

IRPA12 Refresher Course RC-20

**Radiation protection in industrial applications of
radioactive sources:
Prevention of Accidents in
Gammagraphy**

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Introduction: Why this subject?

- **Prone to accidents and leaving orphan sources**
 - Dominant usage in UNSCEAR list of accidents
 - Many instances of orphan sources
 - Radiation injuries and fatalities
- **Terminology**
 - Gammagraphy = gamma (γ)radiography
 - Industrial radiography = X- and γ -radiography

River Tyne, 1972



Contents

- Types of radiography and equipment
- Common causes of accidents
- Examples of serious accidents
- Mechanisms to learn lessons
- Roles of the different “Players”
- Emergency response
- Guidance material and training

Types of radiography (1)

Enclosure radiography

- Purpose built (?) shielded enclosure
 - “temporary” nature of some
 - Non-standard use
- Installed safety systems: warning lights and interlocks (?)
- Should be inherently safer: maintenance an issue
- Problems with open topped enclosures

Types of radiography (2)

Mobile radiography

- Within temporary barriers
- Portable warning and safety systems
- Adverse working conditions
- Often away from supervision
- Access control can be difficult
 - Multi-level
 - Need to liaise with site management and contractors
- Heavy reliance on procedures

Inherently more Hazardous

X-Radiography

- **Typically 100 to 300 kV and 3 to 15 mA**
 - Outputs 30 to 300 mGy.min⁻¹ at 1 m
 - At 10 cm: 3 to 30 Gy.min⁻¹
 - Collimation
- **Need for automatic fail-safe safety and warning systems**
- **Integral part of design of enclosures**
 - Emergency stop buttons/ pull cords
 - Search and lock up

Typical accidents from:

- **poor design and maintenance of safety systems**
- **Lack of awareness and poor procedures**

