

### Ibero-American Forum of Radiological and Nuclear Regulatory Agencies (FORO)



Preliminar results of the FORO project " Application of risk matrix method in industrial radiography"

Walter Adrian TRUPPA NUCLEAR REGULATORY AUTHORITY

16th European ALARA Network Workshop, Berne, Switzerland, 14 – 16 March 2016

### About FORO

Who are we?

an association of Nuclear and Radiological regulators created in 1997 with the aim of promoting Radiation Protection, Nuclear Safety and Security at the highest level in the region.

### **Our Vision**

being a fruitful environment for strengthening safety through the exchange of information and practices, as well as through technical and scientific projects in matters of mutual interest.



Spanish



- > Promote Safety,
- Exchange of information and knowledge,
- > Development of projects of common interest,
- > Harmonization of the regulatory practices, and
- Cooperation with national, regional and international organizations and associations with similar objectives.

### **FORO Members**



Autoridad Regulatoria Nuclear

**C**omissão **N**acional de Energia **N**uclear

Comisión Chilena de Energía Nuclear

Ministerio de Minas y Energía

Centro Nacional de Seguridad Nuclear

Consejo de Seguridad Nuclear

Comisión Nacional de Seguridad Nuclear y Salvaguardias

Instituto Peruano de Energía Nuclear

Autoridad Reguladora Nacional en Radioprotección

### FORO Program

- Radiation protection of workers
- Radiation protection of patients
- Radiation protection of the public and the environment
- Emergency preparedness and response
- Accident and Incident Management
- Control of radiation sources
- Decommissioning and closure of Installations

- Radioactive waste management
- Nuclear safety
- Transport of radioactive material
- Knowledge management
- Human and organizational factors
- > Physical security
- Legal issues

## FORO Activities (1)

### Nine projects completed:

- 1. Prevention of accidental exposures in radiation therapy through the application of probabilistic risk assessment (SEVRRA tool);
- 2. Collaborative approaches between regulatory and health authorities for regulatory control of *medical exposures*;
- 3. Regulatory assessment and inspection of NPPs' ageing management and long-term operation;
- 4. Control of inadvertent radioactive material from scrap metal in recycling industries;

### FORO Activities (2)

- 5. Assessment of stress tests performed to NPPs in the FORO countries;
- 6. Harmonisation of regulatory criteria in emergency preparedness and response;
- 7. Licensing of cyclotrons for the production of radionuclides by positron emission tomography in medical applications.
- 8. Capacity building for regulatory staff related to the safety of nuclear reactors (Recently Finished).
- 9. Guidelines to promote and develop safety culture on practices involving the use of ionizing radiation (Recently Finished).



Two projects under development:

Clearance criteria in radioactive installations. 1.

Risk assessment methodology for industrial practices



2.



- **Risk Matrix Methodology applied to Radiotherapy) TECDOC 1685/S.**
- Probabilistic Safety Assessment applied to Radiotherapy) TECDOC 1670/S.
- Programme of Radiological Protection in Medicine -self assessment guidelines to regulators-) - TECDOC 1710/S.
- Regulatory Practices on Ageing Management and Long Term Operation of Nuclear Power Plants in the Ibero-American Region.



### **ACTUAL PROBLEM**

### Nuclear Events Web-based System

(last four events reported)



#### www.foroiberam.org

Reported by Iran Nuclear Regulatory Authority (INRA) of Iran, Islamic Republic of on 18 Nov 2015. Last update on 18 Nov 2015

RSS Feed

### **ACTUAL PROBLEM**

# Nuclear Events Web-based System (2014-2015)

#### **Radiographer Overexposure**

On September 08, 2015, Nuclear Regulatory Authority (ARN) was informed about a radiological incident during industrial radiography of a boiler's manifold in the Thermoelectric Power Station, located in Río Turbio, Santa Cruz. Two workers were exposed to a radiation field of 1.62 TBq (44 Ci) of...

#### Overexposure to Radiographer

After performing a radiograph, the radiographer believed he had cranked the source back inside the camera. However, when he went to retrieve the film, he noticed that his survey meter was reading off-scale, and then he noticed that his pocket dosimeter also read off-scale. The radiographer's...

