WESTERN SYDNEY
UNIVERSITY

RADIATION MANAGEMENT PLAN

Version 8
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Review History

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RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

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RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Introduction, Policy, Responsibilities and Implementation
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EXECUTIVE SPONSOR	The University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney University RSO; Radiation Safety Support Services Australia Simon@SensaWeb.com.au
KEY TERMS	Radiation safety, Policy, Responsibility, Implementation, Glossary; How to Use this Manual
SUMMARY *Brief summary of the contents of the document*	The Western Sydney University Radiation Safety Policy and Implementation

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Radiation Management Plan
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1. BACKGROUND

Western Sydney University and the Biosafety & Radiation Safety Committee (BRSC) are committed to implement and maintain radiation protection practices, and to ensure that potential radiation exposure staff, students and general public to ionising and non-ionising radiation is kept:

AS LOW AS REASONABLY ACHIEVABLE (ALARA)

(At acceptable Social and Economic Cost)

All staff and students of the University are expected:

- to embrace this principle
- to comply with all of the legislative requirements detailed in this management plan
- to translate As Low As Reasonably Achievable into their activities in relation to the use of radiation within their workplace and laboratories
- to adhere to the content of this RMP and
- to acknowledge their responsibilities to the general public, their fellow students, workers and themselves.

2. UNIVERSITY HEALTH SAFETY AND WELLBEING POLICY

This document should be read in conjunction with the University's Safety & Wellbeing Policy; Risk Management Policy; Risk Management Guidelines and Risk Assessment and management guidance.

3. UNIVERSITY DISCIPLINARY PROCEDURES

3.1. University Staff Disciplinary Procedures

This document should be read in conjunction with the University's Academic Staff Agreement; Professional Staff Agreement and Code of Conduct

3.2. Student Disciplinary Procedures

This document should be read in conjunction with the University's Student Misconduct Rule.

4. GLOSSARY

Absorbed dose	the energy absorbed by matter from ionizing radiation per unit mass of irradiated substance. The SI unit of absorbed dose is the joule per kilogram, with the special name gray (Gy). For radiation protection purposes, the absorbed dose is averaged over a tissue or organ
Accident	any unintended event, including operating errors, equipment failures and other mishaps, the consequences or potential consequences of which are not negligible from the point of view of protection and safety

Activity (with respect to (wrt) radioactivity)	the average number of spontaneous nuclear transformations of a radionuclide occurring in unit time. The SI unit of activity is the becquerel (Bq), which is equal to one nuclear transformation per second
ALARA	As Low As Reasonably Achievable
Annual limit on intake (ALI)	that quantity of a radionuclide which, if taken into the body during one year, would lead to a committed effective dose equal to the relevant annual limit on effective dose
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
ARPS	The Australasian Radiation Protection Society
AS1319	Australian Standard 1319 Safety Signs
AS2243.4	Australian Standard 2243.4 Safety in Laboratories: Pt 4 Ionizing Radiation
AS2982	Australian Standard 2982 Laboratory Design & Construction
Becquerel (Bq)	the special name for the SI unit of activity. It is defined as 1 disintegration per second
Category 1 source	means a sealed radioactive source (or an aggregation of sealed radioactive sources) that is a category 1 source (determined in accordance with Schedule B to the Code)
Category 2 source	means a sealed radioactive source (or an aggregation of sealed radioactive sources) that is a category 2 source (determined in accordance with Schedule B to the Code)
Category 3 source	means a sealed radioactive source (or an aggregation of sealed radioactive sources) that is a category 3 source (determined in accordance with Schedule B to the Code)
Committed effective dose, E(t)	The quantity E(t), defined as: $E(\tau) = \sum_{\tau} w_T \times H_T(\tau)$ where $H_T(t)$ = the committed equivalent dose to tissue or organ *T* over the integration time t elapsed after an intake of radioactive substances w_T = the tissue weighting factor for tissue or organ *T* When t is not specified, it will be taken to be 50 years for adults and the time to age 70 years for intakes by children

Constraint	a prospective and source related value of individual dose (dose constraint) or of individual risk (risk constraint) that is used in planned exposure situations as a parameter for the optimization of protection and safety for the source, and that serves as a boundary in defining the range of options in optimization The dose constraint for each particular source is intended, among other things, to ensure that the sum of doses from planned operations for all sources under control remains within the dose limit The risk constraint is a source related value that provides a basic level of protection for the individuals most at risk from a source. This risk is a function of the probability of an unintended event causing a dose and the probability of the detriment due to such a dose. Risk constraints correspond to dose constraints but apply to potential exposure
Controlled Area	an area to which access is subject to control and in which employees are required to follow specific procedures aimed at controlling exposure to radiation
COP	Code of Practice
CRE	Certified Radiation Expert
CT	Computed Tomography
Dealing	Manufacture, possess (or have control over), use, operate, process, modify or dispose of an apparatus or material considered as 'controlled' by a relevant regulatory body
Derived air concentration (DAC) for occupational exposure	the ALI (of a radionuclide) divided by the volume of air inhaled by Reference Man in a working year (i.e. 2.4 X 10^3 m^3). The unit of DAC is the becquerel per cubic metre (Bq/m^3)
Deterministic effect	an effect, such as partial loss of function of an organ or tissue, caused by radiation and which occurs only above some threshold of dose, the severity of the effect depending upon the magnitude of the dose received
DRA	Designated Radiation Area — an area where the occupational exposure of personnel to radiation or radioactive substances is under the supervision of a radiation protection adviser (RPA) [or RSO]
Dose	a generic term which can mean absorbed dose, equivalent dose or effective dose, depending on context
Effective dose	the product of the equivalent dose (in a tissue or organ) and the tissue weighting factor (w_T), summed over all the tissues and organs of the body. The SI unit is the joule per kilogram, with the special name sievert (Sv)
Emergency Exposure Situation	an unexpected situation of exposure that arises as a result of an accident, a malicious act, or any other unexpected event, and requires prompt action in order to avoid or to reduce adverse consequences
Environmental Exposure	the exposure of wildlife to ionising radiation. This includes exposure of animals, plants and other organisms in the natural environment

Environmental Monitoring	the measurement of external dose rates due to sources in the environment or of radionuclide concentrations in environmental media
EPA	Environmental Protection Authority
Equivalent dose	the product of the absorbed dose (averaged over a tissue or organ) and the radiation weighting factor (w_R) for the radiation that is of interest. The SI unit of equivalent dose is the joule per kilogram, with the special name sievert (Sv)
Glove Box	a closed box with internal pressure not exceeding ambient, having impermeable gloves (for example rubber gloves) and viewing ports in one or more sides, which is used to completely enclose the radioactive substances and the operations on the substances
Gray (Gy)	the special name for the SI unit of absorbed dose. 1 Gy = 1 J kg^{-1}
Half-life	in relation to radioactive decay, the time required for the quantity of a radionuclide to decrease to one half of its initial value
IAEA	International Atomic Energy Agency
ICRP	International Commission on Radiation Protection
Intervention	action taken to decrease exposures to radiation which can arise from existing situations
Ionising radiation	electromagnetic or particulate radiation capable of producing ions directly or indirectly in passage through matter, but does not include electromagnetic radiation of a wavelength greater than 100 nanometres
Irradiating apparatus	apparatus that is capable of producing ionizing radiation, or of accelerating atomic particles, for which a registration/licence is required from the appropriate regulatory authority
IRPA	International Radiation Protection Association
Justification (wrt radiation)	The process of determining whether a practice (or intervention) is, overall, beneficial, as required by the International Commission on Radiological Protection's System of Radiological Protection, i.e. whether the benefits to individuals and to society from introducing or continuing the practice outweigh the harm (including radiation detriment) resulting from the practice
Licence	means a licence (including a temporary licence) in force under section 6 of the NSW Legislation
Monitoring	The measurement of dose, dose rate or activity for reasons relating to the assessment or control of exposure to radiation or exposure due to radioactive substances, and the interpretation of the results
National Directory	means the national guidance documents titled "National Directory for Radiation Protection" [ARPANSA RPS No.6] approved by the Health Ministers for the States, Territories and Commonwealth from time to time
NHMRC	National Health and Medical Research Council

Non-ionising radiation	(a) electromagnetic radiation of a wavelength greater than 100 nanometres, or (b) non-varying electric or magnetic fields, or (c) sonic, infrasonic or ultrasonic waves that are prescribed asnon-ionising radiation for the purposes of this definition
NSW HURSOG	NSW Hospitals and Universities Radiation Safety Officers Group
Occupationally exposed person	a person who, in the course of his or her work, could be exposed to ionizing radiation arising from direct involvement with sources of such radiation
Occupier	in relation to premises, means: (a) the person in occupation or control of the premises, or (b) if the premises have different parts occupied or controlled by different persons, the person in occupation or control of the part concerned
Optimization of Protection (and safety)	The process of determining what level of protection and safety makes exposures, and the probability and magnitude of potential exposures, “as low as reasonably achievable, economic and social factors being taken into account” (ALARA), as required by the International Commission on Radiological Protection System of Radiological Protection
Owner	in relation to any apparatus or thing that has been leased or let out on hire, means the lessee or the person who takes it on hire; for radiation producing items that is the Radiation Management Licence Holder
POEA	Protection of the Environment Administration legislation
POEO	Protection of the Environment Operations legislation
QA	Quality Assurance
QAP	Quality Assurance Program
Qualified person	in relation to the supervision of a person using regulated material means an individual who: 1.holds a radiation user licence for the use of the regulated material, 2 for supervision required under Division 3, Subdivision 2-(Exemptions from licensing requirements-use of radiation apparatus for dental radiography) includes an individual who would, at the time the material is used, be exempt under section 23 from the requirement to hold a radiation user licence for the use of the regulated material.
Radiation apparatus	means a manufactured or assembled article, or any component, part or accessory of such an article, which when in operation contains or acts as part of an electrical circuit, or which acts by electromagnetic amplification employing a resonant space, and emits (or in the absence of effective shielding or other control would emit) ionising or non-ionising radiation
Radiation Laboratory	a laboratory in which irradiating apparatus or sealed radioactive sources are used or stored. It does not contain any unsealed radioactive substances
Radioactive ore	means an ore or mineral containing more than the concentration of uranium or thorium prescribed for the purposes of this definition

Radioactive substance	means any natural or artificial substance whether in solid or liquid form or in the form of a gas or vapour (including any article or compound whether it has or has not been subjected to any artificial treatment or process) which emits ionising radiation spontaneously with a specific activity greater than the prescribed amount and which consists of or contains more than the prescribed activity of any radioactive element whether natural or artificial
Radioisotope Laboratory	a laboratory in which an unsealed radioactive substance is used or stored. It does not contain any irradiating apparatus
Radiological Hazard	the potential danger to health arising from exposure to ionizing radiation; it can arise from external radiation or from radiation emitted by radioactive substances within the body
Radiological Laboratory	a laboratory which incorporates the functions of both a radiation laboratory and a radioisotope laboratory
RML	Radiation Management Licence as issued by the NSW EPA
RMP	Radiation Management Plan
RPS	Radiation Protection Series – ARPANSA publications
RSO	Radiation Safety Officer- a person appointed by the Radiation Licence holder
Radiotoxicity	the toxicity attributable to ionizing radiation emitted by a radionuclide (and its decay products) incorporated in the human body. Radiotoxicity is related not only to the radioactive characteristics of the radionuclide but also to its chemical and physical state and to the metabolism of the radioactive elements in the body or in an organ of the body
S&W	Safety & Wellbeing, formerly know as WHS (Work Health and Safety)
Sealed radioactive source	means a radioactive substance sealed in a capsule, or closely bound in a solid form, so as: (a) to prevent escape or dispersion of the radioactive substance, and (b) to allow the emission of ionising radiation
Sealed source device	means equipment or a gauge, instrument or device that contains a sealed radioactive source and permits the controlled emission of radiation, but does not include a container used solely for the storage or transport of a sealed radioactive source
Sievert (Sv)	the special name of the SI unit for both equivalent dose and effective dose. 1 S v = 1 J kg^{-l}
SOP	Standard Operating Procedures
Stochastic effect	an effect known to occur sometimes as a consequence of exposure to radiation, but which may or may not occur in a particular exposed person, the likelihood of the effect occurring being a function of the dose received

	NOTE: Examples are carcinogenesis in exposed individuals and hereditary effects in the descendants of exposed individuals
Supervision	Supervision of a person using regulated material, by a qualified person (refer to definition) for the purposes of ensuring the person being supervised follows safe radiation work practices for the use of the material.
Supervision (immediate)	means the supervision of the person using regulated material by a qualified person (refer to definition) who is : 1.**physically present in same room/space**, observes and the directs use of material, at all times when the person being supervised uses the material 2.for the purposes of ensuring the person being supervised follows safe radiation work practices for the use of the material.
Supervision (indirect)	means supervision of the person using regulated material by a qualified person who is: 1.physically present **at the same workplace** as the person being supervised at all times when the person being supervised uses the material and **is contactable** by the person being supervised, 2.for the purposes of ensuring the person being supervised follows safe radiation work practices for the use of the material.
Unsealed source	a source which is not a sealed source and which under normal conditions of use can produce contamination

User Licence	The User Licence will be a licence solely for the purpose of the use of radioactive substances or ionising equipment. This licence **does not give** the holder of such a licence the authority to purchase, own, dispose, loan, control storage, transfer radioactive materials or ionising equipment, or approve projects
Weighting Factor	*Radiation weighting factor (w*R)— A number by which the absorbed dose in a tissue or organ is multiplied to reflect the relative biological effectiveness of the radiation in inducing stochastic effects at low doses, the result being the equivalent dose *Tissue weighting factor (w*T)— Multiplier of the equivalent dose to an organ or tissue used for radiation protection purposes to account for the different sensitivities of different organs and tissues to the induction of stochastic effects of radiation

5. GENERAL RESPONSIBILITIES

5.1 Licensing

There are two types of licences under the NSW legislation; Radiation Management Licence issued to DVC on behalf of Western Sydney University and Radiation User Licence (various types for different radioactive material applications) issued to radiation workers for the use of radioactive substances or ionizing radiation equipment.
An example of the University RML is included at the end of this Radiation Management Plan in Attachement 1.

5.2 Radiation Management Licence

As described in the Protection from Harmful Radiation Regulation 2025 & Protection from Harmful Radiation Act 1990 No 13, the Radiation Management Licence holder has the responsibility for:

- The Radiation Management Plan
- all purchases/acquisitions of isotopes and ionising equipment,
- all ownership of isotopes and ionising equipment
- control of user licence applications (that is research and teaching using radiation) at the institute
- control of all sources (sealed and unsealed) and ionising equipment including registrations
- storage,
- security,
- Reporting annually to EPA (covering isotopes both sealed and unsealed, equipment and facilities, and possibly users)
- Records/documentation of all radioactive substances and ionising
- Disposal and trade of all radioactive substances and ionising equipment.

There is only one RML for the university, issued by NSW EPA, for the University based on the University's ABN. For the University this responsibility of RML holder sits with the appointed Deputy Vice-Chancellor of Research (DVCR).

The RML holder must ensure a copy of the radiation management plan is available to;

- all persons who use the regulated material, and
- all occupationally exposed persons employed by the person,

The RML holder must take all reasonable steps to ensure the procedures set out in the radiation management plan for the use of the regulated material are followed by;

- all persons who use the regulated material, and
- all occupationally exposed persons employed by the person.

The RML holder must not

- fail to appoint a Radiation Safety Officer (RSO), and
- allow the functions of the radiation safety officer be exercised otherwise than by the officer.
- The appointed RSO's skillset requirement is defined by the complexity of the radiation practices at the university. At minimum it is required that;
- the RSO radiation related qualifications related to all radiation practices at the university,
- formal radiation training and, strong knowledge of NSW radiation regulation and ARPANSA codes.

5.3 Radiation User Licence

The User Licence will be a licence solely for the purpose of the use if radioactive substances or ionising equipment. This licence **does not give** the holder of such a licence the authority to:

- Purchase or trade or give away or loan any radiation (isotopes or equipment)
- Own radioisotopes or ionising equipment
- Possess, organise or manage storage as part of their licence conditions
- Dispose
- Trade
- Develop local SOPs and procedures if they are employed by a company or institute.

There are also conditions of licence attached to such licences, as set by the EPA.

