, vehicle defects and many other identified trends.

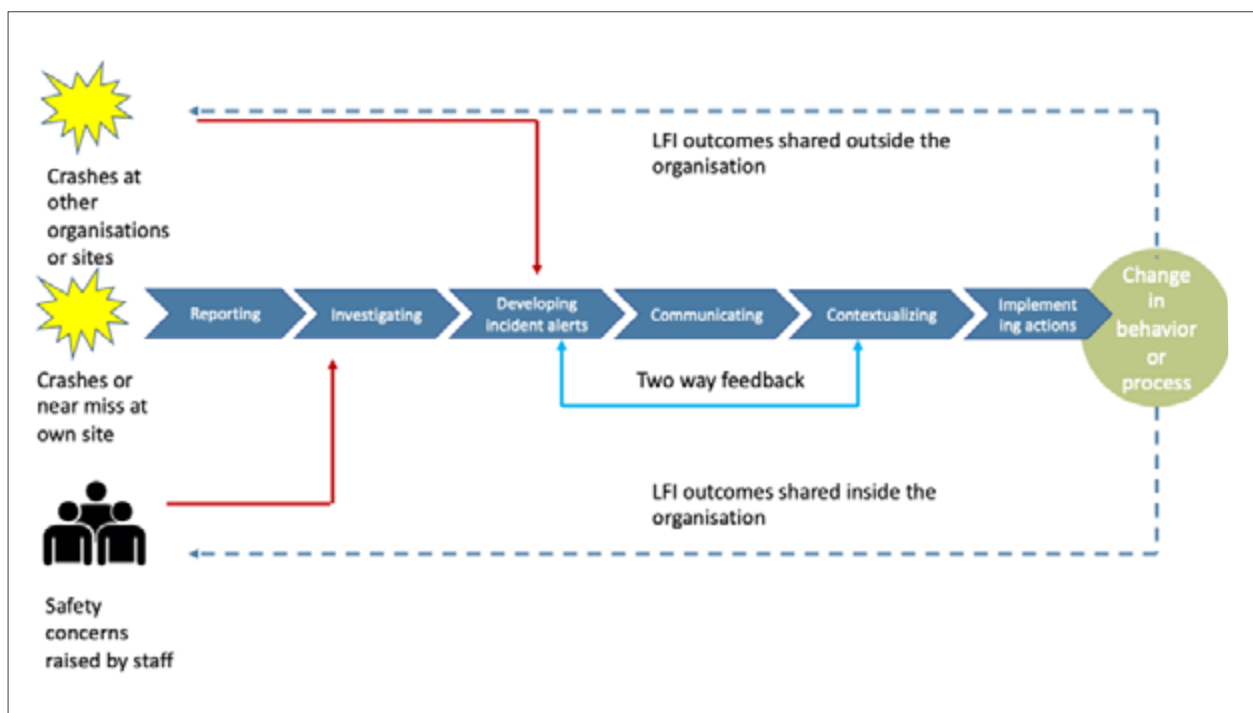
3.5. Learning from Crashes

The single most important reason to invest time, energy and resources in crash analysis is to learn and avoid more crashes in future. Learning from crashes is critical to road safety. Crashes are often repeat events or similar in nature to previous incidents. People then ask: “Why have we not learned from these past events, and why do people continue to make errors or ignore rules?”

Learning From Incidents³ (or LFI) is one of many ways to manage safety in an organisation. LFI is a process through which employees and the organisation try to understand negative safety events to prevent similar future events. If all stages of LFI are properly implemented, the outcome should lead to changes in behaviour or to technical processes. The below graph shows the LFI process⁴.

³ | Text taken from <https://www.hsmemagazine.com/article/learning-from-incidents> (retrieved 20 September 2019)

⁴ | Energy Institute, Hearts and Minds Learning from Incidents, <https://heartsandminds.energyinst.org/>