#### Overexposure of two industrial radiographers

Two industrial radiographers who were involved in an oil refinery projects, overexposed by Gamma radiation of Ir-92, 35 Ci. On 23/09/2015, one of the radiographers dismantled the guide tube without noticing that the source/holder was detached and stocked in the guide tube due to not having survey...

#### Overexposure to Radiographer

While on location at a temporary jobsite, the licensee radiographer attempted to disconnect the guide tube from the radiography camera, without ensuring the source was in the shielded position. The licensee has confirmed a whole body dose of 64 mSv (6.4 rem) which exceeds the statutory dose limit...

#### **Overexposure to Radiographer**

The Lead Radiographer and three assistant radiographers were completing two exposures lasting 35 seconds each. The set-up time for the exposures was approximately 15 to 18 minutes. After completing two exposures, one individual noticed that his pocket dosimeter read off scale, a second individual...

#### Overexposure to workers to radiografic source

Three workers were exposed to doses while working in a bunker. One worker was shielded, two were not. The source is Se-75 1,5 TBq Two workers were exposed to approx. 30 mSv, well above the annual limit of 20 mSv The shielded workers dose was approx. 0.6 mSv. None of the workers had...

#### Dangerous Source at Cárdenas

On April 14th 2015, the National Commission on Nuclear Safety and Safeguards received a report about the theft of a vehicle transporting a radioactive source. This had occurred in the municipality of Cardenas, in the State of Tabasco, Mexico. The stolen source was Ir-92 with an activity of 32 Ci....

#### Missing Dangerous Source at Salamanca

In February 3rd. 2015, the National Commission on Nuclear Safety and Safeguards (this is Mexico's nuclear regulatory authority) was informed by a licensee that three vehicles of its property had been stolen, each one was transporting an Ir-92 source. Therefore, three sources were missing. On the...

#### Theft of a device containig radioactive source

On the 22nd of July 2015 the device containing radioactive source previously reported stolen has been recovered. On the 15th of July 2015 workers conducting industrial gammagraphy lost a device containing a category 2 radioactive source (GammaMat TI-F device with 1.76TBq Ir-192 source) at a...

#### Transport incident of a gamma ray projector

On 16th March 2015, ASN was informed by the ECW company (Courcelles-les-Lens) that one of their gamma ray projects had been carried on the public highway on 2nd March 2015 in conditions failing to comply with a number of requirements stipulated by the transport approval issued by ASN. Indeed, the..

#### Stolen pick-up truck with Ir-192 cat II source

In July 3rd. 2014, at the Municipality of Atizapán de Zaragoza, Mexico State, Mexico, a pick-up truck was stolen, this vehicle was transporting an Industrial Radiography Ir-192 radioactive source, with activity of 1.23 TBq, category II. On July the 4th, 2014, the vehicle was found at the....

# LESSONS LEARNED OF AGCIDENTS REPORTED



What about other possible types of events in industrial radiography?? How many other events do we need to react??

### FIRST STEPS TO BUILD THE PROJECT

IAEA-TECDOC-1685/S

Synergy

FORO - FORO

<image>

FIRST APPROUCH: Regional IRPA Congress 2013, Río de Janeiro, Brazil Aplicación del método de la matriz de riesgo a la radioterapia



Aplicación del método de la matriz de riesgo a la radiografía industrial Experience and collaboration of previous FORO project about Risk matrix in radiotherapy

New FORO document about Risk matrix in industrial radiography

### **ABOUT RISK MATRIX** Consequences **Probability of** (C)failure of Accidental barriers to exposure avoid human error or accidents (p) equipment frequency (f) Risk = R = f x p x C• f is the frequency (or annual frequency of occurrence) of the hazard (initiating event) • **p** is the probability of failure of the barriers provided C is the severity of the potential harm

(consequences)



- The "Risk Matrix" method has been extensively used for <u>safety</u> <u>assessments in different practices and industries.</u>
- The method is characterized by being systematic and simple.
- The basic criteria is to <u>divide each independent variable of the</u> <u>equation of risk.</u> (e.g.: low, medium, high and very high)
- The project includes a <u>strong interaction between the risk matrix and</u> <u>the software named SEVRRA<sub>(1)</sub></u>, to evaluate and compare different risks in industrial radiography.
- (1) Developed by Ibero-American Forum of Radiological and Nuclear Regulatory Agencies (FORO)



