ONR GUIDE			
Conducting Investigations			
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1. INTRODUCTION

1.1 There are a number of ways that ONR can be made aware of a matter that may warrant formal investigation. These include: notification of incidents and events, via ONR's inspection and assessment activities, and concerns/ whistleblowing received about a duty holder. It is an expectation in ONR's Enforcement Policy Statement (EPS) (Ref. 1) that enquiries are made into the circumstances surrounding such matters before taking any enforcement action.

1.2 In its broadest sense, the ONR investigation process commences from when ONR becomes aware of a matter that may warrant formal investigation through to when ONR either records an informed decision that the matter will not be investigated further, or completes the formal investigation. This Guide distinguishes between any initial 'follow-up enquiries' made to obtain sufficient information in order to make a decision as to whether a matter warrants formal investigation or not, and the 'formal investigation' itself.

1.3 In line with the EPS formal investigations are undertaken in order to determine:

- The direct and root causes.
- Whether action has been taken or needs to be taken to prevent a recurrence and to secure compliance with the law.
- Lessons to be learnt and to influence the law and guidance.
- What response is proportionate to a breach of the law.

1.4 Two key pieces of administrative law underpin the investigation process in England and Wales, namely the Criminal Procedure and Investigations Act 1996 (CPIA) (Ref. 2) and the Police and Criminal Evidence Act 1984 (PACE) (Ref. 3), and in Scotland the Criminal Justice and Licensing (Scotland) Act 2010 (Ref. 4) is relevant (see Appendix 1 for further information). It should be noted that all parts of investigatory work, including follow-up enquiries must be conducted with due regard to PACE and CPIA and the equivalent for Scotland. Good practice throughout the investigation process is vital both in the interests of justice and to reduce the likelihood that the outcome of the investigation (including any legal proceedings) can be successfully challenged.

2. PURPOSE AND SCOPE

2.1 The purpose of this document is to guide ONR inspectors through the steps necessary to undertake and record follow-up enquiries and formal investigations and should be read in conjunction with the ONR HOW2 Investigation Process Map. The steps are:

- Step 1 Receive Notification and Act Upon.
- Step 2 Conduct Enquiries and Decide Whether To Investigate.
- Step 3 Plan and Resource Investigation.
- Step 4 Conduct Investigation.

2.2 The sections below provide guidance on the execution of each step of the ONR Investigation Process. Whilst the process for conducting investigations is ONR specific, as appropriate this Guide refers out to the HSE Enforcement Guides (Refs 5&6).

2.3 The process for undertaking and reporting investigations is different for England and Wales, to that for Scotland. Where appropriate this Guide identifies the different approaches required. Advice should be sought from ONR Legal Liaison ahead of

undertaking investigations in Scotland.

3. GENERAL CONSIDERATIONS

3.1 Throughout the investigation process the following points should be borne in mind:

- Investigators must maintain, and be able to demonstrate an open mind e.g. by not making assumptions and only making conclusions when relevant material has been collected and evaluated. Furthermore, the investigation should pursue all reasonable lines of inquiry, whether these point towards or away from the suspect.
- Relevant people (both within and outside ONR) should be kept appropriately informed during the investigation process, without compromising the investigation and any potential subsequent prosecution. A need-to-know policy should be adopted.
- All records should be made on the basis that they are potentially disclosable (including Contact Records, Notebook records, Intervention Reports, and e-mails).
- In totality the investigation team should be suitably qualified and experienced for the investigation process steps they undertake.

3.2 The term Band 1 Delivery Lead has primarily been used in this Guide and should be taken as interchangeable with the term Superintending Inspector.

4. STEP 1 – RECEIVE NOTIFICATION & ACT UPON

4.1 There are a number of ways that ONR can be made aware of a matter that may require investigation. Exceptionally the nature or seriousness of the matter may be such that the decision can be made early on that a formal investigation is warranted. In such situations the Guide for Step 2.2 should be followed. However, in most instances the first decision to be made when the notification is received by the appropriate ONR Inspector is whether the matter warrants follow-up enquiries. This decision is intended to be a simplistic filter to identify those matters for which the relevant investigation criteria would clearly not be met and so it is not necessary to undertake a formal investigation. For concerns / whistleblowing regarding a duty holder due account needs to be taken of guidance published on ONR's website (Ref. 7). The potentially relevant investigation criteria are:

- Nuclear and radiological incident investigation selection criteria provided in Table 1, these also apply for civil nuclear and non-nuclear radiological transport matters (involving Class 7 radioactive material).
- Conventional health and safety criteria provided in Table 2.
- Civil Nuclear Security criteria provided in Table 3.

4.2 Table 4 identifies the different means by which ONR can become aware of a matter, the decisions to be made and the decision maker. An appropriate record should be made of all decisions.