Radiation User Licence holders will be required, by not only the Conditions of Licence that will be applied, but also by the condition that they are working under the requirements of the Radiation Management Licence and the Radiation Management Plan to (including but not exclusive):

- Comply with all the requirements of the Radiation Management Plan
- Comply with any directions from the RSO or S&W (as the direct delegates of the RML holder)
- Ensure radiation safety in their workplace
- Complete all documentation as is required in the legislation and in the RMP
- Supply the University with a copy of their licence, and any other relevant documentation so requested

- And any other matter or process as is required by legislation, mandated codes of practice and the Radiation Management Plan

5.4 Radiation Safety Officer

- Advises and assists employers in meeting legal obligations under the *Protection from Harmful Radiation Act 1990* and its regulations.
- To protect workers, the public, and the environment from radiation risks

Monitoring and Safety Checks

- Review personal radiation monitoring results.
- Run area radiation surveys and inspections.
- Check equipment and workplace safety practices.
- Report unsafe conditions to the employer right away.

Management and Procedures

- Endorse radiation emergency guidelines.
- Review waste disposal and radioactive discharges.
- Oversee investigations of any radiation accidents or incidents.
- Provide the employer with at least one annual written safety report.

6. DOCUMENTATION

None

7. AUDIT

None

8. REVISION & APPROVAL HISTORY

Date	Revision No.	Author and Approval
Jan., 2016	Draft	William Bartolo, Bartolo Safety Management Service
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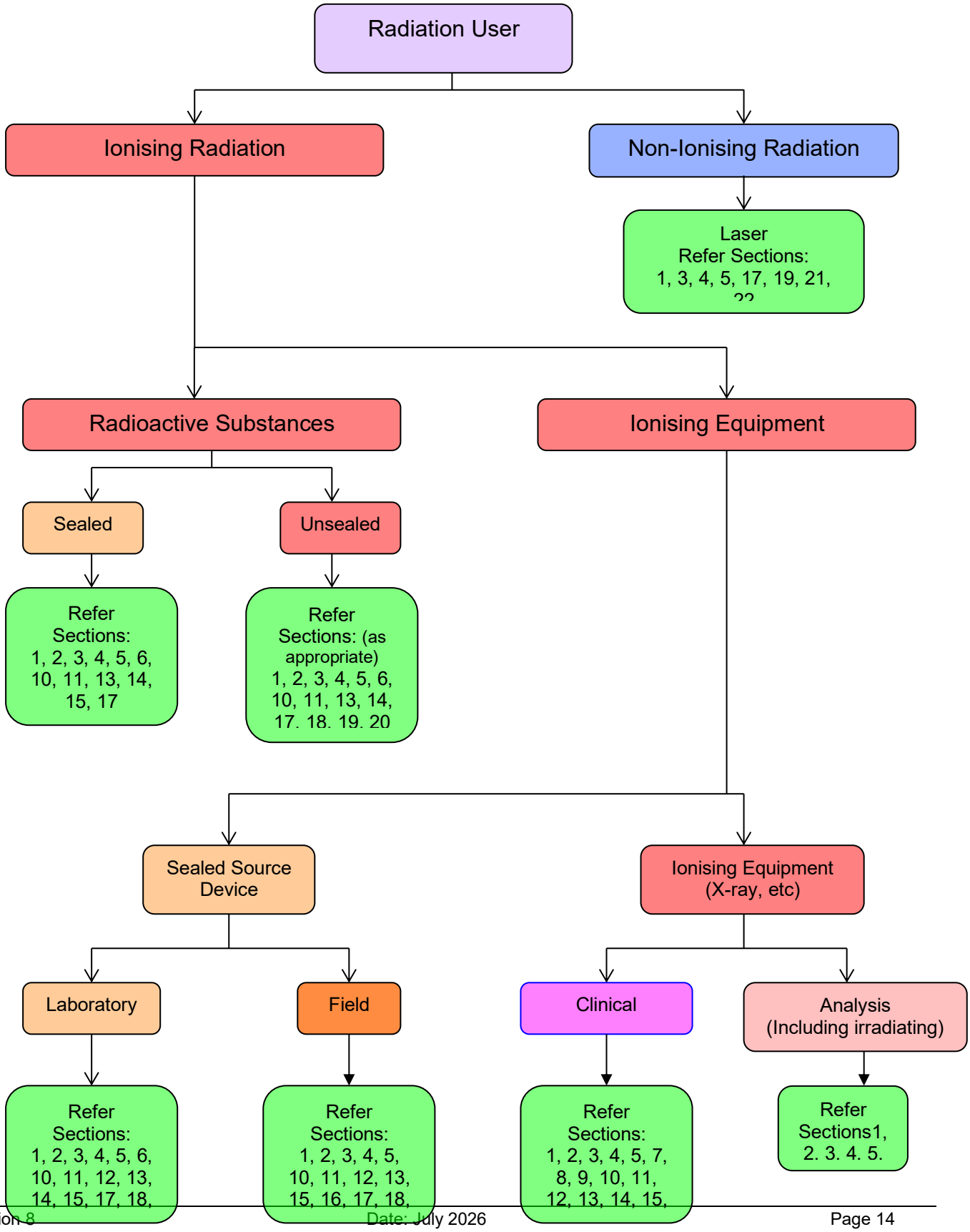
Oct., 2018	Revision 7	T Millar, K Ambrose and W Bartolo
July, 26	Revision 8	S.Turner & D.Wojtalewicz

APPENDIX 1.1How to use this Radiation Management Plan



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RADIATION MANAGEMENT PLAN COVER SHEET

NAME OF DOCUMENT	Radiation exposure and risk
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Background Information for Radiation Users
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FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR	The University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, risk
SUMMARY *Brief summary of the contents of the document*	Information on the nature of radiation, the sources of radiation and the risks associated with radiation exposure.

INDEX - Section 2

1. BACKGROUND

In order to comply with policy it is necessary to understand the nature of radiation, the sources of radiation and the risks associated with radiation exposure. This document provides this information and the objectives of radiation protection.

SI units will be used throughout the documents

2. IONISING RADIATION

2.1. Types of Ionising Radiation

Ionisation is any process by which an atom or molecule gains an electric charge by the removal of an electron. Any radiation which is capable of causing this effect is known as ionising radiation. This differs from non-ionising radiations such as that produced by lasers, UV-lights, mobile phones and microwave ovens.

In terms of teaching and research environments, ionising radiations emitted from radioactive atoms or produced by x-ray sources include:

Alpha (α) particles

These are identical with helium nuclei, having two protons and two neutrons. Alpha particles are usually emitted by heavy radioactive atoms such as uranium and radium. Being large and relatively slow, they quickly dissipate their energy by colliding with the atoms of the material through which they travel causing ionisation to take place. Alpha particles thus have very little power of penetration and are stopped completely by a thin sheet of paper, the outer layer of human skin, or a few centimetres of air. Alpha emitters are most damaging when incorporated into the body, and are not normally used unless securely sealed. However, there is an increasing interest in their use as therapeutic agents when they are directed specifically to the target cells.

Beta (β) particles

These are high speed electrons emitted from the nuclei of radioactive atoms. Being light weight, and emitted with a speed approaching that of light, beta particles have greater penetrating ability than alpha particles of the same energy, but still will be stopped by a few millimetres of aluminium, a centimetre or so of human tissue or a few metres of air, dependent on their energy. Beta emitters are also most hazardous when ingested, but can also be hazardous, externally, especially to the cornea. Beta emitters are often administered as therapeutic agents.

Positrons (β^+)

These have the same mass as an electron but carry a positive charge instead of a negative charge. They have the same properties as beta particles; however, they eventually combine with an electron which results in the emission of 2 gamma rays. Radioactive substances which emit positrons are used in positron emission tomography (PET scans).

Gamma (γ) rays

These are electromagnetic radiation of the same family as visible light, and travel at the same speed. They have a high penetrating power and can pass through several hundreds of metres of air or many centimetres of dense materials such as iron or lead. Gamma emitters are hazardous internally and externally, although less damaging than the particle sources.

X-rays

These are physically identical to gamma rays and differ only in their means of production, which is usually by means of electrons striking a dense material as occurs in a common diagnostic X-ray machine.

Neutrons

These are subatomic particles with no net electric charge and a mass slightly larger than that of a proton. They can be used to measure the concentrations of elements (a technique known as neutron activation analysis) and can be a safety concern in certain applications when the high energy X-rays can produce neutrons in the shielding material.

2.2. Radiation Units and Quantities

Energy (eV)

The energy of particles or rays is expressed in electron volts (eV). An electron volt is the energy acquired by an electron when accelerated by a potential difference of one volt. Since this is a very small amount of energy, we usually talk in terms of keV and MeV, ie. kilo or mega electron volts.

Exposure (C/kg)

This unit measures the amount of ionisation produced in air by a given radiation source. It is measured in coulombs per kilogram of air at normal temperature and pressure and is directly related to the number of radioactive particles or gamma rays per unit area incident on a given body of mass. Exposure is easily and accurately measured.

Absorbed Dose (gray, Gy)

This unit measures the amount of energy deposited per unit mass of material by ionising radiation. One gray is the amount of radiation which will deposit one joule per kilogram of energy in a specified material. The gray is a very large unit and most radiation doses, outside of radiation therapeutic doses, are likely to lay in the milligray (mGy) or microgray (μGy) regions. Note that the tissue or material involved must also be specified along with the absorbed dose.

For example, a chest X-ray gives about 200 μGy to the chest wall, while a radiotherapy treatment may involve 60 Gy (300,000 times as much as the chest X-ray).

Equivalent Dose (sievert, Sv)

This unit is a measure of the biological effect produced, for equal energy absorption, by different types of radiation. The relation between equivalent dose and absorbed dose is given by:

$$\text{Equivalent dose} = \text{absorbed dose} \times W_R$$

where W_R, the radiation weighting factor, is dependent on the type of radiation. For most radiation encountered in the hospital environment W_R is nearly equal to 1, so that equivalent dose often is numerically equal to absorbed dose. The sievert is a large unit and most equivalent doses will be in the millisievert (mSv) and microsievert (μSv) range.

Effective Dose (sievert, Sv)

When a number of tissues or organs are irradiated to different absorbed doses, the biological effect cannot be described simply by equivalent dose, as different organs have varying sensitivities to radiation. In this case, effective dose is used, and is calculated as the sum of the equivalent dose to each irradiated organ multiplied by what is called the tissue weighting factor W_T. That is :

$$\text{Effective dose} = \sum^{\text{all irradiated organs}} \text{equivalent dose} \times W_T$$

Activity (becquerel, Bq)

The radioactivity of a given radioactive source is measured in terms of the number of radioactive disintegrations per second occurring in that source. The unit of radioactivity is the becquerel (Bq) which is the activity of a source giving rise to 1 disintegration per second. Every disintegration is associated with the emission of ionising radiation. The becquerel is a very small unit, and the usual activities encountered in University facilities are in the kilobecquerel (kBq) megabecquerel (MBq) or gigabecquerel (GBq) range.

The specific activity is the activity of a sample divided by its mass (Bq/g).

The activity concentration is the activity of a sample divided by its volume (Bq/m^3 or Bq/ml)

Half-Life

The half-life of a radioactive substance is the time taken for the substance to reach half of its original activity; that is for the disintegration rate to reduce to half its original value. This is known as the physical half-life, in contrast to the biological half-life of a material which refers to the time taken for half an administered substance to be excreted by the body, this value having nothing to do with radiation.

The **effective half-life** (T_E) is a term used to describe the amount of time taken for the body to remove half of the original introduced activity utilising both the physical (T_p) and biological (T_B) half lives, and is given by the relationship:

$$T_E^{-1} = T_P^{-1} + T_B^{-1}$$

Or

$$T_E = \frac{T_P \times T_B}{T_P + T_B}$$

2.3. Sources of radiation exposure (including background)

There are a number of possible situations:

- exposure may be experienced in the workplace (occupational exposure), by members of the public (general exposure), or by patients/volunteers (medical/research exposure). Only occupational and general exposures are limited by regulations.

- the nature of the exposure may be intentional or accidental.

The majority of the average annual radiation dose to the population is from natural sources of radiation. In Australia, the background radiation dose equivalent is of the order of 2-2.5 mSv. The sources of this radiation are many and varied (see Fig. 2.1), but the greatest component is natural radon, which arises from the decay of trace amounts of uranium in the ground. Urban areas in Australia have generally low radon levels, but in some parts of the world such as Cornwall in the UK, radon levels may be very high.

Cosmic radiation arises mainly from the sun, and increases quickly with altitude above sea level, since the earth's atmosphere is a natural radiation shield. Latitude is also important, the levels increasing as the poles are approached.

Radiation from food and drink is, in the southern hemisphere, entirely natural, and thus almost impossible to reduce. Medical sources are the greatest man-made component of background.

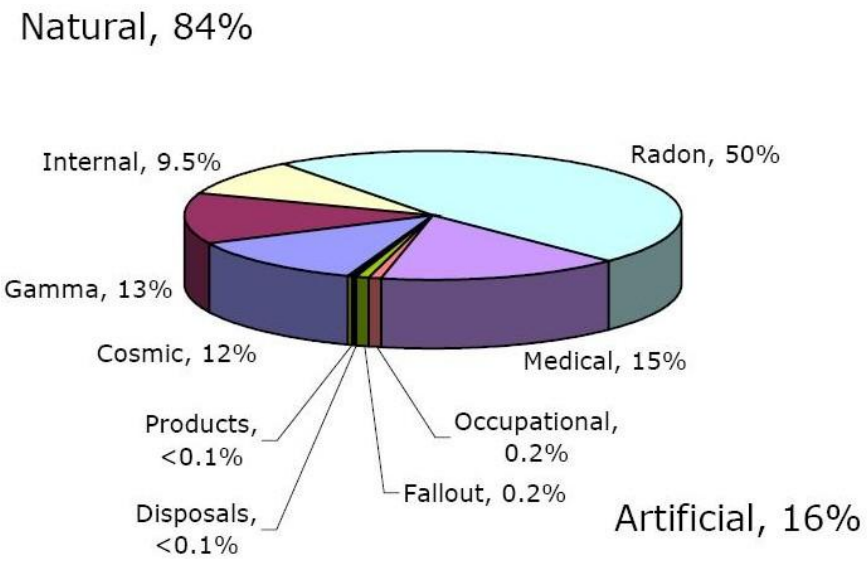


Fig. 1 - Average Annual Radiation Dose to the Population

Source: NRPB (UK) 2005

(Note: The section labelled "Gamma" is due to naturally occurring terrestrial sources, such as granite, mineral sands or other radioactive materials in the soil)

3. RISKS ASSOCIATED WITH RADIATION EXPOSURE

Evaluation of the risks due to exposure to ionising radiation is a complex problem. Most estimates have been extrapolated from data obtained on groups of persons receiving relatively high doses (such as the victims of the Hiroshima and Nagasaki atomic bombs). These estimates assume a linear dose effect relationship down to zero dose. For example, the risks in Table 1 below represent the overall fatal cancer risk to the whole population (ICRP 103).

Table 2.1 - Risks due to radiation assuming no threshold dose

Tissue or Organ Irradiated	Risk per mGy	
Active bone marrow (Leukaemia)	3.8×10^{-6}	1 in 260,000
Bladder	2.3×10^{-6}	1 in 430,000
Bone surface	0.5×10^{-6}	1 in 2,000,000
Lung	11.3×10^{-6}	1 in 88,000
Breast (females)	6.2×10^{-6}	1 in 160,000
Thyroid	1.0×10^{-6}	1 in 1,000,000
Skin	4×10^{-6}	1 in 250,000
Stomach	7.7×10^{-6}	1 in 130,000
Colon	4.9×10^{-6}	1 in 200,000
Oesophagus	1.5×10^{-6}	1 in 660,000
Liver	3.0×10^{-6}	1 in 330,000
Ovary (females)	0.9×10^{-6}	1 in 1,100,000
Total cancer risk	**56×10^{-6}**	**1 in 18,000**
Severe hereditary disorders (all generations)	1.9×10^{-6}	1 in 525,000
Baseline cancer mortality from all other causes	0.15 – 0.25	1 in 4 – 1 in 6

(ref. ICRP 103)

In order to put the above risk in perspective, risks of death of 1 in 1 million from various causes are presented in Table 2, but the public perception of risk can be very different.