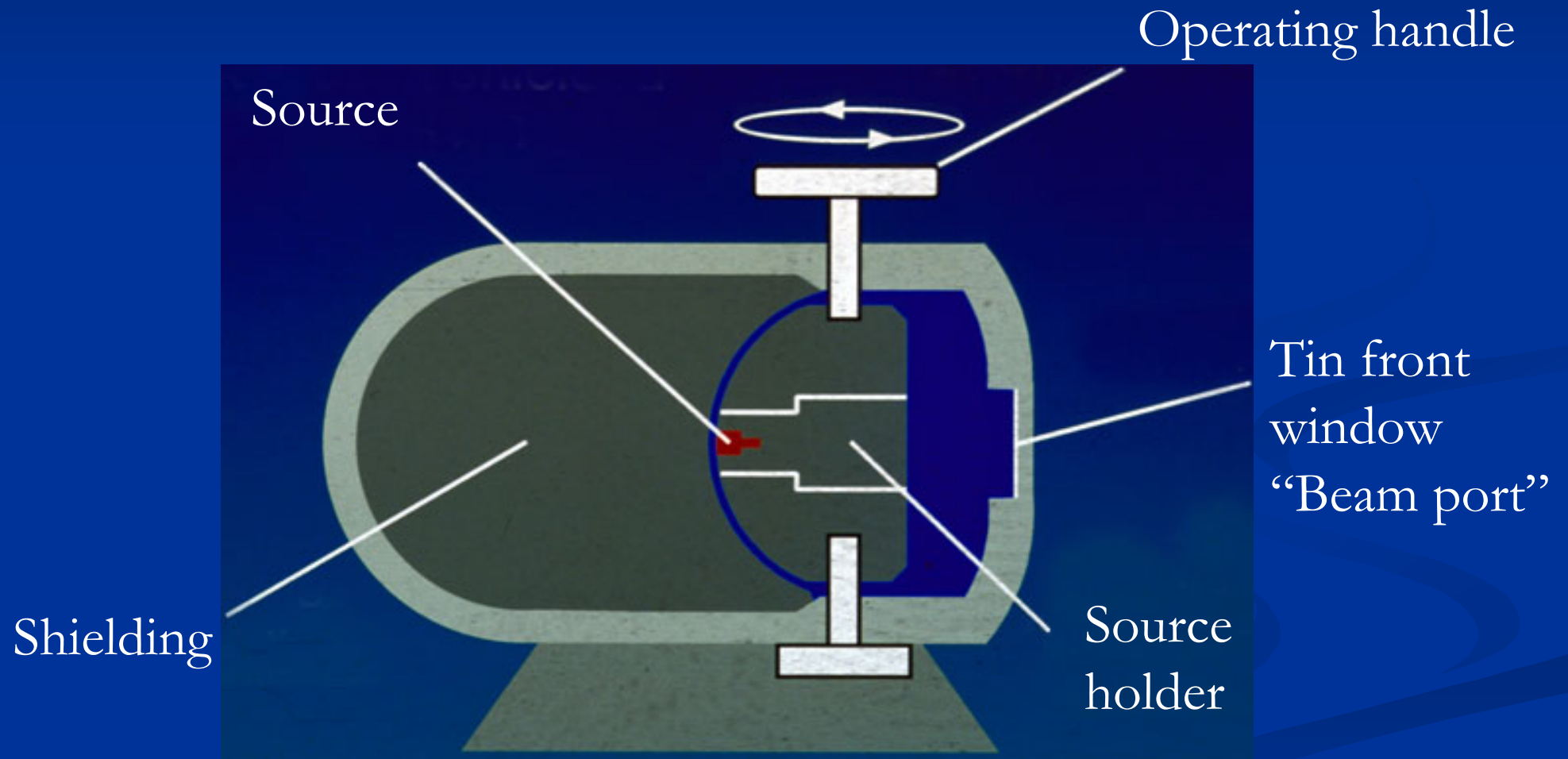
Linear accelerators

- Typically up to 8 MeV
- Outputs $\sim 4 \text{ Gy}\cdot\text{min}^{-1}$ at 1 m
- Specialist uses
- High quality (multiple redundancy) safety systems
- Higher degree of knowledge and training for operators