4.3 Specific points to consider at this stage are:

- The notified Inspector should decide whether there is a need to engage with ONR Inspectors of different disciplines to ensure that an informed decision is made (e.g. conventional fire, health and safety, nuclear, radiological, security, safeguards, or transport).
- If the incident involves a fatality at work then the Work Related Deaths Protocol and associated guidance should be followed (Refs 8,9 &10). Work

related deaths are fatalities as a result of an incident arising out of or in connection with work activities and excludes suicides and deaths from natural causes. For all work related fatalities advice should be sought from the ONR Legal Liaison Service.

- For GB Nuclear Sites that are also COMAH Major Hazards sites the ONR Conventional Health and Safety Team will manage any requirements to investigate COMAH major accidents with support from the HSE.

5. STEP 2 - CONDUCT ENQUIRIES & DECIDE WHETHER TO INVESTIGATE

Step 2.1 Conduct Follow-Up Enquiries

5.1 Follow-up enquiries should be conducted to obtain sufficient information to support an informed decision as to whether the matter warrants formal investigation.

5.2 The follow-up enquiries may be made by undertaking a site visit, reactive inspection or other means of communication deemed appropriate. Specific points to consider at this stage are:

- In exceptional circumstances, the need for prompt enforcement action to make safe i.e. if observed an activity, process or plant item which could give rise to a Risk Of Serious Personal Injury (ROSPI), or is a Matter of Evident Concern (MEC), or Matter of Potential Major Concern (MPMC) (Ref. 11).
- When planning a visit to the site, consider the safety of ONR Inspectors (Ref. 11).
- During follow-up enquiries it is important not to compromise any future formal investigation. Aspects to bear in mind include:
  - Confidentiality to avoid compromising the integrity of a subsequent investigation.
  - Avoiding seeking information[1] from people that could potentially be suspected of having committed an offence under relevant legislation. Guidance is provided in the Enforcement Guide (England and Wales), (Ref. 5), and Enforcement Guide (Scotland), (Ref. 6).
  - That a record should be made in the Inspector's notebook of material gathered during the follow-up enquiries and decisions taken. Guidance on notebook discipline is contained in the ONR General Inspection Guide (Ref. 11).
  - That records relating to follow-up enquiries are potentially disclosable.
- The ONR Inspector will need to decide whether it is appropriate to engage with other agencies. This may well be relevant with any event, incident or accident with potential to cause significant public and media interest, and/or with potential consequences to matters regulated by the other agencies. There are a number of Memorandum of Understanding (MoU) (*available on HOW2*) with other agencies and supporting guidance that indicate when such engagement is likely to be required. This should be done at the earliest opportunity to ensure both 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.
- The Inspector should consider the need under the HASWA s.20(2)(e) and TEA (Part 3, 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

[1] Such information should be obtained via interviews under caution as part of the formal investigation process Step 4.4 refers.

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 will have a significant detrimental impact on operational safety/ security. Likewise, if an Inspector is considering under the HASWA s.20(2)(i) or TEA (Part 3, Schedule 8, Paragraph 12) whether to take into possession any article or substance, they will need to bear in mind the guidance for Step 4.4 on collecting material.

- The performance target for completing follow-up enquiries is five weeks.

Step 2.2 Decide Whether To Investigate

5.3 Once sufficient information is obtained from the follow-up enquiries a decision needs to be made as whether the matter warrants a formal investigation. The relevant investigation criteria (see Tables 1 to 3) should be applied by the ONR inspector leading the follow-up enquiries. If the selection criteria are satisfied a decision then needs to be made whether to formally investigate or not, taking due account of ONR's Enforcement Policy Statement (Ref. 1). In particular the following points from the Enforcement Policy Statement should be taken into account:

> *"32. To maintain a proportionate response, most resources available for investigation of incidents will be devoted to the more serious circumstances. ONR's Annual Plan recognises that it is neither possible nor necessary for the purposes of the relevant legislation to investigate all issues of non-compliance with the law which are uncovered in the course of inspections or in the investigation of reported events.*
>
> *33. ONR will carry out a site investigation of a reportable work-related death unless there are specific reasons for not doing so, in which case those reasons should be recorded.*
>
> *34. In selecting which concerns or reports of incidents, injury or breach of legislation to investigate and in deciding the level of resources to be used, ONR should take account of the following factors:*
>
> - *The severity and scale of potential or actual harm;*
> - *The seriousness of any potential breach of the law;*
> - *Knowledge of the duty holder's past health and safety or security performance;*
> - *The enforcement priorities;*
> - *The practicality of achieving results;*
> - *The wider relevance of the event, including serious public concern."*

5.4 Table 5 summarises who is involved in the decision process and the nature of the record to be made. The decision is to be recorded in an appropriate manner as identified in the table, following appropriate consultation, and approved by the relevant Band 1 Delivery Lead. For a RIDDOR reportable incident of ill-health or injury to a member of the public or a worker then regardless of whether or not the investigation criteria are satisfied, a record must be kept of the decision made.

