Office for Nuclear Regulation

ONR Contact Record

# AWE Aldex 23 Level 2 Exercise

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Date Issued: 25 May 2023

Completed by:

[redacted]

# Contact Information

**Type of Contact:** MS Teams meeting

**Table 1: Contact with**

| Name | Role/ Position Title | Organisation |
|---|---|---|
| [redacted] | Service Manager – Joint Emergency Planning Unit | West Berkshire Council |
| | Senior Emergency Planning Officer | West Berkshire Council |
| | | |

**Table 2: ONR staff**

| Name | Role/ Position Title | Directorate/ Division/ Programme |
|---|---|---|
| [redacted] | Principal Inspector | TD EP&R |
| | Superintending Inspector | TD EP&R |
| | Superintending Inspector | TD EP&R |
| | Principal Inspector | TD EP&R |

# Summary/Key Points

**Introduction**

This is ONR's Contact Record covering regulatory assessment of the Aldex 23 exercise held on 24th May 2023. Aldex 23 was a test of the REPPIR off-site emergency plan (2023/27751) for the AWE licenced nuclear sites at Aldermaston and Burghfield. West Berkshire Council are responsible for the preparation, testing and review of the plan in accordance with Regulations 11 and 12 of REPPIR'19'.

The focus of the exercise was on response to a hypothetical off-site release of radioactive material from the Burghfield site. The scenario was consistent with the bounding event identified for the purposes of detailed emergency planning in AWE's REPPIR Consequences Report.

**Scope of Exercise**

This was a test of most, but not all, aspects of the off-site plan, including:

- Tactical Co-ordination Group (TCG)
- Strategic Coordination Group (SCG)
- Scientific and Technical Advice Cell (STAC)
- Media Advisory Cell (MAC)
- Recovery Coordination Group (RCG)
- Evacuation and Shelter Group - covering the planning (but not physical setup) of a Radiation Monitoring Unit (RMU)

**Focus for ONR Assessment**

ONR's assessment focused on the cells and groups operating at the Strategic Coordination Centre (SCC) at Shaw House, Newbury. This covered all parts of the response, with the exception of the TCG which was operating at a remote location and was not assessed. Key focus areas for the assessment team were:

- Use of and reference to the emergency plan
- Overall adequacy of equipment and facilities at the SCC, use of IT/aids
- STAC organisation, management, competency and contributions
- SCG leadership, focus, clarity on common operating picture, contributions from SCG participants
- Protective actions and information to the public
- Function of the Evacuation & Shelter Group ('RMU Cell') in delivering a credible strategy for operation of an RMU
- Interfaces between SCG and cells and also between cells

**Summary of ONR Assessment (as provided in hot feedback)**

The 'hot feedback' provided by ONR at the end of the exercise reflected a consolidation of the key points observed during the exercise and presented the consensus views of the assessment team – see Annex 1. The participating organisations also provided summary feedback and will be invited to submit this

using the council's formal feedback process. The council will be holding a 'cold debrief' on 8th June to identify key learning.

I thanked the emergency planning team and all those involved for their efforts in planning and facilitating the exercise. The participation of the responding organisations and the professionalism of the players was recognised.

I stated that the ONR assessment team considered Aldex 23 to be a robust test of the off-site emergency plan, meeting the requirements of REPPIR Regulation 12(1) for a test of the plan to be carried out. The exercise did challenge aspects of the plan and, in accordance with one of the key objectives of REPPIR, it has identified valuable learning for improvement of the plan.

In accordance with standard practice, I provided three examples of positive performance and three learning points.

Positive performance:

- There was good representation and participation of players. The test was realistic and covered wide span of activities.
- The SCG was well chaired (by the police gold commander), who had a good grip of the situation and provided clear direction.
- There was good coordination between the different local authorities (noting that the detailed emergency planning zone crosses multiple local authorities).

