Process for Conducting Investigations			
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Prepared by:		Principal Inspector Nuclear Safety	
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ABBREVIATIONS AND ACRONYMS USED

CJ(S)A	Criminal Justice (Scotland) Act 2016
CJL(S)A	Criminal Justice and Licensing (Scotland) Act 2010
CNI	Chief Nuclear Inspector/ Chief Executive
CNS	Civil Nuclear Security
COPFS	The Crown Office and Procurator Fiscal Service
CP(S)A	Criminal Procedures (Scotland) Act 1995
CPIA	Criminal Procedure and Investigations Act 1996
CPS	The Crown Prosecution Service
DDS	Divisional Delivery Support
DWP	Department for Work and Pensions
EDR	Enforcement Decision Record
EMM	Enforcement Management Model
EPS	Enforcement Policy Statement
ESO	Executive Support Office
ICT	Investigation Core Team
IDR	Investigation Decision Record
INES	International Nuclear Event Scale
IRG	Investigation Resource Group
KDL	Key Decision Log
NISR	Nuclear Industries Security Regulations 2003
NM	Nuclear Material
ORM	Other Radioactive Material
PACE	Police and Criminal Evidence Act 1984
PL	Professional Lead
RCIS	Redgrave Court Incident Suite
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RLI	Review-Learn-Improve

1. INTRODUCTION

1.1 This guidance supports the process for conducting investigations under ONR's purposes. There are various ways that ONR is made aware of a matter that may warrant investigation. These include notification of incidents and events, via ONR's compliance inspection and permissioning/ assessment activities and concerns/ whistleblowing received about a duty holder (see Table 1).

1.2 Decisions on enforcement action, including investigation, must accord with ONR's Enforcement Policy Statement (EPS) (Ref. 1). ONR uses criteria and discretion in deciding whether incidents, possible breaches of legislation or concerns/ whistleblowing should be investigated.

1.3 Depending on the seriousness of the matter, an investigation of the surrounding circumstances may be necessary to determine:

- the causes.
- whether adequate investigation and appropriate remedial actions have been taken by the duty holder(s) to prevent a recurrence and to secure compliance with the law.
- lessons to be learnt and to influence the law and guidance.
- what enforcement action, if any, is appropriate.

1.4 The investigation process is in effect from when ONR becomes aware of the matter that may warrant investigation, through to when ONR either records a decision that the matter will be investigated no further, or completes the investigation which may include associated enforcement action including proceeding to a prosecution.

1.5 This guide distinguishes between any preliminary enquiries, which must be made to obtain sufficient information to decide as to whether a matter warrants investigation or not, and the investigation itself.

1.6 Statutory legislation underpins the criminal investigation process and ONR's decision making as an Enforcing Authority. Appendix 1 provides the background on the legal framework for investigations in the jurisdictions of England and Wales and Scotland. All investigatory work, including preliminary enquires **must** be conducted with full regard to the relevant legal framework for the jurisdiction in question.

1.7 Adherence to legal frameworks, enforcement policy and process is vital throughout the investigation both in the interests of justice and to manage the risk of ONR being left open to challenge of maladministration and/or judicial review.

1.8 Confidentiality and potential for subsequent disclosure must be considered throughout the investigation process. All those involved in the process must ensure that investigation proceedings are confined to the investigation team and only those with a legitimate need-to-know. Other staff who are not involved should not offer unsolicited *opinions* either verbally or in writing. This does not apply to information or facts which may be a relevant factor for the investigation e.g. a previous related incident or investigation or specialism regulatory advice from Professional Leads etc.

1.9 The independence of potential expert witnesses must also be maintained by applying the same need-to-know principle. However, within the investigation team, there needs to be a culture of open dialogue and the **lead investigator** must provide regular updates on the investigation progress to the **approval officer,** divisional director and other ONR colleagues within the "need-to-know" group.

1.10 It is important that the behaviours and actions of all staff associated with preliminary enquiries and investigation decision-making reflect ONR's values (Ref. 32). Learning and improvement from the investigation process should also be effectively captured and promulgated for the organisation (see para 8.36 and Ref 46).

2. DEFINITIONS

2.1 Within this document the following unified definitions have been adopted, having regard to the relevant codes of practice (Refs. 3 and 5):-

- The ***decision maker*** is the person responsible for deciding whether to commence (authorise) an investigation and for deciding on investigation outcome up to the point of a report being submitted to the Approval Officer for a prosecution decision. The role of the decision maker would normally be undertaken by the relevant delivery lead who should consult their divisional director when taking on this role. Alternatively, the divisional director may decide to take on the role of decision maker or allocate an alternative decision maker.

- An ***investigator*** is any fully warranted inspector involved in conducting an investigation. All investigators must comply with the duties imposed on them under the relevant legislative frameworks (see Appendix 1), including pursuing all reasonable lines of inquiry, recording information and retaining records of information and other material.

- The ***lead investigator*** is the fully warranted inspector in charge of an investigation and is responsible for: directing the investigation: for ensuring that proper procedures are followed for recording information, retaining of records of information and other material, arising in the investigation and the process of disclosure. The lead investigator must also comply with the duties imposed on them under the relevant legislative frameworks (see Appendix 1).

- The ***disclosure officer*** is the person or persons responsible for reviewing and assessing all material obtained or generated during an investigation; revealing material to the prosecutor during the investigation and any criminal proceedings resulting from it, and certifying that s/he has done this; and disclosing material to the accused at the request of the prosecutor. A solicitor agent or prosecuting counsel cannot act as disclosure officer, though they can provide advice on disclosure and facilitate the duty (Ref. 42).

- The ***prosecutor*** is responsible for conducting/acting on behalf of ONR in criminal proceedings resulting from an investigation. In cases brought by ONR the role will be filled within ONR by the ***lead investigator***, unless otherwise assigned in writing. A solicitor agent may undertake prosecution proceedings on behalf of the lead investigator in England and Wales. In Scotland, the prosecutor will be the Crown Office Procurator Fiscal Service.

- The ***approval officer*** is the fully warranted inspector responsible for deciding whether or not to commence a prosecution on behalf of ONR. The approval officer is appointed by the divisional director and would normally be the relevant delivery lead. Alternatively, and with the agreement of the Chief Nuclear Inspector (CNI), the divisional director may take on the role of approval officer. This appointment should be made in writing at the outset of the investigation. Any changes in appointment must be made prior to any prosecution decision and the reasons for such changes should be fully documented.

NOTE – *The appointment of key investigation roles needs to ensure that those appointed can demonstrate consistent, independent, objective, and impartial decision making that is free from undue interference. In particular, suitable arrangements should be in place for* ***approval officers*** *to remain sufficiently distant from the investigation activities to allow them to reach an objective decision on whether to proceed with a prosecution. These roles may require re-appointment during the investigation if, for example, the independence etc. of the decision-making appears to have been drawn into question.*

- ***Material*** is material of any kind, including information and objects, which is obtained during an investigation and which may be relevant to the investigation. This includes not only material coming into the possession of the investigators (for example, provided by witnesses) but also material generated by investigators (such as an interview record). It also includes material that could weaken or undermine the evidence that is likely to be led by the prosecutor in the proceedings against the accused, or it could materially strengthen the accused's case.

- *Material* may be '***relevant to an investigation'*** if it appears to an investigator, the inspector in charge of an investigation (***lead investigator***) or to the ***disclosure officer***, to have some 'bearing' on any offence under investigation or any person being investigated, or on the surrounding circumstances of the case, unless it is incapable of having any impact on the case;

- ***Sensitive material*** is material, the disclosure of which could give rise to: Serious injury or death to any person; obstruct or prevent the prevention, detection, investigation or prosecution of crime; serious prejudice to an important public interest. The ***disclosure officer*** may need to consult with the officer in charge of the investigation, the prosecuting lawyer and line management before reaching this view.

- The terms ***preliminary enquiry, investigation and criminal investigation*** are used throughout this guide. Preliminary enquiry is used to distinguish the initial stage in the process which may be necessary to gather sufficient information to make an informed judgement against the investigation selection criteria and/or EPS. The terms investigation and criminal investigation are synonymous within this guidance and distinguish the steps in the process following the decision maker authorisation to investigate.

2.2 In ONR, the role ***lead investigator*** and the ***disclosure officer*** are likely to be undertaken by the same inspector. Other inspectors may be called upon as investigators where necessary.

3. GOVERNANCE AND GENERAL CONSIDERATIONS

3.1 The Investigation Sub-Specialism is led by the operational inspection Professional Lead (PL) and includes an Investigation Resource Group (IRG) chaired by the operational inspection PL which has representation from all ONR's purposes. The IRG is supported by the Investigation Core Team (ICT) which consists of Inspectors and Divisional Delivery Support (DDS) staff with suitable experience and training in investigation (see Ref. 37).