5.5 If a decision is made to undertake a formal investigation the ONR Chief Nuclear Inspector's Office should be notified of the decision. On request, that office will provide a report number for the investigation and a unique reference should a Key Decision Log be used.

5.6 If an investigation is not warranted the investigation process should be discontinued. Any further regulatory activities regarding the matter should be undertaken as part of normal regulatory business or using the ONR enforcement process as appropriate.

5.7 For matters involving concerns/ whistle blowing, the ONR FOI team should be made aware of the decision made regarding the follow-up enquiries (Ref. 7).

6. STEP 3 - PLAN AND RESOURCE INVESTIGATION

Step 3.1 Resource Investigation (Lead Investigator and Band 1 Delivery Lead)

6.1 Resource planning is an important activity as experience demonstrates that performing an investigation can be resource intensive. Consideration should be given to whether, as a minimum the Lead Investigator role should be full-time for the duration of the investigation. The Band 1 Delivery Lead should plan for the reallocation of duties from those identified to undertake the investigation and for those persons subsequent reintegration into normal duties. Professional Leads should be consulted as appropriate with regard to securing resource.

6.2 The performance target for completing the formal investigation should be agreed during the planning phase. An initial indicative target to complete a formal investigation is three to four months from approval for the investigation to commence. However, it should be recognised that for complex/ multiple agency investigations the timescales may be significantly longer. Resources and performance targets are to be agreed with the relevant Band 1 Delivery Lead (normally the Delivery Lead who authorised that the formal investigation be undertaken) who should inform the relevant Programme Director of the planned resource commitments. As the investigation progresses the completion date target should be reviewed and any changes communicated to relevant ONR Managers.

6.3 Resource planning should consider whether specialist support is required to support the Lead Investigating Inspector. Consideration should be given to whether any ONR staff are likely to be called to provide expert witness testimony, as anybody who is used as an expert witness must remain excluded from the investigation in order to preserve their independence.

6.4 Programme Delivery Support staff needed to assist with the formal investigation should be identified along with the equipment and facilities for collecting, indexing and storing investigation material. Advice can be obtained from the ONR Conventional Health and Safety Team on the practical arrangements associated with these activities. An ONR template is available for record keeping of material collected and generated (Ref. 12).

6.5 The HSE Enforcement Guides identify the requirements for collecting, retaining and disposing of evidence (Refs 5 & 6). For digital material, specific guidance is provided in Association of Chief Police Officers ACPO Good Practice Guide for Digital Evidence (Ref. 13).

6.6 Consideration should be given as to what portable computer and printer equipment provisions will be required at the site to assist the investigations. In addition, it is recommended that a dedicated TRIM folder be created for the formal investigation.

6.7 Once a decision has been made to undertake a formal investigation the Lead Investigator should consider seeking specific advice from the ONR Legal Liaison Service regarding the planning and conducting of the investigation. This approach is particularly relevant for complex cases. Subsequently, advice and guidance on correct

application of the process can also be sought from the ONR Legal Liaison Service, as and when required during the investigation.

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

6.8 Establish the objectives of the formal investigation including:

- Identify the relevant dutyholder(s) and witnesses.
- Establish the key facts relating to the causes of the incident.
- Identify immediate and underlying causes.
- Identify any lessons learned.
- Ensure action to prevent a recurrence including any wider implications beyond the duty holder(s) concerned.
- Identify the applicable legislation and whether any legal threshold that may have been breached.
- Form a view about enforcement using the EMM framework (Refs 16&17).
- Any other objectives deemed appropriate.

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

6.9 The plan for the formal investigation should be developed by:

- Establishing the investigation techniques to be used.
- Collating and reviewing records and intelligence held on the duty holder.
- Identifying and obtaining standards, benchmarks and sources of relevant guidance.
- Determining reasonable lines of enquiry to use in Step 4.4.
- Identifying and securing people, equipment and other required resources (see Step 3.1 above).
- Considering how the views of injured parties / any bereaved family(ies) will be obtained.
- Considering personal health and safety requirements of investigating staff and making adequate provision as appropriate. Due account should be taken of the relevant guidance in the ONR General Inspection Guide (Ref. 11).

6.10 A decision will need to be made whether a Key Decision Log (KDL) (Ref. 14) should be opened, or if instead key decisions will be recorded in the Inspector's Notebook. A KDL should normally be used unless the nature of the investigation is such that it does not warrant it. Guidance on KDLs is provided in Appendix 2.

6.11 The Lead Inspector should consider the need to develop a communications plan and what factual information may need to be made available to the ONR Communications Team, without compromising the formal investigation.

Step 3.4 Plan The Investigation – Other Agencies (Lead Investigator)

6.12 If other agencies are involved they should be contacted and the investigation roles and objectives agreed with them where required. The guidance provided in paragraph 5.2 on engaging with other agencies should be followed. The relevant Band 1 Delivery Lead should be consulted and kept informed during development of the plan.