Learning points:

- Situational awareness of the radiological risk could have been better, leading to lack of clarity on evolving protective actions (in particular on the need for a RMU and the provision of reassurance monitoring to those exposed).
- The STAC would have benefited from more focus, clearer priorities and tasking.
- Communications between STAC and other groups cells (e.g. Recovery, Media, Evacuation and Shelter) could be improved.

I stated that this hot feedback would be supplemented by further feedback to be submitted as part of the council's feedback process – this can be found in Annex 2.

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## Annex 1 – Consolidated Assessor Comments

### General Conduct of the Exercise

The exercise was attended by 175 people, comprising players, exercise directors, assessors and observers. Cells were well attended and generally in accordance with the plan. The need to decouple the exercise from Level 1 (on-site) play did introduce a degree of artificiality. ONR assessors noted that there appeared to be fewer injects than would normally be expected (possibly due to them being intercepted by the TCG), but this did not detract from the level of challenge faced by the responders. Overall I considered the exercise to be well organised and run and delivered a suitable test of the arrangement in accordance with the requirement of Regulation 12(1) of REPPIR.

### Strategic Coordination Centre General Arrangements

This was the first time that Shaw House had been used for the Aldex exercise (other locations named in the plan were unavailable). Generally the facilities provided adequate space for meetings, although break-out space for organisations to meet and work outside of formal meetings was limited (or possibly not clearly organised).

There were some specific IT issues, but generally network (Wifi) access was adequate. A key exception to this was that videoconferencing, particularly in the SCG and STAC meetings was difficult.

Resilience Direct (RD) was in use, but not by all cells. Posting of information onto RD was not always transparent (possibly due to notifications not being sent), so several organisations were delayed in accessing information or were not aware that material had been posted. The labelling of some information was confusing, for example versions of documents.

In general there were limited options for using map boards or white boards. In part this may have been due to the nature of the (historic) building. Where projectors were available, the use of these to display visual aids and a common picture of the event was limited.

### Strategic Coordination Group

While the start of exercise had been preceded with a simulated virtual SCG prior to all staff arriving at the SCG, there was no initial introduction of the SCG representatives on arrival at the SCC. It was not clear if the SCG Chair knew who was available in this group to offer specific advice. A simple meeting in advance of the formal SCG for all to introduce themselves and their roles would have offered immediate awareness of capabilities. It would also have allowed the Chair to set out immediate priorities for information.

The SCG Chair undertook a meeting with the TCG Chair by telephone following the 0900 TCG. This provided useful information for the SCG Chair to raise points and questions but it was not clear how this information was being shared with the SCG members. It appeared that each representative in the SCG was speaking with their TCG representative to gain the same update, which prevented concurrent action.

The first physical SCG met at 1055, over 4 hours after the initial event. The SCG Chair took the lead and set out the strategic framework and priorities, which were

clear. Generally the SCG Chair showed good command and control. Information on the incident was mainly provided by a Common Operating Picture but there were already two editions of this and it was not clear that all were working from the latest information. Updates from the different representatives indicated that while the shelter in place advice had been issued to those affected, there had been no formal statement of the incident or effect, despite the time elapsed.

Advice on the potential impact of contamination and any plume was confusing as most were using the PACRAM plot provided by the Met Office and not any actual assessment or measurement (which by that time had been published on RD). The first SCG therefore lacked situational awareness with regard to the hazard presented by the site. The expectation would have been for the operator to provide a briefing, supported by UKHSA on the potential radiological risks. Actions to address vehicles that had transited the contaminated area (including a commuter train) were confusing as were measures to control and address the traffic build up due to road closures, including the M4 motorway.

The SCG concluded at 1145 with the next SCG planned for 1430. It was evident that a number of those at the SCG were unclear on their respective priorities and the interactions required with others. This resulted in a lack of impetus that seemed not to recognise the key imperatives of providing the required information to address the known issues. It was assessed that this was mainly a function of unfamiliarity with the process.

