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| ONR Procedure  Processing and Governance of Incident Notifications by ONR |



ONR Procedure

Processing and Governance of Incident Notifications by ONR

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Revision commentary

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| Issue | Description of update(s) |
| 3 | This revision replaces ONR-OPEX-PROC-001 (Issue 2) and includes clarifications of the reporting to external stakeholders. |
| 3.1 | Minor editorial update. |
| 4 | Major update to incorporate changes to the process to align with the launch of the process in WIReD.  Additional process flow charts added as appendices. |
| 4.1 | Review date extended to January 2024 |
| 4.2 | Minor update to reflect changes to incident notification email address (section 4). |
| 5 | Major update to reflect incorporation of RIDDOR incident notification process |
| 5.1 | Minor formatting updates to Appendix A. |
| 6 | Major update: Combining with ONR-RIO-PROC-004 to include governance by allocated inspectors and appropriate directorate board. Update to roles and responsibilities, ministerial reporting process and clarification of defence position. Additional content relating to RIDDOR and governance. |

Contents

[1. Introduction 4](#_Toc193723735)

[2. Processing incident notifications 7](#_Toc193723736)

[3. Governance of the incident by ONR 9](#_Toc193723737)

[4. Reporting incidents in ONR 13](#_Toc193723738)

[5. Reporting to external stakeholders 14](#_Toc193723739)

[6. Records 16](#_Toc193723740)

[7. Further guidance 17](#_Toc193723741)

[References 17](#_Toc193723742)

[Appendix A – ONR Incident Reporting Form (INF2) 18](#_Toc193723743)

[Appendix B – INF2 process flowchart 20](#_Toc193723744)

[Appendix C – Incident Categorisation for ONR Governance 21](#_Toc193723745)

[Appendix D – ONR Specialisms and Areas of Interest 22](#_Toc193723746)

[Appendix E – Ministerial Reporting Criteria (MRC) 29](#_Toc193723747)

[Appendix F – Quarterly Statement timeline 38](#_Toc193723748)

# Introduction

## Purpose

This procedure defines ONR’s arrangements for the processing and governance of incidents notified by dutyholders.

These notifications allow ONR to:

* examine aspects of dutyholder compliance with The Energy Act 2013, the Health and Safety at Work etc Act 1974, and relevant statutory provisions of both these Acts;
* determine whether any follow-up action is required by a dutyholder or ONR;
* provide ONR with Operating Experience (OPEX) to inform regulatory strategies, interventions plans and contribute to ONR’s organisational learning; and,
* inform, where applicable, the Department for Energy Security & Net Zero (DESNZ) of incidents that have occurred on civil GB nuclear sites or during civil transport of radioactive material that meet the Ministerial Reporting Criteria (MRC).

## Scope and applicability

This procedure applies to all incident notifications in the areas of nuclear safety, radiological safety, security, safeguards, transport safety and RIDDOR[[1]](#footnote-2) where ONR is the enforcing authority.

It describes how ONR processes incident notifications, and includes internal governance arrangements.

This procedure excludes notifications of nuclear emergencies received via ONR’s emergency contact telephone number, which are covered by ONR’s Emergency Response Framework (ref. [1]).

ONR’s process for dutyholders to notify incidents to ONR (ref. [2]) defines the criteria dutyholders should use for making notifications. A suite of supporting guidance is available for dutyholders to use depending on the incident type.

**Note:** ONR is the enforcing authority for nuclear site health and safety on GB nuclear sites, authorised defence sites, defence nuclear sites[[2]](#footnote-3) and new nuclear build sites. As a consequence, dutyholders are required to make relevant RIDDOR notifications directly to ONR, with this arrangement commencing in 2024.

## Roles and responsibilities

**Dutyholders** are responsible for

* notifying ONR of incidents according to the process described in ref [2].

**Assigned Inspectors** (AI) are responsible for:

* reviewing the incident and forming the initial view of the incident;
* assigning the incident notification category;
* determining whether Ministerial Reporting Criteria (MRC) have been met, and where this is the case, or where the incident has an INES 1 rating, completing the ONR Incident Notification Form (INF2) in Plain English for Publication (PEP) style;
* assigning the appropriate incident governance category and undertaking the required follow-up;
* appropriately recording related incident notification information on WIReD in a timely manner.

**Organisational Learning** is responsible for:

* maintaining the incident notification processing and governance procedures and guidance on behalf of ONR;
* overseeing efficient incident notification processing including data completeness, quality and timeliness;
* ensuring incident processing compliance with GDPR and [ONR’s privacy notice](https://www.onr.org.uk/access-to-information/privacy-notice/);
* reporting events to DESNZ;
* preparing and issuing the Quarterly Incident Statement of incidents that meet agreed MRC following discussion with DESNZ.

## Definitions

Table 1: Table of definitions

| Abbreviation | Description |
| --- | --- |
| AI | Assigned Inspector – responsible for incident notification follow-up |
| BPF | Business Process Flow |
| CNI | Chief Nuclear Inspector |
| DESNZ | Department for Energy Security & Net Zero |
| DDS | ONR Divisional Delivery Support – administrative staff supporting Regulatory Directorate |
| ESO | Executive Support Office |
| FUR | Follow-up Report |
| GDPR | General Data Protection Regulation |
| HSE | Health and Safety Executive |
| IAEA | International Atomic Energy Agency |
| INES | International Nuclear and Radiological Events Scale (IAEA) |
| INF | Incident Notification Form |
| MRC | Ministerial Reporting Criteria |
| OPEX | Operational Experience |
| OL | Organisational Learning |
| OL DDS | DDS staff within the OL Team, providing administrative support to the notification, follow-up, and onward reporting process |
| RIDDOR | Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) |
| UKINO | UK INES National Officer |
| USIE | Unified System for Information Exchange in Incidents and Emergencies (IAEA) |
| WIReD | Well Informed Regulatory Decisions – ONR’s regulatory records database |

# Processing incident notifications

This process covers the following key activities:

* Receipt and storage of the information submitted by the dutyholder;
* Inspectors recording regulatory judgements about incident information;
* Governance of the incident follow-up; and
* Reporting to stakeholders.

Incidents meeting ministerial reporting criteria or events assessed as being INES 1 or above, that are not related to a defence site or defence transport, require the AI to complete an INF2. An INF2 template is provided in [Appendix A](#_Appendix_A_–). The overall process flowchart for INF2 is presented in [Appendix B](#_Appendix_B_–).

To ensure effective and timely process implementation, each activity in the process is bound by a relevant timeframe. Timeframe compliance can be monitored using WIReD. OL DDS will work closely across ONR directorates and functions, as appropriate, on this matter. These oversight actions (monitoring, identification of delays, sending reminders, etc.) are progressively being automated in WIReD/ONR dutyholder portal.

The focal point for relevant communications is OL DDS contacted via [ONR.Incidents@onr.gov.uk](mailto:ONR.Incidents@onr.gov.uk).

## Receipt and storage of the information submitted by the dutyholder

### Incident notification by the dutyholder

The primary means of submitting incident notifications to ONR is via the appropriate ONR Portal[[3]](#footnote-4).

Alternative means are available where a dutyholder does not have portal access or where the ONR portal is unavailable. Required notifications can be made by email (to [onr.incidents@onr.gov.uk](mailto:onr.incidents@onr.gov.uk) ), or by contacting the ONR/nominated site inspector by phone. Full details, including notification particulars, are provided in ref. [2].