6.13 For investigations involving Work Related Deaths the guidance in paragraph 4.3 refers.

7. STEP 4 - CONDUCT INVESTIGATION

Step 4.1 Commence Investigation (Lead Investigator)

7.1 The formal investigation should be commenced in accordance with the Investigation Plan at the earliest opportunity, and include a visit to the scene of the incident if not already visited as part of the follow-up enquiries.

Step 4.2 Relevant Contacts (Lead Investigator)

7.2 As soon as practicable after beginning the formal investigation, identify and contact as appropriate:

- The injured person(s), if applicable.
- Bereaved families.
- The duty holder(s) to explain your role and the investigation objectives.
- Any employee/safety representatives.

7.3 The significant contacts should be recorded in an appropriate manner.

Step 4.3 Immediate Enforcement Action (Lead Investigator)

7.4 In dealing with matters of evident and potential major concern, ONR's guidance in ONR-INSP-GD-064 Revision 0 General Inspection Guide refers (Ref. 11). ONR Inspectors are to follow the ONR HOW2 Enforcement Process taking due account of the ONR Enforcement Policy Statement, (NS-ENF-GD-002) (Ref.1). The Use of the Enforcement Management Model in ONR (Ref.17), (NS-INSP-GD-051) The Regulation of Conventional Health & Safety on UK Nuclear Sites (Ref. 18), and (ONR-ENF-GD-004 Revision 0) Administrative Use of Warranted Powers (Ref. 19).

Step 4.4 Conduct Investigation (Lead Investigator)

7.5 The investigators should conduct the formal investigation and complete the ONR combined Investigation and Prosecution Report as the investigation progresses, using the template (Ref. 20). Guidance is provided within the template for interpretation for use in Scottish investigations. An additional template for sending papers to the relevant Procurator Fiscal is provided for Scottish investigations (Ref. 21).

7.6 When conducting the formal investigation the ONR Lead Investigator should consider in particular:

- Gathering information - ONR Inspectors should bear in mind guidance in the Enforcement Guides (Refs 5&6) regarding the order of collecting material.
- Analysing the information - ONR Inspectors should consider following the flow in Part B of the Investigation Report (i.e. Plant, equipment and substances/ Systems of work /Training, instruction and supervision / Risk assessment / Outcome and consequences).
- Developing findings - ONR Inspectors should consider following the flow in Part C of the Investigation Report Analysis of Compliance (Causation / Legal provisions / Application of law).
- The need to record significant actions and significant contacts made.

7.7 For further guidance on conducting the formal investigation see the HSE Enforcement Guide (England & Wales) (Ref. 5) and Scotland (Ref. 6). If the ONR template (Ref. 12) is used for recording material collected and appropriately recorded in TRIM it should be referenced from the Investigation Report (paragraph 6.4 refers).

7.8 The formal investigation should continue until the objectives are met unless:

- Information comes to light that the incident is not within ONR's area of responsibility.
- It becomes apparent that the incident does not meet the relevant investigation criteria (see Tables 1 to 3) and/or the related breach of legislation is unlikely to have been serious (i.e. where the outcome of applying the Enforcement Management Model, including applying the duty holder and strategic factors, does not result in a notice or prosecution) and there are no more lessons to be learned.
- Investigation is impractical e.g. where key witnesses or other evidence is unavailable.
- Other developing priorities prevent the formal investigation continuing.
- Disproportionate effort would be required to achieve the established objectives.

7.9 Should the decision be made not to continue the formal investigation then a Decision Record Form (Ref. 15) should be completed to record the rationale. Both the nature of the follow-up enquiries and the formal investigation to-date should be recorded. The ONR Chief Nuclear Inspector's Office should be notified of the decision.

Step 4.5 Regular Review (Investigation Lead and Band 1 Delivery Lead)

7.10 Bearing in mind its purpose, the progress of the formal investigation should be reviewed with the ONR Band 1 Delivery Lead at regular intervals to confirm that the formal investigation is on track to meet the objectives (see Step 3.2) and to decide whether the matter is to be investigated any further (See points in para 7.8). If the same ONR Band 1 Delivery Lead is to act as the Approval Officer at Step 4.6 then they must ensure that they remain sufficiently independent as identified in the guidance for that step.

7.11 The first review should typically be held a month, or sooner, after the decision to formally investigate has been made. Once the formal investigation has made reasonable progress consideration should be given to whether the relevant Programme Director should also participate in the review. For investigations that reach a duration of six months the Programme Director should be involved in a review. Without compromising the integrity of the ongoing investigation, the Lead Investigator should provide a summary of the outcome of that six monthly review to the ONR Chief Nuclear Inspector's Office.

7.12 If the review determines that the formal investigation is to continue, the following further review activities may be undertaken:

- Review the objectives for the formal investigation and revise and/or establish new objectives if necessary, e.g. for the purpose of collecting sufficient investigation material to inform a decision on enforcement action.
- Review whether all reasonable lines of enquiry have been made and identify any additional ones.
- Review whether any analytical investigation methods that have been used remain appropriate.
- Review key decisions recorded in the Key Decision Log, or in Inspectors notebooks.
- Set a date for the next review.