Following the first SCG meeting the Chair held an impromptu discussion with the STAC lead to clarify the situation and prioritise the information requirements. A lack of a map showing a common (and current) picture or any situation board contributed to the mixed perspectives of the incident. The SCG Chair clearly expressed the key information requirement “what is the thing we are dealing with ?”; however, there was confusion as to how best to express the ‘thing ‘ in clear, simple language. Nevertheless, this meeting was a positive initiative by the SCG Chair that helped to clarify issues and offered clear direction to the STAC.

In the second SCG the Chair offered a summary of the current position and then asked the STAC to provide an update. The STAC staff then provided a situation update on those areas that were not contaminated; however, the lack of visual aids mean that this was less than clear as the STAC referred to areas on a grid network that not all had sight of. There was confusion as to what happened to the train that had passed through the plume and no information on actions to address the traffic build up. No further information had been made available to the public or media on the situation and there was a general lack of awareness of the overall situation.

A key issue was poor situational awareness caused by the physical aspects of the SCG (outside of the main meetings) and the lack of common perspective offered by maps and information boards (be they projected or actual). This was exacerbated by a lack of awareness as to who was doing what and what was available to support the delivery of effect. Much of this was a consequence of not being able to practise this type of operation as frequently as possible; however, more frequent table top exercises and a series of common priorities would do much to assuage the issues indicated.

The focus of the SCG appeared to have become internal and not on providing strategic direction to the TCG or addressing the inevitable demands for information form central government that would follow in a real incident.

The Chair of the SCG should be recognised for their efforts in pulling the team together. The Chair did provide a focus and clearly articulated requirements; this resulted in progress, albeit somewhat slow and frustrating. The contribution of the Ambulance Service representative in the SCG is also noteworthy; there was clear evidence of previous experience of a significant event in the setting of sensible and manageable priorities. Had the exercise been allowed to run for longer then there was an indication that a number of key issues would have been addressed.

**Scientific and Technical Advice Cell**

STAC started well, with clarity in the handover from site and good participation and briefs from all agencies involved. Attendance (including those not present, but required) was quickly established. There was no seating plan or tabards and only later were there desk name cards.

The STAC often walked from issue to issue as they were raised, with little planning, urgency or prioritisation. The 'STAC manager' (not the STAC chair) role needs much clearer brief/ tasks to ensure topics are being considered proactively, there is good discipline and also a rhythm/pace to STAC meetings and activities.

A number of actions were placed over lunch but not assigned to anyone in particular, nor with timescale or level of detail required. During the exercise it was not obvious how actions at the STAC were being captured, assigned and tracked, Retrospectively it is apparent that STAC Action Reports were being prepared and saved on RD although the visibility and use of these was unclear.

Outside of the SCG meetings there appeared to be very limited sharing of information/communication between the chairs of the respective cells (including STAC) and the cells' individual actions did not appear actively coordinated by SCG.

A lot of time was spent planning on what to do rather than using what was already set out in the emergency plan (e.g. on decontamination, showering, locations, dealing with discarded clothing, lifting restrictions, etc). The plan was mentioned only towards the mid-point of the exercise, although it was not being actively referred to.

Probably through lack of familiarity, the availability of the fire service to carry out 'washing' of persons was misinterpreted as that an RMU had been set up and was operational. This was a significant error that could have led to public safety failings. Similarly there were mis-understandings of school closures and only later a recognition that this did not include pre-school premises. The terms evacuation and relocation were used interchangeably. Reference to the plan which covers such matters would have helped.

Initially UKHSA appeared to only share verbal summaries of radiation monitoring results – not specific results/maps. There seemed to be unnecessary delays for the first environmental monitoring results to arrive, but this may have been an issue with how the information was communicated (via RD). There was some confusion about the extent of area affected by the emergency, although UKHSA addressed this late in the exercise.

With the exception of some visuals temporarily on the projected screen and a single noticeboard saying when the next STAC meeting was, the STAC did not make use of any visuals such as event boards, action boards, maps, etc. Whilst a map of the initial plume and later a map of the ground-shine doses were displayed on the screen, maps of the DEPZ, metrological conditions and sectors would have significantly enhanced communications and decision making. This meant that the members were not always all aligned.