The notification is initiated by the dutyholder reporting an incident to ONR, providing a brief description of relevant information, an estimate of its significance, a provisional INES rating, an appropriate justification for the provisional INES rating[[4]](#footnote-5) and a summary of the immediate actions taken, as appropriate.

The timeframe for reporting incidents depends on the ONR incident category and significance, as defined in ref. [2]. This may vary from “Immediate” to within a “Month”.

All transport incidents (nuclear and non-nuclear) are assigned to the Transport Competent Authority who will nominate an appropriate AI. For transport incidents involving dutyholders whose organisation is limited in resource, the dutyholder may not have access to the appropriate portal, or be able to complete the particulars in an INF1 form that ONR would require for an incident in these circumstances. Here the AI may complete an INF1 Part A on the dutyholder’s behalf.

### Follow-up Report

Some incident categories require the dutyholder to submit a Follow-up Report (FUR), uploaded to WIReD via the ONR dutyholder portal. Further information on this is provided in Section ‎3.4 below.

**Note:** This step does not apply for RIDDOR incidents.

### Storage of dutyholder’s information

Upon completion of incident notification via the relevant ONR portal an “Active Incident” is created in WIReD, initiating the process of incident governance, including:

* a unique incident number will be generated; and
* an assigned inspector will be allocated to initiate appropriate regulatory response and follow-up the incident to closure.

All INFs and associated documents received from a dutyholder are stored within WIReD.[[5]](#footnote-6) By exception, some documents may be stored in ONR’s recognised document management systems. In this case, OL DDS should indicate the relevant record reference in WIReD.

# Governance of the incident by ONR

## Factual accuracy check of the incident notification

The preparation of INF-Part A is the dutyholder’s responsibility. More on this is contained in (ref. [2]).

ONR Directorates are to establish, and as necessary update arrangements for effective follow-up of incidents by dutyholders within their areas of accountability, consistent with this process.

The AI is to review the Part A of INF1 upon receipt. If any specific details are missing or incorrectly recorded, the inspector should note such observations in Part B of INF1 and request the dutyholder to make the relevant amendments before the AI completes Part B.

Any supporting documentation about the changes should be uploaded into WIReD; OL DDS should be notified in case a Part B completion extension is needed.

OL DDS will review the names of the assigned inspector within WIReD for follow-up of notified incidents to confirm that inspectors are appropriately allocated and available. They will consult with the Nominated Site Inspector or Head of Regulation and reassign where necessary. On occasions, consultation with the Head of Profession may be needed.

## Record of ONR’s initial view of the incident

The INF-Part B form provided in WIReD under the incident number is completed by the AI to:

* provide ONR’s initial view of the incident significance;
* provide a view of the provisional INES rating where appropriate;
* confirm that the dutyholder has provided an adequate technical basis to assess the incident notification;
* confirm the adequacy of dutyholder actions in response to the incident;
* assign relevant specialisms (see below); and
* provide a justified category of ONR’s governance (Appendix C).

The AI should seek advice from relevant specialisms and/or ONR’s other purposes to make an informed judgement on each field in Part B. This is particularly relevant for RIDDOR notifications. **Note**: Assigning a specialism on WIReD does not alert the specialism that advice is required. Separate contact should be made.

The timeframe for Part B completion is ‘three working days’ of the INF1 being assigned to the inspector. It is expected that the relevant directorates will monitor compliance with this requirement, as appropriate[[6]](#footnote-7). Should the AI be unable to complete Part B on time, OL DDS should be informed accordingly and arrange up to three working days extension. Consideration should be given to re-assignment of the incident to another inspector in case of longer unavailability.

Incidents that ONR identifies for investigation are special cases. Where the AI decides that an incident warrants investigation (as set out in ONR guidance on conducting investigations (ref. [3])), then the AI should record the relevant investigation reference number in Part B. To preserve the integrity of the investigation, there is no requirement for the inspector to update the WIReD incident record until the investigation has concluded. In addition, DDS should not share any information about these incidents without prior agreement with the AI.

The inspector should assign relevant specialism(s) in Part B of the INF for awareness, trending and analysis purposes. This is an important mechanism for sharing Operational Experience (OPEX) and learning between sub-directorates and specialisms.

A list of ONR’s specialisms and their areas of interest is provided in Appendix D to help AIs identify potential allocation(s).

## Incident categorisation for governance

Appropriate governance of incidents should be undertaken in accordance with their categorisation (Appendix C refers.) The incident governance category is related to the incident significance, and determines the nature of ONR follow-up activities and oversight.

The AI is responsible for assigning the ONR incident governance category. The AI should seek appropriate support and advice for this within their operational team where required. This will usually involve the Head of Regulation or a delegate. These discussions may be via specific meetings or as part of standing arrangements (e.g. keep-in-touch meetings).

Incidents governance should form a routine agenda item of regulatory directorate boards including at RLT, directorate and sub-directorate levels. The selection of incidents for review should typically be informed by the ONR governance categorisation (Appendix C). Incidents governance should include:

* confirming governance categorisation;
* oversight of ONR follow-up activities and escalation, if necessary;
* identification and sharing of learning (ref. [4]); and
* consideration for wider industry.

Where governance reviews identify required changes to the INF Part B, these should be recorded in the ‘Governance Review comments' field on WIReD. Where appropriate, changes should be implemented by the AI, and recorded in the ‘Inspector feedback on review’ field.

## Follow-up Reports and supporting documentation

FURs are submitted by the dutyholder for relevant incidents.[[7]](#footnote-8) A FUR is expected to contain information such as detailed description of the incident, actual or potential safety, security or safeguards impact, corrective actions and lessons learned. The expected content is further detailed in ref. [2] The timeframe for FUR provision to ONR is within timescales identified in ref. [1] after the incident was recorded by the dutyholder. For incidents that require more time for investigation and definition of preventive measures (refer to ref. [1]), the dutyholder should agree with the AI to submit an interim FUR, which contains the rationale for providing the interim FUR together with details of the outstanding actions and timescales to complete those actions. This should be followed by a final FUR, submitted within a mutually agreed timescale with the AI.

In addition to the FUR, the dutyholder may submit other documents to ONR related to the incident investigation and follow-up, such as causal analysis, INES rating justification, plans for remedial/protective works, etc.

ONR in following-up or investigating an incident may generate records. All applicable documents should be uploaded to the incident record in WIReD under “Documents”.

## Follow-up of RIDDOR incidents

The AI should record the regulatory response to RIDDOR incidents on WIRED. The detail recorded should be sufficient to understand how the decision aligns with the incident selection criteria (ref. [3]). Appendix C indicates where injuries and occupational diseases meeting various criteria sit in relation to ONR governance.

It is appropriate to seek specialist support for dangerous occurrences reported under RIDDOR. For reference, HSE’s list of dangerous occurrences is given here [Dangerous occurrences - HSE](https://www.hse.gov.uk/riddor/dangerous-occurences.htm).

The completion of Part C associated with a RIDDOR notification is at the discretion of the AI but is recommended. When the AI classifies a RIDDOR event as ONR Governance Category 4 (Appendix C refers), the incident can be closed in WIReD without completing Part C.