7.13 The Lead Investigator should record the outcome of the review including:

- The reason(s) for continuing the formal investigation.
- Any agreed revised objectives and further agreed lines of enquiry.
- The date of the next review.

Step 4.6 Enforcement Decision (Lead Investigator and Band 1 Delivery Lead)

7.14 When the formal investigation reaches the point where an enforcement decision is ready to be made the ONR HOW2 enforcement process is to be applied using the relevant Enforcement Management Model (Refs 16&17). Due account should be taken of the expectations in the Enforcement Policy Statement (Ref. 1) as to when ONR would normally prosecute (or recommend prosecution for investigations in Scotland). The Investigation Report should be completed to the level identified in Table 6 and the associated approval process followed. For cases that do not recommend prosecution the amount of information recorded should be proportionate to the amount of effort spent conducting the formal investigation, whilst taking due account of the need to retain information for future regulatory interactions. If used the Key Decision Log should be completed and retained.

7.15 Table 6 identifies that a Band 1 Delivery Lead is to act as the Approval Officer. Approval Officers must be fair and sufficiently independent of the investigation to review the case objectively. The Approval Officer should not therefore be closely involved in directing, or identified with, the formal investigation process. This is fundamental to ensure the fairness, efficiency and accountability of the prosecution process. If the chosen Band 1 Delivery Lead judges that their independence may have been compromised then they should discuss with the Programme Director whether a different Band 1 Delivery Lead should act as the Approval Officer.

In considering a case, the Approval Officer should ensure that:

- The law has been properly applied;
- All relevant evidence is available in an admissible form;
- The Inspector has identified any material that may undermine the prosecution case or assist the defence; and
- ONR has acted in compliance with the Human Rights Act 1998 (Ref. 22).

7.16 The Approval Officer, before they can approve a prosecution, must apply the Code for Crown Prosecutors (Ref. 23) Full Code Test, which consists of two stages:

- The Evidential Stage
- The Public Interest Stage

7.17 The Code also includes a third test, called the Threshold Test which will not apply to ONR.

Step 4.7 Communicate Outcome (Lead Investigator)

7.18 Where appropriate a communication plan will need to be developed with the ONR Communications Team (see discussion in paragraph 6.11 about use of a plan at an earlier stage). The appropriateness and timeliness of publishing the Investigation Report should be considered if a prosecution is not to be pursued.

7.19 The ONR Chief Nuclear Inspector's Office should be notified of the investigation decision. Interested parties should be identified by the Lead Investigator, and as appropriate are to be advised as to the outcome of the formal investigation, and the action required, and by whom, including:

- Any bereaved family.
- Any injured person.

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

7.20 If the incident was a Work Related Death inform the Coroner that the formal investigation has been concluded and agree disclosure of information for the purposes of the inquest.

7.21 ONR Inspectors should confirm that action has been taken regarding any new or previously unknown risks identified during the formal investigation that require communication within ONR or externally. The ONR Inspectors should engage, as appropriate, with ONR Operational Experience (Ref. 24). All significant contacts should be appropriately recorded. If use of the Enforcement Management Model during the formal investigation process results in the need for formal letters to duty holders this can be considered as part of the Follow-Up Action Step 4.8.

Step 4.8 Follow-Up Action

7.22 ONR Inspectors should undertake any follow-up action required. With regard to duty holders this should be in-line with the ONR Inspection Guide (Ref. 11) and the need for any Regulatory Issues (Ref. 25) should be considered. A decision should be made as to whether a Review Learn Improve should be undertaken.

8. REFERENCES

1. ONR Enforcement Policy Statement
2. Criminal Procedure and Investigations Act 1996 (CPIA)
3. Police and Criminal Evidence Act 1984 (PACE)
4. Criminal Justice and Licensing (Scotland) Act 2010
5. HSE Enforcement Guide (England and Wales)
   http://intranet/legal/enforcement-guide-ew/index.htm
6. HSE Enforcement Guide (Scotland)
   http://intranet/legal/enforcement-guide-sc/index.htm
7. ONR Guidance on Complaints, Concerns and Whistleblowing
   http://www.onr.org.uk/complaining-about-onr.htm
   NB. Guidance to inspectors is contained in Appendix 6 of Ref. 11
8. Work-related Deaths: A protocol for liaison (England and Wales)
   http://www.hse.gov.uk/pubns/wrdp1.pdf
9. Work-related Deaths Protocol: Practical guide (England and Wales)
   http://www.hse.gov.uk/pubns/wrdp2.pdf
10. Work-related Deaths: A protocol for liaison (Scotland)
    http://www.hse.gov.uk/scotland/workreldeaths.pdf
11. ONR-INSP-GD-064 Revision 0 General Inspection Guide
12. ONR-DOC-TEMP-101 ONR Schedule of Material
13. Association of Chief Police Officers ACPO Good Practice Guide for Digital Evidence
14. ONR-DOC-TEMP-099 ONR Key Decision Log
15. ONR-DOC-TEMP-098 ONR Decision Record Form
16. Civil Nuclear Security Enforcement Management Model
17. The use of the Enforcement Management Model in ONR
18. The Regulation of Conventional Health & Safety on UK Nuclear Sites
19. Administrative Use of Warranted Powers
20. ONR-DOC-TEMP-102 ONR Combined Investigation and Prosecution Report
21. ONR-DOC-TEMP-100 Additional Template for Scottish Investigations To Be Used For Procurator Fiscal Submissions
22. The Human Rights Act 1988