Table 2.2 Comparative risks associated with a risk of death of 1 in 1 million

Scenario	Cause of Death
Travelling 100 miles by car	Accident
Travelling 1000 miles by jet aircraft	Accident
Travelling 10 miles by bicycle	Accident
Travelling 6 minutes by canoe	Accident
Spending 2 days in Sydney CBD	Air pollution
Smoking 1.4 cigarettes	Cancer, heart disease
Eating 40 tablespoons of peanut butter	Liver cancer
Spending 1 hour in a coal mine	Pneumoconiosis
Living for 150 years within 20 miles of a nuclear power plant	Radiation-induced cancer
Receiving 0.1 mSv of radiation	cancer

** Majority of information taken from W.A. Govt. 2009 Mine Safety Road Show*

4. OBJECTIVES OF RADIATION PROTECTION

Radiation effects are divided into two groups:

- stochastic effects
- deterministic effects

In **stochastic** effects, the probability (but not the severity) of occurrence is related to the magnitude of the dose, without threshold. An example is cancer induction. A small dose will give you a small probability of getting cancer, and a larger dose, a larger probability - however the severity of the cancer is the same in both cases. Hereditary effects are also stochastic. It is highly probable that small doses of radiation carry zero risk (or could even be beneficial). However, for protection purposes, a conservative approach is taken.

With **deterministic** effects, there is a threshold below which the effect does not occur. Beyond this threshold the severity of the effect is related to the dose. An example is a radiation skin burn - a small dose will not produce a burn, a very large dose will, and the larger the dose the worse the burn.

The objective of radiation protection is to prevent harmful deterministic effects, and to limit the occurrence of stochastic effects to acceptable levels.

This objective is achieved by a philosophy based on

- **justification** for any radiation exposure,
- **optimisation** of any dose to the lowest possible levels (As Low as Reasonably Achievable" - the ALARA principle), and
- setting **limits** to the equivalent dose (not including natural or medical radiation) which can be received in any year by workers and the general public.

Dose limits are treated as just that, and not a permitted maximum.

For patients and volunteers, the lowest radiation dose is that which provides the diagnostic information or research data.

The occupational dose limits are set by the International Commission on Radiological Protection and have been incorporated into the ARPANSA Codes and thus the NSW Protection from Harmful Radiation Regulation 2025.

5. THE USES OF RADIATION AND RADIOACTIVITY WITHIN THE UNIVERSITY

The University has several facilities that use ionising radiation The facilities may use any combination of the following:

Diagnostic radiology.

This process uses radiation generating apparatus for diagnostic imaging of a patient. Typical equipment is X-ray machines, CT machines, fluoroscopy machines and dental X-ray machines to produce an internal image of a patient. Bone mineral densitometry and mammography also utilise X-rays.

Magnetic resonance imaging and ultrasonography do not use ionising radiation and do not present a radiation hazard to the patient or to staff.

Analytical radiology.

This is the use of X-rays to diagnose chemical, mineral and physical structures. For example, crystal structures can be analysed using X-ray crystallography or diffraction equipment.

Laboratories.

Some laboratories use unsealed radioactive substances in radioimmunoassays or as tracers when studying how different materials move through biological or other systems, or for chemical analysis.

Sample irradiation.

This process uses high activity sealed sources or high powered linear accelerators to provide extremely large doses of radiation to a sample.

Field work

Using neutrone probe equipped with Am241 source to measure moisture content in the soil.

6. DOCUMENTATION

None

7 AUDIT

None

8. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Dec 2013	Draft	William Bartolo, Bartolo Safety Management Service
Nov 2014	Revised Draft	T Millar, K Ambrose & W Bartolo
Dec 2014	Revised Draft	T Millar, K Ambrose & W Bartolo
Mar 2016	Draft 4	T Millar, K Ambrose & W Bartolo
Nov 2016	Revision 5	BRSC comments, T Millar, K Ambrose & W Bartolo
Feb 2017	Revision 6	BRSC, T Millar, K Ambrose & W Bartolo
Oct., 2018	Revision 7	T Millar, K Ambrose & W Bartolo
July, 26	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	REGULATORY REQUIREMENTS
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure and information for users
DOCUMENT NUMBER	RMP-S3
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of three years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Regulatory requirements, dose, dose constraints, dose limits, registration requirements, licensing requirements, penalties
SUMMARY *Brief summary of the contents of the document*	Procedures to ensure that all staff, students and visitors at the University involved in the occupational use of radiation are informed of radiation specific regulations.

INDEX - Section 3

1. BACKGROUND

To maintain a Radiation Management Licence (RML), the radiation management licence holder and all staff, students or visitors working under that licence must comply with various regulatory requirements that govern the possession, use and exposure of individuals and the environment to ionising radiation.

2. GENERAL PROCEDURES

2.1. All uses of radiation (either radiation apparatus and/or radioactive substances) must have an approved Biological and Radiation Safety Committee Application before any activities pertaining to the radiation can be carried out. This includes purchase.

2.2. The Safety & Wellbeing (S&W) of the University will keep and maintain a Central Radiation Register, which will include records of:

2.2.1. all diagnostic radiation apparatus, sealed source devices such as soil moisture gauges, X-ray analysis equipment and premises in which radioactive substances are kept or used;

2.2.2. the corresponding Registration Number issued by the EPA for each item or premises and their corresponding conditions of use;

2.2.3. user licences including expiry dates and conditions of the licences; and

2.2.4. time and methods of disposal and or decommissioning of such items

2.3. The University will submit any changes to the register to the EPA.

2.4. If any item listed on the radiation register is to be altered, moved (except portable equipment being used in accordance with the approved protocol) or disposed of, it will require written notification and approval by S&W, which will notify the EPA.

2.5. Before a sealed source within a sealed source device is changed S&W must be notified, and approval given by the University's Biosafety and Radiation Safety Committee.

3. RESPONSIBILITIES

For a BRSC Application to be approved, the University is responsible to ensure that:

3.1. all staff, students and visitors at the University involved in the occupational use of ionising radiation have access to and have understood the appropriate acts and regulations;

3.2. the applications must demonstrate how all staff, students and visitors at the University involved in the occupational use of ionising radiation will comply with the regulatory requirements; and

3.3. Any person carrying out work involving radiation apparatus or radioactive substances must be user licensed to carry out such work **(except users exempted by Protection from Harmful Radiation Regulation 2025-Reg.13)**, or have been issued with an exemption approval in writing and working under the direction and supervision of a person holding such a user licence.

4. REGULATORY REQUIREMENTS

4.1. Legislation and Codes of Practice

In NSW, besides complying with the WHS legislation all uses of radiation are governed by the Protection from Harmful Radiation Regulation 2025 & Protection from Harmful Radiation Act 1990 No 13 (which have precedence over the WHS Legislation).

These are administered by the NSW EPA.

The Act allows for the adoption of documents forming part of the National Directory for Radiation Protection (via ARPANSA under the Federal ARPANS Act 1998). The following documents have been gazetted in NSW for such adoption and are relevant to this Radiation Management Plan:

- RPS 1 Recommendations for Limiting Exposure to Ionizing Radiation
- ARPANSA RPS C-1 (Rev. 1): Code for Radiation Protection in Planned Exposure Situations (2020)
- RPS C5 Code for Radiation Protection in Medical Exposure
- RPS 5 Portable Density/Moisture Gauges containing Radioactive Sources
- RPS 6 National Directory of Radiation Protection
- RPS 8 Code of Practice for Exposure of Humans to Ionizing Radiation for Research Purposes
- RPS 10 Radiation Protection in Dentistry
- RPS 11 Code of Practice for the Security of Radioactive Sources
- RPS 17 Radiation Protection in Veterinary Medicine *(not gazetted but being listed as condition of licence)*

In addition, the following three safety guides are available to assist in meeting the requirements of RPS 14.

- RPS 14.1 Safety Guide for Radiation Protection in Diagnostic and Interventional Radiology
- RPS 14.2 Safety Guide for Radiation Protection in Nuclear Medicine
- RPS 14.3 Safety Guide for Radiation Protection in Radiotherapy

Additionally, federal legislation administered by the *Australian Safeguards and Non-Proliferation Office* (ASNO) has precedence on some items e.g. uranyl products.

5. OVERVIEW OF LEGISLATIVE REQUIREMENTS AND GUIDELINES PERTINANT TO APPROVAL OF A RADIATION SAFETY APPLICATION

5.1. Occupational Dose Limits

All staff, students and visitors at the University who are exposed to ionising radiation as part of their employment or studentship are deemed to be occupationally exposed and, therefore, are subject to radiation dose limits as described in Schedule 4 of the Protection from Harmful Radiation Regulation 2025 (**see Appendix 3.1** of this Section). Note that these limits apply to occupational and public exposure only, and not to exposures received as part of medical diagnosis or treatment.

Females, Pregnancy and Age

The basis for the control of occupational exposure is the same for women as for men, except that when a pregnancy is declared by a female employee, the embryo or foetus should be afforded the same level of protection as is required for a member of the public. This may be achieved by controlling the exposure of an employee who declares a pregnancy in a manner which ensures that doses which may be received by the foetus during the remainder of the pregnancy while the employee is at work are no more than the public effective dose limit given in Appendix 3.1 at the end of this document.

Persons under the age of 16 should not be exposed to radiation occupationally and should be treated as members of the public for radiation protection purposes.

5.2. Dose Constraints

A dose constraint is usually set at a value lower than the corresponding dose limit and is used for planning purposes to ensure that the dose limit is not exceeded.

The EPA has specified the following design dose constraints when radiation shielding is being designed, assessed or verified in accordance with NSW Radiation Guideline 7 (Radiation Shielding design assessment and verification requirements):

- 100 µSv per week for occupationally exposed persons from all sources of radiation, and
- 20 µSv per week for members of the general public.

5.3. Registration Requirements and any Special Conditions for the Radiation Apparatus or Radioactive Sources to be used

If you are unsure as to whether or not an item needs to be registered, first consult the Protection from Harmful Radiation Regulation 2025 and then S&W for confirmation. All items that must be registered are not be used until such time as it is registered

Contact Safety Specialist, S&W for more information and organising registration.

5.4. User Licensing Requirements for Staff using Radiation Apparatus or Radioactive Substances

Any person carrying out work involving radiation apparatus or radioactive substances must be user licensed (except university employee operating radiation apparatus exempted from user licence requirement PROTECTION FROM HARMFUL RADIATION REGULATION 2025 - SCHEDULE 2) to carry out such work or have been issued with an exemption approval in writing and working under the direction and supervision of a person holding such a user licence. The EPA issues user licences, for each radiation practice type, to suitably qualified persons and has the power to withdraw or withhold licences when deemed necessary. A separate user licence approvals required for radiation apparatus and for radioactive substances.

Possession of a user licence implies responsibility of the licencee to ensure that the conditions of the user licence are met, that persons working under his/her supervision carry out their work in a safe manner in accordance with written conditions contained in the exemption approval, and that the licencee complies with any local requirements so listed or detailed in the Radiation Management Plan, or imposed by the University Biological and Radiation Safety Committee.

Failure to comply with the requirements of the Protection from Harmful Radiation Act 1990 No 13 and its associated subordinate legislative documents such as the Protection from Harmful Radiation Regulation 2025 and licence conditions, can result in penalties in the form of fines, imprisonment or both. These penalties are applicable to both individuals and the University.

Licence application forms are can be downloaded or obtained from the NSW EPA website http://www.epa.nsw.gov.au/.

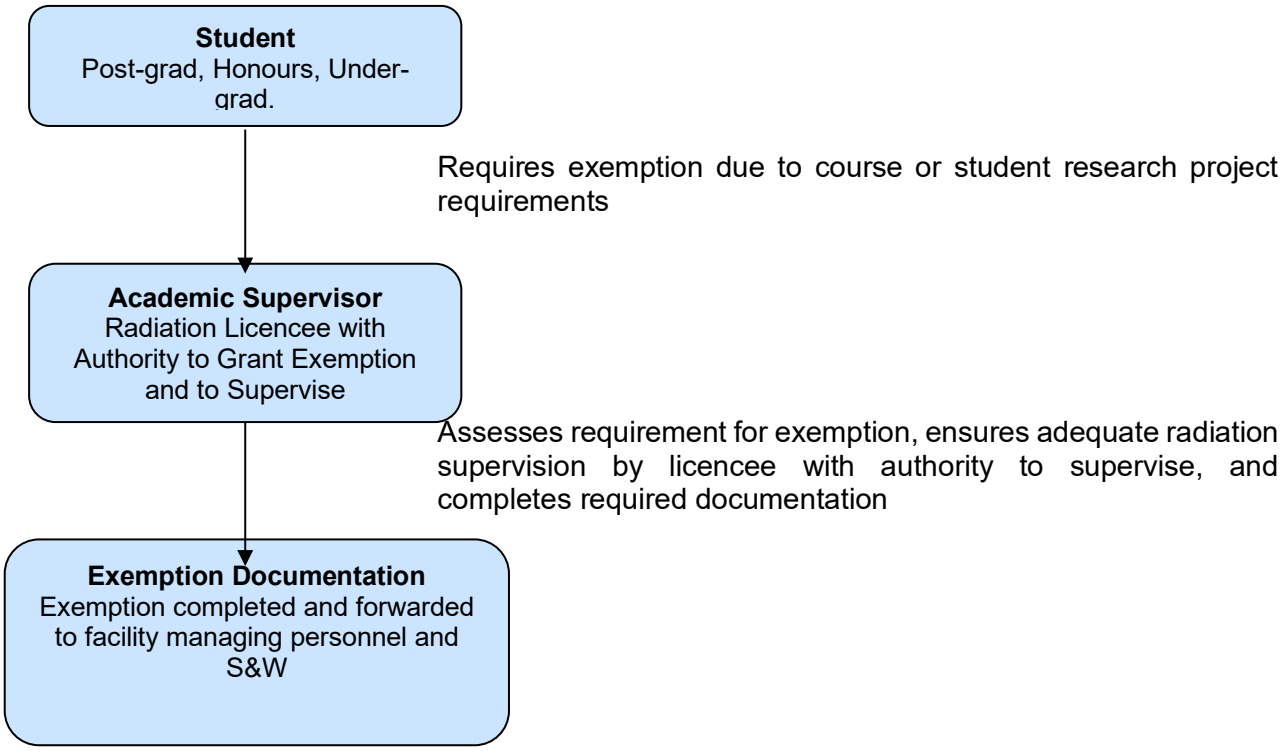
You may obtain details of licence conditions, and exemptions and supervision requirements via the NSW EPA web link, or contact S&W if you need further details.

A radiation licence is not required for staff who are present when radiation apparatus or radioactive substances are used, but do not control the radiation exposure in any way.

5.5. Licence Exemption Procedures – Students Only

Exemptions are only available at the university to students, both undergraduates and postgraduates. The philosophy of Western Sydney University is that a student must obtain own licence for conducting radiation work, unless the use is for a very short period (less than 1 month of their whole enrollment). This condition is applicable to both research and teaching activities.

Whenever there are student work exemptions issued, then there must be appropriate level of supervision provided (as specified in the exemption form, appropriate for the taks performed and approved by the qualified person issuing the exemption) ,



For an Exemption to be granted the following needs to be ensured:

- ONLY STUDENTS, as deemed under Part 2, Clause 17 of the Protection from Harmful Radiation Regulation 2025, may be granted an exemption by an appropriate licencee
- The exemption must be in writing using **the form [WSU-RMP-Section3 Radiation License Exemption Form01],** which can be downloaded from WSU website- Research Forms | Research at Western Sydney University (https://www.westernsydney.edu.au/research/forms).
- The exemption document must specify the radioactive substances or irradiating apparatus
- The exemption must set out the conditions to which the exemption is subject (viz., the class or course, the designated radiation area (DRA) or laboratory in which the work must be done, the times during which the work is allowed, etc)
- The exemption must identify each student, or class of students, to whom it relates The exemption must identify the appropriately licensed person or persons who are to supervise each student, or class of students, to whom it relates
- The exempting licencee must ensure that a copy of the exemption:
  - ⇒ is given to each student to whom it relates,
  - ⇒ is conspicuously displayed at each place in which the radioactive substances or irradiating apparatus to which the exemption relates are proposed to be used, and
  - ⇒ a copy is kept for the local records (School/Centre level)
- Exemptions must be reviewed and renewed annually.