3.2 The IRG is responsible for advising the operational inspection PL on any matter relating to ONR's investigation capability and resilience, i.e. in terms of people, processes and provision of facilities and equipment etc. The operational inspection PL reports to the ONR Technical Director. The IRG also reviews changes to legislation, associated processes and/or precedents and their potential impact on ONR's arrangements.

3.3 Supported by the IRG, the operational inspection PL provides advice and if necessary, challenge to the Division's undertaking of investigations. The ICT also provides subject matter expertise to provide advice and support to ONR inspectors undertaking investigations across the Divisions (see Ref. 37).

4. INVESTIGATION PROCESS

4.1 This document provides guidance to Inspectors and DDS on the investigation process. A simplified flowchart of the process is given in Appendix 2. The key steps in the process are:

- Step 1 Receive notification and act upon.
- Step 2 Conduct preliminary enquiry and decide whether to investigate.
- Step 3 Plan and resource investigation.
- Step 4 Conduct investigation.

4.2 Whilst there is much commonality in the legislative frameworks for investigation in England/ Wales and Scotland, they do differ. For the sake of brevity, the guidance given here primarily relates to England and Wales. Where appropriate, this guide identifies the different approaches required, however, further advice and guidance should be sought from the ONR IRG when undertaking investigation in Scotland.

5. STEP 1 – RECEIVE NOTIFICATION & ACT UPON (DDS / INVESTIGATOR)

5.1 Step 1 commences with ONR becoming aware of a matter that may warrant investigation. Table 1 identifies different means by which ONR may be notified of a matter for potential preliminary enquiries and / or investigation. The demand to undertake a detailed investigation, as set out in all of the proceeding steps, must also be balanced with the requirement to act promptly. This includes ensuring duty holder(s) address risk gaps identified through the application of the Enforcement Management Model (EMM) (Ref. 2) and ONR taking action in accordance with the EPS e.g. promptly deploying inspectors in the event of a work-related death or significant site incident.

5.2 From Step 1 onwards and throughout the investigation process the investigator must consider the EPS and EMM for any initial/ immediate enforcement action that may be necessary to address potential compliance gaps or matters of evident concern (see Ref 29) etc that arise. This action is depicted in the process flow chart at various steps, although it should be considered as an ongoing requirement as the investigation progresses and information is obtained.

5.3 Differences of regulatory opinion should also be considered throughout the process where key decisions are made. Explicit references to resolving differences of opinion are made at various steps within this guidance and those involved with the investigation process should see Ref. 28 for further guidance.

5.4 The first decision is for the investigator to determine whether there is sufficient information to make an informed judgment on whether investigation is warranted. Tables 2 - 5 set out the investigation selection criteria for ONR's purposes. Aligned with ONR's enforcement policy, these indicate where potential investigation should be considered and where preliminary enquiry is required.

5.5 In some cases, it will be immediately evident from the circumstances of the matter that the criteria are met e.g. a fatality (work-related incident). However, other criteria may require an informed judgement to be made by the investigator and may not fall within their specialist area of knowledge. It is therefore important that the investigator engages with appropriate ONR inspectors (e.g. discipline specialists, professional lead/s, delivery lead) to ensure an informed judgement is reached.

5.6 If the investigation criteria are clearly met then the investigator should proceed to Step 2.2 – decision to investigate.

5.7 If there is insufficient information to make an informed judgement (see para 5.5) or the criteria requires it, then preliminary enquiries should be undertaken to gather enough information to make an informed judgment (Step 2.1).

5.8 If it is evident that none of the criteria or EPS factors are met then the investigator may decide to progress no further with the investigation process. This decision must be recorded in a proportionate manner i.e. on the associated INF1 (part B) or in a contact report/ intervention record. In exceptional circumstances for RIDDOR notifications, an email record may suffice. The record should focus on the relevant criterion only and provide a clear justification for the decision (e.g. safety/ security significance, technical basis, duty holder response, regulatory action etc).

5.9 The relevant delivery lead maintains oversight of the incident notifications and subsequent regulatory actions at subdivision level (see Ref 30).

5.10 If the matter relates to complaints and concerns raised then the guidance published on ONR's website (Ref. 8) and ONR-INSP-GD-064 (Ref 16) must be followed. If the matter is a whistleblowing (WB) report then the WB process and guidance must be followed (Refs 44 & 45). All concerns or whistleblowing reports made by nuclear industry workers relating to matters that ONR regulates (or would have regulated prior to vesting in 2014, when part of HSE) should be subject to preliminary enquiry. The Executive Support Office (ESO) has oversight of all whistleblowing reports.

5.11 If the matter involves a work related death then the associated guidance should be followed (Refs 9, 10 and 11). IRG advice should be sought in such situations.

6. STEP 2 - CONDUCT PRELIMINARY ENQUIRIES & DECIDE WHETHER TO INVESTIGATE

Step 2.1 Conduct preliminary enquiry (Investigator)

6.1 Preliminary enquiry should be conducted when there is insufficient information to support an informed judgement on the criteria (Tables 2 to 5) or where it is required (e.g. INES Level 1, concerns, or whistleblowing reports etc).

6.2 Preliminary enquiry should normally be undertaken through site and workplace visit(s). However, preliminary enquiries may be undertaken by other means such as phone calls or emails where the investigator judges this to be appropriate.

6.3 Preliminary enquiries should be commenced as soon as reasonably practicable after notification of the matter. The resulting investigation decision should be recorded appropriately (see paras 6.6 and 6.7 below) within **5 weeks** of notification unless an extension is agreed with the divisional director.

6.4 Investigators must comply with the ONR EPS (Ref.1) and apply the ONR EMM (Ref. 2) throughout the investigation process to test for consistency with the suggested outcome from the preliminary enquiries. A key requirement on the investigator throughout the preliminary enquiry is to consider whether prompt and proportionate enforcement action is necessary, based on prevailing information, to restore compliance or address a hazardous condition.

6.5 The outcome of preliminary enquiry using the criteria in Tables 2 to 5 and/or EPS factors may be to progress to an investigation. To avoid compromising any subsequent investigation, which may lead to prosecution proceedings, the investigator(s) must conduct preliminary enquiries in accordance with the requirements of the relevant jurisdiction (E&W or Scotland). Appendix 3 sets out aspects to bear in mind during preliminary enquiries such as maintaining independence from any duty holder investigation being conducting in parallel until a decision has been made by the decision maker on whether to authorise an investigation.

6.6 If preliminary enquiry shows the investigation criteria are **met** then the potential for investigation should be considered by proceeding with the process and completing an Investigation Decision Record (IDR) (Ref. 12) (proceed to Step 2.2).

6.7 If the criteria are **not met** and the investigator decides not to proceed any further with the investigation process then the resulting decision should be recorded appropriately in a proportionate manner (i.e. in a contact report/ intervention record and sent to their **delivery lead**). The record should provide sufficient information to support the decision including all the investigation criterion and enforcement factors considered relevant, any consultation with any other inspectors/ specialists, judgements made or the exercise of discretion.

Step 2.2 Decision to investigate (Investigator/ decision maker)

6.8 Once sufficient information is obtained from the initial notification or from subsequent preliminary enquiries, a decision needs to be made on whether to proceed to investigation.

6.9 If the investigator judges the criteria are met and the matter warrants consideration for investigation, they must complete part A of IDR having consulted the relevant delivery lead in advance. A unique number for the IDR must be obtained from the ESO and recorded on the IDR.

6.10 The investigator should seek advice from specialists and PLs as appropriate to complete part A of the IDR and record such advice given in the IDR. The investigator should explain how the criteria and/or EPS factors (see 6.12) are satisfied and make an investigation recommendation, with supporting rationale, whether to proceed to investigation for the **decision maker** to authorise.

6.11 The IDR should be passed to the **decision maker** responsible for authorisation to proceed with an investigation. As stated in paragraph 2.1, the **decision maker** is

normally the relevant delivery lead. The **decision maker** must complete part B of the IDR with supporting rationale for the decision. Parts A and B of the IDR should be completed within **5 weeks** of the initial notification unless an extension is agreed with the relevant **divisional director**.

6.12 The output of part A and B of the IDR is an investigation authorisation**.** The decision to undertake an investigation must take account of the relevant factors for investigation within ONR's EPS (Ref. 1) as set out below:

- the severity and scale of potential or actual harm.
- the seriousness of any potential breach of the law (including the risk gap).
- knowledge of the duty holder's past health and safety, security, transport or safeguards performance.
- enforcement priorities.
- practicality of achieving results.
- the wider relevance of event, including serious public concern.

6.13 The decision to undertake an investigation should also be cognisant of ONR's EPS in relation to prosecution and where ONR expects that it will normally prosecute or recommend prosecution (see paras 8.25 and 8.26).

6.14 Once an investigation decision has been made, the **decision maker** informs the ESO of the outcome, copying in the relevant divisional director.

6.15 From this step and onwards in the investigation process, ONR review, learn and improve process should also be considered (see para 8.37).