23. The Code for Crown Prosecutors

24. ONR Operational Experience

25. HOW2 Regulatory Issues Management Process

26. NS-TAST-GD-085 Revision 4 - (AST/005) PEER REVIEW FOR LEGAL AND TECHNICAL ASSURANCE

27. Attorney General's Guidelines on Disclosure

28. Criminal Justice and Licensing (Scotland) Act 2010 Code of Practice

9. TABLES

TABLE 1 : ONR NUCLEAR AND RADIOLOGICAL INCIDENT/EVENT INVESTIGATION SELECTION CRITERIA

The sections below set out the ONR selection criteria for matters that should be considered for potential investigation. Matters that satisfy Criterion 1 or which could potentially satisfy Criterion 2 or 3 should be subject to follow-up enquiries. Based on the findings of the follow-up enquiries the selection criteria to be used for making an informed judgement as to whether a formal investigation is warranted are Criteria 2 and 3.

Criterion 1 : All incidents or events that:

- Are rated at a Level 1 or above on the INES scale, whether deemed provisional or final; or
- 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 incident or event; where it is immediately evident or where follow-up enquiries of the circumstances surrounding the incident reveal that:

- There appears to be a significant challenge, or potentially significant challenge, to nuclear safety;
- It appears there was, or could have been a significant breach of nuclear site licence conditions or other relevant statutory provisions;
- There has been, or there was potential for, a release of radioactivity above, or that approached, the statutory reporting limits;
- There has been, or there was potential for a dose to an individual or group above, or that approached, the statutory dose limits;
- The licensee had acted knowingly in not taking conservative action;
- There have been a number of incidents that have the same apparent cause;
- For transport related incidents or events (involving Class 7 radioactive material): significant breach of any condition or restriction attached to any approval, derogation or other authorisation issued by the Competent Authority.

Criterion 3: Incidents that do not fall within the above criteria, but give rise to public concern, could be subject to investigation.

TABLE 2 : ONR CONVENTIONAL HEALTH AND SAFETY INCIDENT SELECTION CRITERIA

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 incidents 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).

1. Fatalities (Work-related deaths):

- All work-related accidents which result in the death of any person, including non-workers. "Accident" specifically excludes suicides* and deaths from natural causes.
- 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.

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:

- Serious multiple fractures (more than one bone), not including wrist or ankle);
- All amputations other than amputation of digit(s) above the first joint (e.g. fingertip);
- Permanent blinding in one or both eyes;
- Crush injuries leading to internal organ damage, e.g. ruptured spleen;
- 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;
- Any degree of scalping requiring hospital treatment;
- Loss of consciousness caused by head injury or asphyxia;
- 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.

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 Regulations 8 & 9, specifically:
   i. Carpal Tunnel Syndrome,
   ii. Cramp in the hand or forearm,
   iii. Occupational dermatitis,

TABLE 2 : ONR CONVENTIONAL HEALTH AND SAFETY INCIDENT SELECTION 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 a "serious health effect" 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.

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.

5. Major hazard precursor events:

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

- Incidents that result in or have the potential for significant releases of dangerous substances.
- Incidents that could be precursors to major incidents.
- Incidents 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.

TABLE 3 : ONR CIVIL NUCLEAR SECURITY INCIDENT SELECTION CRITERIA
The sections below set out the ONR selection criteria for security matters that should be considered for potential investigation. Matters that satisfy Criterion 1 or which could potentially satisfy criterion 2 or 3 are be subject to follow-up enquiries. Based on the findings of the follow-up enquiries, these selection criteria will assist the Band 1 CNS Inspector in making an informed judgement as to whether a formal investigation is warranted. **Criterion 1: All incidents or events that:** ■ Indicate a breach of NISR 2003 (as amended); or ■ Are assessed by the duty holder or ONR to have an initial estimate of significance of Major; or ■ Are deemed to meet the Ministerial Reporting Criteria. **Criterion 2: Any incident or events where it is immediately evident or where follow-up enquiries of the circumstances surrounding the incident reveal that:** ■ There has been a significant departure from approved security arrangements; or ■ There has been, or there was potential for, theft of NM/ORM or any sabotage to assets on the site; or ■ Where there have been a number of incidents that have the same apparent cause. **Criterion 3: Incidents that do not fall within the above criteria, but give rise to public concern, could be subject to investigation.**