## Closing incidents

### Closing an INF1 (relevant to incidents other than RIDDOR)

**Note**: For all incidents with continued regulatory oversight, the assigned inspector should add periodic notes to the ‘Timeline’ and keep the incident ‘open’ until the inspector is satisfied all relevant regulatory actions have concluded.

For incidents notified by INF1, following the completion of Part B, and the submission of a Final FUR, ‘Part C’ is initiated. The Part C of an incident in WIReD is completed by the AI. It records the AI’s judgment on:

* the incident follow-up state at the time of incident closure in the WIReD incidents database;
* adequacy of the dutyholder’s investigation and FUR;
* final INES rating (if appropriate);
* any ONR follow-up activities undertaken to date recorded in relevant fields including any enforcement decision record and/or any related regulatory issue;
* whether further regulatory action is necessary; and
* whether an INF2 is required.

The AI’s judgement on each of the above items should be supported by references to documents provided by the dutyholder or generated by ONR during assessment (e.g. contact/intervention/assessment/investigation records, letters, etc.) For incidents that ONR has investigated or carried out enforcement action, the inspector should provide relevant references in WIReD. All applicable documents should be available on WIReD under “Documents”.

On completion of ‘Part C’, if the assigned inspector is satisfied that no further action is required, they should progress the BPF to the ‘Close’ stage of the BPF, ensuring that the incident becomes ‘inactive’ and ‘resolved’.

Should the AI not be satisfied with the dutyholder’s investigation or the quality of FUR, they should seek further information from the dutyholder. The AI should consider:

* engaging with identified specialism(s) for advice, prior to closing Part C;
* indicate that dutyholder response needs to be provided at the earliest opportunity to allow for timely incident closure; and
* updating WIReD records.

Should the AI have reservations or is not satisfied with the final INES rating, they should seek advice from the UK INES National Officer (UKINO) to resolve the issue (ref. [5]).

The timeframe for Part C completion is ‘28 calendar days’ after the AI is notified that the final FUR has been received[[8]](#footnote-9). When Part C cannot be completed on time, for reasons such as an on-going ONR investigation, the AI should inform OL DDS via [ONR.Incidents@onr.gov.uk](mailto:ONR.Incidents@onr.gov.uk) and arrange for a suitable extension. In case that more time is needed to follow up the dutyholder’s actions, the AI should consider raising a Regulatory Issue to maintain longer term regulatory focus. This can be addressed by using the “Regulatory Issue” field in WIReD under the incident number and then record the progress, as appropriate. Linking ‘Incidents’, ‘Regulatory Issues’ and ‘Inspection Records’ is recommended as WIReD provides facility for integrated visibility of all related regulatory activities.

### Closing a RIDDOR incident

For RIDDOR incidents, following the completion of Part B, the BPF effectively stalls, as there is no requirement for a FUR from the dutyholder, as such the incident remains ‘active’ on WIReD. The assigned Inspectors should therefore proceed to undertake the following actions, as appropriate;

* On completion of ‘Part B’, if the inspector is satisfied that no further action is required (i.e. treat the event as trend only), the inspector should progress the BPF to the ‘Close’ field, making the incident ‘inactive’.
* If the inspector has undertaken any regulatory action for the incident, the details should be added in the relevant fields of the ‘Part C’. This should include any enforcement decision record and/or any related regulatory issue. When the inspector is satisfied that the incident is closed, they should progress the BPF to the ‘Close’ field, making the incident ‘inactive’.

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# Reporting incidents in ONR

The focal point for incident reporting is the relevant ONR portal.

Registered dutyholders should use the [ONR dutyholder portal](https://onr.powerappsportals.com.) for notifying ONR of incidents, including accessing the RIDDOR portal via this route for any RIDDOR reporting.

For RIDDOR reporting by dutyholders that are not registered for use of the ONR dutyholder portal, the [ONR RIDDOR portal](https://onr.powerappsportals.com/riddor/) should be used. This is generally accessible.

The [ONR incidents mailbox](mailto:ONR.incidents@ONR.gov.uk?subject=INF1) email account remains available as a back-up notification route, if the ONR portal route cannot be used. Ref [2] has full details. INF1 and RIDDOR reporting templates are available on ONR’s website and can be used to provide the required information. In these circumstances, OL DDS will manually upload notifications received by email.

## Access to RIDDOR notifications containing personal data

RIDDOR incident notifications could potentially contain personal data submitted by the dutyholder. To ensure compliance with the General Data Protection Regulation (GDPR) and organisational privacy policy, ONR has identified several fields within the ONR RIDDOR portal that contain this data.

Inspectors will have restricted or limited access and visibility to these fields containing personal information which includes: name, address and position of the affected person. The data will be accessible to ONR staff from the WIReD application interface only. A limited number of individuals have been granted privileged access to these fields. Should any inspector require access to this data to discharge their duties, requests should be made via [ONR.Incidents@onr.gov.uk](mailto:ONR.Incidents@onr.gov.uk) email account providing a brief justification. The OL DDS will then inform the relevant department to provide access to these fields.

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# Reporting to external stakeholders

The focal point for preparation of reports to stakeholders outside ONR is OL DDS [ONR.Incidents@onr.gov.uk](mailto:ONR.Incidents@onr.gov.uk).

## Reporting to DESNZ

An important aspect of ONR’s reporting of incidents to external stakeholders is carried out by communication with DESNZ, with the Nuclear Safety Policy Team and the Civil Nuclear Security Team. ONR provides to DESNZ details of each incident that has occurred on a civil nuclear site or involves transport of radioactive material other than for defence purposes, which meets one of the following:

* INES rating = 1, or
* meets at least one of the Ministerial Reporting Criteria (MRC) (refer to Appendix E, noting this includes INES rated events of 2 and greater.)

Incidents meeting MRC are reported on to relevant Minister/s. ONR shares details of INES 1 events with DESNZ for their information only. INES 1 events are below the MRC and are not shared more widely, with Ministers or elsewhere.

The flowchart in Appendix B illustrates this arrangement.

The AI is expected to discuss the incident with the relevant Nominated Lead for their sub-directorate (typically the Head of Regulation, and potentially the Head of Profession) prior to deciding whether onward reporting is required.

Careful consideration should be given to decisions relating to whether an incident meets the MRC “Events likely to attract, or that have attracted, significant national media or public attention.” Further guidance is provided in Appendix E.

INF2s are required to be completed for INES 1 events and for MRC events. A template is available for use in Appendix A. The AI should complete any required INF2 to describe the incident, the dutyholder’s response and ONR’s follow-up in Plain English for Publication (PEP) style. This should be done once sufficient investigation and follow-up has taken place, allowing the AI to make a well-informed commentary and judgement within the completed INF2. The AI should secure the support of the relevant Nominated Site Inspector if appropriate, and seek approval of the Head of Regulation.

The INF2 should be produced in conjunction with the relevant directorate communications business partner recognising it can be challenging for AIs to convey incident/technical detail in PEP style. Technical detail should be avoided as far as is possible, as should abbreviations. Once approved the completed INF2 should then be sent to [ONR.Incidents@onr.gov.uk](mailto:ONR.Incidents@onr.gov.uk) OL DDS upload this to WIReD and arrange onward communication to DESNZ via MS Teams channel.

**Note:** The INF2 reflects ONR’s view of the incident, hence a factual accuracy check with the dutyholder is not mandatory but could be carried out at the AI’s discretion.

If changes arise post-submission of a completed INF2, the AI should notify OL DDS and submit an updated INF2.