5. DOCUMENTATION

Student Exemption Records

6. AUDIT

Every 2 years

7. REVISION & APPROVAL HISTORY

Date	Revision No.	Author and Approval
Dec 2013	Draft	William Bartolo, Bartolo Safety Management Service
Nov 2014	Revised Draft	K Ambrose, T Millar & W Bartolo
Dec 2014	Revised Draft	K Ambrose, T Millar & W Bartolo
Mar 2016	Draft 4	K Ambrose, T Millar & W Bartolo
Nov 2016	Revision 5	BRSC comments, K Ambrose, T Millar & W Bartolo
Feb 2017	Revision 6	BRSC, K Ambrose, T Millar & W Bartolo
Oct., 2018	Revision 7	K Ambrose, T Millar & W Bartolo
July, 26	Revision 8	S.Turner & D.Wojtalewicz

Appendix 3.1 OCCUPATIONAL AND PUBLIC DOSE LIMITS[1]

Application	Dose limit		
	Occupational (18 years and over) [1]	**Public** [6]	**more than 16 years but under 18 years** [1,5]
Effective dose (see Note 2)	20 mSv per year, averaged over 5 consecutive years (see Note 2	1 mSv in a year (see Note 7)	6 mSv per year
Annual equivalent dose in: Lens of the eye Skin (see Note 3) Hands and feet	 20 mSv (see Note 3) 500 mSv 500 mSv	 15 mSv 50 mSv —	 20 mSv per year 150 mSv per year 150 mSv per year

NOTES:

1 The limits apply to the sum of the relevant doses from external exposure in the specified period and the 50-year committed dose from intakes in the same period.

2 With the further provision that the effective dose must not exceed 50 mSv in any single year. When a pregnancy is declared by an occupationally exposed female, the working conditions of that person should be such as to ensure that the additional dose to the embryo/foetus would not exceed about 1 mSv during the remainder of the pregnancy.

3 With the further provision that the equivalent dose must not exceed 50 mSv in any single year.

4 The equivalent dose limit for the skin applies to the dose averaged over 1 cm2 of the most highly irradiated area of the skin. The dose to the skin also contributes to the effective dose, this contribution being the average dose to the entire skin multiplied by the tissue weighting factor for the skin.

5 Persons under the age of 16 years must not be subject to occupational exposure. Persons under the age of 18 but more than 16 years must not be subject to occupational exposure unless they are under supervision and only for the purpose of training for employment or for the purpose of studies in which sources are used

6 The limits apply to the sum of the relevant doses from external exposure in the specified period and the 50-year committed dose (to age 70 years for children) from intakes in the same period.

7 In special circumstances, a higher value of effective dose could be allowed in a single year, provided that the average over five years does not exceed 1 mSv per year.

INTERNAL ONLY

RADIATION MANAGEMENT PLAN
COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Purchase, Acquisition and Storage
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S4
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney UniversityRSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation Purchase, Radiation Acquisition, Storage of Radiation Emitting materials
SUMMARY *Brief summary of the contents of the document*	Information on the procedures for the purchase and acquisition of Ionising substances and equipment and the storage requirements for such items.

INDEX - Section 4

1. BACKGROUND

The Radiation Management Licence holder has the sole responsibility for the purchase of all radioactive substances, including uranyl salts, sealed source devices, and ionising equipment.

The Radiation Management Licence has the sole responsibility for the storage and disposal of all radioactive substances, uranyl salts, sealed source devices, and ionising equipment.

No holder of a user licence can:

- purchase, acquire by borrowing or trading or changing ownership of radiation (radioactive substance, sealed source devices, and ionising equipment);
- organise, form or control any storage facility for radiation; or
- dispose of radiation (e.g. radioactive substance, sealed source devices, and ionising equipment.).

2. ACQUISITION PROCEDURE

This procedure also applies to acquisition by borrowing, loan, and gifting. Purchase orders (see Appendix 4.1 of this Section for the approved requisition form) of all radiation equipment or radioactive nuclides, or uranyl salts must be sent to the Laboratory Safety Specialist; S&W for endorsement before submission to the procurement team. (**they MUST NOT to be sent** to the University's procurement team before appropriate approvals are obtained). Ensure that ALL required information is provided on Radiation Purchase Requisition Form before sending to S&W for approval.

3. STORAGE PROCEDURE

- The RML holder will be responsible for approving, keeping and maintaining a record of all forms of storage for radiation including rooms, cupboards and fridges.
- The S&W in cooperation with the BRSC will organise, inspect, approve, and ensure the integrity of storage facilities.
- S&W will ensure that an inventory check (equipment and radioisotope solutons) is conducted by the relevant user licensee of the associated storage facility at a minimum interval of every 6 months.
- Refer to Section 13 of the RMP in regards to radioactive waste storage.

Access to such storage unit/s will be restricted and be a part of the initial BRSC approval process. Any subsequent changes to access requirements will require an amendment to the BRSC approval with the local management maintaining a copy of this BRSC amendment.

4. DOCUMENTATION

Radiation purchase requisition form

5. AUDIT

Every two years

6. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, and its revision number and approval history)*

Date	Revision No.	Author and Approval
Jan 2014	Draft	William Bartolo, Bartolo Safety Management Service
Sept., 2014	Revised Draft	K Ambrose, T Millar & W Bartolo
Dec., 2014	Revised Draft	K Ambrose, T Millar & W Bartolo
Mar., 2016	Draft 4	K Ambrose, T Millar & W Bartolo
Feb 2017	Revision 6	K Ambrose, T Millar & W Bartolo
Oct., 2018	Revision 7	K Ambrose, T Millar & W Bartolo
July, 26	Revision 8	S.Turner & D.Wojtalewicz

APPENDIX 4.1

RADIATION PURCHASE REQUISITION FORM

Section A	
Project (Identify the project/activity that includes the use of this source/apparatus)	
Project or Activity Title	
BRSC Reference Number (if applicable)	
CI/Supervisor:	
Contact Person:	
School/Faculty	
Summary (to be completed if purchase does not fall under a research project or teaching activity)	
Please provide an overview of the requirement for this purchase	

Section B	
Location the source or apparatus will be stored/situated	
Campus/Site	
Building Name	
Room Number	
Additional info can be recorded here (e.g. location in the room, etc)	
Who is the responsible supervisor of the space and have they approved the purchase and installation?	
Does the facility meet the required quality, safety, security and any other compliance requirements for the purposes of storing/housing/handling/operating this source/apparatus?	
List personnel who will be handling/operating this source/apparatus	

Section C	
Identify the source/equipment to be purchased (include all relevant details- brand/manufacturer, total activity (Bq)*, model number etc. and whether the purchase covers/includes disposal costs)	
Radioisotopes/unsealed sources (excluding below)	
TC99M Generator (size in Bq/number of generators per yr)	
Ionising Radiation Instrument/Sealed Source eg X-ray	
Non-ionising radiation eg. Laser, RF-heating, microwaves, sonic, MRI	

* Total activity for isotope purchases over one year

Section D	
Purchasing Information	
Supplier (name and address)	
Supplier Contact person **Name:** **Phone:** **Email Address:**	

Office Use Only:
This purchase has been approved for Western Sydney University Signed---------- Date---------- Deputy Vice Chancellor (Research, Engagement, Development and International) Radiation Management Licence:

Once completed this form should be submitted to WHS@WesternSydney.edu.au for processing.

The applicant will be notified of the outcome and if approved, the authorised form will be forwarded to the Supplier (contact noted in section D) confirming the purchase/s have been approved to proceed under the University Radiation Management Licence within the next 12 months from the date above.

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RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Radiation Project Approval (Teaching and Research)
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S5
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation Approval, Project Approval, Project Safety Management
SUMMARY *Brief summary of the contents of the document*	Information on the procedures for the approval application process before radiation acquisition or use occurs.

INDEX - Section 5

1. PHILOSOPHY

To comply with legislation, before commencing any research or teaching involving radiation (materials or ionising equipment – this includes sealed and unsealed isotope sources, XRD/F analysis equipment, X-ray spectrophotometers, clinical X-ray, ionising equipment and lasers), the activity must first be approved by the Radiation Management Licence Holder or his/her delegate. In this case, it is the Western Sydney University BRSC.

This process enables the Radiation Management Licence Holder to document and maintain control of radiation management for approved research or teaching using radiation so that it complies with legislation.

Applications must be made to the Western Sydney University BRSC using the approved form.

2. RESPONSIBILITIES

- The legal responsibility for compliance related to all activities (from purchase to disposal) will be shared between the **RML holder** and the user licencee who has completed the application documentation.
- **The BRSC** is responsible for approving the project and ensuring that all personnel have had the appropriate training.
- **Chief Investigator**: This person will be responsible for ensuring that all aspects of the project are adhered to in accordance to the approved proposal. This includes ensuring that anyone working on the project adheres to the approved project proposal. They are also responsible for ensuring that any changes to the protocol are first approved by the BRSC. This includes adding additional students or researchers to the project and changes to the protocol(s).

3. PROCEDURE

Applications for any project involving use of radiation material must be made to the University BRSC using the approved form, which can be downloaded from:
https://www.westernsydney.edu.au/research/forms

Once completed, the form must be submitted to the Ethics Officer (Animal, Biosafety & Radiation).

In the case of a University staff member using radiation at another institution or university, the person requesting to use the radiation must demonstrate to the University BRSC that they have gained approval by the equivalent committee or person in the other organisation.

Note:
- The University BRSC submission deadlines and meeting times are published on the University portal.
- It is advisable to consult with the University Radiation Safety Officer (RSO) whilst preparing the application.

4. DOCUMENTATION

Application form

The application form will be reviewed by the University BRSC if the legislation changes or a minimum of every 3 years, whichever is sooner.

5. AUDIT

Every 3 years

6. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
May 2014	Draft	William Bartolo, Bartolo Safety Management Service
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Dec 2014	Revised Draft	K Ambrose, T Millar & W Bartolo
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Oct., 2018	Revision 7	K Ambrose, T Millar & W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Radiation Safety and Monitoring in Laboratories
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S6
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, X-rays, radioactive substances, laboratory safety
SUMMARY *Brief summary of the contents of the document*	Procedures to limit the risk to health of staff arising from exposure to radiation from laboratory use of radioactive substances or X-ray devices.

INDEX - Section 6

1. BACKGROUND

Staff involved in laboratory procedures involving radioactive substances may be exposed externally to radiation from the source (mainly beta and gamma radiation) but may also be exposed internally if any of the radionuclide is inhaled or ingested. Radio-isotopes can also enter the body through open cuts. Hence, high standards of laboratory cleanliness and good laboratory techniques will minimise the likelihood of radioactive contamination.

2. RESPONSIBILITIES

2.1. University BRSC

The University BRSC will ensure that the radiation laboratory, associated facilities, equipment and training are compliant with current regulations, the RMP and approved project proposal.

2.2. The Radiation Safety Officer

The RSO will monitor and provide advice on radiation safety within laboratories using radioactive substances, X-ray apparatus and/or lasers. The RSO will have the authority to make immediate adjustments to procedures, or to immediately require a procedure to cease, or to shut down a facility.

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2.3. Chief Investigator

The Chief Investigator is responsible for ensuring that all projects involving radiation have been approved by the BRSC, that all procedures are performed safely, personnel working on the project are appropriately trained (including specific training in radiation safety and emergency procedures) that personnel working on the project are aware of the requirements of the RMP, and, where necessary, that personnel working on the project are issued with and wear personal radiation monitors. The Chief Investigator must ensure that all personnel working on the project are aware of, and comply with, these procedures.

2.4. Personnel working on the project

Must be supplied with the project approval and must perform all procedures in accordance with the BRSC project approval and the RMP.

3. PROCEDURE

3.1. Procedures for the safe handling of unsealed sources of radioactivity

3.1.1. Unsealed source procedures are to be conducted in an appropriate and registered facility (see RMP Section 14).
Note: a substance is only considered to be radioactive if its **specific activity** is at or exceeds 100 Bq/g and is deemed to require licensing if the **total activity** exceeds the thresholds listed in Schedule 1 of the Protection from Harmful Radiation Regulation 2025. If a laboratory's occupants are using substances with activities below this threshold (e.g. greater than (>) 400 kBq of I-125 in a radio-iodination lab), the lab still needs to be registered.

3.1.2. When using unsealed radioactive sources, care should be taken to minimise internal and external contamination. Internal contamination may result from inhalation, ingestion, skin wounds or skin penetration. Note: No unsealed radioactive sources should be manipulated with unprotected hands. Appropriate protective gloves (eg. Nitrile) should always be worn (gloves material should be selected based on the compatibility with base solution carrying radioactive isotope). ^{14}C on the skin may be absorbed into the body at a rate of 0.3% per minute (18% per hour). ^{3}H (as tritiated water) may be absorbed through the skin at a rate of up to 23% per minute. Radionuclides of iodine, such as ^{125}I and ^{131}I can be volatile and should be handled in a fume cupboard.

3.1.3. It should be remembered that penetration of gloves may occur when handling some iodine compounds. A second pair of gloves is thus recommended.

3.1.4. To avoid contamination of hands, gloves should be removed in the proper surgical manner (remove one glove, hold in the other hand and fold the second glove over the first) and disposed of correctly after use.

3.1.5. A laboratory coat or gown must be worn and must be buttoned up when handling radioactivity.

3.1.6. Mouth pipetting of any substance, including radioactive substance, is totally prohibited.

3.1.7. Precautions should be taken to avoid punctures, cuts and any open skin wounds.

3.1.8. Cover all working surfaces with absorbent paper and clearly mark the area as a radiation working area. Plastic backed “underpad” is particularly suitable for this purpose.

3.1.9. Wash hands thoroughly after using radionuclides.

3.1.10. Pure beta emitters such as ^{32}P and ^{35}S should be handled whilst standing behind a protective barrier made of a low atomic number material such as Perspex.

3.1.11. Radionuclides which emit gamma rays, such as ^{131}I, will require shielding with lead.

3.1.12. Food, beverages, smoking items, handbags, cosmetics, handkerchiefs and eating and drinking utensils are prohibited in laboratories where unsealed sources are used.

3.1.13. Food and drinks must never be stored in a refrigerator or freezer designated for radioactive materials.

3.1.14. Contain waste appropriately and immediately.

3.1.15. Be familiar with decontamination and radiation monitoring procedures.

3.1.16. Use only self adhesive labels in radiation working areas.

3.1.17. Monitor radiation exposure by:

3.1.17.1. wearing a body personal radiation monitor and/or finger monitors if appropriate

3.1.17.2. regular thyroid counting after performing iodinations

3.1.17.3. self-monitoring (use a contamination monitor to scan own the body) after working with unsealed sources.

3.1.18. At the end of each procedure, the work area should be completely cleaned and checked for any contamination.

3.1.19. All containers must be clearly labelled with the name of the radionuclide, its chemical form, and activity, along with the measurement time and date. If the material is sterile, this must be clearly indicated. The name of the responsible person should also appear on the label.

3.1.20. All containers of radioactive material must be adequately shielded at all times.

3.1.21. For activities of greater than 50 MBq, the container must never be directly handled. Remote handling devices, such as tongs, must be used instead.

3.1.22. Non-radioactive work, particularly record keeping, must not be performed in the area designated for radioactive work.

3.1.23. Glassware, forceps, scissors and other instruments for use with radioactivity should be marked as such and not removed from the area.

3.1.24. Maintenance work to fixtures and plant should be carried out only after the Radiation Safety Officer has given clearance.

3.1.25. No new procedures involving radioactive substances are to commence until the Radiation Safety Officer has been consulted with regards to radiation safety.

3.2. Personal Protective Equipment

3.2.1. Protective clothing, reserved specifically for radioactive work, shall be worn at all times in the laboratory, even for very low levels of activity. The following shall apply:

3.2.1.1. A yellow gown with elasticized sleeve cuffs will be worn.

3.2.1.2. In high level laboratories (refer to classification of laboratories as per AS 2243.4), in addition to the yellow gown with elasticized sleeve cuffs coats, overshoes or similar or specially designated footwear shall be worn to prevent the transfer of radioactive contamination from laboratory floors.

3.2.1.3. At all times suitable gloves (always double gloving) shall be worn for all work with unsealed radioactive substances, and special care is to be exercised when putting on or removing gloves, to avoid contaminating the hands and the inside surfaces of the gloves.