### RISK MATRIX EXAMPLE

f <sub>H</sub>	$\mathbf{P}_{\mathbf{H}}$	$\mathrm{C}_{\mathbf{VH}}$	R <sub>VH</sub>	f <sub>H</sub>	$\mathbf{P}_{\mathbf{H}}$	$C_{\mathbf{H}}$	$\mathbf{R}_{\mathrm{VH}}$	f <sub>H</sub>	$\mathrm{P}_{\mathbf{H}}$	$C_{\mathbf{M}}$	R <sub>H</sub>	$\mathbf{f}_{\mathbf{H}}$	$\mathbf{P}_{\mathbf{H}}$	$\mathrm{C}_{\mathtt{L}}$	R <sub>M</sub>
fм	$P_{\mathbf{H}}$	$\mathrm{C}_{\mathbf{VH}}$	$\mathbf{R}_{\vee \mathbf{H}}$	fm	$P_{\mathbf{H}}$	$\mathbf{C}_{\mathbf{H}}$	R <sub>H</sub>	fм	$P_{\mathbf{H}}$	$C_{\mathbf{M}}$	R <sub>H</sub>	fм	$P_{\mathbf{H}}$	$C_{L}$	R <sub>M</sub>
$\mathbf{f}_{\mathbf{L}}$	$\mathbf{P}_{\mathbf{H}}$	$\mathrm{C}_{VH}$	R <sub>H</sub>	fL	$\mathbf{P}_{\mathbf{H}}$	$C_{\mathbf{H}}$	R <sub>H</sub>	$\mathbf{f}_{\mathbf{L}}$	$\mathrm{P}_{\mathbf{H}}$	$C^{\mathbf{M}}$	$\mathbf{R}_{\mathbf{M}}$	$\mathbf{f}_{\mathbf{L}}$	$\mathbf{P}_{\mathbf{H}}$	$\mathbf{C}_{\mathbf{L}}$	R <sub>M</sub>
$\mathbf{f}_{\mathbf{VL}}$	$P_{\mathbf{H}}$	$\mathrm{C}_{VH}$	R <sub>H</sub>	fvL	$P_{\mathbf{H}}$	$\mathbf{C}_{\mathbf{H}}$	R <sub>H</sub>	$\mathbf{f}_{\mathbf{VL}}$	$\mathtt{P}_{\Xi}$	$C_{\mathbf{M}}$	Rм	$\mathbf{f}_{\mathbf{VL}}$	$P_{\mathbf{H}}$	$C_{L}$	R <sub>M</sub>
$\mathbf{f}_{\mathbf{H}}$	$\mathbf{P}_{\mathbf{M}}$	$\mathrm{C}_{\mathbf{VH}}$	$\mathbf{R}_{\mathbf{VH}}$	f <sub>H</sub>	$\mathbf{P}_{\mathbf{M}}$	$\mathbf{C}_{\mathbf{H}}$	R <sub>H</sub>	f <sub>H</sub>	$\mathbf{P}_{\mathbf{M}}$	$C_{\mathbf{M}}$	R <sub>H</sub>	$\mathbf{f}_{\mathbf{H}}$	$\mathbf{P}_{\mathbf{M}}$	$\mathbf{C}_{\mathbf{L}}$	R <sub>M</sub>
fм	Р <b>м</b>	$\mathrm{C}_{VH}$	R <sub>H</sub>	fm	$\mathbf{P}_{\mathbf{M}}$	$C_{\mathbf{H}}$	R <sub>H</sub>	fм	Р <b>м</b>	См	RM	fм	$\mathbf{P}_{\mathbf{M}}$	$C_{L}$	R <sub>M</sub>
$\mathbf{f}_{\mathbf{L}}$	$\mathbf{P}_{\mathbf{M}}$	$C_{\text{VH}}$	R <sub>H</sub>	fL	$\mathbf{P}_{\mathbf{M}}$	$\mathbf{C}_{\mathbf{H}}$	R <sub>H</sub>	$\mathbf{f}_{\mathbf{L}}$	$\mathbf{P}_{\mathbf{M}}$	$C_{\mathbf{M}}$	R <sub>M</sub>	$\mathbf{f}_{\mathbf{L}}$	$\mathbf{P}_{\mathbf{M}}$	$C_{\mathbf{L}}$	$\mathbf{R}_{\mathbf{L}}$
$\mathbf{f}_{VL}$	$\mathbf{P}_{\mathbf{M}}$	$\mathrm{C}_{VH}$	R <sub>H</sub>	f <sub>VL</sub>	$\mathbf{P}_{\mathbf{M}}$	$\mathbf{C}_{\mathbf{H}}$	RM	1 <sub>VL</sub>	Рм	См	R <sub>M</sub>	$\mathbf{f}_{\mathbf{VL}}$	$\mathbf{P}_{\mathbf{M}}$	$\mathbf{C}_{\mathbf{L}}$	$\mathbf{R}_{\mathbf{L}}$