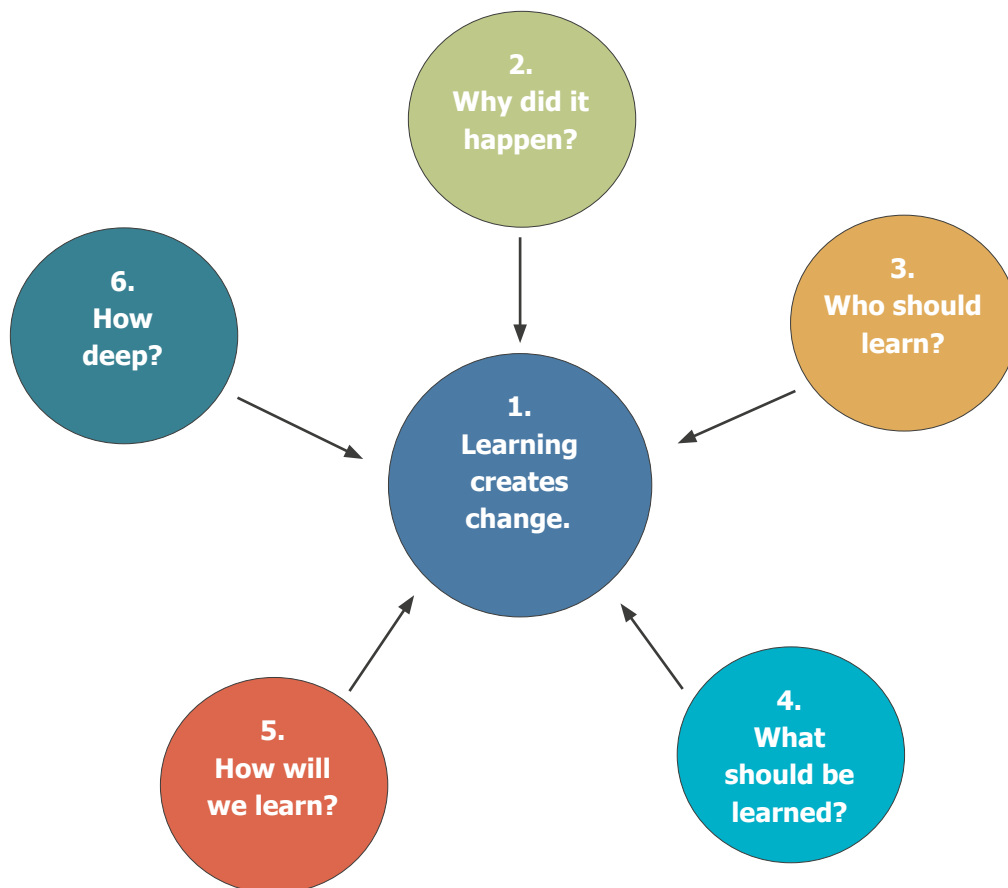


The seven phases of the LFI process:

1. **Reporting:** Every crash or near miss must be reported. Reporting an incident raises awareness of potential problems that could lead to another, similar crash and provides a starting point for LFI. Reporting should be systematic and all events that could potentially jeopardize road safety should be recorded. The organisation should prioritise reporting over other competing goals.
2. **Investigating:** During an investigation, crashes are analysed to identify the causes of the crash. Ideally, immediate, underlying and root causes surface through the investigation process.
3. **Developing incident alerts:** The incident investigation provides a baseline for recommendations for inclusion in 'incident alerts', 'safety alerts', 'lessons learned', 'safety briefings' or 'incident communications' – information bulletins, reports or videos to communicate with staff. The incidents alerts are developed by the road safety team or by managers familiar with work processes and practices and should include data about the context in which the crash occurred and the causes that led to it. They should be clear and help people understand what to do to prevent similar crashes from happening.
4. **Communicating:** Ideally, incident alerts should be communicated to everyone who might benefit from them. Sites should balance between all crash reports and targeting alerts to relevant groups of people. People with responsibility for developing incident alerts normally decide who should receive this information, though supervisors and line managers take responsibility for communicating incident information to their teams.
5. **Reflecting:** People need to be given the opportunity to reflect on the incident alerts, allowing them to think about the relevance of the crash to their own work. People must also be able to offer input and feedback for improving LFI, such as through identifying their own recommendations and actions for improving road safety. This allows people to be actively engaged rather than passive recipients of information.
6. **Implementing action:** During this phase, staff select which actions to implement into their work to enable avoidance of similar crashes. Implementing actions should be conducted once the previous phases are completed. Draw on the expertise of the workforce when implementing actions. LFI should result in a positive change in organisational process or behaviour, leading to an increase in road safety and a decrease in the chances of a similar incident happening. Without a change in organisational processes, practices or people's behaviour, learning cannot have taken place.