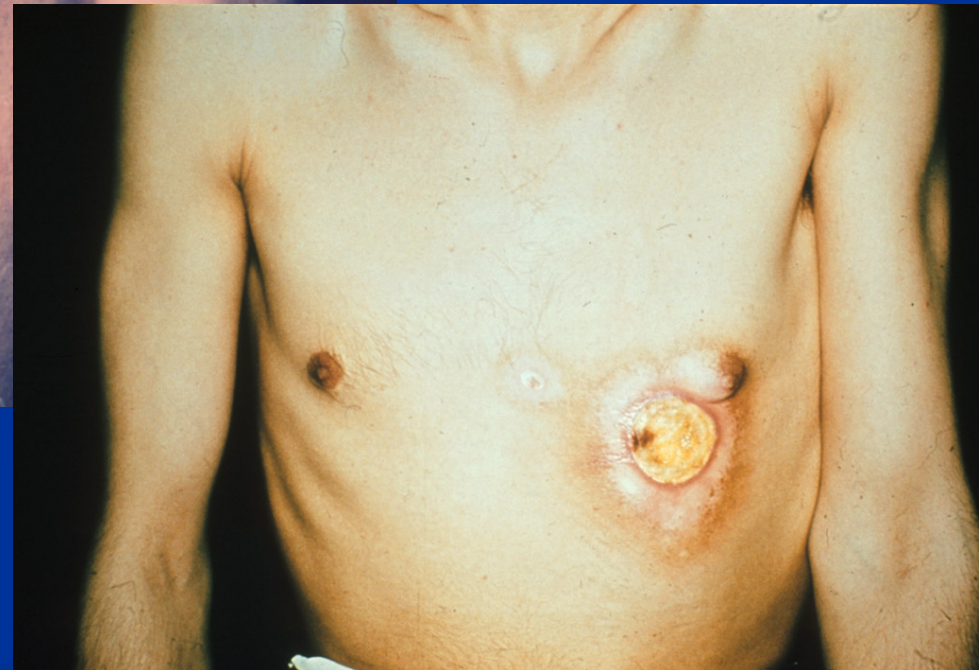
Typical radiography sources

| Radionuclide | Energy (MeV) | Source output at 1m (mGyh ⁻¹ per 37 GBq) | Half Life | Typical use for steel of thickness (mm) |
|--------------|---------------|---|-----------|---|
| Cobalt-60 | 1.17 and 1.33 | 13.0 | 5.3 y | 50–120 |
| Ir-192 | 0.2–1.4 | 4.8 | 74 d | 10–70 |
| Se-75 | 0.12–0.97 | 2.03 | 120 d | 4–28 |
| Yb-169 | 0.008–0.31 | 1.25 | 32 d | 2.5–15 |