$\mathbf{f}_{\mathbf{H}}$	$P_{\mathbf{L}}$	$\mathrm{C}_{\mathbf{VH}}$	R <sub>H</sub>	f <sub>H</sub>	$P_{L}$	$\mathbf{C}_{\mathbf{H}}$	R <sub>H</sub>	$\mathbf{f}_{\mathbf{H}}$	$\mathtt{P}_{\mathtt{L}}$	$\mathbf{C}^{\mathbf{M}}$	$\mathbf{R}_{\mathbf{M}}$	$\mathbf{f}_{\mathbf{H}}$	$\mathbf{P}_{\mathbf{L}}$	$\mathbf{C}_{\mathbf{L}}$	$\mathbf{R}_{\mathbf{L}}$
fш	$P_{L}$	$\mathrm{C}_{VH}$	R <sub>H</sub>	fм	$P_{L}$	$\mathbf{C}_{\underline{\mathbf{H}}}$	R <sub>H</sub>	fм	$P_{L}$	$C^{\mathbf{M}}$	R <sub>M</sub>	fш	$P_{L}$	$\mathbf{C}_{\mathbf{L}}$	RL
$\mathbf{f}_{\mathbf{L}}$	$P_{L}$	$\mathrm{C}_{\mathbf{VH}}$	RM	fL	$P_{L}$	$\mathbf{C}_{\mathbf{H}}$	RM	$\mathbf{f}_{\mathbf{L}}$	$\mathtt{P}_{\mathtt{L}}$	$C_{\mathbf{M}}$	$\mathbf{R}_{\mathbf{M}}$	$\mathbf{f}_{\mathbf{L}}$	$\mathbf{P}_{\mathbf{L}}$	$\mathbf{C}_{\mathbf{L}}$	$\mathbf{R}_{\mathbf{L}}$
$\mathbf{f}_{VL}$	$P_{L}$	$\mathrm{C}_{\mathbf{VH}}$	RM	$f_{VL}$	$P_{L}$	$\mathbf{C}_{\mathbf{H}}$	RM	$\mathbf{f}_{\mathbf{VL}}$	$P_{\mathbf{L}}$	$C_{\mathbf{M}}$	RM	$\mathbf{f}_{VL}$	$P_{L}$	$\mathbf{C}_{\mathbf{L}}$	RL
$\mathbf{f}_{\mathbf{H}}$	$P_{\mathbf{VL}}$	$\mathrm{C}_{\mathbf{VH}}$	R <sub>H</sub>	f <sub>H</sub>	$P_{\mathbf{VL}}$	$\mathbf{C}_{\mathbf{H}}$	RM	$\mathbf{f}_{\mathbf{H}}$	$P_{\mathbf{VL}}$	$\mathbf{C}^{\mathbf{M}}$	$\mathbf{R}_{\mathbf{M}}$	$\mathbf{f}_{\mathbf{H}}$	$P_{\mathbf{VL}}$	$\mathbf{C}_{\mathbf{L}}$	$\mathbf{R}_{\mathbf{L}}$
fм	$P_{\mathbf{VL}}$	$C_{\mathbf{VH}}$	RM	fM	$P_{\mathbf{VL}}$	$\mathbf{C}_{\mathbf{H}}$	RM	fм	$P_{\mathbf{VL}}$	$C_{\mathbf{M}}$	$\mathbf{R}_{\mathbf{M}}$	fм	$P_{\mathbf{VL}}$	$C_{\mathbf{L}}$	RL
$\mathbf{f}_{\mathbf{L}}$	$\mathrm{P}_{\mathbf{VL}}$	$\mathrm{C}_{\mathbf{VH}}$	RM	$f_L$	$\mathrm{P}_{\mathbf{VL}}$	$\mathbf{C}_{\underline{\mathbf{H}}}$	$\mathbf{R}_{\mathbf{L}}$	$\mathbf{f}_{\mathbf{L}}$	$\mathrm{P}_{VL}$	$\mathbf{C}_{\underline{\mathbf{M}}}$	$\mathbf{R}_{\mathbf{L}}$	$\mathbf{f}_{\mathbf{L}}$	$\mathrm{P}_{\mathbf{VL}}$	$\mathbf{C}_{\mathbf{L}}$	$\mathbf{R}_{\mathbf{L}}$
$\mathbf{f}_{VL}$	$P_{\mathbf{VL}}$	$\mathrm{C}_{\mathbf{VH}}$	RM	$f_{VL}$	$P_{\mathbf{VL}}$	$\mathbf{C}_{\mathbf{H}}$	RL	$\mathbf{f}_{VL}$	$P_{\mathbf{VL}}$	$C_{\mathbf{M}}$	$\mathbf{R}_{\mathbf{L}}$	$\mathbf{f}_{VL}$	$P_{\mathbf{VL}}$	$\mathbf{C}_{\mathbf{L}}$	RL

