Office for Nuclear Regulation

ONR GUIDE			
Guidance for INF1 Governance and event Oversight			
Document Type:	ONR Guide		
Unique Document ID and Revision No:	ONR-OPEX-GD-004 Revision 0		
Date Issued:	November 2019	**Review Date:**	November 2022
Approved by:	C Tait	Regulatory Oversight Manager	
Record Reference:	CM9 Folder 4.4.2.19122. (2019/302768)		
Revision commentary:	First formal issue from interim guidance; clarification of preliminary enquiries and inspector follow-up, guidance on inclusion of specialisms		

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Published 10/19

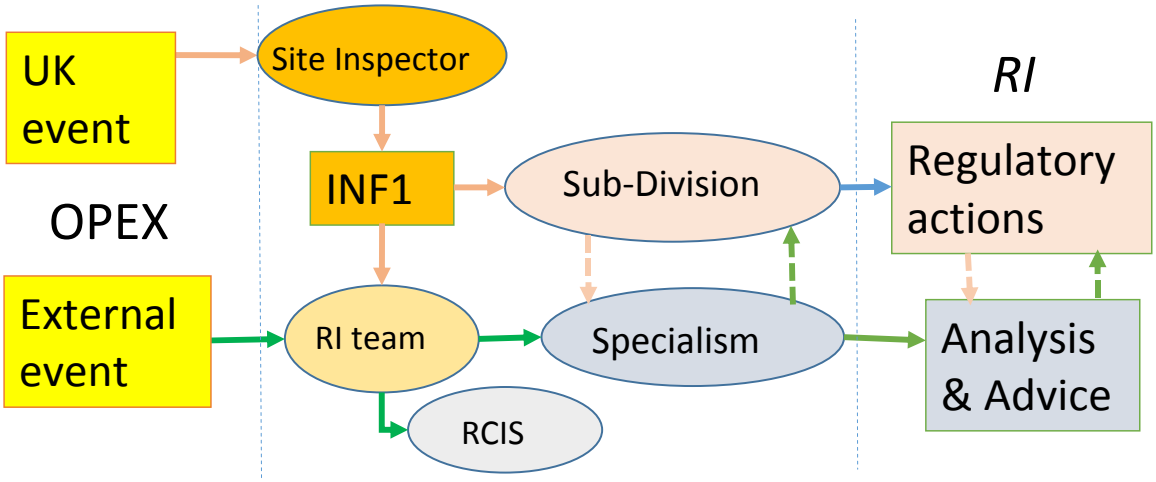
1. INTRODUCTION

1.1 In order to generate a clear narrative or line of sight from the receipt of an INF1 from a dutyholder, through to assessment of necessary ONR action, such as a requirement to conduct preliminary enquiries or other follow up by an Inspector and eventual operational experience and regulatory intelligence extraction, a system of governance categorisation has been developed (Annex A).

1.2 The level and detail of governance or oversight is outlined in this guide. Noting that individual sub division processes for event review can be adapted to meet the optimum arrangements for effectiveness and efficiency, the method of governance at Delivery Lead level is flexible and may be integrated into the overarching routine sub division governance processes.

1.3 Another important aspect of INF1 form processing in ONR is the review and follow-up by the specialisms, for which the reported event is subject of interest. Section 4 of this guidance provides an overview of the relevant process and produced documents.

1.4 The diagram below outlines the ONR units involved in the INF1 form processing and the main outputs:



1.5 The fundamental output from the governance process at Delivery Lead level is to ensure that events are followed up proportionally, and that records of discussion and actions taken are maintained and available for those events categorised as requiring governance at this level (e.g. Categories 2-3). Additionally the Delivery Lead governance process should provide an input into the sub divisional monthly or quarterly review of events.

2. PURPOSE AND SCOPE

2.1 This guidance applies to INF1s received after 30 November 2019 via the current INF1 instructions (Ref. 1). Conventional Health and Safety events are not reported via this system but are subject to preliminary enquiries and assessment against ONR's investigation criteria as described in (Ref. 2).