Step 2.3 Proceed with Investigation – Assign key roles

6.16 If the decision to proceed with an investigation is authorised, the **divisional director** in discussion with the relevant **delivery lead**, must assign the key roles having regard for the relevant Code of Practice (Ref. 3 or Ref. 5) including:

- **Lead Investigator** (Inspector in charge of the investigation),
- **Investigator(s**),
- **Disclosure Officer**,
- **Decision Maker**
- **Approval Officer**
- Divisional Delivery Support (DDS).

6.17 Further guidance on these roles and appointments to them is provided in the Definitions - section 2.1. IRG advice should be sought in relation to ICT membership of the investigation team (Investigator/ DDS) to ensure there is sufficient experience available to undertake the investigation.

6.18 The **lead investigator** must ensure that:

- Unique numbers for the Combined Investigation and Prosecution Report and Key Decision Log (KDL) are obtained from the ESO (Ref 17 and 21.).

- The OTiS team creates and issues a unique Sub Project activity (@level 3) to the **lead investigator** to cascade to relevant staff for use against specific investigation activity recording.

- A unique electronic folder and physical storage to be used for the investigation are obtained via ICT DDS.
- Requirement of any external resources (e.g. Solicitor Agent) is actioned through completing finance form at Appendix 1 to ONR-FIN-GD-008 (Ref. 14) and submitting to the ESO.
- For matters involving concerns raised, the General Enquiries Team are made aware of the decision to investigate.
- For matters involving whistleblowing reports the Executive Support Office are made aware of the decision to investigate.

6.19 Once a decision has been made to undertake an investigation, the **lead investigator** should seek advice from the IRG on the planning and conduct of the investigation. This is particularly relevant for potentially complex cases. Advice and guidance on application of relevant due process should also be sought from the IRG as necessary during the investigation.

6.20 The **lead investigator** should ensure that a KDL is opened and maintained throughout the investigation. The KDL should be stored in ONR's electronic management system such that all revisions can be seen. The KDL should provide a contemporaneous record of all key decisions that affect the course of an investigation, the reasons for those decisions and the outcome. Information recorded in the KDL provides a critical record and audit trail for the management of the investigation and demonstrates the accountability and integrity of the investigation process.

6.21 A KDL is not a diary of the actions taken, nor is it meant to substitute for an investigation notebook, which should be maintained separately. It is essential that only one KDL be maintained per investigation to ensure a coordinated investigation strategy and overall management control. Further guidance on KDLs is provided in Appendix 5.

7. STEP 3 - PLAN AND RESOURCE INVESTIGATION (Lead Investigator / Delivery Lead / DDS)

Step 3.1 Resource Investigation

7.1 Resource planning is an important activity as experience shows that performing an investigation may be resource intensive, depending on its complexity. Therefore, consideration should be given to whether the **lead investigator** should be allocated full-time to the investigation and associated activities. The **delivery lead** should plan and arrange for the re-allocation of duties from those identified to undertake the investigation, and for those persons' subsequent re-allocation into normal duties on completion of the investigation

7.2 As part of the planning process, the **lead investigator** should consider the requirements for any specialist support. **Professional leads** should be consulted as appropriate about securing this resource.

7.3 Consideration should be given to whether any ONR staff may later be needed to provide **expert witness** testimony during any subsequent court proceedings. Such individuals should be identified early and be kept separate from the investigation to preserve their independence.

7.4 DDS staff needed to assist with the investigation should be identified along with the equipment and facilities for collecting, indexing, and storing investigation material. Advice can be obtained from the ONR **ICT** on the practical arrangements associated with these activities. The resource planning referred to here also applies to resourcing of DDS staff. An ONR template is available for record keeping of material collected and generated (Ref. 15).

7.5 External specialist resource (such as from HSE's Science Division (previously HSL)) see Ref. 36, or a solicitor agent may be required during the investigation (see Ref. 35) and can be secured using the previously obtained finance procurement order (Ref. 14).

7.6 To enable resource tracking, all internal and external resourcing should be booked to the OTiS sub project activity and procurement order numbers, respectively.

7.7 The **lead investigator** should agree resource estimates with the relevant **delivery lead**, in consultation with their **divisional director**.

7.8 Consideration should be given to what equipment provisions will be required at the site or at other remote locations to assist the investigation.

7.9 The time required for completion of the investigation should be considered during the planning step below. Investigations should be completed as soon as reasonably practicable**.** No specific completion target has been set here, reflecting the potential variety in investigations ONR may conduct. Instead, regular progress reviews between the **lead investigator** and **approval officer** must be undertaken and should consider explicitly whether appropriate progress is being made. See **Step 4.5** for more details on progress reviews.

Step 3.2 Plan the Investigation – Setting Objectives (Lead Investigator)

7.10 The objectives of the investigation should be identified and will include matters such as:

- Identifying the relevant duty holder(s) and potential witnesses.
- Establishing the key facts relating to the potential causation, recognising that an actual/physical event may not necessarily have occurred.
- Identifying the immediate and underlying causes and any wider implications beyond the duty holder(s) concerned.
- Identifying the relevant legislation and what potential breaches may be applicable.
- Establishing whether an offence (or offences) may have been committed and, if so, which offences.
- Ensure remedial actions have been taken by the duty holder(s) to prevent a recurrence and to secure compliance with the law.
- Support application of the ONR EMM to determine what enforcement action, if any, is appropriate.

Step 3.3 Plan the Investigation – Developing the Plan (Lead Investigator)

7.11 The plan for the investigation should be developed, in accordance with the legal framework (see Appendix 1) and by:

- Establishing the investigation techniques to be used.
- Collating and reviewing material (e.g. records, information and enforcement history) held on the duty holder(s).

- Identifying and obtaining relevant standards, benchmarks, and sources of relevant good practice.
- Determining all reasonable lines of inquiry to use in Step 4.4.
- Identifying and securing people, equipment and other required resources (see Step 3.1).
- Considering how the views of victims of crime (victim personal statement) will be obtained (see Ref 38).
- Considering health and safety requirements of investigating staff and making provision as appropriate. Due account should be taken of the relevant guidance in the ONR General Inspection Guide (Ref. 16).

7.12 The **lead investigator** should consider the need to develop a communications plan in conjunction with the ONR Communications Team. Care should be taken to avoid communications, which may compromise the investigation.

8. STEP 4 - CONDUCT INVESTIGATION

Step 4.1 Commence Investigation (Lead Investigator)

8.1 The investigation should be commenced in accordance with the Investigation Plan at the earliest opportunity, and if appropriate include a visit to the scene/place of the matter under investigation.

Step 4.2 Identify Relevant Contacts (Lead Investigator)

8.2 As soon as practicable after beginning the investigation, the **lead investigator** should identify or confirm:

- Who the duty holder(s) are to explain ONR's role and the investigation objectives.
- Potential witnesses.
- Any injured persons and any bereaved families.
- Any employee representatives or safety representatives.

Step 4.3 Immediate Enforcement Action (Lead Investigator)

8.3 As stated in Step 1, matters of evident or potential major concern should be dealt with promptly and in accordance with the EPS (Ref.1) and the EMM (Ref.2).

Step 4.4 Conduct Investigation (Investigator(s))

8.4 The **investigator(s)** should conduct the investigation in accordance with the investigation plan and identify and follow all reasonable lines of inquiry. They should be fair and objective; a fair investigation does not mean an endless investigation. Investigator(s) must ensure they follow relevant legislative frameworks for the jurisdiction (see Appendix 1) and ONR's associated investigation process in particular the guidance, templates, forms and handling evidence workflow etc on HOW2 – conducting investigations. A practical guide has been developed to assist investigators should they find it necessary to question witnesses and capture information at various stages of an investigation (see Ref. 19).

8.5 Normally the **lead investigator** will complete the ONR combined Investigation and Prosecution Report (Ref. 17) as the investigation progresses. If it becomes apparent early on that the investigation should not be continued i.e. that there are grounds for early termination of the investigation, the combined Investigation and Prosecution Report may not be completed (see the explanatory cover sheet in Ref. 17 and para 8.11 below).

8.6 In this case, the **decision maker** must record the rationale for this decision of early termination in part C of the IDR, following discussion with the **lead investigator**, other **investigators**, divisional director and other relevant parties (e.g. Professional Lead(s)).

8.7 If there is a difference of regulatory opinion in relation to the decision for early termination of the investigation then this should be addressed through ONR's resolving differences of regulatory opinion process (Ref. 28) specifically dealing with differences in regulatory opinion on enforcement action. Where the decision has been challenged, the decision should not be enacted until the difference of opinion process is completed.

8.8 When conducting the investigation, the **investigator(s)** should be mindful of other relevant ONR guidance on investigation and consult with IRG as appropriate.