3.2.1.4. Suitable eye protection must be worn at all times whilst in the Designated Radiation Area (the laboratory).

3.2.2. Paper towels will be used for drying hands after washing. Air dryers may not be used. Paper towels used for drying hands are to be discarded as active waste.

3.2.3. All protective clothing worn in radioisotope and radiological laboratories shall be removed before leaving, and left in, or immediately outside, the laboratory; the latter place shall then be regarded as an ‘active’ area, i.e. possessing a potential

contamination hazard. Contaminated protective clothing shall not be laundered with uncontaminated items, as these should be laundered separately.

3.3. Laboratory Decommissioning

For Laboratory decommissioning procedures please Refer to Section 14 *Radiation Shielding and Facilities Design*.

4. EMERGENCY PROCEDURES

4.1. Spills of radioactive material are not to be regarded as an unavoidable hazard in the day-to-day operation of the department. Any spill has a degree of risk and acceptance of minor spills could lead to a casual approach to major spills. Accidents involving radioactive material must be reported to the University S&W.

The following procedure should be followed on discovery of a contamination problem:

All persons involved in the incident are to vacate the immediate vicinity of the spill but are not to move freely around the laboratory area, as this involves a danger of spreading contamination.

NOTE: As a practical radiation safety rule, as "person involved in incident" consider **anyone who was in the laboratory or controlled area at the time of the spill until contamination surveys demonstrate they were not contaminated**. Appropriate immediate action shall depend :

1. **The radionuclide involved** (e.g. P-32, I-125, C-14, tritium).
2. **The activity spilled**.
3. **The likelihood of airborne contamination or splash contamination**.
4. **Results of contamination monitoring**.

IMMEDIATELY notify the person responsible for laboratory operations (Laboratory Manager or TRTS Team Leader/Coordinator and the University S&W and/or RSO

If the contamination is due to a container spill of liquid and hands are protected with gloves, stand the container back up and ensure that it is adequately shielded. If the problem is due to a leaky container, place suspect item in a labelled plastic bag.

Seal off the area involved and ensure that personnel do not walk on any potentially contaminated floor area. Discard any clothing which is contaminated and place it in a labelled plastic bag.

Consult with Radiation Safety Officer to determine disposal of bags and waste items

4.2. For further information related to incidents involving contaminated or exposed persons, decontamination of the person procedure refer to paragraph 3 RMP Section 17 “Handling. Investigation and reporting radiation incidents”.

5. X-RAY DIFFRACTION AND FLUOROSCOPY SAFETY

The following has been extracted from current Codes of Practice, Guidelines and Regulations, and include:

- Locating shielding as close as practicable to the source of radiation. Precautions should be taken to protect laboratory workers and persons in adjacent areas from direct and scattered radiation.
- Indicator warning lights
- Development of Safety Procedures
- Training
- Interlocks
- Placarding of DRAs (designated radiation areas)
- Monitoring

5.1. General Working Rules for all X-Ray Analysis Units

5.1.1. Each person who uses an X-ray analysis unit shall avoid exposing any part of the body to a primary X-ray beam.

5.1.2. No person shall allow the X-ray tube of an X-ray analysis unit to remain energised unless all warning lights, as required by the Code (ARPANSA/NHMRC RHS 9), are operating correctly.

5.1.3. No X-ray tube shall be energised:

5.1.3.1. while outside its protective tube housing, or

5.1.3.2. with an unshielded aperture in the tube head or protective barrier.

5.1.4. No sample, collimator, monochromator or analysing crystal shall be changed or adjusted while a primary X-ray beam passes through that collimator or is incident on that sample or crystal unless:

5.1.4.1. The sample, collimator, monochromator or crystal, during and after the change or adjustment, is within a shielded enclosure, and

5.1.4.2. The change or adjustment is done by remote means from outside the enclosure.

5.1.5. Immediate measures shall be taken to remove potentially hazardous situations arising from X-ray beams that may be emitted due to equipment defect, misalignment or any other reason.

5.1.6. A list of additional working rules shall be drawn up for each X-ray analysis unit where necessary to ensure safety. This is of particular importance for units which do not meet the requirements of the ARPANSA (1984) Code for enclosed or partly enclosed units.

5.1.7. The necessary operations of the X-ray analysis equipment shall not be performed by inexperienced persons unless under immediate supervision of an experienced operator.

5.1.8. Alignments or adjustments shall not be carried out visually while the X-ray tube is energized, unless a viewing system is used which is shielded or designed to prevent exposure of the eye or other parts of the body to the primary beam.

5.1.9. The X-ray analysis unit shall not be operated when there is inactivation of an interlock or with part of its enclosure removed without prior approval of the statutory authority or unless the X-ray tube is wholly enclosed by the tube housing with all apertures completely covered by interlocked shutters and/or fixed covers.

5.2. Safety Guidelines for Enclosed Installations (NHMRC/ARPANSA)

User responsibilities that must be adopted

The user shall be responsible for their safe use of X-ray analysis equipment at all times and shall ensure that:

- all legislative requirements are satisfied;
- all safety features required are implemented and are regularly serviced and maintained in good working order;
- the requirements outlined in this safety manual are completed and maintained;
- no X-ray analysis unit is operated while a safety feature is removed, modified or inactivated except under the approval of the appropriate Government Authority;
- in the case of an actual or suspected exposure to the intense primary beam, the persons involved are referred for medical examination*, medical reports are retained, and full details of the incident are verbally reported to the statutory authority as soon as possible (refer to Section 17 of RMP for comprehensive information on reporting requirements and procedures).

  NOTE: *Ensure GP or emergency medical staff are aware of RPS G-3 Emergency Exposure Guide - PART 1.

  - Immediately for Environmental contamination
  - 48hrs for all other incidents
- Formal reporting with in 10 days
- the signs required for the work area are prominently located and are maintained in a clean, intact and legible state;

Each operator of an X-ray analysis unit shall:

- at all times carry out established procedures of operation and maintenance, and
- report to the RSO any actual or suspected case of excessive exposure, endeavour to determine its cause, and take steps to prevent its recurrence.

5.3. Safety Guidelines for Partially Enclosed & Open Installations (NHMRC/ARPANSA)

For units that do not meet the requirements of enclosed apparatus, more stringent controls and requirements are to be implemented. Partly enclosed units which incorporate fixed shields and/or barriers shall be designed to give a clear and positive warning if the barriers or shields are incomplete or not in place. A clear and unambiguous notice shall also be displayed on or near the unit indicating the hazards of operating the unit while barriers or shields are incomplete.

Each partly enclosed unit shall satisfy the relevant requirements for enclosed units plus the following additional requirements:

5.3.1. It shall be so constructed that it incorporates an enclosure or enclosures which partly enclose the primary X-ray beams sufficiently to ensure that no person may inadvertently expose any part of their body to a primary beam. The enclosure shall:

5.3.1.1. be interlocked, or fixed so as to require the use of tools for removal.

5.3.1.2. incorporate collimator shields, and

5.3.1.3. contain appropriate shielding material or be located at a sufficient distance from the X-ray tube that the dose of radiation at any accessible point five centimetres from the surface of each partial enclosure shall not exceed 25 μGy in one hour.

5.3.2. It should be so sited that if for any reason a shutter is opened while an entrance to an enclosure is uncovered or barriers are incomplete, the resultant primary beam is directed away from areas that may be occupied. If such siting is not possible, beam stops or fixed shields shall be placed to adequately protect persons in these areas from the beam.

5.3.3. It should be sited in a separate room or cubicle in which there are no other radiation sources.

5.3.4. It should be so constructed such that all operations are most easily and quickly carried out with all shields in place and all interlocks in operation.

5.4. Non Complying X-Ray Units

Each X-ray analysis unit which does not comply with (i.e. does not meet the requirements for an enclosed or partly enclosed unit) shall not be used until modified to meet those requirements, unless the user has prior approval of the statutory authority to do so for an interim period. When such approval is given a set of working

rules approved by the statutory authority shall be drawn up for use pending the required modifications or replacement by a unit that complies. These working rules shall be designed to achieve the same standard of safety as the required modifications of the equipment, shall be prominently displayed on or near the X-ray analysis unit, and shall be rigorously implemented. The interim working rules shall include rules and requirements as follows:

5.4.1. The rules required for partly enclosed units shall be included, and implemented whenever the unit is used.

5.4.2. Supplementary interim rules shall be included to minimize the risk that any person will be exposed to a primary X-ray beam from the unit or otherwise receive a dose of radiation in excess of the recommended dose limit.

5.4.3. A check-list of step-by-step procedures shall be prepared and used during the following operations:

5.4.3.1. before initiating an exposure

5.4.3.2. during an exposure

5.4.3.3. in terminating an exposure, and

5.4.3.4. during any non-routine operation of the unit, such as alignment of an X-ray beam.

5.4.4. The unit shall not be operated if any person other than those essential to its operation occupies the cubicle, room or area in which the unit is placed.

5.4.5. No alteration should be made to the analysing equipment in use with the unit unless the X-ray tube is de-energised.

5.4.6. Interim working rules shall include the requirements for siting given in the previous sections, with the requirement 'should' being replaced by 'shall'.

5.4.7. The requirements of the following section (radiation monitoring) shall be incorporated in the working rules with the following amendments:

5.4.7.1. The requirement 'should' in personal monitoring shall be replaced by 'shall'.

5.4.7.2. Periodical monitoring shall be performed not less than once in each month and the unit shall be thoroughly examined for hazards and all safety features checked at least once in each week. This requirement is the same as that for a partly enclosed unit.

6. RADIATION MONITORING

Monitoring, where appropriate, includes the measurement of doses received by laboratory workers, external dose rates in the laboratory, amount of radioactive contamination on surfaces and articles in the laboratory, and radioactive contamination in the air and in effluents. The radiation monitoring program must be documented and should be reviewed periodically and amended in the light of operational experience.

The type and degree of monitoring required depends on the circumstances and the level of exposure. When assessed doses are well below the dose limits, group or area monitoring strategies may suffice.

Workers in laboratories where radioactive substances or sources of ionizing radiation are used shall have ready access to radiation monitoring equipment as specified by the RSO. In particular, at least one appropriate contamination monitor shall be available for every laboratory where unsealed radioactive substances are used. If high activity sources (sealed or unsealed), or irradiating apparatus could give rise to an external radiation hazard, a dose-rate monitor shall be available.

The advice of the RSO shall be obtained:

(i) on the type and characteristics of the radiation and contamination monitors required for unsealed radionuclide work proposed or being carried out; and
(ii) whether a radiation monitor is required, and if so, the appropriate type for work with sealed radionuclide sources or irradiating apparatus.

Further information and advice on the choice of suitable instruments may be obtained from the RSO.

6.1. Personal Monitoring

Individual personal monitoring shall be implemented when required by the regulatory authority or as advised by the RSO.

The type and degree of monitoring required depends on the circumstances and the level of exposure. Any estimate to assess the level of exposure should take into account the potential exposure in an unplanned incident situation.

For any worker who regularly works in a Supervised DRA or who enters a Controlled DRA only occasionally, it may be appropriate to assess the occupational exposure on the basis of the results of workplace monitoring or individual monitoring.

For any worker who usually works in a Radiation Controlled area, or who occasionally works in a Radiation Controlled area and may receive a significant dose from occupational exposure, individual monitoring should be undertaken if it is appropriate, adequate and feasible. Individual personal monitoring may use of any one, or a combination of whole body dosimeter, extremity dosimeters, direct reading personal dosimeters, personal air samplers, whole body monitoring and biological monitoring as appropriate.

The aim of personal monitoring is to ensure that the doses received by the individual are kept within those listed in Appendix 3.1 of RMP Section 3, and any dose constraints so applied by the institute or the RSO.

Continuous personal monitoring of an external dose should be performed by a dosimetry service accepted by the regulatory body. For controlling individual exposure on a day-to-day basis, or during a particular task, it may be necessary to use supplementary dosimeters of the direct reading type (active dosimeters). If a worker is liable to receive an equivalent dose to the extremities, skin or lens of the eye that is a sizeable fraction of the relevant dose limit, these tissues and organs should be monitored separately.

Where sudden unexpected increases in exposure might result in a significant dose being received by a worker, provision should be made for the continuous monitoring of dose rate using an instrument fitted with appropriate audio and/or visual alarms to warn of unacceptable conditions.

If there is a possibility of exposure to unsealed radioactive substances, the activity concentration in air or intake of radioactivity into the body should be established to be used as an indication of whether there is a potential for a significant individual exposure. If this level is exceeded, the RSO will advise on measurement procedures to be implemented, including additional direct measurements of the individual's internal exposure (for example, thyroid monitoring of persons working with radio-iodine, or urinalysis for persons working with soluble radionuclides).

In cases where individual monitoring of the worker is not feasible, the occupational exposure should be assessed on the basis of the results of workplace monitoring and information on the locations and durations of exposure of the worker.

6.2. Area Monitoring

6.2.1. External radiation

The purpose of area monitoring for external exposure is to identify any areas where appreciable dose rates exist, or where changes have occurred, so that appropriate action, such as provision of shielding or restriction of working time, may be taken to reduce the radiation exposure to personnel. Monitoring instruments may be fixed or portable.

6.2.2. Surface contamination

Work with unsealed radioactive material creates the potential for contamination of surfaces. Regular and frequent contamination monitoring is needed to identify the presence of surface contamination and prevent the inadvertent transfer of such contamination at levels exceeding specified values under normal operating conditions (either the values in AS/NZ 2243.4 Table B2 or 4 Bq/cm^2).

Components comprising or being close to the targets of heavy particle accelerators or close to high activity neutron sources should be checked for induced radioactivity before handling.

For further information on surface contamination monitoring techniques, see RMP Section 10.

6.2.3. Airborne contamination

Airborne contamination can occur in laboratories. If operations involving radioactive substances might produce airborne radioactive contamination in the working atmosphere, then the work should be performed in a fume cupboard or glove box. If this is not feasible, some form of air monitoring shall be instituted as advised by the RSO

6.3. Radiation Monitoring in Association with X-ray Analysis Equipment

Radiation monitoring is an essential aid in the control of radiation hazards in the vicinity of X-ray analysis units and radioactive materials. However, with X-ray analysis units, the accurate measurement of radiation from these units is often difficult, and a person seeking to do such measurement needs specialized equipment, careful technique, and an understanding of the principles involved. The performance of measurements following an accidental exposure of a person to a primary beam is important, as a realistic assessment of the dose received is needed to assist in the prediction and treatment of radiation injury. However, radiation monitoring required during use of X-ray analysis units need not be as accurate. In this case, simple measurements directed towards prevention of exposure to primary beams and reduction of leakage and scattered radiation to suitably low levels are adequate. The following rules should apply:

- Accurate measurements of radiation exposure or dose, or their rates, in primary, scattered or leakage beams should only be attempted by, or under the supervision of, a person competent to perform such measurements.
- Accurate measurements of leakage and scattered radiation should only be attempted if difficulty is encountered in ensuring the radiation levels are well below the requirements of legislation and guidelines.

6.3.1. Personal Monitoring and X-ray Analysis Equipment

Personal monitors are usually inadequate indicators of exposure to the narrow beams of radiation which may be emitted from X-ray analysis units. However, personal monitors have been found useful in the discovery of some cases of exposure of persons to primary beams from X-ray analysis units and in the assessment of whole-body dose due to exposure of leakage and scattered radiation from such units. This will only be appropriate for open and semi-enclosed X-ray units.

6.3.2. Monitoring of Equipment for X-ray Analysis Equipment

The user of each X-ray analysis unit shall ensure that regular radiation monitoring of the unit is carried out to detect unintended radiation emissions and to assist in preventing such emissions. The following requirements shall apply to such radiation monitoring.

Each instrument used for dose rate monitoring shall comply with the following requirements:

- Its sensitivity shall be adequate to give a positive indication with a time response of not more than 20 seconds for a true dose rate of 10μGy h^{-1} when measured in a field of radiation uniform over the sensitive volume of the detector and having an effective energy within the range of the unit
- If provided with meter indication, the meter shall be either:
    - calibrated in arbitrary units only, and the appropriate method of conversion from these units to exposure rate or dose rate for a radiation field uniform over the sensitive volume of the detector indicated on the instrument, or
    - calibrated in units of exposure rate or dose rate, with a statement clearly displayed on the instrument that its calibration is correct only for a radiation field uniform over the sensitive volume of the detector.
- Each of these radiation surveys shall be conducted with the X-ray tube of the analysis unit operated at the maximum rated voltage and the maximum rated current for that voltage, and with no filtration in the primary beams other than the inherent filtration.
- Periodical radiation monitoring shall be carried out on each X-ray analysis unit that is operated on a regular basis. The frequency of monitoring should be not less than that given in the following schedule, but some variation of this schedule may be warranted with certain units or periods of use:
-

Type of Unit	*Frequency of Monitoring*
Enclosed	*Quarterly*
Partly Enclosed	*Monthly*

NOTE: These times are for infrequently used research units.