Risk = R = f x p x C



- <u>SEVRRA is a software (tool)</u> developed by the Ibero-American Forum of Radiological and Nuclear Regulatory Agencies <u>to facilitate</u> <u>the assessment of the risk level of different applications, uses and</u> <u>standardize regulatory activities</u>, by promoting best practices.
- SEVRRA gives the <u>opportunity to identify strengths and weaknesses</u> of the services of industrial radiography, regarding on the implementation of safety measures and barriers with the aim of reducing the probabilities of a radiological incident/accident and its consequences.

### THE PROJECT: STEP BY STEP

STEP 1: MEETING IN CUBA. Establishment of criteria and methodology to apply in the risk matrix of industrial radiography.

STEP 2 AND 3: MEETINGS IN MÉXICO evaluation of different incident, accidents, barriers, frequencies and consequencies.

Evaluation of SEVRRA software for industrial radiography. The tool is a especific program which takes into account the iniciator (failures), barriers and consequencies.



Nine authorized companies for industrial radiography in México were invited to participate in the technical meetings and an important group of operators attend the two meetings sharing experiences.

STEP 4: LAST MEETING IN MADRID (NEXT APRIL) to discuss and prepare the final document.

# EVALUATION OF EVENTS (INICIATOR)

#### Catálogo de sucesos iniciadores - 1 a 10 de 20

Orden 🔺	Substanz		< > >>											
Orden 🔺	Subotana		<< < > >> Mostrar todo registros Limpiar fitro											
	Suberapa	Etapa	Práctica	Consecuencia	Frecuencia	Nombre	Código	No						
	Ninguno 🔻	Ninguno	Radiografía Industrial móvil con fuentes de radiación X 🔹	Ninguna 🔻	Ninguna 🔻									
1	Ninguna	ADQUISICION	Radiografía Industri	CM	FB	Se adquiere un equipo con	AD-EH-CEFB	1						
1	Ninguna	ALMACEN EN SEDE CENT	Radiografía Industri	CMA	FB	Sustracción del equipo de	AL-EH-SERXA	2						
1	Ninguna	TRANSPORTE	Radiografía Industri	CMA	FMB	Falla de los medios de fi	TR-FMF	3						
1	Ninguna	PRETRABAJO	Radiografía Industri	СМ	FM	No se realiza evaluación	PT-NETAC	. 4						
1	Ninguna	OPERACIÓN - IRRADIAC	Radiografía Industri	СМ	FB	Error al conectar la cons	OP-EH-ECCC	5						
2	Ninguna	ALMACEN EN SEDE CENT	Radiografia Industri	СМ	FMB	Caída del equipo dañándos	AL-EH-CC	6						
2	Ninguna	TRANSPORTE	Radiografía Industri	CMA	FB	Error de fijación del equ	TR-EH-EF	7						
2	Ninguna	PRETRABAJO	Radiografia Industri	СМ	FM	Error al definir el área	PT-EDAC	8						
2	Ninguna	OPERACIÓN - IRRADIAC	Radiografía Industri	CA	EMB	Fallo del temporizador de	OP-FTPC	9						
3	Ninguna	TRANSPORTE	Radiografia Industri	CMA	FB	Robo del equipo durante e	TR-EH-SET	10						
	1 A 1 A 1 A 1 A 1 A 1 A 2 A 2 A 2 A 2 A 3 A	Ninguna     1     Ar       Ninguna     2     Ar       Ninguna     3     Ar	ADQUISICION Ninguna 1 Ar ALMACEN EN SEDE CENT Ninguna 1 Ar TRANSPORTE Ninguna 1 Ar PRETRABAJO Ninguna 1 Ar OPERACIÓN - IRRADIAC Ninguna 2 Ar TRANSPORTE Ninguna 2 Ar PRETRABAJO Ninguna 2 Ar ODERACIÓN - IRRADIAC Ninguna 2 Ar	Radiografia Industri     ADQUISICION     Ninguna     1     Advice Automatical Advices and Automatical Automatical Advices and Automatical Automatical Advices and Automatical Automatical Advices and Automatical Advices	CM     Radiografía Industri     ADQUISICION     Ninguna     1     Addition       CMA     Radiografía Industri     ALMACEN EN SEDE CENT     Ninguna     1     Addition       CMA     Radiografía Industri     TRANSPORTE     Ninguna     1     Addition       CMA     Radiografía Industri     PRETRABAJO     Ninguna     1     Addition       CM     Radiografía Industri     PRETRABAJO     Ninguna     1     Addition       CM     Radiografía Industri     OPERACIÓN - IRRADIAC     Ninguna     1     Addition       CM     Radiografía Industri     OPERACIÓN - IRRADIAC     Ninguna     2     Addition       CMA     Radiografía Industri     TRANSPORTE     Ninguna     2     Addition       CMA     Radiografía Industri     TRANSPORTE     Ninguna     2     Addition       CMA     Radiografía Industri     PRETRABAJO     Ninguna     2     Addition       CMA     Radiografía Industri     PRETRABAJO     Ninguna     2     Addition       CA     Radiografía Industri     OPERACIÓN - IRRADIAC     Ninguna     2     Addition       CMA     Radiografía Industri     TRANSPORTE     Ninguna     3     Addition	FB       CM       Radiografia Industri       ADQUISICION       Ninguna       1       A         FB       CMA       Radiografia Industri       ALMACEN EN SEDE