7. **Change in behaviour or processes:** Learning should result in a change in behaviour and/ or process. This can be as simple as updating a procedure, or as complicated as changing the culture of the organisation. Learning can only be said to have taken place if there is evidence of the change. The organisation should have in place a means of gathering this evidence. For example, in many organisations, recommendations from crash investigations are recorded in order to track when recommendations have been completed and to measure the effectiveness of the recommendations.

Feedback loops: Learning should not be a one-way process; there should be an opportunity to provide feedback in order to improve the process and the information communicated. The first of these feedback loops is in the reflection phase. This phase should allow for opportunities for two-way feedback between the frontline (drivers, passengers) and those developing the incident alerts (road safety team). The second feedback loop is during or after the implementation actions phase, when improvements made should be reported back to the workforce. In this way staff can see the impact of their involvement in the LFI processes. The third feedback loop comes after the implementation actions phase and represents sharing the results of LFI internally in the organisation or externally with other organisations. This is the only way the whole industry can learn from road traffic crashes.



Learning from incidents principles ⁵.

Principle 1: Learning is demonstrated by a change in practice (how things are done).

The word 'learning' is used differently to mean different things. Some use learning to mean that an incident has been investigated, while for others it means that the outcome of the investigation has been communicated to the staff. However, we cannot say that learning has taken place, for an individual or an organisation, until we have evidence that things are being done differently.

Principle 2: For people to change their practice, they have to relate knowledge about a crash (or near miss) to their own work situation.

Complex incidents likely require opportunities for staff to reflect on how the incident relates to their own work. For each crash that we want to learn from, we need to ask:

Why did the crash happen?

Have similar crashes occurred before?

Did the investigation identify causes that were common in previous crashes?

Was the crash the result of a complex set of causes that people need to be aware of?

Principle 3: People learn by actively engaging with information.

Just because someone has received the information, does not mean they have learned. We should always consider who to actively engage at each stage of the crash lifecycle:

Who should be included in the investigation or analysis process?

Who should crash alerts be sent to? To everyone or specific teams?

Are opportunities for reflection provided?

Are processes in place that would allow people to give feedback and contribute their own expertise and ideas?

Principle 4: Some knowledge is written down, but a lot of knowledge exists only as practice or 'culture'.

Consider which type of knowledge you are trying to change:

- Procedures
- Work processes
- Decision making, attitudes and behaviours
- Information about crashes

Also consider how knowledge can be retained and how crash information can be stored so that they can be used to learn from other related crashes.

⁵ | Energy Institute, Hearts and Minds Learning from Incidents, <https://heartsandminds.energyinst.org/>

Principle 5: Knowledge cannot be simply written down in a new procedure and may be best learned on the job.

Identify what the best way is to learn from a particular crash:

Are formal activities (safety meetings, training courses) or informal learning activities (learning by doing, informal discussions, etc.) more appropriate?

What informal learning activities can help improve learning from incidents?

How can relevant information from informal discussions be captured and fed into formal road safety activities?

Principle 6: Learning needs to be two-way.

The organisation informs the individual, and group knowledge is used to inform the organisation.

For each crash we want to learn from we should consider:

Was the crash caused by organisational issues (such as management issues, prioritisation of programme delivery over safety) rather than technical issues and human error?

Are you ready to change the organisational issues?

Do you provide opportunities for people to raise organisational issues without the fear of being blamed?

Is learning from crashes high on your priority list?



3.6. Selecting which recommendation to implement

Once you have analysed the root cause(s) of the crash, it is time to identify and [implement recommendations or interventions](#). The aim of this step is to agree on the general interventions, not to design each intervention (which may require additional expertise). The safety team needs to agree upon selection criteria first, then brainstorm possible interventions, and finally use the criteria to select the priority interventions.

Possible intervention selection criteria include:

- **Response to root cause(s):** Above all, the intervention(s) selected must respond to the root cause(s) of the problem.
- **Affordability:** Do the necessary resources exist to follow through with this intervention and maintain it? Are there other ways to act on this intervention that might cost less? Can someone advocate for more resources to be allocated to this area?
- **Feasibility:** Are systems in place to support this intervention? Is it realistic and within the control of the organisation?
- **Time available:** How long will the intervention take to implement and demonstrate results? Do you have enough time? Are there constraints on the time frame?
- **Appropriateness/acceptability:** Will staff agree with and support the intervention? Did they suggest the intervention? Are they aware of what is being proposed?
- **Benefit:** Are the benefits of the intervention worth the resources necessary to implement it?