2.2 The governance aspects of this guidance form the basis of INF1 oversight that should be applied proportionately during routine governance. When followed they will assist the preparation of annual intelligence reviews.

2.1 The frequency, format and formality of the Delivery Lead governance should be sufficient to confirm correct categorisation, facilitate routine discussion of events, to

identify emergent trends and requirements for intervention as part of routine inspection activity. It may be appropriate for stages of INF1 governance to be delegated to a Delivery Management Group Lead, or Nominated Inspector for a multi-facility site.

3. ASSIGNING AN EVENT CATEGORY TO AN INF1

3.1 On receipt of an INF1 report from the relevant DDS the selected Site Inspector should review the event, and determine/assign an initial event category from the guidance in Annex A and record it in the INF1 Part B. Instructions for completing the Part B are described in (Ref. 1).

3.2 As a general guide, events that are characterised as meeting ONR's Investigation, Criteria (Ref. 2) should be categorised as 2b. Events where there is currently insufficient information to make an informed decision against the investigation criteria and the inspector judges that preliminary enquiries are to be conducted should be categorised 2a. In the event of a decision to conduct a formal investigation being made, the category will be revised upwards to 2b.

3.3 Category 3 should be assigned to events which do not meet the investigation criteria, but the inspector judges require follow-up during routine site inspection interactions and intervention(s), for example to gain assurance in the dutyholder's actions or the adequacy of its LC7 arrangements. Inspectors will need to consider how to include these activities within site intervention plans and how any outputs will be recorded (normally in an intervention record or contact record).

3.4 Category 1 events are expected to be infrequent and immediate response will be self-evident.

3.5 Inspectors should use Category 4, when the investigation criteria are not met and no follow-up is required; this category will be used to support trending of events.

4. ASSIGNMENT OF SPECIALISMS

4.1 The purpose of assigning ONR specialisms to INF1s is to identify which specialisms may wish to consider the event for quarterly trending and analysis. It is permissible for more than one specialism to be identified. A list of ONR's specialisms is provided in Annex B, along with their areas of interest. If the specialism identifies potential areas of concern not covered by the Site Inspector, then the specialism should provide necessary advice to enable the inspector to review the categorisation.

4.2 The Site Inspector should record the assigned specialism(s) in the INF1 Part B.

5. DELIVERY LEAD/INSPECTOR INF1 GOVERNANCE AND ITS RELATIONSHIP TO SUB DIVISIONAL MONTHLY GOVERNANCE REVIEWS

5.1 It is established ONR practice that monthly governance meetings are held to discuss a range of relevant "governance inputs." INF1s should be a component of the standing agenda for these meetings. It is recognised that different divisions have different governance structures; Delivery Leads should utilise the guidance to best fit the methodology into their own structures.

5.2 In the context of INF1s, "governance" is simply a review of all INF1 events and their subsequent follow up to assess relevant aspects detailed below:

- correct category assignment
- progress
- follow up relevance and proportionality

- if further follow up is required
- quality of relevant inputs/outputs
- potential for issue raising
- potential for OPEX output/learning note
- review and impact of ONR actions
- identification of events for escalation for consideration at sub division reviews.

5.3 The selection of events for review will be at Delivery Lead/Sub Divisional Review Chair's discretion and will form a component of sub division monthly meetings.

6. SUB DIVISION ROUTINE INF1 GOVERNANCE REVIEWS

6.1 Many sub divisions operate a monthly governance process for review and discussion of INF1s. It is appropriate for relevant governance aspects detailed in Section 5 to be reviewed at these meetings with input from inspectors and delivery leads, either on the basis of a prepared inspector/nominated lead input or as part of the managed agenda.

6.2 It is important that the agenda for these meetings includes sufficient time for discussion of those governance aspects that warrant noting for the record and for follow on monthly oversight, and for subsequent integration into quarterly governance and intelligence reviews.