Shutter type container



Radiation injury from Shutter type container

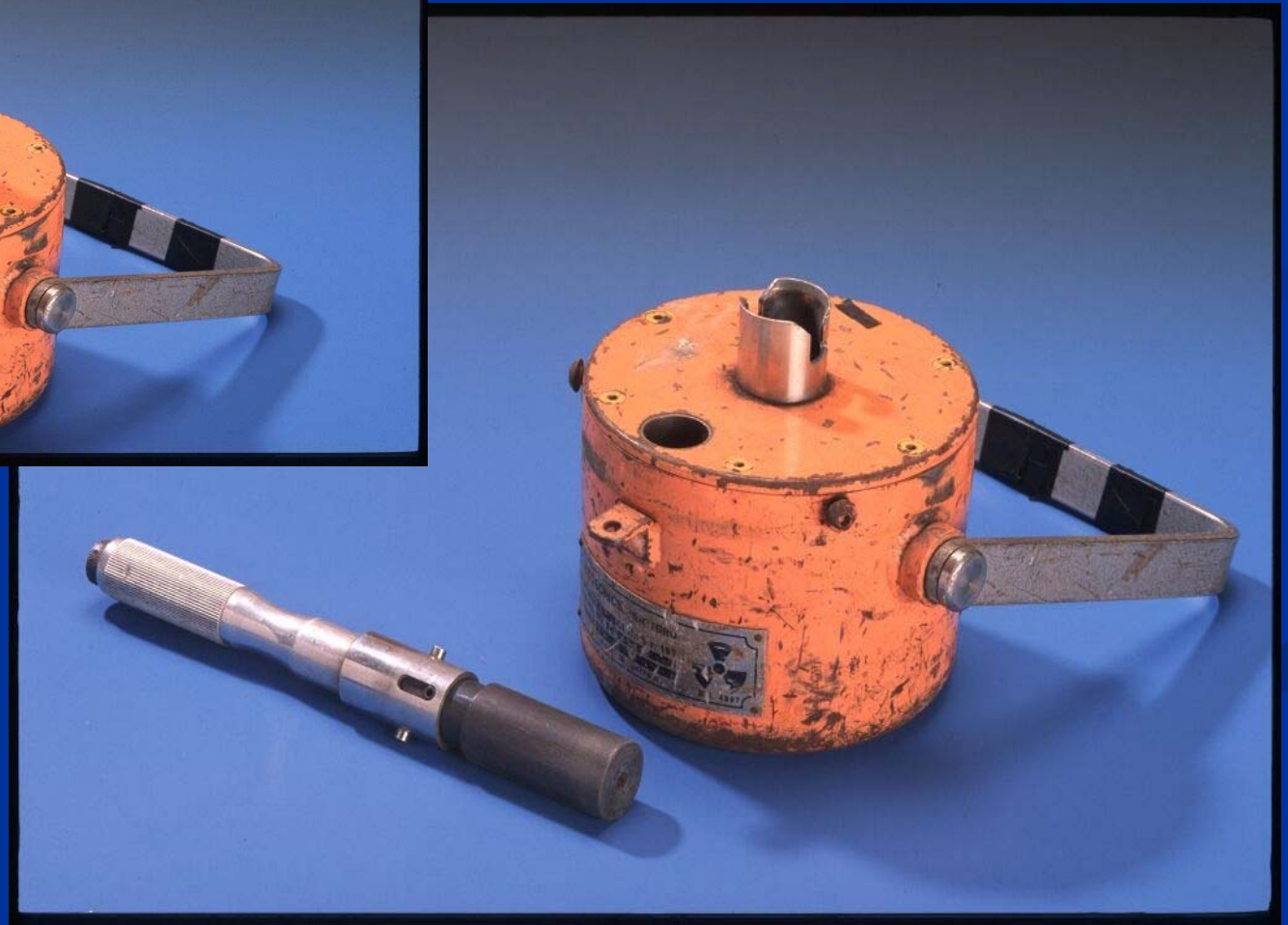


“Torch” type container

High cumulative doses
due to proximity



Misuse leading to