7. DOCUMENTATION

Premises Registration Certificates
Equipment Registration Certificates

8. AUDIT

Every 2 years

9. REFERENCES

NHMRC (now by ARPANSA) RHS No.9: Code of practice for protection against ionising radiation emitted from X-ray analysis equipment (1984).

NHMRC (now by ARPANSA) RHS No.21: Revised statement on cabinet X-ray equipment for examination of letters, packages, baggage, freight and other articles for security, quality control and other purposes (1987).

NHMRC (now by ARPANSA) RHS No.22: Statement on enclosed X-ray equipment for special applications (1987).

10. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
May 2014	Draft	W Bartolo, Bartolo Safety Management Service
Feb., 2015	Draft 2	K Ambrose, T Millar, W Bartolo
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Nov, 2016	Revision 5	BRSC comments, K Ambrose, T Millar, W Bartolo
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July, 2026	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Radiation Safety in Radiology (Human & Veterinary)
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S7
DATE OF PUBLICATION	
RISK RATING	
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REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, X-rays, radiology, medical imaging, Veterinary imaging, PPE, lead aprons, protective clothing
SUMMARY *Brief summary of the contents of the document*	Procedures to limit the risk to health of staff and members of the public arising from exposure to radiation from diagnostic radiology at any facility at the University or associated with the University.

INDEX - Section 7

1. BACKGROUND

Any research involving diagnostic procedures must have a Radiation Medical Practitioner (radiologist or medical specialist for human research; veterinarian or veterinary radiologist for animal research) as a named investigator on the project.

Personnel involved in diagnostic or interventional radiology procedures could receive a radiation exposure principally from scattered radiation from the volunteer, animal or patient being examined. In normal circumstances no one, other than the volunteer, animal or patient, should be exposed to the primary X-ray beam, but such exposure could occur unintentionally.

Members of the public (for example, the mother of a paediatric volunteer or patient) may need to be in an Imaging Room while a diagnostic or interventional radiology procedure is taking place and could also receive a radiation exposure.

University personnel or members of the public in adjoining areas will be adequately protected as long as the required radiation shielding has been installed as required in RMP Section 14.

In addition, a medical physicist is required to provide Human Research Ethics and Animal Ethics Committees with a radiation dose estimation and risk assessment for any research studies that involve the research subjects receiving an exposure from ionizing radiation, for humans in accordance with the requirements of RPS8 (ARPANSA 2005) .

2. RESPONSIBILITIES

2.1. The Radiation Medical (radiologist medical or veterinary) Practitioner

The above named person is responsible for the clinical management of the volunteer, animal or patient undergoing a diagnostic or interventional radiology procedure. This includes the decision to proceed with a radiology procedure based on the specialist's knowledge of the potential risks and benefits of the procedure, taking into account the clinical information, and the sensitivity and specificity of the procedure. For volunteers, the radiologist, etc. need to ensure that the proposed procedures are compatible with the medical status of the volunteer including pregnancy.

2.2. The Referrer

The referrer of the patient for a research diagnostic procedure needs to be satisfied that the procedure is justified being aware that the patient will receive a radiation exposure. The referral[1] must state the clinical question that the diagnostic procedure is intended to answer and the research reason for this exposure. The referral should also alert the radiation medical practitioner when the referrer is aware that a female patient is pregnant or is breast-feeding.

[1] The referral may be in hard copy or electronic form.

2.3. The Radiographer

The radiographer is responsible for performing diagnostic radiology procedures as prescribed by the radiation medical researcher or practitioner in accordance with the University's written standard protocols.

This will include:

- correctly identifying the volunteer or patient, the procedure and the site to be examined;
- following established imaging protocols to ensure optimal data acquisition and analysis;
- performing quality assurance procedures for instrumentation and image quality.

2.4. The Radiation Safety Officer

The RSO will monitor and provide advice on radiation safety within facilities performing diagnostic or interventional radiology.

3. PROCEDURE

3.1. Procedures to minimise radiation exposure

The radiation dose to the operator or a member of the public can be minimised by prudent positioning relative to the X-ray tube, patient and/or structural shielding. Where there is no structural shield and the operator has to remain in the room during general radiography, such as with mobile radiography, the operator should stand:

- at least two metres away from the X-ray tube;
- and outside the primary beam.

In these circumstances the operator should, wear protective aprons:

- Where a person is required to be present in a controlled area during an X-ray exposure, such as in a fluoroscopy suite, that person should not remain any closer to the patient or the X-ray tube than is necessary. The operator should ensure that any person who is required to remain in the room during the radiation exposure wears protective clothing or stands behind protective shields.

The design of all radiology suites should include a protected area in which the operator's console is located. The operator's console should be the only area within the radiology suite that radiography and remote controlled fluoroscopy systems (usually over-table X-ray tube systems) are operable.

3.2. Personal protective equipment

Aprons[2], thyroid shields and other personal protective devices should meet the requirements of the EPA Radiation Standard 4 *section A1.1.7* Aprons and gloves must have radiation attenuation of not less than 0.3 mm lead equivalence at 100 kVp.; A1.1.4 Aprons must cover the full width of the front of the body from the throat to within 10 cm of the knees, as well as the sides of the body. Wrap-around types of aprons must cover from the shoulder blades to below the buttocks. Fastenings must be provided to keep aprons closed.1 Refer to part A3 for different types of x-ray protective clothing. Where aprons have two overlapping front panels the total of the two panels when worn correctly must not be less than 0.3 mm in lead equivalence at 100 kVp.

Operators and other staff should use thyroid shields in all cardiology and interventional radiology suites. Relevant staff should be provided with protective gloves for use during all radiological procedures in which the hands and forearms may be in the primary beam.

All personal protective clothing should be clearly labelled with its lead equivalence and a unique identification number as specified by AS/NZS 4543.3.2000 and examined under fluoroscopy at least annually to confirm its shielding integrity. If damage to an apron is seen or suspected, it must be reported to the Radiation Safety Officer immediately and the apron removed from service until its shielding integrity can be checked.

3.3. Protection of Relatives and Carers

- Any relatives of the volunteer or patient should be discouraged from entering the room during an examination unless they are required to assist with the examination. If they insist they must be asked to stand at least 2 m away from the patient and must wear a protective apron.
- Any person aiding an examination (e.g., restraining the volunteer or patient) shall use a protective apron and avoid facing the direct primary beam. If their hands are near the primary beam, they should be provided with protective gloves.
- When children (as a volunteer) are to be examined, parent participation should be encouraged and adequate protection provided to the parents along with clear instructions as to the parent's role.

[2] Most protective aprons no longer contain lead, but are an alloy of high atomic number materials. References to aprons apply to all personal protective clothing of such design.

4. VETERINARY

4.1. Diagnostic radiology must only be undertaken if:

(a) there is a clear indication for the procedure; and
(b) it can be done without undue radiation hazard.

4.2. Only people who are essential to a procedure are permitted to be present during radiological examinations.

4.3. Each person present during a radiological examination must be:

(a) properly instructed to enable them to understand their part in the proposed procedure; and
(b) where practicable, positioned behind a protective screen.

4.4. Each person who is unable to position themselves behind a protective screen must:

(a) wear a protective apron; and
(b) remain as far as practicable from:
i). the primary X-ray beam,
ii). the animal, and
iii). the X-ray tube assembly.

4.5. Adequate facilities and devices must be available to ensure:

(a) physical control over the animal; and
(b) protection of the operator.

4.6. Radiography must only be carried out using an appropriate X-ray machine that satisfies the relevant requirements of Schedule B, ARPANSA RPS 17.

4.7. Radiography may be considered in two categories:

(a) radiography within a defined X-ray room or area. A defined X-ray room or area must have sufficient shielding to ensure that no person can receive a radiation dose in excess of the relevant radiation protection limits specified in RPS1.; or
(b) radiography outside a defined X-ray room or area when a mobile or portable X-ray machine is taken to the animal. An X-ray examination must not be carried out outside

a defined X-ray room or area unless it is not practicable to bring the animal to that room or area.

4.8. For further information and controls please refer to ARPANSA RPS 17 Schedule B.

4.9. The handling and exposure of the animals must comply with the Animal Research Act 1985 and also the Australian code of practice for the care and use of animals for scientific purposes.

5. DOCUMENTATION

None

6. AUDIT

The integrity of protective aprons to be audited at least on an annual basis.

Staff radiation exposures to be reviewed quarterly.

7. REFERENCES

PD2025_006 Clinical Procedure Safety

Code of Practice for Radiation Protection in the Medical Applications of Ionizing Radiation, ARPANSA 2019

Radiation Protection in Veterinary Medicine. RPS No. 17. ARPANSA. July 2009

EPA Policy on X-ray protective clothing

NSW EPA: Radiation Standard 4 2023

Animal Research Act 1985 No 123

Animal Research Regulation 2010.

8. **REVISION AND APPROVAL HISTORY** *(state the author of the document, the date it was written, its revision number and approval history)*

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INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Optimisation of Exposures during Radiology
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S8
DATE OF PUBLICATION	
RISK RATING	
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REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner – Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, X-rays, radiology, medical imaging
SUMMARY *Brief summary of the contents of the document*	Procedures to optimise volunteer or patient exposure to radiation from diagnostic X-ray procedures involved in research.

INDEX – Section 8

1. BACKGROUND

Within the NSW Protection from Harmful Radiation Regulation 2025 there is provision to protect personnel, volunteers and patients from unnecessary doses of radiation during research using diagnostic radiology procedures. The minimal doses of radiation required for diagnostic purposes may not be exactly known and hence procedures are required that allow such research to occur, while at the same time offering protection of the volunteer from undue radiation.

In general the minimal radiation required is a balance between volunteer or patient dose and image quality. If the image is compromised by reducing the dose to protect the volunteer or patient, then this may ultimately lead to repeat examinations and therefore higher volunteer or patient doses. The dose required will be determined by the image quality required for the research project and the size and shape of the volunteer or patient.

Typical uses of diagnostic radiology are bone X-ray, fluoroscopy, and CT procedures. Adaptation of normal protocols is a necessary part of diagnostic radiology to minimise radiation and to take into account different anatomical shapes, sizes and ages, as well as volunteers or patients who are pregnant.

2. RESPONSIBILITIES

2.1. The Chief Investigator

Prior to research commencing, the chief investigator must obtain approval from:

- The University Human Research Ethics Committee, AND
- The University Biological and Radiation Safety Committee

OR

- under circumstances where the owner and responsibility of the radiation equipment being used for the research is not the University, but an outside organisation or institute, before commencing research the chief investigator must submit the approvals from that organisation's or institute's equivalent committees to the Research Office for minuting at the appropriate University committees.

2.2. The Radiation Medical Practitioner (The Radiologist)

The Radiologist is responsible for the clinical management of the volunteer or patient undergoing the approved diagnostic procedure. This includes providing advice to the volunteer or patient about the procedure that is to be performed and ensuring that the imaging protocol to be followed has been optimised so as to minimise the radiation exposure to the volunteer or patient.

2.3. The Radiographer

The radiographer is responsible for performing the radiology procedures as prescribed by the radiologist in accordance with the approved protocol, including any protocol modifications specified for a particular patient.

2.4. The Radiation Safety Officer

The RSO will oversee and provide advice on radiation safety within Schools/departments performing diagnostic radiology.

Note: RSO responsible for advisory role in the area of medical radiology must be qualified health physicist.

3. PROCEDURE

Procedures for the correct identification of the volunteer or patient, procedure and sites
All clinical research staff shall comply with the NSW Health Policy Directive . PD 2025_006 Clinical Procedure Safety.

A poster or trolley slip must be displayed in the vicinity of volunteer or patient interviews where correct identification is being determined

Note: There are further resources available to support the above Health Policy Directive at the following link – Clinical Excellence Commission – Clinical Procedure Safety. Typically, the procedure ensures that the volunteer or patient (if necessary via a parent or guardian) has been

- provided with enough information about the procedure and its hazards to make an informed consent;
- asked to state their name, date of birth and address;
- asked to state the nature of the procedure that they believe is about to be undertaken; and
- asked about their pregnancy status if female and of childbearing age

In addition, immediately prior to the start of the procedure, the radiographer or radiologist should confirm that an identity check of the volunteer or patient matches that on their paperwork indicating the patient, procedure and site for the study requested.

4. PROCEDURES FOR EXPOSURE OPTIMISATION

4.1. Radiography

The radiographer will:

- tailor the kVp, beam filtration and mAs to the volunteer's specific anatomy;
- restrict the number of exposures per examination to the minimum necessary;
- choose the most efficient image receptor required to achieve the diagnostic information (e.g., fast versus slow intensifying screen speed, correct matching of film and screens);
- avoid the universal use of anti-scatter grids, most particularly in the context of radiography and fluoroscopy of volunteer's under the age of 18 years;
- collimate the primary X-ray beam to within the size of the image receptor in use and only expose the clinically relevant region of interest. This has the added benefit of simultaneously improving image quality and lowering dose;

- avoid the use of extremely short source to clinical target distances, as this can lead to unnecessarily high skin doses;
- shield radiosensitive organs such as the gonads, lens of the eye, breast and thyroid whenever feasible, unless they are the clinical target.

  Note: where the use of shielding will obscure the desired information relevant to the examination (e.g. ovarian shields in an abdominal X-ray) the use of such shielding is discouraged.

  Note: protective drapes do not guard against radiation scattered internally within the body and only provide significant protection in cases where part of the primary X-ray beam is directed towards structures outside the immediate area of interest; and
- exercise extra care when using digital radiography systems with wide dynamic ranges, such as Computed Radiography (CR) and flat panel detectors. Choosing the appropriate image processing parameters is just one aspect of the procedure that the operator needs to consider. Volunteer dose may be increased to excessive levels without compromising image quality in the phenomena known as 'exposure creep' and it is therefore recommended that Automatic Exposure Control (AEC) devices be utilised with digital imaging systems.

Additional information can be obtained from the European guidelines which have been developed to provide specific advice on good technique when radiographing paediatric patients and adult patients, respectively, and from the IAEA Radiation Protection of Patients website.

4.2. Fluoroscopy

The radiographer will:

- use automatic brightness control (ABC), low frame rate, pulsed fluoroscopy, and last image hold (LIH) routinely when they are available;
- optimise the radiographic geometry (i.e. avoid geometric magnification) as poor technique combined with poor geometry can cause patient skin doses to be unnecessarily elevated such that deterministic effects may occur. The X-ray tube should be kept at maximum distance from the patient and the imaging receptor as close to the patient as possible;
- use the largest image intensifier or flat panel field size collimated down to the region of interest that is consistent with the imaging needs. That is, avoid electronic magnification (i.e. use of small field sizes). Electronic magnification results in dose rates to the patient that may be several times higher than those that apply when the largest field size is chosen;
- choose the lowest dose rate options available commensurate with image quality requirements. This may mean keeping tube current as low as possible by keeping the tube voltage as high as possible or using pulsed fluoroscopy if it is available;
- avoid the universal use of anti-scatter grids. Remove the grid when examining small patients or when the imaging device cannot be placed close to the patient;

- minimise the fluoroscopy time. However, operators should be aware that elapsed fluoroscopy time is not a reliable indicator of dose. Volunteer size and procedural aspects such as locations of the beam, beam angle, image receptor dose rate, and the number of acquisitions can cause the maximum skin dose to vary by a factor of at least ten for a specific total fluoroscopy time;
- choose the lowest frame rate and shortest run time consistent with diagnostic requirements during digital image acquisition procedures (e.g. digital subtraction angiography (DSA) and cardiac angiography);
- consider employing additional strategies including the use of additional or k-edge beam filtration, and radiation-free collimator adjustment whenever possible;
- consider options for positioning the volunteer or altering the X-ray field or other means to alter the beam angulation when the procedure is unexpectedly long so that the same area of skin is not continuously in the direct X-ray field (skin sparing); and
- be aware that dose rates will be greater and dose will accumulate faster in larger volunteers. However, in complex procedures, operator choices and clinical complexity are more likely to affect volunteer dose than the physical size of the volunteer.