7. DIVISIONAL BOARD AND REGULATORY LEADERSHIP TEAM ROUTINE INF1 GOVERNANCE REVIEWS

7.1 Divisional Boards and Regulatory Leadership Team Meeting agendas should facilitate governance of those incidents categorised as 2b and 1 respectively.

7.2 In summary, depending on the complexity of the sub division, a proportionate INF1 governance process is required - based on event category that ensures a review of each INF1 selected for follow up (Categories 2-3) with trending review of Category 4 events on a monthly basis.

8. REFERENCES

Relevant ONR Guidance www.onr.org.uk:

Ref. 1 Incidents Notification and Reporting Process, ONR-OPEX-IN-001, Revision 5

Ref. 2 Process for Conducting Investigations, ONR-ENF-GD-005, Revision 3

Ref. 3 Enforcement Guide, ONR-ENF-GD-006, Revision 1

Ref. 4 ONR Guidance: Notifying and Reporting Incidents and Events to ONR, ONR-OPEX-GD-001, Revision 5

9. ANNEX A – INF 1 GOVERNANCE CATEGORY GUIDANCE

Category	Incident Significance	Action Summary	Governance Oversight Level
1	Significant Incident which meets ONR Investigation Criteria (e.g. Typically events INES 3 and above, major national interest)	Investigation Decision justified in Investigation Decision Record. (For an investigation ONR report led by CNI DCI level appointee).	**ONR Level governance (RLT)**
2b	Meets ONR Investigation Criteria	Investigation Decision justified in Investigation Decision Record.	**Divisional level governance**
2a	Potential to meet ONR investigation criteria (Consult Tables 2-4 of ONR-ENF-GD-005 Ref 2). Preliminary enquires required.	Decision on whether remains at 2a or moves to 2b made after conducting Preliminary Enquiries Any – change recorded on INF1 database	**Sub-Divisional Level governance**
3	Minor shortfall that does not meet the ONR investigation criteria. However, selected by site inspector for follow-up during routine interventions (e.g assurance, LC7 compliance). Typical INES 0/NR	Site Inspector tracking via routine site interventions.	**Site Inspector follow up**
4	Minor shortfall that does not meet the ONR investigation criteria. Of interest as a low level event to trend Typical INES 0/NR	Noted. No further formal action by Site Inspector, however considered for trending as part of sub division and specialism quarterly review and annual intelligence reports	**No further action by Inspector. Considered via Regulatory Intelligence Trend review**

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10. ANNEX B – ONR SPECIALISMS AND AREAS OF INTEREST

Specialism	Areas of Interest
Mechanical Engineering	NS03, NS08, NS09, NS12, NS14 Events in Safety Systems, Structures and components (SSC) e.g. Ventilation, Containment which have mechanical engineering causation or consequences, Maintenance related events EMIT, Pressure Systems, Nuclear Lifts, Cranes, Obsolescence/Reliability, Emergency Power Generation
Structural Integrity	Events related to structural integrity of metal structures (pressure vessels, storage tanks, pipes, valves) which are SSCs, defects in welds, brittleness, control of metallurgical properties Graphite where structural in reactor core
Civil Engineering & External Hazards	NS08, EIMT of SSCs, Containment, PCPV, Silos, Ponds, Docks, shiplift, foundations Prestressing, Concrete, Structures, Soil, Rock, tunnels, buried items, stores, weather envelope, Flooding, Seismic, Extreme Weather Events, Aircraft, Missiles, Flora/fauna intake fouling, Tidal/storm surges, dam failure, watercourse containment failure, lightning, ice
Electrical, Control and Instrumentation	Electrical, Control and Instrumentation; Loss of fault detection and mitigation, Interlocks. Float Valves, Sensor/Actuator failures, Failure on Proof Test, Safety Mechanism Failure, Unrevealed fault dependency, failure to fail safe, Obsolescence/Reliability, Electro Magnetic Interference Loss of Electrical Supply and other essential supplies (gas,H20,steam,compressed air) Criticality Incident Detection Systems, Radioactivity in Air Monitors. Instrumentation software control systems
Chemistry and Chemical Engineering	Reactor chemistry primary coolant, Chemical processing/control /reactivity control coolant chemistry
Nuclear Liabilities Regulation	RS 03, 04 events in Decommissioning and Waste Management Facilities. Defects in Waste Storage Facility leading to deterioration in storage conditions. Inappropriate waste characterisation/sentencing/accumulation, leakage from waste packages, events in waste treatment plants, waste records quality, waste transport events, non-compliant waste consignments. HAW/LLW labelling errors radioactive waste imported or transported inadvertently
Radiological Protection and Criticality	Non-compliance with IRR, loss of containment, release of RA, unexpected personal dose exposures, personal contamination (clothing and skin), potential intakes of radioactive materials (where whole body or bio-assay sampling has been requested). NS02, NS05, and NS16, criticality operational rule non-compliance, emergency response capability loss, radiation interlocks, area designation, contamination migration, unplanned exposure, degradation of shielding or shielding systems and devices. Any reporting made under the RS Radiological Safety Incident criteria, or any event where the levels are below those that would trigger the reporting under the RS incident criteria.
Fault Studies	Loss of protective measures /lines of defence leading to automatic actuation of safety systems (including for a reactor, manual reactor trip). PSA/DBA anomalies in safety case i.e. Events that challenge fault screening or frequency assumptions and require safety case revisit such as HAZOP failings and unexpected fault sequence/initiating event.