INF2s are not required for defence incidents.

The Chief Nuclear Inspector (CNI) Annual Report typically reports on incidents that have met MRC so INF2s usually provide this content.

## Ministerial Reporting - ONR's Quarterly Statement of Civil Reportable Incidents

Incidents that have occurred at civil nuclear installations or during transport other than for defence purposes, and that are considered to meet at least one of the MRC, will be included in ONR's Quarterly Statement of Civil Reportable Incidents. This is issued by the CNI to the relevant Ministers and incident summaries are published on ONR’s website.

The Quarterly Statement of Civil Reportable Incidents contains:

* 1. A letter from the CNI to Ministers (namely the Secretary of State DESNZ, Secretary of State for Scotland, Secretary of State for Wales) , including the reporting period and number of incidents meeting MRC;
  2. An Appendix featuring details from the relevant INF2(s) for these incident(s).

The directorates are expected to provide all the relevant INF2s in a timely manner to support the preparation of the ‘Quarterly Incident Statement’. OL DDS prepare and issue the ‘Quarterly Incident Statement’ following the incident reporting timeline presented in [Appendix F](#_Appendix_D_–).

OL DDS will review WIReD periodically to ensure INF2 submissions align with incident notification categories and incident details captured in WIReD. For security incidents, refer to 5.4 below.

OL may contact the AI to understand latest incident developments ahead of interactions with DESNZ, typically quarterly meetings.

For incidents with an INES rating ≥ 2, the UKINO prepares a publication record, arranges its review and approval by ONR (AI, Head of Regulation and Communications) and DESNZ safety team. The UKINO then publishes it to the IAEA Unified System for Information Exchange in Incidents and Emergencies (USIE) website [5].

## Defence sites

ONR does not report incidents on defence facilities or incidents relating to transport of radioactive material for defence purposes to DESNZ. For any defence incident notification that involves sharing information with any external parties, ONR will first liaise with the Defence Nuclear Safety Regulator (DNSR) and if so advised, the Ministry of Defence (MoD) directly prior to any distribution of content outside ONR. Restrictions relating to content or circulation may be necessary.

## Security incidents

Oversight of security incident notifications with reference to MRC is carried out by the nominated duty security inspector, and by the Security lead for Incidents. ONR will share information meeting MRC requirements with DESNZ in relation to security incidents but any decision to publish this information externally via ONR’s Quarterly Statement or otherwise will be made on a case by case basis in consultation with ONR’s nominated Communications Lead and the Security Head of Regulation.

# Records

All documentation relating to an incident is stored in WIReD under the incident notification number.

By exception, some documents may be stored in ONR’s recognised document management system due to the sensitivity of information. In such case, OL DDS should clearly indicate the relevant record reference in the appropriate WIReD records.

The following types of records are created and stored on WIReD:

* INFs submitted by dutyholders.
* Dutyholders’ FURs and/or other applicable documents submitted to ONR.
* INF2s, if applicable.
* Internal and external e-mails, as appropriate.

All other related documents could be uploaded by OL DDS or the AI.

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# Further guidance

The following documents provide further guidance on incidents reporting:

* ONR Technical Inspection Guide on Licence Condition 7 (ref. [6]) provides guidance for inspectors and expectations from dutyholders regarding the notification and reporting of incidents.
* IAEA General Safety Guide – GSG-13 (ref. [7], section 3.34) contains good practices for notification of events by authorised parties and their follow-up by regulatory bodies.

# References

|  |  |
| --- | --- |
| [1] | ONR, “ONR-EP-FW-001 - ONR’s Emergency Response Framework”. |
| [2] | ONR, “ONR-OL-PROC-002 - Process for Notifying Incidents to ONR”. |
| [3] | ONR, “ONR-ENF-GD-005 - Conducting Investigations”. |
| [4] | ONR, ONR-OPEX-PROC-001, Production of Alerts, Advice Notes and Inspector Awareness Briefs. |
| [5] | ONR, “ONR-OPEX-GD-002 - The Role of the UK International Nuclear & Radiological Event Scale (INES)”. |
| [6] | ONR, “NS-INSP-GD-007 - LC7 Incidents on the Site”. |
| [7] | IAEA, “IAEA General Safety Guide (GSG) 13 - Functions and Process of the Regulatory Body for Safety,” IAEA, Vienna, 2018. |

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# Appendix A – ONR Incident Reporting Form (INF2)

**Note: This form should be completed by the AI in conjunction with their nominated Communications Business Partner so as to ensure it is written in Plain English for Publication (PEP) style.**

Guidance is included within this as highlighted text. Authors should remember to delete the guidance prior to submitting the form for peer review/approval.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Incident ID | Site / Transport dutyholder | Date of Occurrence | Final ONR Incident Category | Final INES Rating | Final ONR Governance Category | |
| YYYY/NNNN | Name | DD/MM/YYYY | ABNM1 | N Type**2** | Nx**3** | |
| Incident Description | Summary of the Description from INF Part A  **Note**: Do not complete INF2 for defence incidents. | | | | | |
| Duty-holder’s Response | Summary of the Duty-holder’s immediate response to the incident - from INF Part A | | | | | |
| ONR’s Action | Summary of ONR’s suggested regulatory actions, usually described in INF Part B | | | | | |
| Ministerial Reporting Criterion | Indicate which Ministerial Reporting Criterion applies and explain why. If none apply, please explain why. | | | | | |
| Completed By  Name and signature of Inspector completing the INF2 | Signature: | | | | | Date: |
| Print Name: | | | | |
| Reviewed by Head of Regulation  Signed INF2 confirms that the description of the event is factually / technically accurate. | Signature: | | | | | Date: |
| Print Name | | | | |
| Reviewed by Comms  Signed INF2 confirms the clear English summary of the event written in an appropriate manner for a non-technical audience | Signature: | | | | | Date: |
| Print Name: | | | | |
| Reviewed by Deputy or Head of Comms  Signed INF2 confirms INF2 is ready for submission to CNI. | Signature: | | | | | Date: |
| Print Name: | | | | |

**Definitions:**

* **Incident ID** – Number allocated to INF1 form generated in ONR’s Incidents Database for this incident
* **Site /Transport dutyholder** – Name of the site where the incident occurred, or Name of the consignor for Transport incidents
* **ABNM1 -** ONR Incident Category estimated by the dutyholder and recorded in part A of the INF1 – as per ref. [2]​, for example, NS05
* **N Type2** - INES rating (Number and Type) of the incident at the time of reporting to DESNZ – as per the IAEA INES Manual, for example, 1 Anomaly
* **Nx3 -** ONR Governance Category, decided by the Assigned Inspector and recorded in Part B of the INF1 - as per Appendix C ​, for example, 2a – Preliminary enquiries.

**End of INF2 form**

# Appendix B – INF2 process flowchart

A diagram of a flowchart

AI-generated content may be incorrect.