CENT       Ninguna       1       A         FMB       CMA       Radiografia Industri       TRANSPORTE       Ninguna       1       A         FMB       CMA       Radiografia Industri       TRANSPORTE       Ninguna       1       A         FM       CM       Radiografia Industri       PRETRABAJO       Ninguna       1       A         FB       CM       Radiografia Industri       OPERACIÓN - IRRADIAC       Ninguna       1       A         FB       CM       Radiografia Industri       OPERACIÓN - IRRADIAC       Ninguna       2       A         FB       CMA       Radiografia Industri       ALMACEN EN SEDE CENT       Ninguna       2       A         FB       CMA       Radiografia Industri       TRANSPORTE       Ninguna       2       A         FM       CM       Radiografia Industri       PRETRABAJO       Ninguna       2       A         FM       CM       Radiografia Industri       PRETRABAJO       Ninguna       2       A         FMB	Se adquiere un equipo con       FB       CM       Radiografía Industri       ADQUISICION       Ninguna       1       A         Sustracción del equipo de       FB       CMA       Radiografía Industri       ALMACEN EN SEDE CENT       Ninguna       1       A         Falla de los medios de fi       FMB       CMA       Radiografía Industri       TRANSPORTE       Ninguna       1       A         No se realiza evaluación       FM       CM       Radiografía Industri       PRETRABAJO       Ninguna       1       A         Error al conectar la cons       FB       CM       Radiografía Industri       OPERACIÓN - IRRADIAC       Ninguna       1       A         Caída del equipo dañándos       FMB       CM       Radiografía Industri       ALMACEN EN SEDE CENT       Ninguna       1       A         Caída del equipo dañándos       FMB       CM       Radiografía Industri       OPERACIÓN - IRRADIAC       Ninguna       2       A         Error al definir el área       FB       CMA       Radiografía Industri       TRANSPORTE       Ninguna       2       A         Error al definir el área       FM       CM       Radiografía Industri       PRETRABAJO       Ninguna       2       A <td>AD-EH-CEFB       Se adquiere un equipo con       FB       CM       Radiografía Industri       ADOUISICION       Ninguna       1       Ad         AL-EH-SERXA       Sustracción del equipo de       FB       CMA       Radiografía Industri       ALMACEN EN SEDE CENT       Ninguna       1       Ad         TR-FMF       Falla de los medios de fi       FMB       CMA       Radiografía Industri       TRANSPORTE       Ninguna       1       Ad         PT-NETAC       No se realiza evaluación       FM       CM       Radiografía Industri       PRETRABAJO       Ninguna       1       Ad         OP-EH-ECCC       Error al conectar la cons       FB       CM       Radiografía Industri       OPERACIÓN - IRRADIAC       Ninguna       1       Ad         AL-EH-CC       Caída del equipo dañándos       FMB       CM       Radiografía Industri       OPERACIÓN - IRRADIAC       Ninguna       2       Ad         TR-EH-EF       Error al conectar la cons       FB       CMA       Radiografía Industri       ALMACEN EN SEDE CENT       Ninguna       2       Ad         TR-EH-EF       Error al conectar la cons       FB       CMA       Radiografía Industri       TRANSPORTE       Ninguna       2       Ad</td>	AD-EH-CEFB       Se adquiere un equipo con       FB       CM       Radiografía Industri       ADOUISICION       Ninguna       1       Ad         AL-EH-SERXA       Sustracción del equipo de       FB       CMA       Radiografía Industri       ALMACEN EN SEDE CENT       Ninguna       1       Ad         TR-FMF       Falla de los medios de fi       FMB       CMA       Radiografía Industri       TRANSPORTE       Ninguna       1       Ad         PT-NETAC       No se realiza evaluación       FM       CM       Radiografía Industri       PRETRABAJO       Ninguna       1       Ad         OP-EH-ECCC       Error al conectar la cons       FB       CM       Radiografía Industri       OPERACIÓN - IRRADIAC       Ninguna       1       Ad         AL-EH-CC       Caída del equipo dañándos       FMB       CM       Radiografía Industri       OPERACIÓN - IRRADIAC       Ninguna       2       Ad         TR-EH-EF       Error al conectar la cons       FB       CMA       Radiografía Industri       ALMACEN EN SEDE CENT       Ninguna       2       Ad         TR-EH-EF       Error al conectar la cons       FB       CMA       Radiografía Industri       TRANSPORTE       Ninguna       2       Ad						