radiation burns to
the fingers



Projection type / remote exposure containers

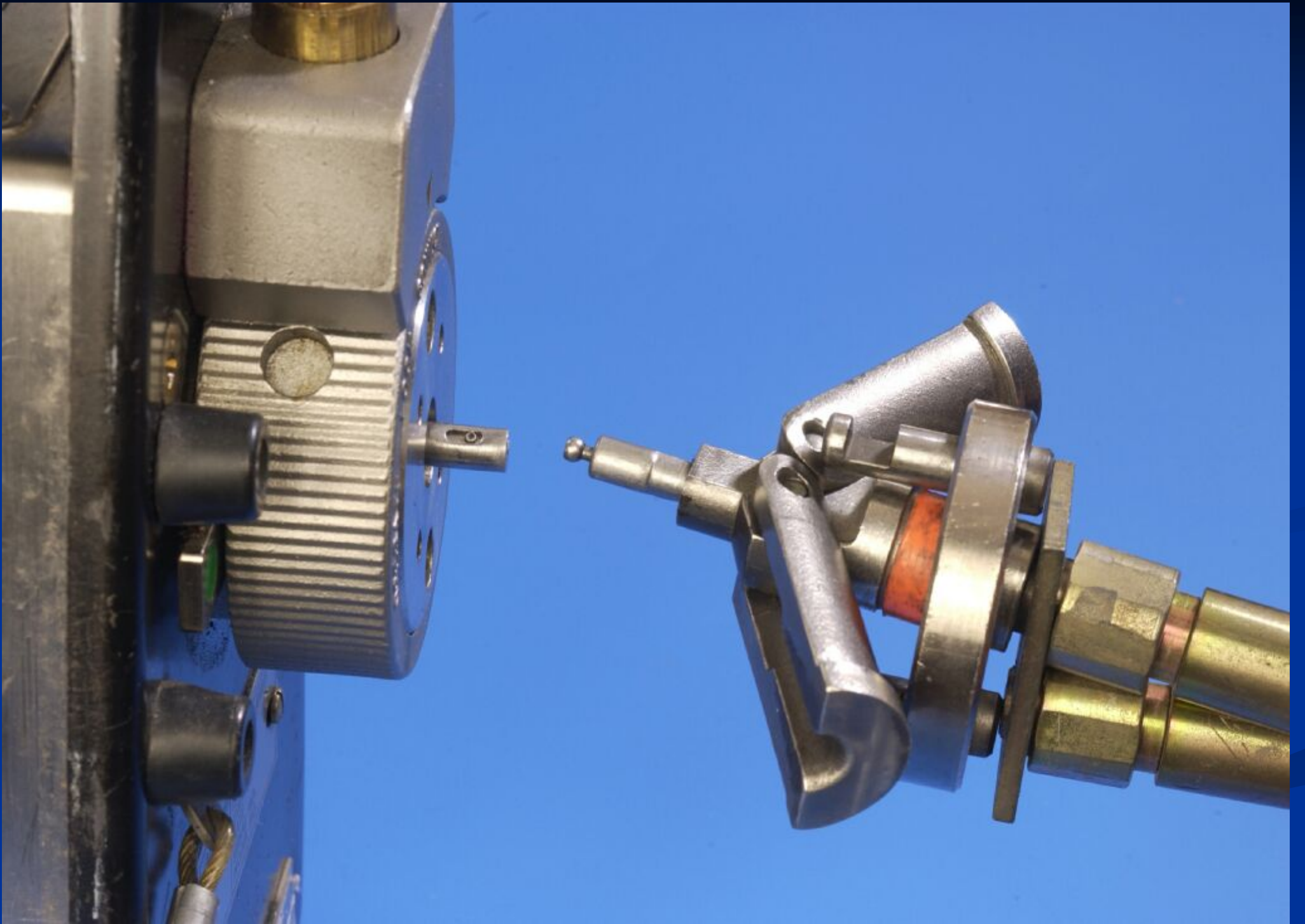


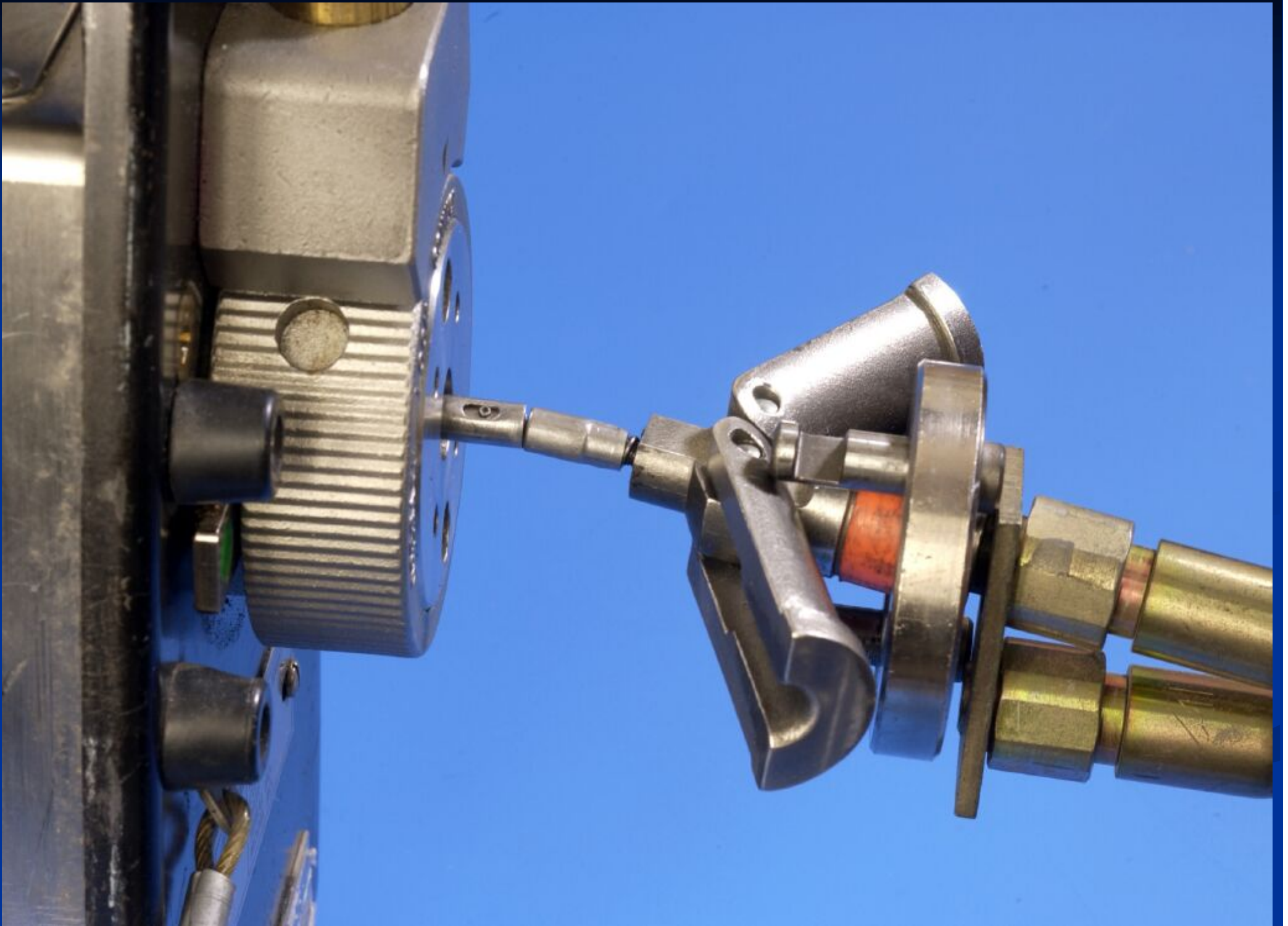
Projection type / remote exposure containers