TABLE 4: STEP 1 "RECEIVE NOTIFICATION AND ACT UPON" DECISIONS TO BE MADE AND DECISION MAKER	
Input (Means of Notification)	**Decisions to be made and Decision Maker**
Line 1 INF1 or telephone notification of incident	An appropriate Inspector, typically when completing Part B of the INF1, is to decide whether follow-up enquiries are warranted. Such follow-up enquiries may lead to a decision to: (a) formally investigate the matter (see next step of process), or (b) for the matter just to be followed up by the ongoing INF1 process and routine regulatory business.
Line 2 Incident Notification to CNS	An appropriate Inspector and a Band 1 CNS Inspector will undertake an initial screening to decide whether follow-up enquiries are warranted. Such follow-up enquiries may lead to a decision to: (a) formally investigate the matter (see next step of process), or (b) for the matter just to be followed up by the ongoing INF1 process and routine regulatory business.
Line 3 Receive transport related incident for non-licensee	Whilst non-licensees are encouraged to use INF1 via the ONR web-site they can notify ONR in other ways. An appropriate Inspector is to decide whether follow-up enquiries are warranted when notified of the event.
Line 4 Event Report Under RIDDOR	The ONR Conventional Health and Safety Superintending Inspector (or their delegated representative) will designate an appropriate Conventional Safety Inspector to decide whether follow-up enquiries are warranted when notified of the event.
Line 5 Duty Holder has a significant event resulting in RCIS set up	A relevant ONR Inspector for the duty holder is to decide whether follow-up enquiries are warranted when notified of the event.
Line 6 Concern/Whistle Blowing received regarding a duty holder	An appropriate ONR Inspector is to decide whether follow-up enquiries are warranted when notified of the event. If the concern/whistle blowing notification has not come via the ONR Enquiries email route the ONR FOI team are to be made aware of the notification. For all concern/whistle blowing matters the FOI team are to be informed of whether follow-up enquiries are warranted.
Line 7 Matter identified during inspection and/ or assessment activities that warrants follow-up enquiries	An appropriate ONR Inspector makes the decision that follow-up enquiries are warranted.
Line 8 Matter reported to ONR by another regulator	An appropriate ONR Inspector is to decide whether follow-up enquiries are warranted when notified of the matter.

TABLE 5 : STEP 2 "CONDUCT ENQUIRIES AND DECIDE WHETHER TO INVESTIGATE" DECISIONS TO BE MADE, DECISION MAKER, AND RECORD TO BE MADE		
Input	**Decisions to be made and Decision Maker**	**Record To Be Made[2],[3]**
Follow-up enquiries conclude that selection criteria are not satisfied and hence a formal investigation is not to be undertaken.	Decision made by Lead Inspector undertaking follow-up enquiries.	Record made consistent with those expected for the nature of the follow-up enquiries e.g. Contact Record or Intervention Record.
Follow-up enquiries conclude that selection criteria are satisfied and when due account is taken of the Enforcement Policy Statement either a formal investigation is proposed or is not.	Decision is made by the relevant Band 1 Delivery Lead, based on a recommendation by the Lead Inspector undertaking follow-up enquiries.	The decision should be recorded in an ONR Decision Record Form (DRF) (Ref. 15) including: (a) the nature of the follow-up enquiries, (b) how the criteria were satisfied, and (c) the rationale for the decision made.

[2] For an INF1 the record should be cited when completing Part C of the INF 1 database (ONR-OPEX-IN-001 refers).
[3] The exception being decisions relating to conventional health and safety matters which are to be recorded in COIN.

TABLE 6 : CONCLUDE INVESTIGATION RECORDS AND DECISION MAKERS	
Decision Made and Records Produced	**Decision makers/ checks / reviews**
The Lead Investigator recommends that there is a case for prosecution - complete Parts A, B & all of C of the investigation report and EMM1.	The Lead Investigator signs-off the report, the report is subject to a peer review (Ref. 26). The relevant Band 1 Delivery Lead countersigns the investigation report, and for England and Wales acts as the Approval Officer. The Approval Officer needs to consider the aspects identified in the guidance for Step 4.6 and complete Part D of the investigation report. The relevant Programme Director countersigns the decision if content to endorse it.
The Lead Investigator does not recommend that there is a case for prosecution - complete Parts A, B & C10 and C11 & EMM1.	The Lead Investigator signs-off the report, the report is subject to a peer review (Ref. 26). The relevant Band 1 Delivery Lead countersigns the investigation report to confirm they approve the recommendation made. The relevant Programme Director countersigns the decision if content to endorse it.

APPENDIX 1 : BACKGROUND ON LEGAL FRAMEWORK FOR INVESTIGATIONS

A1.1 This Appendix provides an overview of the legal framework for conducting ONR investigations.