# SCREEN OF SEVRRA SOFTWARE

	SEVRRA	
FORO	Foro iberoamericano de Organismos Reguladores Radiológicos y Nucleares	



stapa 1: ADQUISICIO	N
Stapa 2: ALMACENAS	IIENTO
Stapa 3: ALMACENTE	MPORAL
Etapa 4: TRANSPORT	E
Etapa 5: PRETRABAJO	0
Stapa 6: OPERACIÓN	
tapa 7: MANTENIMI	ENTO

#### Resumen de la Práctica (Sucesos Iniciadores)

Mi cuenta

Núm.	Etapa	Riesgo Muy Alto (RMA)	Riesgo Alto (RA)	Riesgo Medio (RM)	Riesgo Bajo (RB)	No Aplica (NA)	Registrados	Total por Etapa	Complete
1	ADQUISICIÓN	0	0	0	0	0	0	8	0
2	ALMACENAMIENTO	0	0	0	0	0	0	12	0
3	ALMACENTEMPORAL	0	0	0	0	0	0	6	0
4	TRANSPORTE	0	0	0	0	0	0	12	0
5	PRETRABAJO	0	0	0	0	0	0	8	0
6	OPERACIÓN	0	0	0	0	0	0	25	0
7	MANTENIMIENTO	0	0	0	0	0	0	4	0
	Total	0	0	0	0	0	0	75	0

nismos Jucleares

	A	5
	- Contraction	4

							the second se	and the second se	
lisis de riesgo	Mi cuenta	1		Acerca de SEVRRA	1		Ayuda	Salir	
1 ADQUISICIÓN	0	2	5	1	0	8	8	0	
2 ALMACENAMIENTO	0	6	6	0	0	12	12	0	
3 ALMACENTEMPORAL	0	0	0	0	0	0	6	0	
4 TRANSPORTE	0	0	0	0	0	0	12	8	
5 PRETRABAJO	0	0	0	0	0	0	8	0	
6 OPERACIÓN	0	0	0	0	0	0	25	0	
7 MANTENIMIENTO	0	0	0	0	0	0	4	8	
Total	0	8	11	1	0	20	75	2	