SCG lacked situational awareness from STAC of the radiological hazard presented by the event. In the SCG meetings the expectation would be for the operator to provide a briefing on the current situation, followed by wider technical advice led by STAC on the potential radiological risks. A key issue was the lack of clarity on the technical understanding of the radiological hazard at different times in the scenario. It was not generally apparent what the public dose was or whether the significant exposure pathways (initial ingestion from the plume followed be re-suspension) was fully understood. Very few participants were aware of what the actual source term was.

The UKHSA view expressed in the final SCG meeting was that doses were low, that no monitoring or decontamination would be required and that people could be released from sheltering after self-decontamination. This appeared to be inconsistent with both the plan and the scenario; the stated position had not been discussed or agreed at STAC.

STAC and TCG spent a lot of time discussing what to do with the quarantined train that had passed through the plume, but spent no time on considering all the vehicles that similarly passed through the plume towards destinations locally, London, Bristol, etc – at one point this was raised by Met Office and should also have been prompted by reports that the public were driving through road closures. TCG seemed to have self-tasked and had already moved the stuck train and were taking people off it, whilst STAC were still debating whether to move it. The decision to move the train and monitor/decontaminate the passengers appeared to have been made without the knowledge of STAC.  Although ONR was not present at the TCG, there appeared to be other strategic decisions that were being made by TCG (such as provision of decontamination advice) and it was not clear whether these were appropriately informed by relevant (STAC) expertise.

With the exception of ruling out a security related hazard, STAC did not consider public health effects from other harmful substances - for example, the public plan refers to potential for contamination from asbestos and beryllium.

Videoconferencing in the STAC did not work well and this limited participation by the TCG, EA and FSA. This led to a number of mismatches between STAC and TCG. Recognising this early on, TCG asked for a member of STAC to join TCG to help solve this, but the person initially assigned was a remote UKHSA exercise participant that had not and did not attend STAC.

The Burghfield public information does not appear to include any information for the public/ households on basic personal decontamination. UKHSA did offer up a standard leaflet they had during the exercise, but this would seem to be an omission from the information pre-distributed to the public.

**Evacuation & Shelter (& Radiation Monitoring Unit) Cell**

The emergency plan refers to a Evacuation & Shelter cell and a separate group to consider the radiation monitoring strategy/RMU. For this exercise it is understood that the roles were intended to be covered by a combined cell.

The STAC and Evacuation & Shelter (& RMU) cell did not seem clear on their remit and areas of responsibility with regards to this element of the plan. They were awaiting tasking from SCG rather than actively making decisions in line with the plan. There also seemed to be limited communication between the chairs of the respective cells. It would be expected that they would interact outside of meetings and agree common positions.

The cell was unclear on the need for rest centres to host evacuated or relocated individuals. It was positive that they identified eight potential locations but seemed unclear as to whether they should activate them, awaiting direction from SCG or STAC which did not provide clear expectations. The Chair of the cell did not actively explore the issue with STAC or SCG.

The plan requires that an RMU should start to be established upon notification of an off-site emergency (e.g. Section 5 of plan), but all players seemed unaware of this. The SCG Chair seemed to recognise that something was needed but was confused between decontamination and RMUs. Consequently, the SCG Chair assumed an RMU and decontamination facility was being established and neither of the other Chairs corrected this. As a result re-assurance monitoring was not given the consideration required.

The UKHSA decision that no monitoring or decontamination would be required and that people could be released from sheltering after self-decontamination appeared to be inconsistent with the plan. The Ambulance Service representative rightly reminded the SCG that people would be worried and were self-presenting at hospitals etc seeking reassurance monitoring, so provision was likely to be required.

Practically all members of the Evacuation & Shelter (& RMU) cell were unaware that the plan already identifies vulnerable groups that are likely to have been affected by the emergency and set out trying to obtain this information. Fortunately a single member of the group brought the plan to the attention of participants to avoid unnecessary work and delays.

In summary, the members of the Evacuation & Shelter (& RMU) cell seemed generally competent and were addressing key issues with social care etc, however they were missing clear direction regarding the need to establish an RMU.