Source “pigtail”

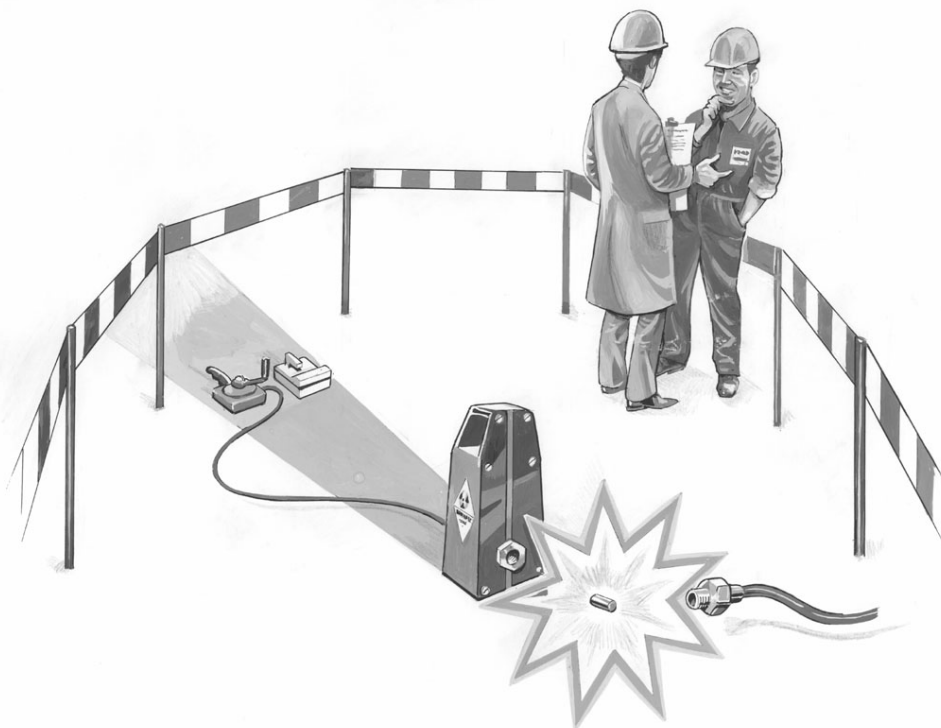






Commonest direct cause of accidents

FAILURE TO ADEQUATELY MONITOR



Typical radiation injuries



Effective Control

Increased Risk of Loss of Control



Root Causes

- Lack of, or ineffective
 - Regulatory body
 - Regulations
 - Regulatory enforcement
 - Radiation protection services
 - Training of workers and management
 - Commitment by management to safety
 - RP programme in the organisation
 - Co-operation between employers

