

Radiological incident feedback (RELIR)

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RELIR

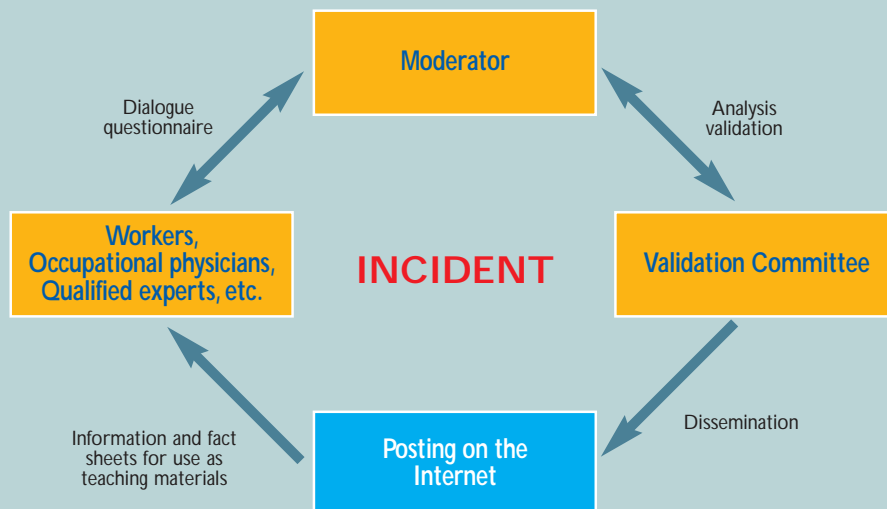
A feedback network available to all

- Set up by the "Qualified Expert Group" of the French Society for Radiological Protection
- In conjunction with INRS⁽¹⁾, IRSN⁽²⁾, Institut Curie and CEPN⁽³⁾

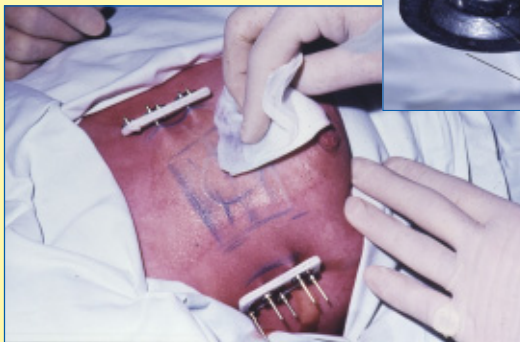
GOAL To select relevant incidents for use in training and accident prevention programs

- OBJECTIVES**
- Learning in order to avoid new incidents
 - Fostering exchange of information between radiological protection specialists and non-specialists
 - Producing documents as teaching materials

FLOWCHART



Data sheet example



Photos: Institut Curie

Circumstances:

One lost Iridium¹⁹² line (254 MBq)
 During ablation of 5 Iridium lines at the end of the treatment, somebody realized that one was lost; this line was found in a dirty linen bag in a pillowcase.

Radiological consequences:

One person was considered as exposed when she changed the pillowcase (the received dose was evaluated at 35 μSv); but the received dose could have been much higher (dose rates at 3 cm = 6 μSv/s).

Lessons to be learned from this incident:

- Active and passive dose monitoring of the workers taking care of these patients should be implemented;
- The radioactive lines' fixation technique should be improved;
- The lines must be checked everyday;
- Any exit of the zone must be checked;
- Health care workers must be trained before any intervention;
- An internal guideline about good practice measures in case of an incident must be drawn up and disseminated.

This approach is consistent with a process underway in Europe (IRID system in the UK, EURAIDE project at European level, etc.)

Web site : www.relir.cepn.asso.fr

⁽¹⁾INRS: Institut National de Recherche et de Sécurité (National Research and Safety Institute) - ⁽²⁾IRSN: Institut de radioprotection et de sûreté nucléaire (Institute for radioprotection and nuclear safety)

⁽³⁾CEPN: Centre d'Etude sur l'évaluation de la Protection dans le domaine Nucléaire (French Nuclear Protection Evaluation Center)