Specialism	Areas of Interest
Fuel and Core	Events relating to fuel loading/removal, dry storage, reactor reactivity, and poor configuration control of plant systems during maintenance, non-compliance with limits and conditions (tech specs, operating rules, etc.)
Operational Inspection	Inspection Process Anomalies, Site Arrangements where event is serious enough to expect most licensees to be aware of the event. E.g. Heysham 1 Auxiliary Steam Leak Event Injuring 5 Persons; Sellafield discovery of unstable chemicals or where ONR has something to learn about its inspection practices. E.g. New themes for consideration – Licensee cold weather preparations
Transport	All TS coded events, events involving the loading/unloading/packing/maintenance of packages (not just TS04 and TS05) and events involving transport packages on site whether or not being used for transport at the time.
Nuclear Internal Hazards and Site Safety	Internal Hazards - flooding, fire, collapse, dropped loads, vehicle impacts, explosions, missiles, Fire Service Callout, Local Process Fires, Oil smouldering, ignition events, fire loading excess Site health and safety – All RIDDOR events where hazards/risks to workers/contractors/public were not related exclusively to nuclear safety (e.g. under COMAH, LOLER, COSHH, CAR, CDM, PUWER, WAH etc)
Human and Organisational Capability	Procedural Non Compliance, Procedural design inadequacy, complexity, lack of clarity, Human Error, Distraction, Malicious Act, Ergonomics Lack of Supervision Duly Authorised Person, SQEP, Poorly conceived organisational change, Nuclear baseline anomaly, Insufficient competent resource, Lack of training, inadequate training records, Events with LM contributory causations. Governance/Peer Review failure Intelligent Customer failure (new build focus), Supply Chain incidents including counterfeit, fraudulent, suspect items (CFSI), falsification of product certification including malpractice of records , Intelligent Customer Failings, Quality incidents - Procedural Non-compliance, Incorrect Component specification on supply, Component failed due to incorrect application/specification, Event relating to inadequate implementation of quality specification/installation parameters, Quality Non-conformance with stated safety consequences Document and Records – Inadequate arrangements, or inadequate implementation of arrangements for the provision of safety related documents and records including Lifetime Quality records (LTQRs)
Safeguards	RS RA accountancy event, Loss of RA material
Security	All SC, SG02, SG03 & SG04categorised events, incidents involving counterfeit, fraudulent or suspect items, any act of falsification (e.g. of records, certifications), events requiring evacuation of controlled areas, human error affecting safety or security of nuclear or radioactive material.