Radiation Accidents and Incidents

What does the University and HSE require?



Reporting radiation incidents/accidents

- What is and what isn't an accident?
- What actions are required under the regulations?
- When would we need to notify the authorities?
- How to report incidents

Actions required under the regulations



- Depending on the severity of the incident/accident, different actions are required
- Most incidents/accidents will be dealt with locally in consultation with the Safety Office, no notification of authorities necessary
- Some incidents/accidents require a formal investigation and notification of HSE, EA or ONR by the RPA

• Unless a minor spill, contact the SO for advice and dose assessments

What is a radiation accident?

IRR17, paragraph 238:

"...small contained spillages of radioactive material and other incidents that could not result in exposures of concern [...] are not radiation accidents. An exposure of concern is where the accident, or actions such as clean-up, resulted or could result in a significant exposure, i.e. an exposure which significantly exceeds normal planned exposures."

Examples of unplanned doses:

- skin contamination or exposure to X-rays
- significant spill requiring closing-off area for decontamination
- If unsure contact us

Notable incidents not directly resulting in a radiation dose

- Loss or suspected loss including during transport.
- Release or spill of significant quantities
- Unauthorised/forced entry to an area containing radioactive sources.
 - Fires, floods or structural collapse of an area containing radioactive sources.
- Any unexpected delivery of radioactive sources to a department, or unexplained failure of an expected item to arrive.
- Any suspected loss or unauthorised interference with materials in a radioactive waste store.

Example 1: contamination – no dose



- Contamination found on the floor after S-35 work
- Low energy beta emitter, no external dose
- Contingency plan followed: screen for spread of contamination, incl. soles of shoes
- No contamination outside supervised area detected
- Spill cleaned-up carefully
- No skin doses received
- Cause of incident found to be leaky container

Example 1: contamination – no dose



What does IRR require?

- IRR 13(2)(d) If contingency plan arrangements were carried out the employer must analyse the cause of the incident and determine any required measures to prevent a recurrence.
- A record must be made and kept for 2 years

- AssessNet reporting system will cover this
- RPA review
- No reporting to authorities necessary

Example 1: contamination – no dose



Measures to prevent a recurrence - lessons learned

does contingency plan require adjusting?



- is all equipment in good condition?
- was monitoring adequate to prevent spread of contamination?
- would PPE have provided adequate protection in case of personal contamination?

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• Contamination of glove with P-32 after dispensing stock solution



- Contamination monitor off-scale
- Glove removed within 1 min
- No contamination underneath





- RPS informed who contacts the Safety Office and DSO
- The incident is logged on Assessnet

- further actions depend on dose received
- contamination or dose-rate monitor reading is most useful
- do you know the monitor response to your radionuclide?





If no measurements are available:

- Estimate dose based on volume of droplet and time of contact
- 50 ul droplet of 0.37 MBq/ul solution results in a skin dose of 583 mSv/min.



- Overexposure?!
- -> immediate investigation by SO and notification to HSE and Occupational Health of potential overexposure.



Refinement of dose estimate – attenuation by glove



- assuming thickness of 0.1 mm and 1g/cm³ density of glove material
- 2.5-fold attenuation of dose from P-32 (Varskin calculation)
- revised dose estimate of 230 mSv
- still actionable dose (under reg. 24; over 30% of a dose limit and exceeding skin dose investigation level of 50 mSv)
- requiring immediate investigation but not immediate notification



Investigation

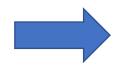
- Interview persons involved
- Are control measures adequate?
- Is the contingency plan suitable?
- Was the contingency plan followed?
- Are systems of work ensuring doses are kept ALARP?





Improvements to procedure – suggestions?

- Lower activity concentration?
- Smaller volume/aliquots?
- Frequency of contamination checks?
- Remote handling tools?
- Shielded racks?



With good control measures in place, are accident doses unlikely to exceed levels requiring classification?



Reporting after formal investigation



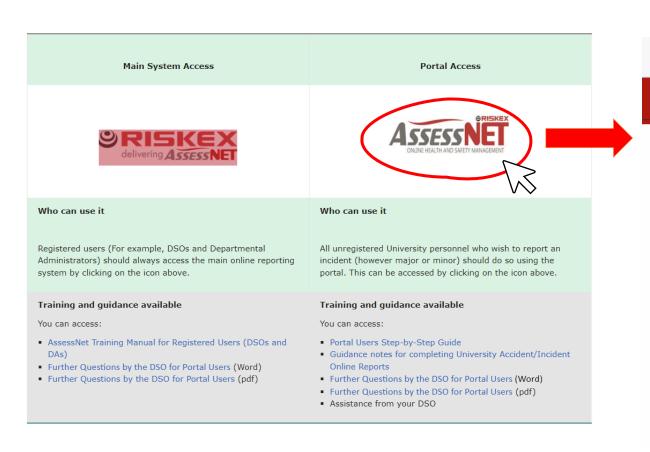
- RPA will investigate and summarise in report
- HSE and affected person will be informed of the outcome
- Report kept for 30 years and until affected person is 75
- also logged on AssessNet, but reported directly to HSE (not RIDDOR)

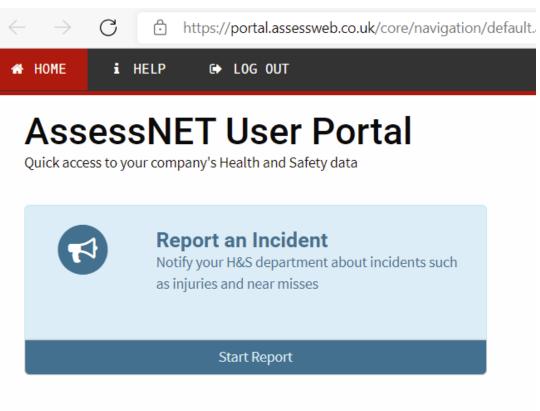
• Exemption: failure of certain irradiators to de-energise or retreat to safe position is RIDDOR reportable, irrespective of any dose received

Reporting incidents on AssessNet



https://www.safety.admin.cam.ac.uk/subjects/accidents-and-incidents





Reporting incidents on AssessNet



- you should already have informed the SO radiation team and your DSO if unplanned exposures/incident happened
- once you have dealt with the immediate aftermath of an accident, submit an incident report without delay
- log incident as a "near miss" unless there is also an injury
- incident type can be changed by DSO
- DSO will supply further detail in consultation with RPS