A1.2 In making adequate arrangements to carry out our duties as a enforcing authority to investigate two key pieces of Administrative law underpin this process, in England and Wales, namely the Criminal Procedure and Investigations Act 1996 (CPIA) (Ref. 2) and the Police and Criminal Evidence Act 1984 (PACE) (Ref. 3). In Scotland the Criminal Justice and Licensing (Scotland) Act 2010 (Ref. 4) applies. ONR has taken due regard to these Acts and their associated codes of practice, in drawing up the investigation process and Guide.

A1.3 The HSE Enforcement Guides (Refs 5&6) provide detailed legal guidance and should be appropriately followed for ONR investigations.

A1.4 PACE provides a framework for the legal exercising of powers, identification and dealing with suspects including taking of statements. Working with due regard to PACE 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.

A1.5 The Criminal Procedure and Investigations Act (CPIA) 1996 (Section 23(1)) Code of Practice applies only to police officers. However, other investigators (including ONR Inspectors) are required to “have regard” to any relevant provisions of it. The 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*’.

A1.6 Some points from the CPIA Code are summarised below. The list is not exhaustive, consequently ONR Investigators should read the Code to be familiar with relevant provisions:

- 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 in the course of 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;
- 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.

A1.7 Whilst the legal disclosure process does not take place until after the formal investigation process is complete, requirements associated with disclosure do have a bearing on how investigation material is collected and recorded. The Criminal Procedure and Investigations Act (CPIA) 1996 (Section 23(1)) Code of Practice (Ref. 2) includes a definition for the role of a Disclosure Officer. Their role is to examine material retained during the investigation and to decide what material is to be disclosed subsequent to the investigation being completed. Consequently, investigators 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 by the Attorney General (Ref. 27). 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. Usually the Lead Investigator will act as the Disclosure Officer during the formal investigation process.

A1.8 For Scotland a Code of Practice (Ref. 28) has been issued under Part VI of the Criminal Justice and Licensing (Scotland) Act 2010 (“the Act”) and provides guidance in relation to the disclosure of evidence in criminal proceedings. Under section 164 of the 2010 Act, police forces, prosecutors and other investigating agencies, as prescribed by regulations, must have regard to the code in carrying out their functions in relation to the investigation.

APPENDIX 2: KEY DECISION LOGS

A2.1 This Appendix provides some background information on the use of Key Decision Logs (KDLs), a template is provided in Ref. 14.

What is a key decision log?

A2.2 A Key Decision Log (KDL) is a contemporaneous record of the key decisions that affect the course of a formal investigation and the reasons for those decisions. 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 formal investigation to ensure a coordinated investigation strategy and overall management control.

What to record

A2.3 The KDL is not intended to capture every decision made during an investigation. Key decisions are the decisions taken in the management of a formal investigation that materially affect the course of the formal investigation. Routine formal investigation decisions are decisions that merely reflect the implementation of the investigation process, for example, should not be recorded. Key decisions are likely to be made on the following issues (this list is not exhaustive):

- Liaison with emergency services or other enforcing authority on site.
- Liaison with site management/control.
- Primacy under work-related death protocol.
- Involvement of specialist(s) and/or independent expert(s).
- Media strategy.
- Instructions given to the duty holder.
- Health and safety implications e.g. immediate danger, prevention of further harm.
- Preservation of evidence.
- Resource allocation/withdrawal.
- Witness evidence, witness identification, vulnerable witnesses, interview strategy.
- Interpreters and translators.
- Suspect identification, unsolicited comments, interview strategy.
- The obtaining of investigation material.
- Prioritisation of actions.
- Contact with bereaved family.
- Issue of notices.

A2.4 Where decisions are made by others involved in the formal investigation, the Lead Inspector should still enter and sign the Key Decision Log. The person making the decision should also sign the entry.

A2.5 For large formal investigations 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 is available to the investigation team but care should be taken regarding access where sensitive issues are dealt with. It is equally important to record decisions and reasons for not doing something as for doing something and to record any changes or retractions of previous decisions.

Background

A2.6 KDLs will help investigators to demonstrate that all reasonable lines of enquiry have been followed, and will provide justification for not following or for discontinuing lines of enquiry.

A2.7 Whilst a formal investigation is ongoing, the KDL will assist in the management of the investigation by helping to structure the thoughts of the investigator and Band 1 Delivery Leads, and will help in the monitoring and review of the formal investigation as described in Step 4.5 of the investigation process.

A2.8 The KDL should enhance communication with all those involved in the formal investigation, especially following staff changes, helping them to be clear about the direction and priorities of the investigation.

A2.9 Recording the rationale behind decisions at the time they were made can explain why they were correct in the circumstances and on the basis of the information existing at the time, and without the benefit of hindsight. This will be helpful in explaining to third parties that a logical decision making process was followed, and why decisions were changed or the course of the formal investigation was changed in the light of developing information and events.

A2.10 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 reasons behind the decisions.

A2.11 KDLs also provide accountability and transparency in justifying decisions, including those about resourcing of relative priorities, and task allocation between investigators.