Results from WG 4

«Learning from radiography accidents»

The role of different stakeholders in preventing accidents

- Radiography companies:
  - Hold the license and are in principle responsible in case of an accident
  - Responsible to handle the situation at site, or have a contract with a company that can deal with the situation.
  - Have procedures, competence etc.

The role of different stakeholders in preventing accidents cont.

- Radiographers and supervisors:
  - Radiographers are responsible for carrying out radiography according to procedures.
- Clients:
  - Can sometimes have co-responsibility for an accident at their site, for example on nuclear power plants and offshore installations

The role of different stakeholders in preventing accidents cont.

- Regulatory bodies:
  - Issue licensees with all relevant requirements.
  - Are not directly responsible for accidents, but have to be notified and are involved in investigation
  - have relevant regulations and guidance material/norms available
  - Oversee the users radiation protection system through licensing and inspection
  - Be able to give advice

Recommendations

- Training and education of radiographers is important
  - Responsibility of employer to ensure time made available for training
  - Certified initial education and training
  - Need to have regular refresher training
  - Demonstrate competence through internal audits
  - Employer to ensure appropriate on the job training given

Recommendations cont.

- Maintenance of equipment is important,
  - need procedures to maintain equipment locally and to return to manufacturer/supplier after specified number of cycles
  - The local procedure should include the manufacturer recommendations for routine maintenance.

- Involvement of employees at all levels in the enterprise is important, so procedures makes sense – important for users to take ownership and to improve the safety culture

Some types of radiography accidents are repeated again and again: what steps can we take to target these specific accidents?

- Half of the accidents are with the equipment.

Recommendation:

- Manufacturer/distributer should involve/consult users in order to understand issues faced by users and improve the equipment design
- Establish forum for exchange of information and experience between stakeholders

Can more be done in terms of analysing the underlying causes of radiography accidents, and then sharing and disseminating this information?

- Underlying causes of incidents/accidents are well known
- Still important to evaluate incidents – to learn from them

- Regulatory body:
  - share information through established national and international notification mechanisms (IRS - IAEA, OTHEA, ASN etc.)
  - share information with industrial radiography associations.
  - share information to the radiographer through training and education courses etc.

Recommendations

- Companies to establish internal incident reporting system
- Encourage a no blame culture when reporting incidents
  - Companies may be more likely to report externally
  - Radiographers also more likely to report through internal incident management systems