Interviewing of Suspects

8.9 The interviewing of suspects differs considerably from the questioning of witnesses. The interviewing of suspects should only be conducted by ONR personnel (select members of the ICT) who are suitably experienced and have received formal training in the legal requirements for interviewing suspects. Consequently, where a **lead investigator** identifies the requirement for a suspect to be interviewed, they **must** request support from the IRG. Ref. 41 provides guidance in this area but is **not** a replacement for adequate training.

Step 4.5 Regular Review

8.10 Throughout the investigation, the **lead investigator** should routinely review:

- The objectives for the investigation and revise and/or establish new objectives as necessary.
- Whether all reasonable lines of inquiry are being followed and identify any additional or expired ones.
- Whether any analytical investigation methods that are being or have been used remain appropriate and sufficient.
- The Key Decision Log.

8.11 The status of the investigation should also be reviewed at intervals of no greater than **one month** by the **lead investigator** and **decision maker.** This review should consider whether any additional resource is necessary and if the timescales continue to be appropriate or require adjustment. In certain circumstances, there may be grounds for early termination of the investigation before its objectives are met. Equally, the **decision maker** may decide on early termination of the investigation. Reasons for early termination of an investigation might include:

- Information comes to light that the matter under investigation is not within ONR's field of enforcement responsibility.
- It becomes apparent that the matter under investigation does in fact not meet the selection criteria and/or the possible breaches of legislation are unlikely to meet the policy in the ONR EPS or EMM.
- The investigation is impractical e.g. where key witnesses or other evidence is unavailable.
- The length of time elapsed since the incident would limit the realistic prospect of conviction.
- Excessively disproportionate effort would be required to achieve the established objectives or resource priorities have changed.

8.12 If a decision is made for early termination of the investigation, then the guidance in para 8.6 should be applied. Similarly, if there is a difference of opinion on this decision, then the guidance in para 8.7 applies.

8.13 The **decision maker** is responsible for briefing upwards on the progress of the investigation. This will normally be via the routine monthly update to the relevant divisional director and ESO. The **decision maker** should ensure that these briefings do not undermine any future prosecution decision. Any briefing records produced need to be included within the scope of potentially disclosable material (see section 2).

Step 4.6 Enforcement Decision (Lead Investigator / Approval Officer)

8.14 On completion of the investigation, the **lead investigator** will make an enforcement recommendation to the **approval officer**, via the Combined Investigation and Prosecution Report (Ref. 17). This should be completed as soon as is reasonably practicable.

8.15 Prior to submission to the **approval officer**, the report should be reviewed by IRG's Legal Advisor for legal correctness and independently peer reviewed by an ICT Inspector selected/ identified by the IRG Chair.

8.16 If the **lead investigator** makes an investigation enforcement recommendation **to prosecute**, they must complete all of parts A (investigation details), B (factual report) and C (analysis of compliance) of the Combined Investigation and Prosecution Report, the appendixes of the report, and the accompanying Enforcement Decision Record (EDR) Ref. 13. Once those parts are accepted as being complete e.g. the **approval officer** does not require further information in order to make a decision, the **approval officer** must complete all of part D (approval officer's consideration and decision). The **approval officer** should also complete part C of the IDR by referencing the Combined Investigation and Prosecution Report.

8.17 If the enforcement recommendation of the **lead investigator** is **not to prosecute**, they must complete all of parts A and B and as a minimum, C12 (application of ONR's EPS and EMM) and C13 (recommended action) of the Investigation and Prosecution Report, together with the EDR. The **approval officer** must complete parts D1 (review of application of EPS and EMM to circumstances presented by investigator) and D3 (providing a decision on the final enforcement or prosecution action) as a minimum. The **approval officer** should also complete part C of the IDR by referencing the Investigation and Prosecution Report.

8.18 The **approval officer** will make the final investigation enforcement decision on whether a prosecution is appropriate following engagement with the **lead investigator**, the **divisional director** other interested parties such as PLs, technical specialists and, where relevant, the **solicitor agent**, recording/referring to any advice given. The final enforcement decision should be taken as soon as is reasonably practicable after receiving the enforcement recommendation from the **lead investigator.**

8.19 This final investigation enforcement decision must be made in accordance with the ONR EPS, EMM and the Code for Crown Prosecutors reflecting the relevant jurisdiction (Ref. 22 and 26). ONR's EPS sets outs when ONR will normally prosecute (or recommend prosecution in Scotland). The EPS also states other circumstances, such as public interest, where they may consider or recommend prosecution (see 8.25 and 8.26 below).

8.20 In **England & Wales** when considering a case for prosecution, the **approval officer** must ensure that:

- The legislation has been properly applied.
- All relevant material and evidence are available in an admissible form.
- Inspectors have identified any material that may undermine the prosecution case or assist the defence.
- ONR has acted in compliance with the Human Rights Act 1998 (Ref. 23).
- The general principles within section 2 of the CPS Code for Crown Prosecutors (Ref. 22) are met.

8.21 The **approval officer**, before they can make a final decision to proceed to a prosecution, must apply the CPS Code for Crown Prosecutors Full Code Test, which consists of two stages below. Further guidance is provided in Reference 27.

- The Evidential stage
- The Public Interest stage

8.22 The CPS Code also includes the Threshold Test, which does not apply to ONR and need not be considered.

8.23 In **Scotland**, recommendations to prosecute are made to a Procurator Fiscal. In such cases, the Crown Office and Procurator Fiscal Service (COPFS) Prosecution Code (Ref. 26) should be referred to and applied to the ONR decision making process.

8.24 If there is an internal challenge to the final investigation enforcement decision then the guidance in para 8.7, relating to difference of regulatory opinion, should be applied.

8.25 ONR's EPS (Ref. 1) states that ONR will normally prosecute (or recommend prosecution in Scotland), where, following an investigation or other regulatory contact, one or more of the following circumstances apply:

- Death was a result of a breach of the legislation.
- The gravity of an alleged offence, taken together with the seriousness of any actual or potential harm, or the general record and approach of the offender warrants it.
- There has been reckless disregard of health and safety, security, transport or safeguards requirements.
- There have been repeated breaches which give rise to significant risk, or persistent and significant poor compliance.
- A dutyholder's standard of managing its legal responsibilities is found to be far below what is required by the legislation and to be giving rise to significant risk.
- There has been a failure to comply with a notice or direction.
- False information has been supplied wilfully, or there has been an intent to deceive, in relation to a matter which gives rise to significant risk.
- Inspectors have been intentionally obstructed in the lawful course of their duties.

8.26 ONR's EPS also states that ONR will, in the public interest, consider prosecution or recommend prosecution, where following an investigation or other regulatory contact, one or more of the following circumstances apply:

- It is appropriate in the circumstances to draw general attention to the need for compliance with the law and the maintenance of standards required by law, and conviction may deter others from similar failures to comply with the law.

- A breach which gives rise to significant risk has continued despite relevant warnings from employees, or their representatives, or from others affected by a work activity.

Step 4.7 Communicate Outcome (Lead Investigator)

8.27 The ESO should be notified of the investigation decision. Interested parties should be identified by the lead investigator, and, as appropriate, are to be advised of the outcome of the investigation, any actions required, and by whom. These include:

- Any bereaved family.
- Any injured person.
- Any complainant.
- The duty holder(s).
- Any employee/safety representatives.
- Other parts of ONR.
- Other agencies.
- Other stakeholders e.g. trade associations.

8.28 If the decision is **not to proceed with a prosecution** then the victims right to review (VRR) guidance should be followed (Ref. 34).

8.29 If the matter under investigation was a Work-Related Death, the Coroner (or in Scotland, the Procurator Fiscal) must be informed that the investigation has concluded and to agree disclosure of information for the purposes of the inquest.

8.30 Where appropriate, a communication plan will need to be developed with the ONR Communications Team (see section 7.12).

Step 4.8 Follow-Up Action

8.31 ONR inspectors should undertake any follow-up actions required. With regard to duty holders, this should be in-line with the ONR Inspection Guide (Ref. 16) and the need for any Regulatory Issues (Ref. 24) should be considered.

Step 4.9 Proceed to Prosecution

8.32 If the **approval officer** makes the decision to proceed to or recommend a prosecution, the proceedings through to court will be led by ONR's solicitor agent supported as necessary by ONR inspectors and DDS staff, or in Scotland by COPFS. ONR's involvement is likely to be in the following areas: technical support from the **lead investigator, approval officer**, specialist inspectors and expert witnesses; administrative support for evidence management and disclosure; communications team support to assist with media handling.

8.33 Once information has been laid, ONR's subsequent costs are not recoverable from duty holders as stipulated in the Health and Safety and Nuclear (Fees) Regulations 2016 (Ref. 31). Therefore, the necessary funding must be drawn down in the form of a grant from the Department for Work and Pensions (DWP) such that ONR does not unduly penalise other duty holders and ONR's overall cash flow is protected.