**Media Cell**

The participation of Crown Media in simulated media interviews and the closing press conference provided a sense of realism.

The medial cell was well attended and the various organisations (including the various local authorities) worked effectively together. Initial interaction with the STAC to build technical understanding was delayed.

Only a few press releases were issued. The first was a statement read to the simulated press over 5 hours after the event had occurred. This essentially said

roughly what was known at approx. 9am and provided little information to the public (as evidenced by the media reporters closing remarks saying that this just left many more questions than it answered).

A press conference was held at 1615. This highlighted the shortcomings in the SCG's knowledge of the situation (including passing information on what had been released) and thereby the ability to build public confidence/support.

**Recovery Cell**

The Recovery Cell was mobilised at the start of the exercise but were working with limited information (for example from STAC) on the likely type an extent issues to be faced during recovery. Despite this, the cell carried out useful work to identify the factors that might need to be addressed during recovery, but without clear sight of what the specific issues were (e.g. on the nature and extent of contamination).

## Annex 2 – Aldex 23 Survey Responses provided by ONR 16th May 2023

Notes:

This annex details the ONR responses provided to West Berkshire Council's on-line 'Survey Monkey' post-exercise survey. The council intends to collate all responses and present these at the cold debrief meeting to be held on 8th June.

The survey questions were developed by West Berkshire Council primarily for exercise players. ONR's responses reflect those of assessors and in some cases reflect observations across a number of aspects of the exercise.

The questions (in italics) were those set by West Berkshire Council. ONR responses are recorded in normal text. ONR free text responses are preceded by a rating selected from the list of available descriptors defined in the survey.

Questions and responses of a factual nature are not recorded here.

*Q4 How effective do you feel Aldex 23 was in achieving the identified objectives ?*

*4(1) To improve all responding agencies awareness of the AWE Off-Site Emergency Plan (escalation, activation and mutual aid) and the[ir] responsibilities withjn the plan*

> Very effective: The exercise was well attended by the agencies. The scenario was realistic and relevant to the potential radiation emergencies that could occur at the AWE(B) site. It provided participants with a good understanding of the issues that would need to be addressed in a real emergency.

*4(2) To continually evaluate the contents of the AWE Off-Site Emergency Plan, including any supporting documents through the planning, exercising and debriefing stages of the exercise*

> Very effective: The exercise has provided a robust test of the off-site emergency plan, with key elements of the plan being covered in the exercise scope. The debrief process should provide the evidence which will identify the key learning points to be taken forward.

*4(3) Through the principles defined by Joint Emergency Service Interoperability Programme (JESIP) evaluate the multiagency response at both a Tactical and Strategic level, including the supporting material used to aid the coordination: TVLRF ERA, ResilienceDirect (RD) GIS, Agency Situation Reports and the Common Operating Picture (COP).*

> Somewhat effective: Observations were of the strategic response, which was generally well coordinated and managed; this was a strong point of the overall exercise. Communication between cells/group could have been better at times, for example the RMU/Evac/Sheltering Cell and Recovery Cell seemed to be working without a full understanding of the evolving picture of the radiological hazards. Sharing of electronic information was mixed – RD was used extensively but notifications of new posts were not always sent. This meant that at times not all were using the same information, a key example being the updated plume information that was posted at 10:30 but which was

not referred to in the first SCG meeting. Overall the strategic response was hampered by limitations with situational awareness; this was likely due to lack of practice in this situation and would likely have improved had the exercise run for longer.

*4(4) Evaluate the effectiveness of information shared between the AWE (B) and the response structure, including any others supporting incident room or cross border collaboration*.

Somewhat effective: By design, Aldex 23 did not include Level 1 (on-site) exercising. Information on the situation at site was therefore mostly driven by the exercise script. When information from site did become available (e.g. plume/monitoring data) this could have been better promulgated to the various interested parties by the operator, who could have been more proactive on explaining the radiological risk.