4.3. CT Procedures

CT procedures are increasingly common and give rise to some of the highest radiation doses in diagnostic medical imaging. Accordingly, all common CT procedures should follow established protocols which have been optimised for volunteer dose and image quality. The operator of a CT scanner should tailor the technical factors of the examination (kVp, mAs, nominal collimated X-ray beam width, pitch, volume of volunteer scanned) to the:

- individual volunteer anatomy; and
- diagnostic information being sought.

Whenever possible, automatic exposure control (AEC) which varies the current according to the attenuation through the volunteer should be employed. Dose reductions of 30% to 60% have been reported using AEC compared to protocols which use fixed mA.

4.4. Pregnancy And Protection Of The Embryo/Foetus

The radiologist or radiographer will:

- enquire about the possibility of pregnancy in all female volunteers or patients of childbearing age;
- indicate to the volunteer or patient why there is a need to know, to avoid them taking offence and refusing to answer or answering less than truthfully;
- use an interpreter if there is any possibility that a language barrier would prevent the volunteer or patient from understanding the question;
- not proceed with diagnostic radiology in the abdominal region if there is any doubt about the status of pregnancy (Note: General radiographic examinations of the

extremities, head and skull, mammography and CT examinations of the neck and head can be undertaken on pregnant or possibly pregnant women without concern as the scattered dose to the foetus is minimal);

- Ensure signs are displayed in prominent places throughout each facility where X-rays are used advising volunteers to notify staff if they may be pregnant. These signs will be written in several languages relevant to the community. An example might read as follows:

IF IT IS POSSIBLE THAT YOU MIGHT BE PREGNANT,
NOTIFY THE RESEARCHER BEFORE YOUR X-RAY EXAMINATION.

However, the posting of signs in no way absolves the researcher, radiographer or the radiologist/physician/surgeon of their responsibility to enquire about the possibility of pregnancy in all female volunteers of childbearing age. When asking the volunteer about the possibility of pregnancy it is also important to indicate to the volunteer why there is a need to know, to avoid them taking offence and refusing to answer or answering less than truthfully. When language barriers exist, it may be useful to seek the service of an appropriate interpreter.

When doubt exists about the pregnancy status of an individual woman and moderate or high doses to the lower abdomen are involved, the Researcher/Radiologist should consider serum β-HCG testing before starting the procedure.

General radiographic examinations of the extremities, head and skull, mammography and CT examinations of the neck and head can be undertaken on pregnant or possibly pregnant women without concern as the scattered dose to the foetus is minimal.

4.5. Procedure when the volunteer is known to be pregnant

The radiographer will:

- Consult with the researcher and radiologist to determine if the procedure is still required
- Consult with the researcher and radiologist to determine the appropriate radiation exposure settings and procedures to minimise exposure of the foetus
- Keep written records of such consultations

Note the written record of consultation will include:

(i) the volunteer's height and weight

(ii) the particular X-ray apparatus used

(iii) the part of the body irradiated and projection (e.g., AP, LAT)

(iv) the entrance field size

(v) the focus to surface distance (FSD)

(vi) the x-ray filtration in mm of Aluminium

(vii) the kVp, mAs (or mA and time) and the number of exposures for radiographic studies

(viii) the kVp, mA, total screening time and, where available, the dose-area product (DAP) for fluoroscopic studies

(ix) the kVp, mA, slice thickness, rotation time, pitch, scan length and the DLP (dose length product) for CT studies.

4.6. Procedure when a volunteer is found to be pregnant AFTER a radiological procedure

A medical physicist will:

- estimate the radiation dose to the foetus/conceptus
- advise the obstetrician or medical practitioner caring for the patient or volunteer of the calculated dose and provide additional information if available to allow evaluation of any possible risk to the foetus/conceptus.

4.7. Patient radiation doses for common procedures

The tabulated numbers are guides only as the actual dose that an individual receives may vary substantially depending on the:

- patient's anatomy;
- equipment used; and
- exact type of examination undertaken.

See Attachment 1 following.

5. DOCUMENTATION

As listed in the above sections

6. AUDIT

Survey of doses against the Diagnostic Reference Levels

7. REFERENCES

PD2025_006 Clinical Procedure Safety

The Safety Guide for Radiation Protection in Diagnostic and Interventional Radiology (RPS 14.1), ARPANSA 2008
RPS C-5 Code for Radiation Protection in Medical Exposure 2019

Code for Radiation Protection in Planned Exposure Situations (RPS C-1)

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July, 2026	Revision 8	S.Turner & D.Wojtalewicz

APPENDIX 8.1

Approximate effective doses arising from common radiological examinations in adults

Effective Dose Range (mSv)	Radiological Examinations
0 – 0.1	Extremities Skull Cervical spine Chest Bone densitometry
0.1 – 1.0	Thoracic spine Lumbar spine Abdomen Pelvis Pelvimetry Mammography (2 view)
1.0 – 5.0	Intravenous pyleogram (IVP) Barium swallow Barium meal CT head CT cervical spine CT chest (without portal liver phase)
5.0 – 10.0	Barium enema Angiography – coronary Angiography – pulmonary Angioplasty –coronary (PTCA) CT chest (with portal liver phase) CT renal (KUB) CT abdomen/pelvis – single- phase CT thoracic spine CT lumbar spine
>10	Angiography – abdominal Aortography – abdominal Transjugular intrahepatic porto-systemic shunt (TIPS) RF cardiac ablation CT chest/abdomen/pelvis CT abdomen/pelvis – multi-phase studies

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RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Radiation Exposure of Volunteers for Research
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
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AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service Bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, X-rays, radiology, medical imaging, radiotherapy, research, HREC
SUMMARY *Brief summary of the contents of the document*	Procedure for ensuring that the radiation dose and associated risk for research protocols are clearly and accurately calculated so that they allow proper consideration by the University HREC and the University BRSC before approval and, so that they allow

	proper consideration by the volunteers or patients to allow informed consent.

INDEX – Section 9

1. BACKGROUND

Research protocols must comply with the Code of Practice - Exposure of Humans to Ionizing Radiation for Research Purposes (ARPANSA RPS 8 (May 2005)). This Code of Practice is designed to ensure that researchers proposing to expose research participants to ionising radiation provide the participants and the University HREC and the University BRSC with information that allows consent to be properly considered by the research participants and approval considered by the University HREC and the University BRSC.

This Code of Practice applies to research involving healthy volunteers and/or patients who are exposed to radiation which is **additional** to that received as part of any normal clinical management. Thus, it applies to, but is not restricted to, research with diagnostic/therapeutic agents and procedures, including Phase I, II, III and IV clinical trials and novel procedures.

Normal clinical management with regards to radiation is defined as typical or routine radiation management or investigation of a patient.

Knowledge of normal clinical management with regards to radiation is important to proposal preparation because

(a) a proposal might be a modification of normal clinical management with regards to radiation, or;
(b) the volunteer or patient will be exposed during the research to additional radiation due to their normal clinical management.

2. RESPONSIBILITIES

2.1. The Chief Investigator

The Chief investigator must:

- ensure that the selection of the participants is conducted according to the requirements of RPS 8, the HREC, and the BRSC.
- provide information regarding normal clinical management to the HREC, the BRSC and the independent assessor (medical physicist). This information on normal clinical management will include:
  - the number of radiation procedures being performed;
  - the frequency or time interval between the radiation procedures; and
  - the anatomical region being exposed to radiation;
- obtain an independent assessment or verification by a medical physicist of the total effective dose and relevant organ doses for those radiological procedures that are performed specifically for the research protocol.
- ensure that the research participant is provided with sufficient written information in a language that is comprehensible to the volunteer or patient about the purpose, methods, radiation dose, associated risks and any discomforts of the radiation exposure to enable the research participant to give informed consent.
- Ensure that for novel uses of radiation, the actual doses received are calculated or measured

Note: Due to the long latent period associated with certain carcinogenic effects of radiation and the possibility of genetic effects, special consideration must be given to the age, pregnancy status and whether the participant is breast-feeding. Refer to RPS 8 for details.

2.2. The Radiation Safety Officer, RPA or Medical Physicist

The RSO or medical physicist must:

(a) independently verify the total effective dose and organ doses and radiation risk assessment which have been provided by the researcher; or

(b) assess the expected total effective dose and organ doses which will be received by the research participant as a result of their participation in the research and the corresponding radiation risks; and

(c) where the dose constraints specified in RPS8 are exceeded, obtain verification of the dose assessment by a second medical physicist who must be independent of the researcher.

2.3. The Human Research Ethics Committee and the BRSC

When assessing research proposals involving ionizing radiation the Human Research Ethics Committee and the BRSC should work closely together and consider the balance between the likely benefits and risks associated with any radiation exposure including consideration of the advice provided in Annex 1 of RPS8.

3. PROCEDURE

3.1. Procedure to be followed by the Chief Investigator

The chief investigator must

(a) Complete and submit both HREC and BRSC applications.

(b) Ensure that the volunteers or patients are given a written description of the procedure and the dose and dose frequency that they received.

(c) Ensure that the volunteers or patients over the age of 13 are advised to retain the written description of the procedure and the dose and dose frequency that they received for at least five years or, in the case of the volunteer or patient being 13 or younger, to keep the records at least to the age of 18. This will enable the volunteer or patient to provide to researchers or medical practitioners with this information if required.

(d) Ensure that there is a measure or calculation of the actual doses received by the volunteer or patient when the procedure includes novel uses of radiation and report these in accordance with their project approval to the University BRSC.

Note: The information on the forms will include:

(a) the reasons why it is necessary to expose research participants to ionizing radiation;

(b) the precautions to be taken to keep radiation exposure to a minimum;

(c) a statement confirming that the site(s) at which the examination or procedure will be performed is actively involved in a relevant quality assurance program;

(d) for novel uses of radiation, the arrangements for a review and reporting to the BRSC of radiation doses actually received and the arrangements for retention of dose records

(e) the radiation dose assessment and risk assessment obtained from the RSO or medical physicist; and

(f) the written information to be given to research participants relating to the doses and risks associated with the radiation exposure.

3.2. Novel Uses of Radiation

In most research, the estimate of the radiation exposure of the research participant determined by the medical physicist will be close to the actual exposure received during the research project. This will not necessarily be the case for novel uses of radiation. This type of research will include, for example, the initial use of a new radiopharmaceutical or the initial use of a new radiology imaging device. The dose estimations available to the HREC may have been calculated based on the results of animal experiments or derived using anthropomorphic phantoms. In these circumstances, it is essential that the actual doses received are calculated or measured and should be included in any reports on the project which are prepared by the researcher for the BRSC and Ethics Committee.

4. DOCUMENTATION

BRSC Approved Application form
HREC Approved Application form

5. AUDIT

Every 2 years

6. REFERENCES

Code of Practice - Exposure of Humans to Ionizing Radiation for Research Purposes (ARPANSA Radiation Protection Series Publication No. 8 (May 2005))

NSW PD2025_006 Clinical Procedure Safety

ARPANSA Code for Radiation Protection in Medical Exposure guideline RPS 14.2
RPS C-5 Code for Radiation Protection in Medical Exposure 2019

Code for Radiation Protection in Planned Exposure Situations (RPS C-1)
AS/NZ 2982.1 Laboratory Design and Construction Part 1 General Requirements

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INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

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AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, X-rays, radioactive substances, radiation monitors
SUMMARY *Brief summary of the contents of the document*	Procedures to ensure that all appropriate staff are issued with, and wear, personal radiation monitors, and that survey meters are maintained and calibrated.

INDEX – Section 10

1. PHILOSOPHY

The Protection from Harmful Radiation Regulation 2025 lists those occupationally exposed persons to whom an employer must provide a personal radiation monitor. This includes those people using radiation in medium or high level laboratory for research and teaching as well as those people using soil moisture gauges, sealed source devices, and for clinical purposes. The Regulation also requires the employer to provide a copy of the employee's radiation exposure record to the employee when the employee leaves the employer's employment. In addition, the Code of Practice for Radiation Protection in the Medical Applications of Ionizing Radiation (RPS 14) & Code of Practice for Radiation Protection in the Medical Applications of Ionizing Radiation (RPS C-5)requires a personal radiation monitor be provided to each occupationally exposed person (clinical) who is likely to be exposed to ionising radiation in excess of 1 mSv in any one year.

University personnel who are expected to receive greater than thirty percent of the annual recommended effective dose limit of 20mSv should be subject to continuous individual personal monitoring. If the radiation worker is already covered in the legislative list then this radiation worker MUST be issued with a personal dosimeter. Such a person is an 'occupationally exposed person'.

2. RESPONSIBILITIES

2.1. Safety & Wellbeing (S&W)

S&W in co-operation with the RSO will then:

- ensure that personal radiation monitors are provided to all appropriate occupationally exposed persons;
- maintain the personal dose records of these occupationally exposed persons;
- provide a radiation dose record on request from Human Resources, to be given to staff member when they cease to be employed by the organisation;
- advise on the selection of the appropriate personal dosimetry service; and
- Notify the wearer, supervisor and Radiation Management Licence Holder when a high dose is recorded or when damage or loss of a monitor is reported by the wearer.

The S&W shall ensure that all dosimetry records and notices are stored centrally in a location accessible by the relevant persons, and kept Until the user reaches (or would have reached) 75 years of age, or atleast 30 years after the worker ceases the radiation work.

2.2. Area Dosimeter Administrator.

The School or Centre will appoint an Area Dosimeter Administrator. This local area administrator will:

- ensure where appropriate that a personal monitoring device designated by the Radiation Monitoring unit, is obtained for each occupationally exposed person;

- ensure that monitors are promptly sent for processing at the end of each wearing period.
- correspond with S&W;
- ensure that the results for each wearing period is given to the badge wearer;
- ensure that a radiation dose record is organised to be given to staff member when they cease to be employed by the organisation;
- immediately notify S&W whenever a “high” or abnormal dose is recorded or that the badge is lost or damaged; and
- ensure that all dosimetry records and notices are forwarded to S&W for the central records and for review and storage by S&W

2.3. Occupationally Exposed Persons

Personnel issued with a personal radiation monitor must:

- wear the monitor in a position appropriate for the work being undertaken;
- wear the monitor at all times when working with ionising radiation or in the Designated Radiation Area regardless of whether radiation work is being conducted or not;
- submit their monitor to their administrator for processing at the end of the wearing period;
- leave their monitor at their designated place for after-hours storage. Dosimeters **SHALL NOT** be taken home; and
- The local area administrator responsible for a monitored School or Centre must keep the control monitor, provided by the dosimetry service in accordance with their instruction), in the designated area. This will be an area of low background radiation levels, normally an office area.

3. PROCEDURE

3.1. Personal Radiation Monitors

(a) All personal dosimeters shall be issued, processed and calibrated by a personal monitoring device (PMD) provider approved to do so by the NSW EPA.

(b) Body dosimetry devices are normally worn somewhere on the trunk of the body, such as a collar, lab coat pocket, waist or on a lanyard. However, when working with distinct sources, the dosimeter should be placed in the area of the body most likely to receive the highest amount of radiation exposure.

(c) When not being worn, dosimeters must be stored in an area of low radiation background, such as an assigned locker or office desk drawer.

(d) Dosimeters **SHALL NOT** be taken home or left in a car.

(e) The local area administrator responsible for a monitored School or Centre must keep the control monitor provided by the dosimetry service in accordance with their instruction. This will be an area of low background radiation levels, normally an office area.

3.2. Electronic Personal Dosimeters

Electronic Personal Dosimeters (EPDs) allow instantaneous measurement of the dose and dose rate. These are used in certain situations where it is necessary to continuously and immediately be able to determine the current accumulated dose. EPDs do not replace the normal personal monitoring devices but can be used in addition to them.

EPDs may also have an alarm operating on a dose rate threshold or an integrated dose threshold. If either alarm does activate it is an indication that the wearer is to immediately cease radiation work and to contact the Radiation Monitoring Unit. The Work Health and Safety Unit or RSO will recommend an EPD to a staff member if electronic monitoring is required. The Local Area Administrator should contact S&W or the RSO if it is believed that electronic monitoring is required.