8.34 The **lead investigator** must ensure that:

- ONR Finance are promptly informed of the decision to proceed to or recommend a prosecution. A unique cost-centre relating to the prosecution will be created and relayed to the **lead investigator** for assigning any associated costs to e.g. legal, hotel, travel and subsistence etc.

- The OTiS Team are informed of the decision. This allows OTiS Team to provide ONR Finance with the effort related to prosecution and Finance to calculate a cost. (*this can be covered in one email, with the bullet above and sent to both Finance and OTiS*).

- An update is made to the previously completed finance form (Appendix 1 to ONR-FIN-GD-008 Ref. 14) and the DWP Statement of Requirements form (Appendix 2 to ONR-FIN-GD-008) is drafted. This should be done in conjunction with ONR Finance.

8.35 The ESO will liaise with ONR Finance and ONR Procurement to facilitate the draw-down of a grant to fund the prosecution. ONR-FIN-GD-008 (Ref. 14) explains the process above and contains both the finance form and statement of requirements templates for completion.

Review Learn Improve

8.36 Staff involved in the investigation process and undertaking enforcement activities (i.e. Lead Investigators, Professional Leads, Decision Makers, Approval Officers, IRG, and DDS) should consider whether any learning should be promulgated across ONR through the Review-Learn-Improve (RLI) process (see Ref. 33).

8.37 A RLI exercise is an opportunity to undertake a retrospective analysis of an activity, identifying relevant learning (including examples of good practice) and identifying suitable means for those examples to be taken forward in a way that supports continuous improvement of our processes. On completion of an investigation where the investigation/ prosecution report is completed, the lead investigator should complete an RLI exercise and share relevant learning with the ICT and other relevant staff.

8.38 Learning from investigations is captured on the ONR investigation intranet page (Ref 46), which also includes information relevant to the investigation sub-specialism and related work.

9. REFERENCES & FURTHER SUPPORTING INFORMATION

1. ONR Enforcement Policy Statement
2. ONR-ENF-GD-006 - Enforcement Management Model in ONR
3. Criminal Procedure and Investigations Act 1996 (CPIA) and associated code of practice
4. Police and Criminal Evidence Act 1984 (PACE) and associated codes of practice (codes C, D, E & F)
5. Criminal Justice and Licensing (Scotland) Act 2010 and associated code of practice.
6. Criminal Procedure (Scotland) Act 1995
7. Criminal Justice (Scotland) Act 2016
8. ONR Guidance on Concerns, Whistleblowing and Complaints (NB. Guidance to inspectors is contained in Appendix 6 of Ref. 16)
9. Work-related Deaths: A protocol for liaison (England and Wales)
10. Work-related Deaths Protocol: Practical guide (England and Wales)
11. Work-related Deaths: A protocol for liaison (Scotland)
12. ONR-DOC-TEMP-098 ONR Investigation Decision Record (IDR) Form
13. ONR-DOC-TEMP-128 - ONR Enforcement Management Model Enforcement Decision Record (EDR)
14. ONR-FIN-GD-008 - ONR Investigation and Prosecution process – Finance Arrangements
15. ONR-DOC-TEMP-101 - ONR Schedule of Material
16. ONR-INSP-GD-064 - General Inspection Guide
17. ONR-DOC-TEMP-171 - ONR Combined Investigation and Prosecution Report
18. ONR-GEN-GD-010 - Guide to Collecting and Exhibiting Material as Evidence
19. ONR-ENF-GD-013 – Witness Statement Taking
20. ONR-DOC-TEMP-100 - Additional Template for Scottish Investigations to be used for Procurator Fiscal Submissions
21. ONR-DOC-TEMP-099 - ONR Key Decision Log
22. The CPS Code for Crown Prosecutors – October 2018
23. The Human Rights Act 1988
24. HOW2 Regulatory Issues Management Process
25. Attorney General's Guidelines on Disclosure
26. Crown Office and Procurator Fiscal Service Prosecution Code
27. ONR-ENF-GD-020 - The role of the Approval Officer in enforcement decisions
28. NS-INSP-IN-002 - Resolving Differences of Regulatory Opinion
29. NS-INSP-GD-051 - The Regulation of Conventional Health and Safety on GB Nuclear Sites

30. ONR-OPEX-GD-004 - Guidance for INF1 Categorisation Governance and Oversight
31. Health and Safety and Nuclear (Fees) Regulations 2016
32. ONR Strategy 2020 – 2025
33. ONR Review – Learn – Improve – Process (RLI)
34. ONR-ENF-IN-031 - Victims Right to Review
35. ONR-GEN-GD-004 - Accessing legal advice
36. ONR-ENF-GD-019 - Access to Health and Safety Laboratories' services for investigation purpose
37. ONR-ENF-GD-027 - The role and responsibilities of an Investigation Core Team Member
38. ONR-ENF-GD-023 - Victim Personal statements in England and Wales
39. ONR-ENF-GD-024 - Investigative Interviewing
40. ONR-ENF-GD-013 – Witness Statement taking
41. ONR-ENF-GD-008 - Interviewing Suspects – Guidance for ONR Inspectors in Great Britain
42. ONR-ENF-GD-026 – Conducting Investigations Disclosure Guidance
43. ONR-ENF-GD-022 - Investigation powers provided to inspectors by the Health and Safety at Work etc. Act 1974, and the Energy Act 2013
44. CNI-ESO-PROC-001 - Whistleblowing: Process for Handling Protected Disclosures
45. CNI-ESO-IN-001.03 - Whistleblowing: Handling Protected Disclosures (formerly WB0004)
46. ONR investigation intranet page

IMPORTANT NOTE:

Inspectors are advised to always seek the latest legal publications from Westlaw or Redgrave's Online or by liaison with the IRG, the links above are correct at publication but should be regarded as for information only.

10. TABLES

TABLE 1: STEP 1 "RECEIVE NOTIFICATION AND ACT UPON"

For All notifications

A warranted inspector must decide whether sufficient information is available to determine if the relevant ONR investigation criteria detailed in tables 2 to 4 have the potential to be met. If it is clear that the investigation criteria are NOT met, then this decision must be recorded by the inspector.

All decisions must be appropriately recorded.

If there is insufficient information to make an informed decision, then preliminary inquiry should be undertaken to allow this.

If it is clear that the investigation criteria are met then preliminary inquiry may not be required and the inspector can progress straight to completion of part A of the IDR, having informed the relevant delivery lead in advance.

Input (Means of Notification)	Output
INF1 or telephone notification of incident or event	Decision whether to undertake preliminary enquiry recorded within an INF1 part B. For telephone notifications decision may alternatively be recorded within a pre-notification, contact or intervention record.
Event Report Under RIDDOR	As described for INF1 or telephone notification with the exception that, if it is clear that the investigation criteria are NOT met, the decision may be recorded by an inspector in an email.
Duty Holder has a significant event resulting in RCIS set-up	As described for INF1 or telephone notification with the inspector being identified by the relevant Delivery Lead in consultation with the RCIS Director.
Concern/Whistle Blowing received regarding a duty holder	As described for INF1 or telephone notification with the inspector being appointed by the relevant Delivery Lead in consultation with the Executive Support Office (ESO) or General Enquiries Team on Concerns. If the concern/whistle blowing notification has not come via the ONR Enquiries email route, the ESO (for Whistleblowing) or ONR Policy (for Concerns) must be informed of the notification and kept appraised of subsequent progress and developments.
Matter identified during inspection and/ or assessment activities	Decision not to undertake preliminary enquiry recorded within contact or intervention record.

TABLE 1: STEP 1 "RECEIVE NOTIFICATION AND ACT UPON"	
Matter reported to ONR by another regulator	Decision not to undertake preliminary enquiry recorded within contact or intervention record.

TABLE 2: NUCLEAR SAFETY AND TRANSPORT CRITERIA

This table sets out the selection criteria relating to nuclear safety and transport purpose matters that should be subject to a preliminary enquiry and/ or considered for potential investigation.

Matters that only satisfy Criterion 1 or which could potentially satisfy Criterion 2 or 3 should be subject to preliminary enquiry unless it is evident from the nature of the event or /incident that an investigation is warranted without the need for preliminary enquiries.

The selection criteria to be used for making an informed judgement as to whether an investigation is warranted are Criteria 2 and 3.

Criterion 1: All incidents or events that:

a) Are rated at Level 1 or above on the INES scale, whether deemed provisional or final; or
b) Are deemed to meet the Ministerial Reporting Criteria/ONR Publication Criteria (Annex 1 of ONR-OPEX-IN-001 “Incident Notification and Reporting Process” refers).

Criterion 2: Any matter; where it is immediately evident or where preliminary enquiries of the surrounding circumstances reveals that:

a) There appears to be a significant challenge, or potentially significant challenge, to nuclear safety;
b) It appears there was, or could have been a significant breach of nuclear site licence conditions or a relevant statutory provision;
c) There was, or there was potential for, a release of radioactivity above, or that approached, the statutory reporting limits;
d) There was, or there was potential for a dose to an individual or group above, or that approached, the statutory dose limits;
e) The duty holder knowingly did not take conservative action;
f) There were several incidents or events with the same apparent cause;
g) For transport related incidents or events (involving Class 7 radioactive material): a significant breach of any condition or restriction attached to any approval, derogation or other authorisation issued by the Transport Competent Authority.