*4(5) Test the effectiveness of the information provided by the Scientific & Technical Advisory Cell (STAC) in formulating operational decisions, warning and informing, press and public communication.*

Somewhat effective: STAC was well attended with generally good contributions from the participating agencies. Meetings were prolonged and lacked rhythm/pace. Better planning, prioritisation, allocation of tasks and use of common resources (maps, plume data etc) would have helped in the delivery of more focussed advice to SCG. A key issue was the formulation and delivery of a sound technical understanding of the radiological hazard at different times in the scenario. Ultimately, this led to provision of advice at the final SCG that did not reflect the emergency plan and was not clearly derived from discussions at STAC.

*4(6) Establish and successfully manage a proportionate Media Advisory Cell (MAC) to deliver media handling, stakeholder engagement and Public warning & Informing.*

Very effective: The MAC was well represented by the different organisations and worked well together. After a slow start a link was established with the STAC. The MAC was able to deliver media statements.

*4(7) Successfully demonstrate the use of the Urgent Protection Actions (UPA) to protect Public Health and the identification of vulnerable people in the immediate risk area.*

Somewhat effective: There was a clear understanding of the required urgent protective actions and the scope of these. Initially the RMU/Evac/Sheltering Cell were unaware that the plan already identified vulnerable groups likely to have been affected by the emergency and set out trying to obtain this information. The STAC and RMU/Evac/Sheltering Cell did not seem clear on their remit and areas of responsibility. They were awaiting tasking from SCG rather than actively making decisions in line with the emergency plan.

*Q6 When considering the information provided at the start of the exercise, how effective was the group/cell in the  ?*

*6(1) Identifying the immediate scenario owners priorities and assigning task owners*

N/A: Overall view based on observations across a number of cells/groups.

*6(2) Reviewing the conflicting priorities with other cells*

Somewhat effective: Overall view based on observations across a number of cells/groups - no specific issues identified in terms of conflicts, but communications across cells generally could have been more active.

*6(3) Using the AWE offsite plan and the documents specific to the areas being covered e.g. Communications, Recovery*

Somewhat effective: Overall view based on observations across a number of cells/groups - reference to the emergency plan was mixed.

*Q7 How effective do you think the Common Operating Picture (COP) was in the following areas ?*

*7(1) Providing a shared situational awareness of the scenario to all partners*

Somewhat effective: See comments on situational awareness against Question 4.

*7(2) Recording and clearly documenting critical information and decision[s] being made during the exercise*

Somewhat effective: With the exception of the RMU/Evac/Sheltering Cell and the Recovery Cell, minutes and/or action reports were prepared and recorded on RD by the various cells/groups. Probably due to time pressures, some of these did not seem to be fully accurate or complete.

*Q9 How effective do you feel the plan(s) you used were in providing relevant and up to date information that was easy to follow?*

Somewhat effective: The plan(s) provided clearly identifiable information that was relevant to the exercise. Section 9 in particular covered key aspects of the response such as the requirement for a RMU and decontamination, however there was limited reference to this and the advice being provided deviated from it without a clear basis.

*Q10 How effective do you feel the plan(s) you used were in providing a clear steer about mitigation options?*

Somewhat effective: Key advice provided to SCG was for self-decontamination. Whilst this is mentioned briefly in the plan (Section 8.5.1) this is only in relation to people outside at the time of the incident. The requirement for/process of self-decontamination is not included in the information to the public; this would seem to be a key element of the response for the radiation hazard in question. The requirements for a RMU/mass decontamination set out in the plan did not feature in the final advice.

*Q11 How effective do you feel the plan(s) you used were in enabling groups to structure meetings with agendas and supporting annexes?*

Not very effective: The SCG chair demonstrated sufficient knowledge of the plan and an understanding of the key issues; this helped the chair to provide a focus for the meetings and to articulate requirements. The observations made

in the STAC in the response to Question 4 may indicate a review of Action Card Z to be appropriate.

*Q12 How suitable do you feel the venues were for the exercise?*

*12(1) Parking and access to the building*

Extremely suitable: Plentiful parking with easy assess to the building.