Morocco 1984

- 1.1 TBq Ir-192 industrial radiography source
- Disconnected from drive cable and fell out
- Picked up and taken home
- Out of control March - June
- 8 died
- Initially diagnosed as poisoning

Cairo, Egypt 2000

1.85 TBq Ir-192 industrial radiography source

- Similar causes and scenario to Morocco accident
- Picked up by farmer
- Farmer and son died

Yanango, Peru 1999

- 1.37 TBq Ir-192 : remote exposure container: source detached
- Picked up by welder and taken home
- Pain in right thigh: sought medical assistance
- Meanwhile wife sat on source in trousers
- Loss of source identified and its recovery within 24 hours
- Heroic medical treatment but lost one leg

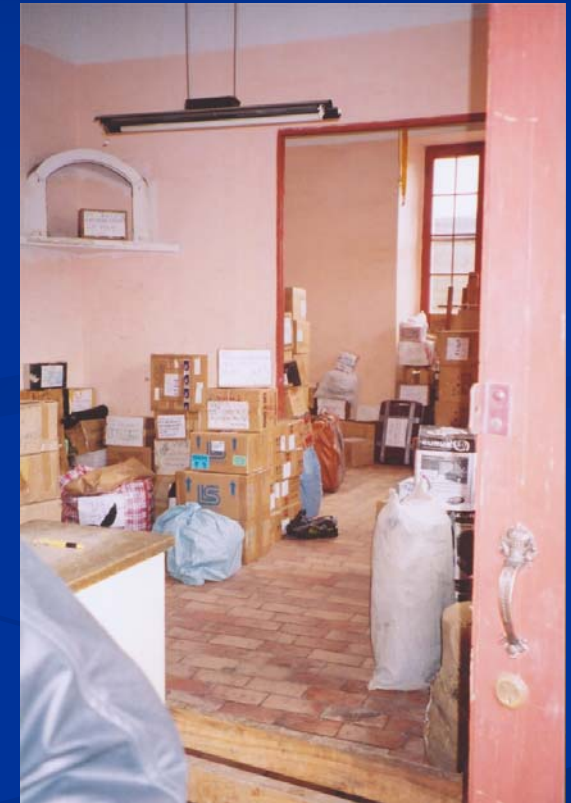
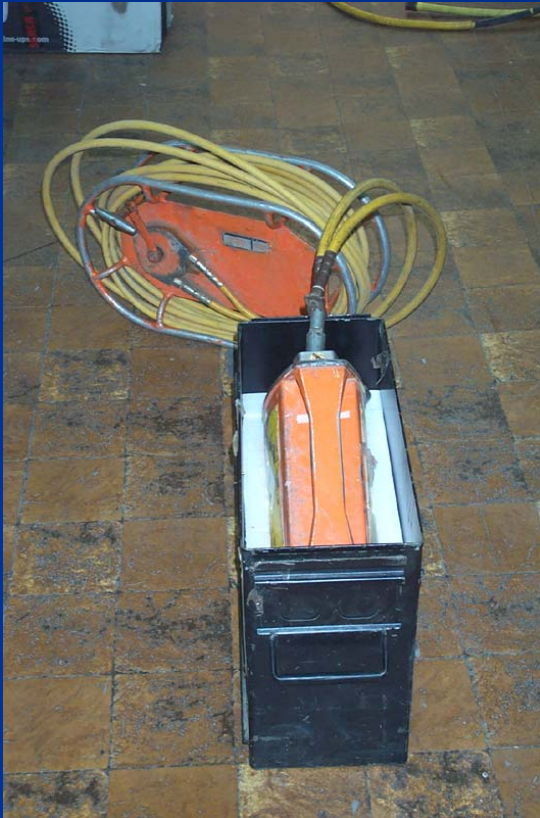


Radiography accident in Cochabamba, Bolivia, 2002

- 670 GBq Iridium-192 source in remote exposure container
- Lone working in trench
- Failed to monitor after exposure
- Could not remove drive cable



