Round Table Discussion 1

1. General: Contingency plans are required for all “radiation accidents”, defined as any accident where immediate action is required to prevent or reduce the exposure to ionising radiation. ACOP guidance paragraph 238 clarifies that incidents that do not result in “exposures of concern” are not radiation accidents. How do you locally define what constitutes a radiation accident?
5. General: There are a number of particularly unusual items on the market which areas can buy without adequate RPA involvement (e.g portable dental units) or which are very different to standard practice (portable CT systems). Does anyone have local experiences on the considerations of such equipment?
2. General/NM; Nursing homes which may care for patients following radioisotope administration need to consider their responsibilities under the graded approach of IRR17. How does your centre deal with the discharge to nursing homes? Does your service act as an RPA to any nursing homes?
3. RT: The standard linac and treatment protocols has changed significantly over the years. What unusual experiences have been had in accommodating different regimes, or moving to FFF radiotherapy?
6. Interventional: There is a lot of advice on the dosimetry and PPE requirements with interventional x-ray use. Has anybody had difficulties with ensuring staff compliance with appropriate usage?

Round Table Discussion 2

1. General: The installer of an article for use at work with ionising radiation must perform a critical exam on how that article has been installed. Is the installer adequately equipped to perform this task or do you end up needing very clear expectations or in-house confirmation of correct installation? Particularly for installation of room shielding, lead-glass screens and lead-doors.
4. General: Retrofitting CR equipment with digital detectors has become increasingly common. What agreements do you expect for this and what additional measures have you taken in your risk assessments?
5. Dental: For many dental practices the only access to the controlled area can be blocked by the operator during use. What do you advise in terms of the requirements for lights and signs at the point of entry?
5. RT: Has your centre had any experience of part activation? Have you taken steps to confirm/rule this out as a concern?
6. Interventional/NM: What infection prevention measures regarding ring / fingertip dosimeters are taken at your centre? Have you sought the advice of the supplier or your local infection prevention team regarding the matter?

*During Both round table table discussions we hope run 2 different groups through a discussion with Anthony Murray regarding his nuclear medicine dose calculation audit