# Learning from radiography accidents: how do we stop them from happening again?

WG 2 – Group 3

# Radiographer:

- They must be informed about how they have to react when an incident happen:
  - Stop working! Apply ALARA!
  - Keep calm!
  - Communicate!
  - Wait for help!

# **NDT** company:

- Risk-Analyses:
  - Clear goals
  - Dose constraints
  - Describe expected results
  - Define means
- Setup proper emergency plans and tools:
  - Simulation
  - Audit
- Regular training and re-training
- Audit the radiographers
- Inform the client about the risk and justification

#### **Client:**

- Must be aware of the risk when ordering radiography
- Must provide a suitable working environment at risk
- Minimal requirements for the job must be provided by the responsible persons (work safety instructor, healthcare management, etc.) from client
- Coordinate activities

# **Regulatory bodies:**

- Verify and evaluate the <u>justification</u>
- Collect events to make thematic analyses
- Communicate the analyses events (e.g. OTHEA)
- Evaluation of emergency plans and operational procedures
- Coordinate with the NDT-society (Meetings,...)
- Good practise charters

#### Recommendations to the stakeholders:

- Communicate / Cooperate
- Improve the commitment with safety culture (ALARA)
- → NDT companies must have a realistic emergency plan(s) based on risk-analyses feasible by trained radiographer and approved by regulatory bodies.

# Some types of accidents are repeated again and again,...

- →Establish a management process to identify all initiators (deviations, failures, procedures).
- → Treat the underlying causes.
- → Follow up the implementations (lessons learned e.g RP-training).
- → Identify good practise to prevent consequences.
- →NDT-companies (regulatory bodies, clients):

  Identify Treat Follow up