Cochabamba: transport to La Paz



Cochabamba accident

- 55 passengers exposed for 8 h journey
- Source collected and recovered next day
- Delay in informing authorities
- Investigations by authorities and IAEA

Cochabamba: dose reconstruction



Passenger doses from reconstruction: 0.19 Gy

Worker doses from Chromosome Aberration Analysis: ~ 0.2 Gy

Learning the Lessons: Feedback mechanisms

- **IAEA**
 - Accident investigation reports
 - Safety series No. 7
 - RADEV → Regulatory Authority Information System (RAIS)
 - INES
- **IRID, UK** www.irid.org.uk
 - Fields to categorise and aid navigation
 - Descriptive field for use in training
- **RELIR, France:** www.relir.cepn.asso.fr
- **European ALARA Network**
 - Newsletters and website www.eu-alara.net
 - Workshops – Rome, October 2001
 - NDT ALARA Network

Guidance Documents

- IAEA

- Safety Series 13 (1999): new one in preparation

- National Authorities

- NRC: Industrial Radiography Toolkit

- www.nrc.gov/materials/miau/industrial-uses/rad-toolkit.html

- HSE: Work with Ionising Radiations and ACOP

- www.hse.gov.uk/radiation/ionising/publications.htm

Roles: Regulators

Effective Regulatory Infrastructure

- Regulations adapted to national needs
- Appropriately resourced regulatory body (s)
- Appropriately trained regulators
- Enforcement programme
- Support of critical mass of RP infrastructure

Sets tone for compliance and safety culture

Qualified Experts

- Meets national qualification or certification criteria
- Often consultants not employee
- Management retain responsibility for compliance
- Major part of RP infrastructure
 - Range of clients, interface with regulators etc

**Well placed to have positive influence
on RP practices**

Management

- Key responsibility
- Safety culture
 - Procedures, local rules, equipment, RP programmes
 - Risk assessments
 - Supervision, maintenance, reviews, investigations
- Training
- Co-operation with clients and others

Well managed operations are quickly apparent to regulators and crucial to RP compliance

Radiographers

- Appropriately trained
- Follow procedures
 - **MONITOR AFTER EACH EXPOSURE**
 - Personal alarm monitors: useful but an adjunct
- Ability to deal with problems on site
 - Recognition of problems
 - Pressure from clients and others
 - Emergency situations
- Report back issues to management

Responsibility to work safely

Clients

- Responsibility for those working on their sites
- Financial “muscle” and thus influence
- Co-ordination and co-operation of workforces
 - Permit to work schemes
 - Temporary source storage arrangements
- QEs can help clients “police” their sites
- Should feature in regulatory programme

Clients can be very influential on RP practices:

Use that influence

Emergency Preparedness

- Risk assessments
- Development of emergency plans
- Training to recognise an emergency and implement response
- Appropriate equipment
- Exercises and periodic reviews of plans
- Reporting and identification of lessons

Training

**TRAINING,
INCLUDING REFRESHER TRAINING,
UNDERPINS
SAFETY IN INDUSTRIAL RADIOGRAPHY
AND
THE PREVENTION OF ACCIDENTS**

IAEA Training Materials for Industrial Radiography

- Radiation Protection in Industrial Radiography
 - RPO, operators and managers
 - Lecture plan, lecture notes, module overview, practical exercises, PP presentations, other info
 - 1 to 2 weeks
- Training for Regulators on Authorisation and Inspection.....
 - Regulatory inspectors
 - 3 Parts
 - I: Organisation and implementation of National regulatory program for control of radioactive sources: 1 week
 - II: Authorisation and Inspection.... : 1 week
 - III: On the job training : 6 to 8 weeks

Conclusion

- Industrial radiography still provides significant potential for accidents
- Accidents continue to happen
- Means to prevent accidents are well documented

Needs appropriate regulatory infrastructure

And

Commitment of those involved