*12(2) Wifi and Telephone connectivity*

Very suitable: Wifi seemed to be adequate. Arrangements for hybrid meetings (videoconferencing) did not always work well (e.g. TCG dial-in to the SCG meetings).

*12(3) Meeting rooms and Facilities*

Very suitable: There were multiple rooms in use by SCG participants - it was not clear that all were aware as to who was operating in each room and the various roles of those present. In addition, the fact that there were no map boards or white boards on which to place common information

*Q13 How effective do you feel the exercise was in its delivery of:*

*13(1) Pre-exercise communication and delegates joining instructions*

Very effective: Pre-exercise communications and instructions were clear and comprehensive, if a little last minute.

*13(2) Knowledge of the scenario at the start of the exercise*

Very effective: It was clear from the pre-distributed COP what had happened. It did introduce a degree of artificiality, but given the format of the exercise it was a necessary precursor for startex.

*13(3) Support throughout the day with any problems identified*

Very effective: No problems experienced, but sufficient exercise staff on hand.

*13(4) Valuable experience*

Very effective: This provided a valuable experience for all participants to come together and put into practice the off-site plan.

*Q14 When considering the response to a radiation emergency, what 3 areas do you think require improvement, and where possible what could be done to improve them?*

Situational awareness of the radiological risk could have been better, leading to lack of clarity on actions required following the initial release/exposure. The requirement for radiation monitoring and the provision of medical reassurance to those exposed is part of the plan and needs to be a focus for delivery. The exercise indicated that advice on self-decontamination should also be a key part of the plan and public information.

The STAC was operating under time pressure, but would have benefited from more focus, clearer priorities and tasking. Improved familiarity with the hazards from AWE sites and the plan would help.

Lines of communications between cells/groups (e.g. Recovery, Media, RMU/Evacuation/Shelter) could be improved. The role of the RMU/Evacuation/Shelter cell, working in collaboration with STAC, is key and would benefit from a clearer purpose and objectives in the plan.

Q15 When considering Aldex 23, what do you think went well?

There was good representation and participation of the players. The test was realistic and covered a wide span of activities. Overall, the exercise provided a robust test of the emergency plan.

The Strategic Coordination Group was well chaired. The chair had a good grip of the situation and provided clear direction. The meeting with the STAC chair after the first SCG was a timely intervention that provided an opportunity to re-focus.

There was good coordination between the different local authorities (noting that the DEPZ crosses multiple local authority areas).

# 1. Issues

## 1.1. Issues Raised

**Table 3: Issues raised**

| WIReD Unique ID Ref. | Issue Title | Owner (inspector) |
|---|---|---|
| | | |
| | | |
| | | |

## 1.2. Issues Closed

**Table 4: Issues closed**

| WIReD Unique ID Ref. | Issue Title | Owner (inspector) |
|---|---|---|
| | | |
| | | |
| | | |

## 1.3. Circulation List

**Table 5: Circulation list**

| Organisation | Name/responsibility | Date |
|---|---|---|
| ONR | [redacted] | 25 April 2023 |

# 2. Export Control

| | | |
|---|---|---|
| During this contact, has export controlled information (ECI) been shared outside the UK? | **Yes** | |
| | **No** | **X** |

**Table 6: Export licence use - tracking information**

| | | |
|---|---|---|
| **Export licence ref:**<br>View Export Licence Library | | |
| **Company name and address of end user:**<br>View Export Licence Library | | |
| **Trigger list information shared:**<br>Click here to access guidance. | Choose an item. | |
| **Which reactor technology and/or site is this information regarding?** | (e.g., HPR1000, EPR, Sellafield) | |
| **Reason for ECI exchange:** | (e.g., GDA, IAEA mission, design review, supply chain inspection) | |
| **Country of ECI technology origin:** | | |
| **Means of transfer:** | **Shared verbally (either via teleconference or videoconference)** | |
| | **Documents shared electronically** | |
| | **Documents shared physically** | |