Criterion 3: Incidents or events that do not fall within the above criteria but could reasonably give rise to public concern. All concerns or whistleblowing reports made by nuclear industry workers relating to matters that ONR regulates (or would have regulated prior to vesting in 2014, when part of HSE) fall under this criterion.

TABLE 3: NUCLEAR SITE HEALTH AND SAFETY CRITERIA

Drawn from the HSE Revised Incident Selection Criteria (2014)

Criteria for selection for investigation of notified work-related accidents, ill-health and dangerous occurrences

Scope: The following criteria apply to all relevant incident or events notified to ONR and are aligned to those for other enforcing authorities. Predominantly, notification will be via RIDDOR reports, but the criteria remain relevant for notifications received via other means (e.g. contact by emergency services, INF1, COMAH Competent Authority).

Criterion 1: Fatalities (Work-related deaths):

a) All work-related accidents which result in the death of any person, including non-workers. "Accident" specifically excludes suicides* and deaths from natural causes.
b) Other deaths arising from a preventable work-related cause,* where there is a likelihood of a serious breach of health and safety law, and where it is appropriate for ONR to investigate.

*Note that in such circumstances ONR will continue to apply the HSE guidance on the application of HSWA section 3.

Criterion 2: All work-related accidents resulting in a "Specified Injury" [RIDDOR Reg. 4(1)] to any person, including non-workers, that meet any of the following conditions:

a) Serious multiple fractures (more than one bone), not including wrist or ankle);
b) All amputations other than amputation of digit(s) above the first joint (e.g. fingertip);
c) Permanent blinding in one or both eyes;
d) Crush injuries leading to internal organ damage, e.g. ruptured spleen;
e) Any burn injury (including scalding) which covers more than 10% of the surface area of the body or causes significant damage to the eyes, respiratory system or vital organs;
f) Any degree of scalping requiring hospital treatment;
g) Loss of consciousness caused by head injury or asphyxia;
h) Any injury arising from working in an enclosed space which leads to hypothermia or heat induced illness, or requires resuscitation or hospital admittance for more than 24 hours.

Criterion 3: Cases of Occupational Disease:

The following notifications of cases of occupational disease, other than those arising from circumstances or situations which have already been investigated:

a. All reports of cases of occupational disease which are reportable under RIDDOR 2013 Regulations 8 & 9, specifically:
   i. Carpal Tunnel Syndrome,
   ii. Cramp in the hand or forearm,
   iii. Occupational dermatitis,

TABLE 3: NUCLEAR SITE HEALTH AND SAFETY CRITERIA

iv. Hand Arm Vibration Syndrome,

v. Occupational asthma,

vi. Tendonitis or tenosynovitis in the arm or forearm,

vii. Any cancer attributed to an occupational exposure to a known human carcinogen or mutagen,

viii. Any disease attributed to an occupational exposure to a biological agent.

b. Other reports of cases of occupational disease with the potential to cause death or serious consequences as defined in the Enforcement Management Model (EMM), and which arise from working practices that are likely to be ongoing at the time the report is made.

Criterion 4: Incidents which indicate a likelihood of a serious breach of health and safety law:

This includes any incidents considered liable to give rise to serious public concern, where, from the facts known, the application of the EMM would give rise to an initial enforcement expectation of a notice or a prosecution.

Criterion 5: Major hazard precursor events:

All relevant precursor events should be considered for potential investigation using the following selection criteria:

a) Incidents or events that result in or have the potential for significant releases of dangerous substances.
b) Incidents or events that could be precursors to major incidents.
c) Incidents or events that indicate that duty holders are not adequately controlling major hazards.

The range of potential precursor events covered by these criteria is broad and it is important that the criteria are not limiting, allowing the significance of each event to be judged based on its individual circumstances and characteristics.

Criterion 6: Incidents or events that do not fall within the above criteria but could reasonably give rise to public concern. All concerns or whistleblowing reports made by nuclear industry workers relating to matters that ONR regulates (or would have regulated prior to vesting in 2014, when part of HSE) fall under this criterion.

TABLE 4: CIVIL NUCLEAR SECURITY CRITERIA

This table sets out the criteria relating to civil nuclear security matters that should subject to a preliminary enquiry and/ or considered for potential investigation.

Matters that only satisfy Criterion 1 or which could potentially satisfy Criterion 2 or 3 should be subject to preliminary enquiries unless it is evident from the nature of the incident/event that an investigation is warranted without the need for preliminary enquiries.

The selection criteria to be used for making an informed judgement as to whether an investigation is warranted are Criteria 2 and 3.

Criterion 1: All incidents or events that:

a) Indicate a significant breach of NISR 2003 (as amended); or
b) Are assessed by the duty holder or ONR to have an initial estimate of significance of Major*;

Criterion 2: Any incident or event where it is immediately evident or where preliminary enquiries of the surrounding circumstances reveal that:

a) There has been a significant departure from approved security arrangements; or
b) There has been, or there was potential for, theft of NM/ORM or any sabotage to assets on the site; or
c) Where there have been a number of incidents or events that have the same apparent cause.

Criterion 3: Incident or events that do not fall within the above criteria but could reasonably give rise to public concern. All concerns or whistleblowing reports made by nuclear industry workers relating to matters that ONR regulates (or would have regulated prior to vesting in 2014, when part of HSE) fall under this criterion.

***Major** – Total loss of defence in depth resulting in high risk to site, or where malicious acts have been carried out against the site. Typical examples include:*

- *Site incursion with intent to disrupt or cause damage.*
- *Any sabotage to assets on site.*
- *Amy theft of NM/ORM or confirmed compromise of SNI.*
- *Total loss of Security Management System for periods in excess of four hours.*

TABLE 5: NUCLEAR SAFEGUARDS CRITERIA

The paragraphs below set out the criteria for nuclear safeguards matters that should subject to a preliminary enquiry and/ or considered for potential investigation.

Matters that only satisfy Criterion 1 or which could potentially satisfy Criterion 2 or 3 should be subject to preliminary enquiries unless it is evident from the nature of the incident/event that an investigation is warranted without the need for preliminary enquiries.

The selection criteria to be used for making an informed judgement as to whether an investigation is warranted are Criteria 2 and 3.

Criterion 1: All incidents or events that:

a) Indicate a significant breach of the Nuclear Safeguards (EU Exit) Regulations 2019 (as amended);

Criterion 2: Any incident or event where it is immediately evident or where preliminary enquiries of the surrounding circumstances reveal that:

a) There has been, or there was potential for a significant failure to maintain a system of accountancy and control of safeguarded nuclear material; or
b) There has been a significant deviation from operations as described in the Basic Technical Characteristics (BTC); or
c) There have been multiple and/or significant errors in reporting by the duty holder; or
d) There has been evidence of interference with safeguards equipment; or
e) The duty holder had acted knowingly in not taking conservative action; or
f) There have been several incidents or events that have the same apparent cause.

Criterion 3: Incident or events that do not fall within the above criteria but could reasonably give rise to public concern. All concerns or whistleblowing reports made by nuclear industry workers relating to matters that ONR regulates (or would have regulated prior to vesting in 2014, when part of HSE) fall under this criterion.

APPENDIX 1 – BACKGROUND ON LEGAL FRAMEWORK FOR INVESTIGATIONS

A1.1 This Appendix provides an overview of the legal framework for conducting investigations under this process.

A1.2 As well as creating duties, the Health and Safety at Work etc. Act 1974 and the Energy Act 2013 allow for the appointment of inspectors. Those inspectors are provided with powers so they can investigate to determine whether or not duties are being complied with and, if necessary, require remedial steps to be taken. Further information on powers are found in ONR-ENF-GD-022 (Ref. 43).

A1.3 Those powers are investigatory powers, provided to help inspectors determine the causation of any failures to comply with duties. However, those powers are not provided for the purpose of investigating criminality, they do not proceed from the point of compliance with the Article 6 rights of the Human Rights Act 1998: the right to a fair and public trial or hearing. To investigate matters where the investigation might ultimately end in criminal proceedings, legislation and associated Codes of Practice that have developed over time to prevent miscarriages of justice must be followed by those involved in an investigation. The following describes some of those key pieces of legislation.

A1.4 In England and Wales there are two main pieces of relevant legislation, namely the Criminal Procedure and Investigations Act 1996 (CPIA) (Ref. 3) and the Police and Criminal Evidence Act 1984 (PACE) (Ref. 4). When considering the decision for prosecution following investigation, the CPS Code for Crown Prosecutors is also applicable (Ref 22).

