The role of national reporting mechanisms for radiation incidents

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This presentation will provide an overview of national reporting mechanisms for radiation incidents in Nuclear Medicine. The fundamental role of an incident reporting system is to enhance safety by learning from failures in the health care system. It provides useful data from which locations can compare local practice with national averages and improve practices based on implementing actions to prevent occurrence of similar incidents.

The definition of an Accidental Medical Exposure from the International Atomic Energy Agency (IAEA) (96 IAEA) "International Basic Safety Standards (BSS) for Protection against Ionising Radiation and for the Safety of Radiation Sources" has been adopted by Ireland and the UK. An adverse event is:

- Any therapeutic treatment delivered to either the wrong patient of the wrong tissue, or using the wrong radiopharmaceutical, or with a dose or dose fractionation differing substantially from the values prescribed by the medical practitioner or which lead to undue secondary effects.
- A diagnostic exposure significantly greater than intended or repeated so as to exceed guidance levels.
- Equipment failure, accident, error or mishap with potential for causing patient exposure significantly different from that intended.

Each European country has adopted their own unique system for reporting medical radiation incidents. During this presentation, the national systems for reporting medical radiation safety incidents to patients, staff and members of the public will be discussed.

References
1. IAEA. International Basic Safety Standards for Protection against Ionizing Radiation and for the Safety of Radiation Sources Safety Series 115.