### FINAL SEVRRA REPORT



SEVRRA Foro iberoamericano de Organismos Reguladores Radiológicos y Nucleares



Núm.	Etapa	Riesgo Muy Alto (RMA)	Riesgo Alto (RA)	Riesgo Medio (RM)	Riesgo Bajo (RB)	No Aplica (NA)	Analizados	Total por Etapa	Completo
1	ADQUISICIÓN	0	0	5	3	0	8	8	
2	ALMACENAMIENTO	0	3	6	3	0	12	12	<ul> <li>Image: A second s</li></ul>
3	ALMACENTEMPORAL	0	0	0	0	6	6	6	
4	TRANSPORTE	0	5	5	1	1	12	12	<ul> <li>Image: A start of the start of</li></ul>
5	PRETRABAJO	0	0	6	2	0	8	8	<ul> <li>Image: A start of the start of</li></ul>
6	OPERACIÓN	0	3	13	9	0	25	25	<ul> <li>Image: A start of the start of</li></ul>
7	MANTENIMIENTO	0	0	0	1	3	4	4	<ul> <li>Image: A start of the start of</li></ul>
	Total	0	11	35	19	10	75	75	7

### FINAL SEVRRA REPORT



### FINAL SEVRRA REPORT

#### Sucesos Iniciadores con riesgo Alto y Muy Alto

En base a la información que hemos vertido, los siguientes sucesos iniciadores los obtuvimos con Riesgo Alto y Muy Alto:

Código SI	Suceso	Riesgo de	Riesgo	Barreras y
	Iniciador	Referencia	Obtenido	Reductores Faltantes
AL-DXF-AMR	Incendio en el almacén	RM	RA	B-44, RF-42,
AL-DXE-AMR	Explosión en el almacén que daña el equipo	RA	RA	RF-45,
AL-DXEXT-AMR	Eventos naturales que afecten la instalación con la consecuente pérdida de control de la fuente y equipos.	RA	RA	Ninguna
TR-HUR-VET	Hurto del vehículo que ocasiona que la fuente caiga en el dominio público	RA	RA	RF-96, RF-97, RF-104, RC-33,
TR-ROB-VET	Robo con violencia del vehículo que ocasiona que la fuente caiga en el dominio público	RA	RA	RF-96, RF-97, RF-104, RC-33, RC-63,
TR-ROB-CONT	Robo con violencias del equipo (proyector) que ocasiona que caiga en el dominio público	RA	RA	RF-96, RF-97, RF-104, RC-33,
TR-TRA-VTP	Accidente en un transporte no autorizado que ocasiona que el equipo (proyector) caiga en el dominio público	RA	RA	RC-33,
TR-HUR-VTP	Hurto del equipo (proyector) durante el traslado en transporte no autorizado que ocasiona que caiga en el dominio público	RA	RA	RC-33,
OP-HUR-CONT	Intento de hurto del equipo (proyector) durante los trabajos	RA	RA	RF-107, RF-142, RC-33,
OP-ROB-CONT	Robo con violencia del equipo (proyector) durante los trabajos	RA	RA	RC-33,
OP-HMDS-PE	Errores durante la ejecución del plan de emergencia que afecta la efectividad de las respuestas planificadas	RA	RA	RF-136,

### CONCLUSIONS

- Methodology of Risk Matrix and SEVRRA software can detect deviations, failures and errors during the practice.
- This situation gives the opportunity to correct and solve situations which can lead into radiological consequences.
- SEVRRA software is friendly and easy to apply.
- No special or specific knowledge on the risk matrix methodology is necessary for radiographers.
- The risk evaluation is a good tool to reduce the rate of incidents / accidents, and to avoid unjustified radiation exposure of workers and the public.
- The project provides a methodology and an innovative tool to reduce the radiological risk.
- More details and final results of the project coming soon...!!!.

### CONCLUSIONS

 $\checkmark$  It is necessary to strengthen radiation safety measures.

- ✓ We need to reduce the probability of occurrence of radiological events.
- ✓ One only commitment. One only philosophy.