A1.5 In Scotland there are three key pieces of relevant legislation: Criminal Procedure (Scotland) Act 1995 (Ref. 6), Criminal Justice and Licensing (Scotland) Act 2010 (CJLSA) (Ref. 5) and Criminal Justice (Scotland) Act 2016 (CJSA) (Ref. 7). With reference to prosecution proceedings in Scotland brought by the Procurator Fiscal, the Crown Office and Procurator Fiscal Service, Prosecution Code applies (Ref. 26).

A1.6 PACE and CJSA provide frameworks for the legal exercising of powers, including identification and dealing with suspects and taking of statements. Working according to the Acts ensures that those suspected of a crime know what they are being suspected of, are treated fairly and consistently, and ensures their right to a fair and just trial.

A1.7 The CPIA Code of Practice (Ref. 3) and the Code of Practice issued under part VI of the Criminal Justice and Licensing (Scotland) Act 2010 (Ref. 5) refer to police officers. However, other investigators (including ONR inspectors) are required to “have regard” to any relevant provisions of the codes. The CPIA Code of Practice preamble states that ‘*It sets out the manner in which police officers are to record, retain and reveal to the prosecutor material obtained in a criminal investigation and which may be relevant to the investigation, and related matters*’. The CJLSA Code sets out similar requirements.

A1.8 Further important points from both Codes are summarised below. The list is not exhaustive.

- In conducting an investigation, the investigator should pursue all reasonable lines of inquiry, whether these point towards or away from the suspect. What is reasonable in each case will depend on the particular circumstances.
- During the investigation, a range of material will be obtained and some generated. *Material* is material of any kind, including information and objects,

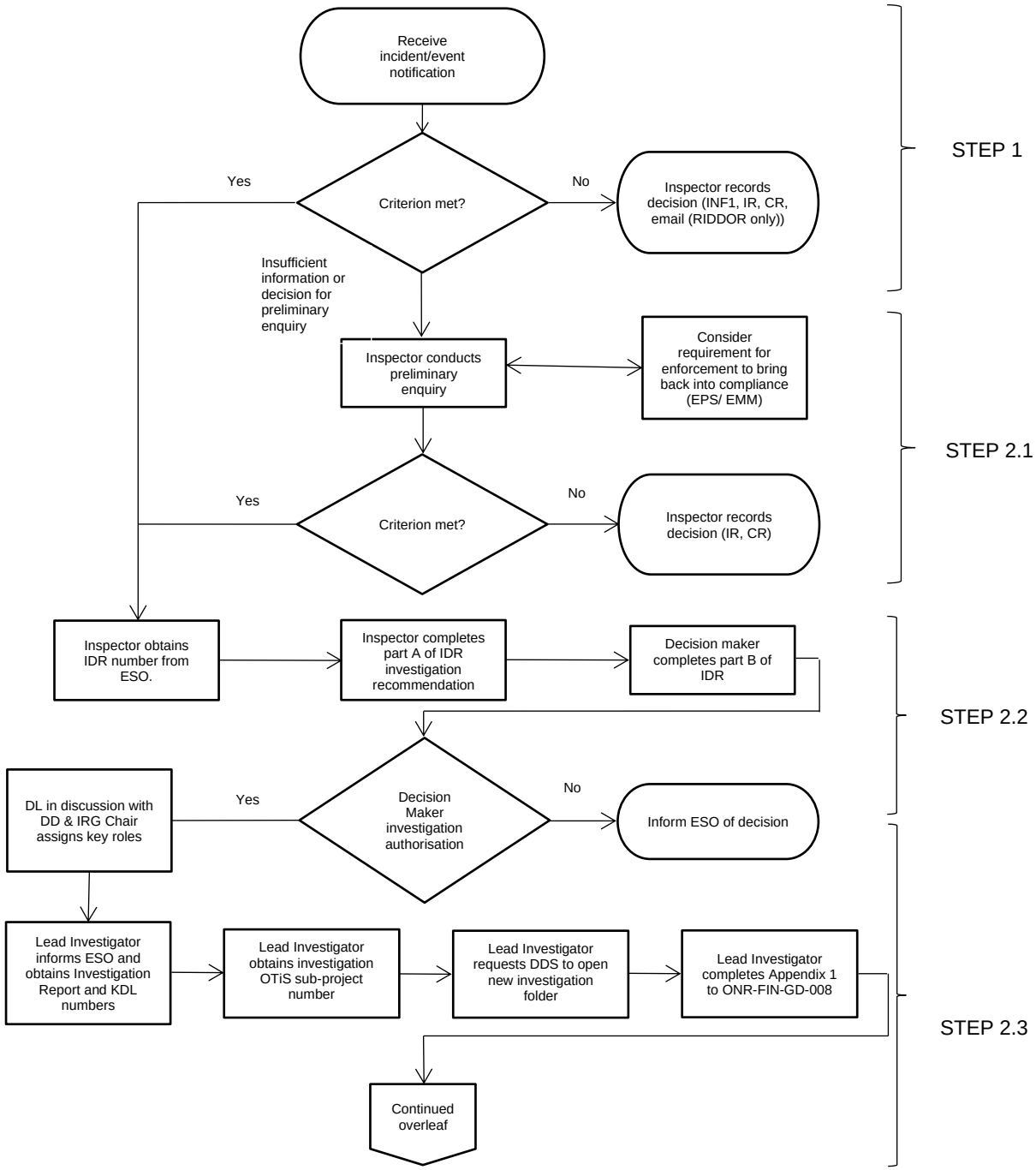
which is obtained or inspected during a criminal investigation and which may be relevant to the investigation. This includes not only material coming into the possession of the investigator (such as documents seized in the course of searching premises) but also material generated by themselves (such as interview and notebook records);

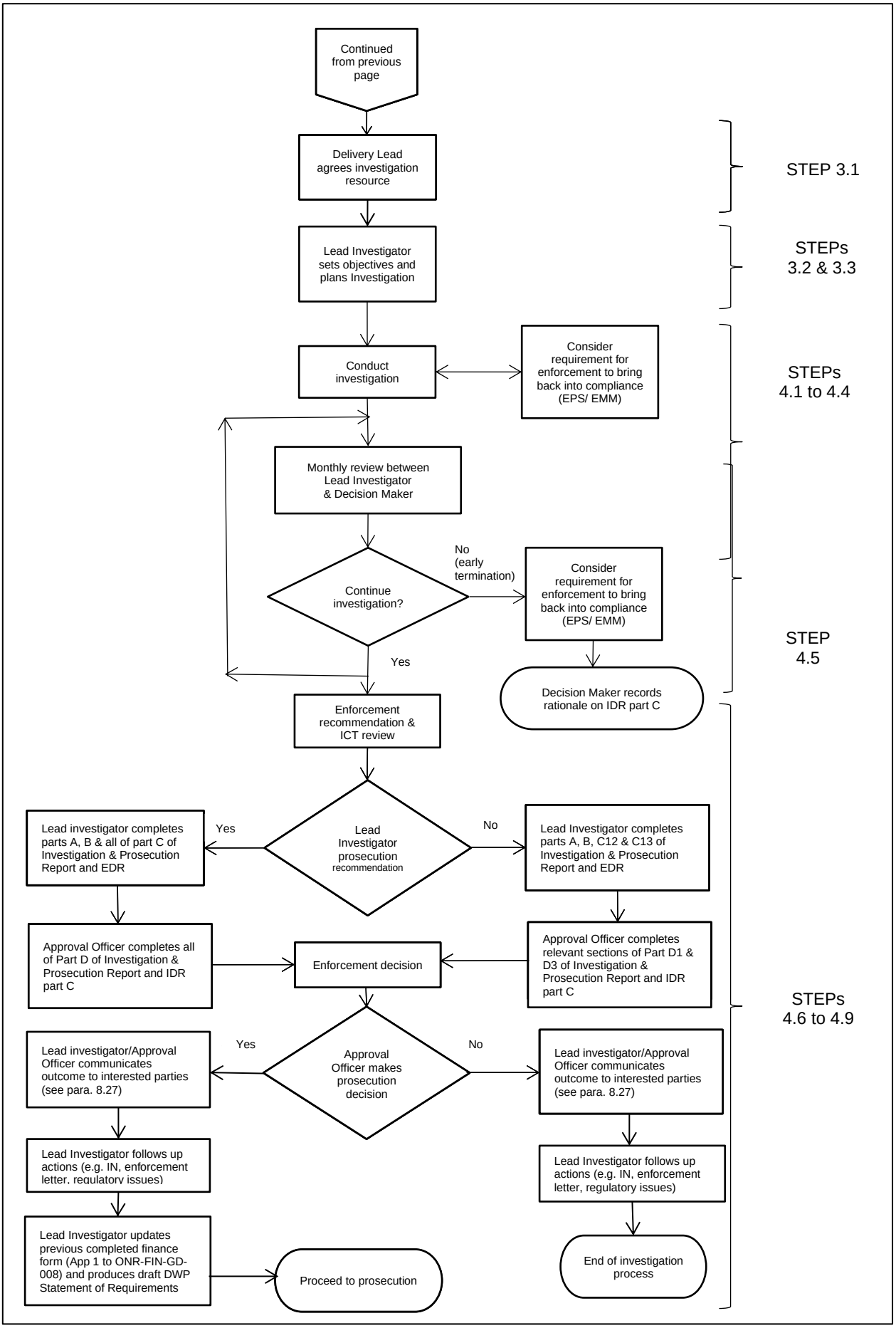
- Material may be *relevant to an investigation* if it appears to an investigator, or to the disclosure officer, that it has some bearing on any matter under investigation or any person being investigated, or on the surrounding circumstances of the case, unless it is incapable of having any impact on the case;
- Duties in relation to retaining material need to be kept in mind during all stages of the investigation;
- Negative information is often relevant to an investigation. If it may be relevant it must be recorded. An example may be a number of people present in a particular place at a particular time who state that they saw nothing unusual.
- Where information which may be relevant is obtained, it must be recorded at the time it is obtained or as soon as practicable after that time.