# Appendix C – Incident Categorisation for ONR Governance

|  |  |  |  |
| --- | --- | --- | --- |
| Cat. | Incident Significance | Action Summary | Governance Oversight Level |
| 1 | Significant incident that meets ONR investigation criteria in ref. [3].  Typically, events INES ≥3 and of major national interest. Criterion 1 fatalities (work-related deaths.) | Investigation decision justified in Investigation Decision Record. | ONR level governance (RLT). |
|
| 2b | Meets ONR Investigation Criteria in ref. [3]. Criterion 2 to 6 within scope.[[9]](#footnote-10)  Typically, INES ≥1. | Investigation Decision justified in Investigation Decision Record (ref. [3]). | Directorate level governance. |
|
| 2a | Potential to meet ONR investigation criteria. Preliminary Enquires required (consult Tables 2 - 4 of ref. [3]). Criterion 2 to 6 within scope.9  Typically, INES ≥1 | Decision on whether incident remains at 2a or moves to 2b made after conducting Preliminary Enquiries. Any change in category recorded on WIReD with explanation. | Sub-Directorate level governance. |
| 3 | Minor shortfall that does not meet the ONR investigation criteria in ref. [3]. Specified injuries not covered under criterion 29. Selected by the assigned inspector for follow-up during routine interventions (e.g., assurance, LC7 compliance). Typically, INES 0.[[10]](#footnote-11) | Assigned inspector follow-up via routine site interventions. | Assigned inspector follow-up. |
| 4 | Minor shortfall that does not meet the ONR investigation criteria. Minor over 7 day injury.  Of interest as a low-level event for trending purposes.  Typically, INES 0.10 | No further formal action by AI. Considered for trending and analysis purposes (subdivision, Regulatory Intelligence and specialism(s). | No further action by the assigned inspector. |

**Note**: For Dangerous Occurrences reported under RIDDOR, seek specialist input.

# Appendix D – ONR Specialisms and Areas of Interest

| Specialism | Areas of Interest |
| --- | --- |
| Mechanical Engineering | Anything relating to mechanical engineering. Items having mechanical engineering causation or consequences may include:   * NS03 - mechanical engineering incidents that meets the criteria of NS08 or NS12 and the overall impact means that an adequate safety case to continue operations cannot be made. * NS05 – breaches to the operational limits and conditions or operating rules relating to mechanical engineering SSCs. * NS08 – mechanical engineering related defects or misconfigurations affecting mechanical engineering-based SSC performance. * NS09 – mechanical engineering related event or abnormal condition that resulted in the manual or automatic operation of a protection system or other engineered safety features thereby challenging safety systems * NS12 – Quality assurance or analysis outcomes leading to or indicating SSC can no longer perform its safety function(s). * NS14 – lifting equipment faults.   Reactor control rod, AGR gas re-circulator, Emergency power generation, Containment, Nuclear ventilation system (filter, duct, fan), Scrubber, Stack (chimney / exhaust), Cooling, Heat recovery, Glovebox, Vacuum, Flask, Container, Drum, Mechanical handling, Nuclear lifting (equipment, accessory), Crane (mobile, gantry, EOTC, boom etc.), Remote handling, Pressure system (tank, pipe, flange, vessel, receiver), Valve, Pressure relief, Seal, Boiler, Steam plant, Mechanical interlock, Seismic restraint, Shield door, Bolting, Bearing, Lubrication, Spares & obsolescence, Fuelling, Support, Machine, Gearbox / transmission, Clutch, Brake, Damper, Relief system (e.g. pressure, venting), Stop, block, derailer, Chain, wire rope, Choke, orifice plate, Pipe, Insulation, and Interlock.   * Regulation compliance – LOLER, PUWER, DSEAR, PER/PSSR/PESR (pressure), Carriage of dangerous goods, supply of machinery (safety) regulations. * Computational analysis (FEA, CFD, DEM) * Examination, Inspection (including statutory examination), Maintenance (technical aspects, procedures, periodicities), and Testing * Qualification * Destructive / non-destructive testing (NDT) * Containment * Design assurance * Reliability |
| Structural Integrity | Events related to structural integrity of metal structures (pressure vessels, storage tanks, pipes, valves) and non-metallic components (HDPE pipework, composites).  Fabrication (control of metallurgical properties, welding), in-service degradation mechanisms (corrosion, stress corrosion cracking, fatigue, creep, etc), Non-Destructive Testing (NDT), design assessments, material condition (brittleness, defects in welds).  Graphite reactor core integrity. |
| Civil Engineering and External Hazards | Civil Engineering: NS03 & NS08, LC28 Examination Inspection Maintenance and Testing of Structures, Systems and Components including: Buildings, Structures, Roofs, Containment, Pre-stressed Concrete Pressure Vessel, Silos, Ponds, Docks, Shiplift, Stacks, Stores, Foundations, Gutters, Drains and drainage (including sluices and settling ponds), Sea walls/defences, Natural defences (dunes, slopes, embankments), Excavations, Tunnels, Buried items, Cut-off walls, Temporary structures (crane bases), Weather envelope, Anchors, Tendons, Fixings, Soil Nails, Ground Anchors, Rock Bolts and Prestressing. Materials including Concrete, Steel, Reinforcement, Soil, Rock, Aggregates and Backfill.  External Hazards: NS13. Where initiated by or related to an external hazard: NS01, NS04, NS05, NS07, NS08, NS09, NS10, NS11, NS12, NS14, NS16 & AN01. External hazards include: Flooding (coastal flooding, fluvial flooding, pluvial flooding, tidal/storm surges, compound flooding, snow melt), Seismic (earthquake, liquefaction and tsunami), Extreme Weather Events (rainfall, wind, tornado, lightning, extreme ambient temperatures, extreme water temperatures, snow and ice), Geological hazards (landslides, volcanic ash), Space Weather (ground level effects, geomagnetically induced current, solar energetic particles, flare, coronal mass ejection), Biological intake fouling, Aircraft impact, Missiles, External industrial hazards, Loss of Cooling Chain, Loss of Offsite Power, Loss of Grid, Dam failure and Watercourse containment failure. |
| 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 | Excursion of any chemistry control parameter (limit or condition) necessary in the interests of safety. While not exhaustive, this includes chemistry control for means of criticality, corrosion, operator radiation exposure, waste minimisation and production/control of dangerous substances and explosive atmospheres.  Degradation, failure or maloperation of any structure, system or component which is either:   * a result of poor chemistry control; or * necessary to maintain chemistry within the safety operating envelope. This should also extend to effective sampling and monitoring in line with the above.   Inadequate implementation of any instruction, training requirement or staffing relevant to chemistry to maintain operation within the safe operating envelope.  Failure to control of substances hazardous to health (including analytical chemicals) and bulk chemical commodities required to support safe nuclear operations or presenting a COMAH burden. While not exhaustive, this includes diesel, biocides, hydrazine, acids, alkalis, hydrogen and other gases. |
| Nuclear Liabilities Regulation | Nuclear Liabilities Regulation (NLR) is a broad topic for ONR but there are four key relevant areas; the safe management of radioactive waste, the safe management of nuclear matter (spent fuel, uranic materials and plutonium), decommissioning and land quality management. Relevant events in these areas may include those relating to:   * Licence conditions 32, 34 and 35 * Characterisation * Contaminated land * Degradation of waste storage conditions * Inspection and maintenance of radioactive waste storage facilities * Inventory control and records * Misconsignment * Passive safety * Segregation |
| Radiological Protection and Criticality | Non-compliance with IRR17, loss of containment, release of radioactive material, unexpected personal dose exposures, personal contamination (clothing and skin), potential intakes of radioactive material (where whole body or bio-assay sampling has been requested). Incidents relating to industrial radiography, noting RIDDOR specifically lists amongst ‘dangerous occurrences’ failures of radiation generators to de-energise appropriately or sources failing to retract as intended to a safe position.  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. |
| ALARP Working Group (WG) | The ALARP WG is a cross-ONR multi-specialism working group tasked with providing ONR’s centre of expertise on matters relating to ALARP.     * Incidents in which the foreseeability or understanding of a risk or hazard was inadequate. * Incidents in which it is believed that a risk may not have been reduced so far as is reasonably practicable (SFAIRP) with serious or potentially serious consequences as a result. * On the identification of anomalies with a previously-made ALARP argument e.g. significant undermining of the assumptions relating to the likelihood or consequence of a risk, or the nature of the time, trouble or cost elements of a sacrifice. |
| Fault Analysis | Fault Studies:   * Incidents in which there was a loss or significant challenge to protection measures/lines of defence (e.g. multiple failures within a line of protection) * Incidents in which there was manual intervention to ensure safety (e.g. manual reactor trip). * Incidents in which a fault sequence has led to any significant relocation or release of radioactivity from its normal place of containment or where radiation levels have exceeded normal levels. * Incidents in which limits and conditions of operation relating to the availability or condition of safety systems have been significantly threatened or breached (e.g. misconfiguration of protection systems, unexpected unavailability of lines or protection). * On the identification of anomalies in the safety case relating to the design basis analysis, e.g. unexpected or unpredicted faults conditions, incorrectly modelled initiating events, fault sequences or consequences.   Probabilistic Safety Assessment (PSA):   * Incidents which reveal levels of risk approaching or exceeding SAP Numerical Target Basic Safety Levels * Identification of errors, software issues or other concerns affecting PSA modelling including live risk monitors. * On the identification of anomalies in the safety case relating to the PSA, e.g. unexpected or incorrectly modelled initiating events, fault sequences or consequences   Fuel and Core:   * Incidents in which there were any causal factors or impacts relating to reactivity control, heat removal or integrity of the nuclear fuel or its cladding, whether this be within a reactor or being assembled/disassembled, handled, transported or stored * Incidents in which there were any causal factors or impacts relating to the performance of or damage to reactor core components, whether this be within a reactor or being assembled/disassembled, handled, transported or stored * Incidents in which any limits and conditions of operation directly related to the reactor core, nuclear fuel, or reactor core components have been significantly threatened or breached * On the identification of anomalies in the safety case relating to the design or operation of nuclear fuel or its cladding, or reactor core components. |
| 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.  Where an incident highlights a systematic failure of SSCs or equipment, which ONR has something to learn about its inspection practices e.g. New themes for consideration – Licensee cold weather preparations. |
| 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 | Leadership and Management for Safety – Leadership & Management, Governance, Safety Management Systems, Design Authority, Knowledge Management, Internal Challenge.  Human factors – Human error, distraction, malicious act, ergonomics, nuclear baseline anomaly, procedure quality, procedure non-compliance, poor HMI design, alarm flood, poor task design, poor workspace design, anthropometrics, shift pattern/fatigue, excessive overtime, high/low workload, poor work planning, excessive noise, high/low temperature, poor lighting, access issues, time pressure, poor organisation learning, safety culture, insufficient competent resource, lack of or poor training, supervision/oversight, poorly conceived organisational change, lack of resource , novel task, complex task, lapse in attention, poor communication, intelligent customer failure, maintenance/latent error, poor decision making, configuration control issues, violation  Supply Chain – Incidents including events relating to suppliers (including contractors), intelligent customer, substandard supplier performance, issues with supplied goods or services, specifications, supplier selection and supplier capability, supplier quality management arrangements, deviations from specified requirements, non-conformances, supply chain oversight and assurance, Counterfeit, Fraudulent & Suspect Items (CFSI), quality plans, and records including Lifetime Quality Records (LTQR’s).  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, resourcing (capacity/capability), incorrect specification of equipment/components, application and management of the IMS, Ineffective application of a graded approach for nuclear safety.  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 | All SG notifications (01-09) and AN-01. Incidents comprising: RS01, RS02, RS03, RS04, RS05, RS07, RS13, RS14, SC10c, SC10e, TS01, TS02, TS04 and TS09, where related to qualifying nuclear materials for safeguards purposes (e.g., uranium, plutonium and thorium). RS & RA accountancy event. Loss of RA material |
| Cyber Security and Information Assurance | A cyber incident or any other matter which results in the theft, attempted theft, loss or unauthorised disclosure of SNI. Such incidents may be in either physical or electronic form, actual or suspected with the ability to compromise the confidentiality, integrity or availability of Sensitive Nuclear Information (SNI) or Operational Technology (OT). Examples include transmission of SNI over an insecure network, the presence of malware, loss of assets such as a laptops or mobile devices, unauthorised exfiltration of data or incidents which reduce the confidence in the claims and/or reliability of OT and/or have the ability to result in an uncontrolled radiological consequence. |
| Protective Security | All SC, SG02, SG03 & SG04 categorised events. Human error affecting safety or security of nuclear or radioactive material. Incidents requiring evacuation of controlled areas. Incidents involving counterfeit, fraudulent or suspect items, any act of falsification (e.g., of records, certifications). |

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# Appendix E – Ministerial Reporting Criteria (MRC)

The following tables provide a description of the MRC, origin of the legislation and naming convention;

## Appendix E.1 – **MRC** - **General**:

**Dutyholder notification timeframes for all criteria listed in the table below are IMMEDIATE**

|  |  |  |
| --- | --- | --- |
| Description of Criteria | Origin of Legislation (ONR Incident Category) | MRC Naming |
| Events likely to attract, or that have attracted, significant national media or public attention.[[11]](#footnote-12) | (AN01) | MRC-MEDIA |
| Events that are categorised as INES level 2 and above. | (INES) | MRC-INES |

## Appendix E.2 – Area of Regulation – **MRC - Nuclear Site Health and Safety**:

**Dutyholder notification timeframes for all criteria listed in the table below are IMMEDIATE**

|  |  |  |
| --- | --- | --- |
| Description of Criteria | Origin of Legislation (ONR incident category) | MRC Naming |
| Events reportable to ONR under RIDDOR which resulted in either:  One or more deaths at a nuclear licensed site  OR  Two or more persons (workers or non-workers) suffer non-fatal but RIDDOR reportable injuries. | RIDDOR (AN01) (HS01, 02 & 03) | MRC-NSHS |
| A major accident meaning an occurrence such as a major emission, fire, or explosion resulting from uncontrolled developments in the course of the operation of any establishment to which the Control of Major Accident Hazards (COMAH) Regulations 2015 apply, and leading to serious danger to human health or the environment (whether immediate or delayed) inside or outside the establishment, and involving one or more dangerous substances.[[12]](#footnote-13) | COMAH15 |