A1.9 Requirements associated with disclosure have a bearing throughout an investigation with respect to how investigation material is collected and recorded. The role of the disclosure/reviewing officer is described in section 2 of this guide. Their role is to examine material retained during the investigation and to propose what material is to be disclosed after the investigation being completed.

A1.10 The final decision on disclosure will generally be taken by the prosecutor and their agent(s) following discussion with the disclosure/reviewing officer and any prosecuting counsel (e.g. Barrister). Consequently, investigator(s) need to bear this in mind whilst obtaining and generating investigation material and associated communications and need to be aware of the disclosure guidelines produced for the relevant jurisdictions and ONR guidance Ref. 42. The guidelines state a “golden rule” that fairness requires full disclosure should be made of all material held by the prosecution that weakens its case or strengthens that of defence.

APPENDIX 2 – INVESTIGATION PROCESS FLOWCHART





APPENDIX 3 – ASPECTS TO BEAR IN MIND DURING PRELIMINARY ENQUIRIES

A3.1 During preliminary enquiries, it is crucial not to compromise any subsequent investigation that may take place. Aspects to bear in mind include ensuring:

- Independence from any duty holder investigation being conducting in parallel until a decision has been made by the **decision maker** on whether an ONR investigation is warranted.
- Compliance with the requirements for the collection and preservation of material that may be used in evidence in a timely and admissible form.
- Confidentiality, to avoid compromising the integrity of a subsequent investigation.
- Before questioning people inspectors should have a clear opinion on the individual's status as potential witness or suspect. Inspectors' should not speak to someone as a witness if they have reasonable grounds to suspect them of having committed the offence under investigation. If during the questioning of a person, their status changes to a suspect then questioning should cease immediately and a caution offered. (see para 8.9 on interviewing of suspects which must follow Part C of PACE CoP).
- That a suitable record is made in the inspector's notebook of material gathered during the preliminary enquiries and decisions taken. Guidance on notebook discipline is contained in the ONR General Inspection Guide (Ref. 16).
- That records relating to preliminary enquiries are disclosed as appropriate.
- That the inspector considers whether to engage with other agencies. There are Memoranda of Understanding (MoU) (available on HOW2) with other agencies and supporting guidance that indicate when such engagement is required. This should be done at the earliest opportunity to ensure the organisations share data, information and intelligence, that we work together effectively during the response and to allow a joint or coordinated investigation to be organised if appropriate. This may well be relevant for an event, incident or accident with reasonable potential for significant public and media interest, and/or with potential consequences to matters regulated by the other agencies.
- That the inspector considers the need under HSWA s.20(2)(e) and TEA (Part 3, Schedule 8 Paragraph 14) to issue a formal notice to leave an item or area undisturbed for so long as is reasonably necessary for the purpose of investigating. Circumstances where this may be appropriate include matters that are potentially very serious or where the inspector is not certain that a duty holder will comply with an informal arrangement to leave an item or area undisturbed. When considering such action, the inspector will need to bear in mind whether the requirement to leave undisturbed could have a significant detrimental impact on operational safety/ security. Likewise, if an inspector is considering under HSWA s.20(2)(i) or TEA (Part 3, Schedule 8, Paragraph 12) whether to take into possession any article or substance (which appears to have caused or to be likely to cause danger to health or safety), they will need to bear in mind the guidance for Step 4.4 on collecting material.

APPENDIX 4 – INVESTIGATION DECISION RECORD - DELETED

The investigation decision record (Ref. 12 - ONR-DOC-TEMP-098) has been removed from this guidance and can now be found on HOW2 templates.

APPENDIX 5 – KEY DECISION LOGS (KDL)

A5.1 This Appendix provides some background information on the use of Key Decision Logs.

A5.2 The lead investigator should ensure that a Key Decision Log (KDL) is opened and maintained throughout the investigation. The KDL should be stored in ONR's electronic management system such that all revisions can be seen.

What is a key decision log?

A5.3 The KDL is a contemporaneous record of all key decisions that affect the course of an investigation, the reasons for those decisions and the outcome. Information recorded in the KDL provides a critical record and audit trail for the management of the investigation and demonstrates the accountability and integrity of the investigation process.

A5.4 A KDL is not a diary of the actions taken, nor is it meant to substitute for an investigation notebook, which should be maintained separately. It is essential that only one KDL be maintained per investigation to ensure a coordinated investigation strategy and overall management control.

Guidance for Use of Key Decision Logs

A5.5 The purpose of this log is to record the key decisions made during the investigation and the reasoning behind those decisions. A single log is to be used for one investigation. At the end of the investigation the log is to be retained with the investigation papers. This log is disclosable in any legal proceedings.

A5.6 Only one decision should be recorded per page. The Inspector in charge of the investigation (**lead investigator**) should record, sign and date the decision. Where decisions are made by other investigators, the **lead investigator** must make the decision to endorse the recommendation and thereafter record it. If the lead investigator is absent (e.g. on leave) whoever has the lead in their absence should act in this capacity. The inspector making the recommended decision should also countersign the entry.

A5.7 There are **mandatory** parts of the KDL which should be completed at the start of the investigation, e.g. key investigation role holders, investigation team etc.

What to record

A5.8 The KDL is not intended to capture every decision made during an investigation. Key decisions are those decisions taken in the management of an investigation that materially affect the course of the investigation. Key decisions are likely to be made on the following issues (this list is not exhaustive):

- Initial information received by ONR.
- Initial response.
- Resource allocation/withdrawal.
- Liaison with site management/control.
- Instructions given to duty holder.
- If fatality, primacy under Work Related Death Protocol.
- If fatality, liaison with emergency services or other Enforcing Authority on site.
- Initial investigation strategy
- Prioritisation of actions and identification of initial lines of inquiry.
- Main lines of inquiry and their priority.
- Involvement of Specialist(s) and/or Independent Expert(s).

- Health and safety implications e.g. prevention of further harm, immediate danger.
- Preservation of evidence.
- Witness evidence, witness identification, vulnerable witnesses, interview strategy.
- Media strategy.
- Other Actions: Interpreters and translators.
- Suspect identification, unsolicited comments, interview strategy.
- The obtaining of investigation material.
- Contact with bereaved family.
- Issue of Notices.
- Discontinued lines of inquiry.

A5.9 It is important to hold review meetings, for example end of day team meetings, to ensure that all key decisions with attendant reasons are accurately recorded. The log belongs to the investigation and needs to be available to the investigation team, but care should be taken regarding access where sensitive issues are dealt with. It is equally important to record the decisions and reasons for not doing something as it is for doing something, as well as recording any changes or retractions of previous decisions.

Rationale for KDLs

A5.10 KDLs will help investigators to demonstrate that all reasonable lines of inquiry have been followed and will provide transparent justification for not following or for discontinuing lines of inquiry.

A5.11 Whilst an investigation is ongoing, the KDL will assist in the management of the investigation by helping to structure the thoughts of the **lead investigator** and will help in the monitoring and review of the investigation as described in Step 4.5 of the investigation process.

A5.12 The KDL should enhance communication with all those involved in the investigation, especially following staff changes, helping them to be clear about the direction and priorities of the investigation.

A5.13 Recording the rationale behind decisions at the time they were made can help explain why they were correct in the circumstances and on the basis of the information available at the time, and without the benefit of hindsight. This will assist in assuring third parties that a logical decision-making process was followed, and why decisions or the course of the investigation were changed in the light of developing information and events.

A5.14 Investigation decisions may be challenged several years after they were taken, for example, during legal proceedings. Such challenges can be difficult to defend without contemporaneous records of the underlying basis and rationale.

A5.15 KDLs also provide accountability and transparency in justifying decisions, including those about resourcing of relative priorities, and task allocation between investigators.