## Appendix E.3 – Area of Regulation **– MRC - Nuclear Safety and Radiological Safety:**

**Dutyholder notification timeframes for all criteria listed in the table below are IMMEDIATE**

| Description of Criteria | Origin of Legislation (ONR Incident category) | MRC Naming |
| --- | --- | --- |
| 3(a) any occurrence on a licensed site involving the emission of ionising radiations or the release of radioactive or toxic substances, causing or likely to cause death, or serious injury, on or off the site. | NI(DO)R65 (RS01) | MRC-SAF-01 |
| 3(b) any occurrences during transport causing or likely to cause death or serious injury or the breach of containment of a transport package. | NI(DO)R65 (TS01) |
| 3(c) any explosion or fire on a licensed site affecting or likely to affect the safe working or safe condition of the nuclear installation. | NI(DO)R65 (NS01) |
| 3(d) any uncontrolled criticality excursion. | NI(DO)R65 (NS02) |
| Confirmed exposure to radiation of individuals which exceed or are expected to exceed, the dose limits specified in Schedule 3 to IRR17 | IRR17 (RS08) | MRC-SAF-02 |
| Any incident that meets either of these criteria:  Any operations that identify defects or misconfigurations with higher classification safety Systems, Structures and Components (SSC) that prevent performance of the SSC’s safety case defined nuclear safety functions (NS08),  **or**  Any safety analysis and/or quality assurance activity that identifies higher safety classification Systems, Structures and Components cannot perform their safety case defined nuclear safety functions (NS12).  **and the overall impact means that an adequate safety case to continue operations cannot be made.** | NI(DO)R65 (NS03) | MRC-SAF-03 |
| Abnormal occurrences leading to a confirmed release to atmosphere or spillage of a radioactive substance which exceeds or is expected to exceed, the limits set out in Column 5 of Part 1 of Schedule 7 to IRR17, except where the release is in a manner specified in an Authorisation under the Environmental Permitting (England and Wales) Regulations 2016 [[13]](#footnote-14) or Environmental Authorisations (Scotland) Regulations 2018 (EASR18). | IRR17 (RS02) | MRC-SAF-04 |
| Abnormal occurrences leading to a release or suspected release or spread of radioactivity, on or off site, which requires special action or special investigation by the Operator. | NI(DO)R65 (RS03) | MRC-SAF-05 |

## Appendix E.4 – Area of Regulation **– MRC - Transport:**

**Dutyholder notification timeframes for all criteria listed in the table below are IMMEDIATE**

| Description of Criteria | Origin of Legislation (ONR Incident category) | MRC Naming |
| --- | --- | --- |
| A radiation emergency: a situation arising during the course of the carriage of a consignment of class 7 dangerous goods that requires urgent action in order to protect workers, members of the public or the population (either partially or as a whole) from exposure;  **Or**,  Any occurrence during the carriage of nuclear matter, causing or likely to cause death, or serious injury to persons by reason of the radioactive properties of such nuclear matter. **Or**, Emergency arrangements have been initiated in relation to class 7 dangerous goods even if, in the event, no intervention was made pursuant to those arrangements. | CDG09 NI(DO)R65 (TS01) (TS03) | MRC-TRAN-01 |
| Theft or loss of High Consequence Radioactive Material in carriage (High Consequence Radioactive Material (HCRM) is defined in ADR[[14]](#footnote-15) 1.10.3.1.3.) | CDG09 (TS02) | MRC-TRAN-02 |
| An occurrence during loading, carriage or unloading of class 7 dangerous goods involving:   * 1. any release of activity greater than A2 (IAEA SSR6 Table 2) of radioactive material from the packages or from the conveyance if being transported unpackaged;   **or**   * 1. exposure leading to a breach of the limits set out in IRR17 to workers or members of the public. | ADR  (TSO4) | MRC-TRAN-03 |
| An occurrence during loading, carriage or unloading of class 7 dangerous goods, where there is reason to believe that there has been a significant degradation in any Type B(U), Type B(M), Type C or Fissile package safety function (containment, shielding, thermal protection, or criticality) that may have rendered the package unsuitable for continued carriage without additional safety measures. (As defined in ADR 6.4). [[15]](#footnote-16) | ADR NI(DO)R'65 (TS05) | MRC-TRAN-04 |
| An occurrence where class 7 dangerous goods have been transported with any non-compliance regarding radiation or contamination levels where those levels are greater than ten times the prescribed regulatory limits (as set within ADR); **excluding where material activity is within excepted package limits.** | ADR (TS06) | MRC-TRAN-05 |

## Appendix E.5 – Area of Regulation **– MRC - Safeguards**:

**Dutyholder notification timeframes for all criteria listed in the table below are IMMEDIATE**

|  |  |  |
| --- | --- | --- |
| Description of Criteria | Origin of Legislation (ONR Incident category | MRC Naming |
| An event affecting the health and safety of IAEA safeguards personnel, This includes conventional health and safety injuries, unexpected radiological exposure/dose and any other accidents or rule breaches that have a negative impact on the individual’s health and safety. | IAEA VOA (SG01a/i) | MRC-GUARD-01 |
| Denial or restriction of IAEA inspector access to a facility/site/location where access would be expected in accordance with the UK/IAEA Voluntary Offer Safeguards Agreement (VOA) (INFCIRC/951) or the UK Additional Protocol Agreement (INFCIRC/951 Add. 1). | IAEA VOA (SG01a/ii) | MRC-GUARD-02 |
| IAEA safeguards seals on equipment or plant deliberately detached by non-IAEA staff, lost or showing signs of deliberate tampering, or evidence of tampering with IAEA equipment. | IAEA VOA (SG01a/iii) | MRC-GUARD-03 |
| A discrepancy involving 1 significant quantity (as defined in NS(EU)R'19) or more of qualifying nuclear material resulting from material unaccounted for (MUF), or shipper-receiver differences (SRD). | NS(EU)R19 (SG01b/i) | MRC-GUARD-04 |
| Failure to locate a discrete ‘item’ containing qualifying nuclear material as it is reported in the operator’s nuclear material accountancy system. | NS(EU)R19 (SG01b/ii) | MRC-GUARD-05 |

## Appendix E.6 – Area of Regulation **– MRC - Security**:

**Dutyholder notification timeframes for all criteria listed in the table below are IMMEDIATE**

| Description of Criteria | Origin of Legislation (ONR Incident category) | MRC Naming |
| --- | --- | --- |
| Any malicious unauthorised incursion on to the premises or any attempted or suspected such incursion. | NISR2003 (SC10a) | MRC-SEC-01 |
| Any incident occurring on the premises involving an explosive or incendiary device or suspected such device, or a firearm or replica firearm. | NISR2003 (SC10b) | MRC-SEC-02 |
| Any theft or attempted theft, loss or suspected loss, or unauthorised movement of: nuclear material used or stored on the premises; nuclear material in transit to or from the premises, and in the case of premises which form part of a nuclear site, any theft or attempted theft, loss or suspected loss, or unauthorised movement of other radioactive material used or stored on them. | NISR2003 (SC10e)  IRR17  (RS13) | MRC-SEC-03 |
| Any theft, attempted theft, suspected theft, or, any loss or unauthorised disclosure of, sensitive nuclear information classified as SECRET or above. | NISR2003 (SC10f & 22a) | MRC-SEC-04 |
| Any unauthorised access or attempted unauthorised access to sensitive nuclear information classified as SECRET or above. | NISR2003 (SC10g & 22b) |
| Any confirmed cyber attack that resulted in the compromise (loss of confidentiality, integrity or availability) of:   * Operational Technology categorised as ‘minor’ or above. * Information Technology and/or associated network(s) handling sensitive nuclear information | NISR03 (SC10j) | MRC-SEC-05 |

# Appendix F – Quarterly Statement timeline

## Appendix F.1 - Process for engaging with the Department and communicating relevant incidents.

| Step | Title | Period \* | Description |
| --- | --- | --- | --- |
| 1a | In-quarter prompt reporting | Qtr. N | Incidents reported to ONR that are likely to attract significant national media interest will be communicated to DESNZ by ONR’s Organisational Learning (OL) at the earliest opportunity. |
| 1b | In-quarter preparation of INF2s | Qtr. N  W1,M1> W4,M3 | ONR Sub-Divisions prepare INF2s.  INF2 wording cleared through Heads of Regulation & Communications (Comms) Team  Completed INF2s sent to OL. |
| 2 | End of quarter cut off | Qtr. N+1  W1,M1 | The Ministerial Reporting of Incidents letter is produced quarterly. The cut off dates for the reporting periods are: 31st March, 30th June, 30th September and 31st December. |
| 3 | End of quarter review | Qtr. N+1  W1>2, M1 | OL team meet with ONR’s HoR to discuss updates to existing INF2 or identify new INF2s. |
| 4 | ONR Meeting with DESNZ | Qtr. N+1  W4, M1 | OL will provide details of all INF2 produced in the period. ONR and DESNZ will meet to discuss all INF2s and agree which meet the MRC for formal reporting to Ministers. |
| 5 | ONR prepares Ministerial Report | Qtr. N+1  W1, M2 | OL will prepare the Ministerial report of Incidents including covering letter. Report will be cleared through ONR Comms Team ahead of Approval by CNI/CEO |
| 6 | ONR submits Ministerial Reporting of Incidents letter to DESNZ and devolved Governments | Qtr. N+1  W3, M2 | Report of incidents that meet the MRC issued under a covering letter to relevant recipients Changes to distribution list to be agreed with DESNZ. |
| 7 | ONR Quarterly Incident Report published | Qtr. N+1  W1, M3 | ONR Comms publishes the quarterly incident report on the ONR website. |

\* Periods listed in the table are for indicative purposes only; ONR and DESNZ reserve rights for minor deviation from the timeline table in unforeseen circumstances like changes in personnel, national holidays, etc.,

## Appendix F.2 - Illustration of process for engaging with the Department and communicating relevant incidents

1b. INF2 updates. Directorate reviews INF2. If necessary INF2 updated to reflect latest position. INF2 cleared through local Comms business partner. Updated.

1a. New INF2 – Directorate prepares INF2s and clears through local Comms business partner. INF2 sent to OL

End of quarter

3. End of quarter review

OL meets with HoR to discuss updates to existing INF2s, or identifies any new INF2s

4. ONR meeting with DESNZ

Consideration of material to be included in the Ministerial report

5. ONR Internal governance

Reviews by OL, Comms & CNI/CE.

6. Ministerial report submission

Letter sent to Ministers

7. Quarterly incidents report publication

Incidents published on ONR website

Quarter N

W

1

M

1

W

2

W

3

W

4

W

1

M

2

W

2

W

3

W

4

W

1

M

3

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3

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Quarter N + 1

W

1

M

1

W

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W

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W

4

W

1

M

2

W

2

W

3

W

4

W

1

M

3

W

2

W

3

W

4

## Appendix F.3 - Process of managing changes to Ministerial Reporting Criteria

| Changes to MRC identified by DESNZ | | Changes to MRC identified by ONR | |
| --- | --- | --- | --- |
| Step | Action | Step | Action |
| 1 | DESNZ identifies a need to add/amend one or more MRC | 1 | ONR identifies a need to add/amend one or more MRC |
| 2 | DESNZ communicates the details of the need to change the MRC to ONR | 2 | ONR communicates the details of the need to change the MRC to DESNZ |
| 3 | DESNZ shares suggested changes to MRC with ONR for discussion at quarterly incidents review meeting | 3 | ONR shares suggested changes to MRC with DESNZ for discussion at quarterly incidents review meeting |
| 4 | DESNZ writes to ONR (Head of Organisational Learning), formally proposing changes to MRC | 4 | ONR writes to DESNZ (Head of Nuclear Safety Policy) formally proposing changes to MRC |
| 5 | ONR writes to DESNZ accepting changes | 5 | DESNZ writes to ONR accepting changes |
| 6 | ONR updates relevant guidance and shares with DESNZ | 6 | ONR updates relevant guidance and shares with DESNZ |

1. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). [↑](#footnote-ref-2)
2. Pursuant to an agreement between the ONR and the Health and Safety Executive under Section 13(3) of the Health and Safety at Work Act 1974 and Section 90(1) of the Energy Act 2013. [↑](#footnote-ref-3)
3. ONR’s RIDDOR portal should be used for all RIDDOR notifications. The ONR dutyholder portal should be used by registered users as their route to access the RIDDOR portal, and for making all other incident notifications [↑](#footnote-ref-4)
4. Sufficient information should be provided to enable the AI and UKINO to understand how the provisional rating was determined. [↑](#footnote-ref-5)
5. Where the portal is unavailable, incident information sent via alternative routes can be entered manually by ONR into WIReD thereby commencing incident governance. [↑](#footnote-ref-6)
6. Automated reminders within WIReD are being considered as part of future enhancements. [↑](#footnote-ref-7)
7. FURs are currently submitted to ONR by email. Direct FUR submission via the ONR dutyholder portal is a planned future enhancement. [↑](#footnote-ref-8)
8. The future WIReD development plan includes issuing a reminder to the AI one calendar week before the Part C completion due date. [↑](#footnote-ref-9)
9. Criterion 2: All work-related accidents resulting in a ‘Specified injury’ [RIDDOR Reg.4(1) to any person, including non-workers. Criterion 3: Cases of occupational disease. Criterion 4: Incidents which indicate a likelihood of a serious breach of health and safety law. Criterion 5: Major hazard precursor events. Criterion 6: Incidents or events that do not fall within the above criteria but could reasonably give rise to public concern. [↑](#footnote-ref-10)
10. Events without safety significance are rated on the INES scale as Level 0 (Below Scale).   
    Events that have no safety relevance with respect to radiation or nuclear safety are not rated on the INES scale. [Note: Security events are typically assigned a provisional INES rating of 0 in WIReD until an alternative ‘not rated on INES scale’ provision becomes available.] [↑](#footnote-ref-11)
11. **Note**: Decisions relating to whether an incident meets this MRC should be taken considering the responses to the following supporting questions:

    * Has the event been highlighted by UK national media?
    * Does the event involve a dutyholder currently subject to enhanced media or Government interest?
    * Has the incident generated media interest and media approaches to dutyholder or ONR press teams for comment?
    * Is any enforcement action due for publishing, that could attract significant media interest?

    Is the event part of a series of reports that constitutes a broader issue, and therefore more likely to attract national media interest? [↑](#footnote-ref-12)
12. Note: A dutyholder that is making a notification to ONR in relation to this criterion will already be making a notification under other incident notification categories including RIDDOR. COMAH incident notification can be included in the WIReD record and captured in the INF1 and 2 as necessary. [↑](#footnote-ref-13)
13. The Environmental Permitting (England and Wales) Regulations 2016 have replaced those dated 2010 which were referenced in correspondence between ONR/DESNZ [↑](#footnote-ref-14)
14. Where ADR requirements are referenced, the applicable RID requirement also applies. [↑](#footnote-ref-15)
15. **Note:** Occurrences involving other package types (excepted, industrial, Type A packages) do not fall within scope**.** [↑](#footnote-ref-16)