3.3. Extremity Monitors

Plastic rings incorporating a radiation monitor are available for staff to request and wear if their hands are likely to be exposed to significant radiation exposure. The ring is normally worn on the index or middle finger of the hand that does the most holding (e.g., for a right-handed person that is usually the left hand) with the active surface on the palm side of the wearer's hand.

3.4. Actions to be taken if the Radiation Dose Constraints are Exceeded

S&W has established the following actions are to be taken when the dose reported for a personal radiation monitor exceeds certain dose constraints:

Monitoring Period			Actions to be taken
Monthly	**Quarterly (3 Monthly)**	**Semi-Annual (6 Monthly)**	
-	0.5 mSv to 1.5 mSv	0.5 mSv to 3 mSv	**When dose exceeds 0.5 mSv as notified by dosimetry monitoring company:** Wearer must immediately notify line manager and S&W Laboratory Safety Specialist to investigate and record the circumstances concerning the receipt or possible receipt of the dose. An incident (near miss) report must be completed by wearer or responsible person using the WSU incident management reporting system e.g. DoneSafe.
0.5 mSv to 1.5 mSv	1.5 mSv to 4.8 mSv	3 mSv to 9.6 mSv	**When dose exceeds 30% of the legal dose limit:** Wearer must immediately notify line manager and S&W Laboratory Safety Specialist to investigate the circumstances concerning the receipt or possible receipt of the dose. This incident must be notified to manager and Faculty Manager as soon as practicable. The wearer or responsible supervisor must submit an incident report form as soon as practicable but not later than 2 business days using WSU incident reporting system e.g. DoneSafe.
> 1.5 mSv	> 4.8 mSv	>9.6 mSv	**When dose exceeds the legal dose limit:** The dosimetry monitoring company must report these doses directly to the Radiation Control Section of the EPA, and the University will be required to provide a report of the investigation conducted within seven (7) working days after notice of result. The wearer must immediately notify line manager and S&W Laboratory Safety Specialist. S&W will liaise with the RSO to investigate the circumstances concerning the receipt or possible receipt of the dose. The wearer must submit an incident report form within 2 business days using WSU incident reporting system e.g. DoneSafe. A report will be escalated to manager and Faculty Manager The RSO/S&W will advise the Radiation Management Licence Holder and BRSC of the exceeded dose and investigation report as soon as report is completed and submitted to EPA.
• *The dosimetry monitoring company highlights doses of 0.5 mSv or higher, regardless of wear period.*			

These numbers have been set by the RSC and are based on laboratory averages, the industry standard 30% notification threshold and the internal rule set by the NSW EPA that recommends organisations set their action and investigation levels below what the regulatory authority would work at, to ensure the health and safety of employees and other persons for which they have a duty of care. For further advice or information, please refer to ICRP 103 and the IAEA General Safety Requirements Part 3, or contact the EPA.

4. RADIATION DETECTOR/SURVEY METERS

A radiation detector/survey meter is required to undertake radiation checks or surveys. A detector/survey meter is considered appropriate for use if it:

(a) has sufficient measurement range to measure ambient dose equivalent rates at least throughout the ranges of 0.5 $\mu Sv \cdot h^{-1}$ to 1 $mSv \cdot h^{-1}$ from the radioactive sources used;

(b) continues to indicate, either visibly or audibly, when radiation levels exceed the maximum reading in any measurement range

(c) indicates the measured quantity with a measurement uncertainty not greater than ± 25% inclusive of uncertainty due to response variation with energy over the range of energies of the radiation to be measured;

Radiation monitor/survey meters must be calibrated annually at an appropriate calibration facility.

Documentation must be kept by the Chief investigator or Lab Manager of all calibrations, problems, repairs and services.

5. RADIATION TESTING AND AREA SURVEYS

Refer to Section 6 for details on monitoring in areas where X-ray analysis equipment is located and used.

5.1. For Surface Contamination

- **Select** a portable detector and determine the following information about the detector: 1. Type; 2. Sensitivity; and 3. Efficiency.
- **To scan** the surface, hold the detector probe approximately 5 cm from and perpendicular to the surface and move the probe over the surface in a regular organised fashion to cover the whole surface of the structure.
- When a site of contamination is located, define the edges, or extent, of the spill and mark out the contaminated area using chalk or some other removable marker. Roughly estimate the activity of the spill, and then decontaminate as appropriate.

5.1.1. Wipe (Smear) Test Method

To ensure that the area was appropriately decontaminated perform wipe test using in-house methodology described below or order ready to use wipe test kit from ANSTO and follow the instructions.

Determine the approximate surface area of the features (viz., bench top, sinks, etc) and what area in square metres is to be tested with each filter paper. Divide the area into sampling segments of 10 x 10 cm and allocate each area an identifying code

Supplies

- Laboratory Coat
- Disposable Gloves
- Scissors
- 4cm Filter Papers
- Scintillation Vials
- Scintillation Fluid
- Marking Pen
- Coloured Chalk

Methodology

- Wearing double gloves, wipe the surface of each sampling segment with the dry filter paper. Count the filter papers for at least 30 seconds using either a very good contamination meter that is appropriate for the isotope or a scintillation counter.

- **If a Scintillation Counter or Gamma counter is being used conduct the following**: When the area of the segment has been sampled, cut the filter paper into fragments to fit the scintillation vial. Place into the vial and add scintillation fluid. Mark the lid with its identifying code.

- Once all the sampling segments are done and the scintillation vials are complete, make up a control vial using a clean filter paper.

- Count for 5 minutes per vial (should be for at least 1 hour per vial for better accuracy) and determine the areas contaminated and then apply the following formula on the scintillation counter data. Remember from the theory to incorporate the counter efficiency and any other details that may need to be considered for the determination.

- **With results from either method,** apply the formula and determine whether the bench areas are contaminated.

The contamination level can be calculated from the formula:

contamination level (Bq/m^2) = C_c x ($100/E_c$ x ($1/A$) x ($100/E_F$)

where
C_c = count rate, corrected for background, in counts per second
E_c = overall percentage efficiency of the counting system
A = area smeared in M^2
E_F = percentage of the contamination picked up by the paper

The last quantity, E_F, is quite difficult to determine and is not reproducible. It is dependent on various parameters, such as physical and chemical nature of the contamination, the nature of the base surface and so on. In some circumstances E_F

is taken as 100% and in these cases it is the 'removable' contamination which is being determined. More usually a figure of 10% is assumed.

Is the bench contaminated, using the level of 4Bq /Cm^2 and greater as being contaminated.

Note: The 4Bq /Cm^2 is not the regulatory level or the level used in the Australian Standard. For instance, the regulatory level for isotope ^{32}P is 1 x 10^9 and the Standard uses DWLs as the levels for contamination.

5.2. For Storage Locations

As for surface contamination using a portable monitor and measure all external accessible surfaces of the storage location.

5.3. For Area Monitoring

Using a portable monitor measure the dose rates in the general areas throughout the DRA.

6. DOCUMENTATION

Personal radiation dose records

Area/Contamination/Storage dose records

Radiation Instrument Records (service, repairs and calibration)

7. AUDIT

Every 2 years

8. REFERENCES

Code of Practice for Radiation Protection in the Medical Applications of Ionizing Radiation (RPS 14)

NSW Protection from Harmful Radiation Regulation 2025

ARPANSA Code of Practice for Radiation Protection in the Medical Applications of Ionizing Radiation (RPS C-5)

9. REVISION AND APPROVAL HISTORY

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Oct., 2018	Revision 7	K Ambrose, T Millar, & W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

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RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Calibration and Quality Assurance Procedures for Radiological and Radiation Safety Instruments
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S11
DATE OF PUBLICATION	
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LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, radiology, medical imaging, nuclear medicine, calibration, quality assurance
SUMMARY *Brief summary of the contents of the document*	Procedure for the calibration and quality assurance of equipment used in medical imaging, nuclear medicine and radiation monitoring.

INDEX – Section 11

1. BACKGROUND

This document provides procedures necessary to ensure compliance in relation to the calibration and quality assurance of equipment used in medical imaging, nuclear medicine and radiation monitoring. This is to ensure compliance with the current legislation as well as NSW Guideline No.1, NSW Guideline No.6, ARPANSA RPS 14, ARPANSA RPS C-5, ARPANSA RPS 6, ARPANSA RPS 10, RPS F-1 and ARPANSA RPS 17.

From time to time, random inspections of equipment and procedures take place and to pass these inspections, it is essential that proper records are kept regarding calibration of instruments.

2. RESPONSIBILITIES

2.1. Radiation Management Licence Holder

In accordance with the ARPANSA Medical Code of Practice (RPS14), the Chief Executive (in NSW this is the Radiation Management Licence (RML) holder or the delegate) must ensure that a comprehensive equipment Quality Assurance program is established, performed, maintained and regularly reviewed at any site where radiation-producing equipment or radioactive sources are used.

The RML holder may delegate to the Director of Safety and Wellbeing the process and record keeping for the QA program. Additionally, this delegation may include that the process is conducted, maintained and regularly reviewed in the future, but not the responsibility for a QA program.

The Chief Executive must also ensure that the results of each Quality Assurance program and their outcomes are clearly documented.

The Chief Executive must, following any repair, maintenance or modification on radiation-producing equipment, or equipment containing radioactive source(s), that could impact radiation safety, ensure that:

(a) the operation of the equipment is re-assessed so that the radiation safety of patients, staff and the public is maintained; and

(b) a radiation survey is carried out by a medical physicist.

2.2. Radiation Safety Officer

The RSO or medical physicist (where applicable*) must undertake or oversee the calibration and annual quality assurance program, and carry out, plan and design, any radiation surveys that are required (at least annually).

*note an RSO must now be a medical physicist for dose assessment and all radiation research and training operations involving clinical/medical radiation sources and apparatus.

2.3. Radiographer or Nuclear Medicine Technologist

The radiographer or nuclear medicine technologist must undertake the calibration and quality assurance program according to the protocols approved by the RSO or medical physicist.

3. PROCEDURE

3.1. Calibration, Acceptance and Tests of Radiation Apparatus

All diagnostic and interventional X-ray equipment used must be registered with the NSW EPA via inclusion in the Radiation Management Licence Schedule/Inventory. To be registered, the equipment must pass a series of compliance tests performed by a Consulting Radiation Expert (CRE) who has been accredited by the EPA for the particular class of equipment (e.g. mammography, dental, general radiography). The requirements for compliance and registration are specified in NSW **Radiation Standard 6:** Compliance requirements for ionising radiation apparatus used in diagnostic imaging (2024).

All new X-ray equipment must be tested for compliance using the test protocols in Part 6 of this guideline. Any deficiencies identified by the CRE must be corrected and retested by the CRE before the equipment can be used clinically.

NOTE: EPA registration will be for either 2 or 5 years. Equipment which produces relatively high doses, such as CT scanners, have a 2 year registration period, while low-dose equipment, such as bone densitometers, have a 5-year registration period.

3.2. Repair and Maintenance of Diagnostic and Interventional Radiation Apparatus

Radiation apparatus must only be repaired by qualified service engineers who possess a current radiation licence. Whenever the repair may have compromised the imaging performance of the equipment or any of the radiation safety features the relevant compliance tests must be repeated and passed successfully before the equipment is reused clinically. If an X-ray tube is replaced, full compliance tests must be performed and the Certificate of Compliance issued and retained by the RML Holder.

The RML Holder must, following any repair, maintenance or modification on radiation-producing equipment, or equipment containing radioactive source(s), that could impact radiation safety, ensure that:

(a) the operation of the equipment is re-assessed so that the radiation safety of patients, staff and the public is maintained; and

(b) a radiation survey is carried out by a medical physicist.

3.3. Radiology Quality Assurance

3.3.1. Acceptance Testing

At installation, a series of acceptance tests shall be performed to define the acceptable range of parameters that will be monitored in the subsequent constancy tests. The compliance tests necessary for equipment registration will form part of the acceptance tests.

3.3.2. Constancy Testing

Constancy tests designed to assess the subsequent performance of the equipment, image quality and patient dose should be performed at regular intervals. The following table of testing frequencies has been recommended by the ACPSEM (Recommendations for a technical quality control program for diagnostic X-ray equipment, 2008)

Category of Equipment	Recommended Interval Between Tests
Mammographic, CT and fluoroscopic X-ray apparatus (fixed or mobile).	6-12 months
General radiographic X-ray apparatus (including dental OPG and cephalometric)	12 months. (Maximum 24 months)
CR/DR image receptors and other image processing systems	12 months
Dental (intra-oral) and DEXA	36 months

The RANZCR, in its Standards of Practice for Diagnostic and Interventional Radiology, Version 9, require the following minimum equipment quality control (extracted directly from that document):

Section 8-2-2 Bone Mineral Densitometry Equipment Quality Control (2008)
The radiology unit performing BMD must comply with the quality control requirements of the Accreditation Guidelines for Bone Densitometry, published by the ANZBMS (2018)".This requires:

- Quality control procedures are documented and kept within the vicinity of the equipment
- All tests are recorded and kept within the vicinity of the equipment
- At time of installation, machine calibration and testing by supplier. Accuracy and precision evaluation:
    - In vitro: short-term precision

- In vivo: short-term precision

- Calibration and quality control according to manufacturer's specifications. The QC phantom shall be scanned at least twice weekly (and preferably daily) using the same scanning parameters. This phantom is not the daily calibration phantom, but is an anthropomorphic (or quasi-anthropomorphic) phantom recommended by (or at least acceptable to) the manufacturer.

Section 9-1-1 Computer Tomography Performance Testing (2008)

The radiology unit shall, as a minimum, undertake all quality control requirements as determined by the manufacturer including maintenance and calibration.

Section 9-3-4-2 Computer Tomography Dose (2008)

The radiology unit maintains and regularly reviews CT scanning protocols which are optimised to limit patient radiation exposure.

Where the CT unit being used is capable of displaying DLP or CTDI figures, the practice shall review CT patient dosimetry for specific common scan protocols, and shall document the typical dose length product for the specified protocols. These documents are to be kept in the vicinity of the apparatus.

Section 10-3-2-1 General X-Ray Image Review - Plain Film (2008)

The radiology unit shall ensure that X-ray repeats are monitored and reviewed in adherence to the ALARA Principle.

Section 10-3-2-2 CR/DR Performance Testing (2008)

The radiology unit shall maintain a Quality Assurance (QA) program specifically designed to assess the performance of its CR/DR equipment. The radiology unit shall as a minimum follow the manufacturer's recommended QA program.

An acceptable QA program must, as a minimum, include:

- Must keep in the vicinity of the equipment and maintain dose output records (to commence from acceptance testing) and reviewing dose optimisation at least 6 (six) monthly ensuring that any general increase in dosage levels is identified and examined, and where required corrected; and
- Conducting analysis of repeats and recording findings and corrective and/or preventive action taken.

Section 10-4-1 Radiation Safety - Fluoroscopic Examinations (2008)

A log must be kept near the apparatus and maintained of screening times and (where the fluoroscopy equipment is capable of this) dose for all fluoroscopic examinations.

Corrective action shall be taken as necessary to minimise patient exposure.

Section 13-2-2 Diagnostic Mammography Quality Control for Film Screen Mammography Units (2008)

There must be documented procedures for quality control checks as specified in the ACPSEM Standard for Facility Quality Control Procedures" (Craig AR et al, *Recommendations for a mammography quality assurance program, Appendix 1*, Aust Phys Eng Sci Med, 2001, 24:107-131).

Section 13-2-3 Diagnostic Mammography Annual Equipment Testing (2008)

Mammography equipment must be tested annually in accordance with the ACPSEM Standards for Mammography System Performance and Medical Physics Testing" (Craig et al. *Recommendations for a mammography quality assurance program*, *Appendix 2*, Aust Phys Eng Sci Med, 2001, 24:107-131).

Section 13-2-4 Diagnostic Mammography Annual Equipment Testing - CR/DR Mammography Equipment (2008)

Computed radiography (CR) and full field digital (DR) mammography equipment shall be tested in accordance with the manufacturer's guidelines, and the RANZCR Mammography Quality Assurance Program (CR/DR).

Section 13-6-1 Mammography Radiation Dose Limit (2008)

The radiology unit must not exceed the Mammography Radiation Dose Limit requirements of the RANZCR Mammography Quality Assurance Program.
The average glandular dose as determined by the dosimeter must not exceed 2 mGy (200 mrad) per view, using the RMI-156 phantom or another of equivalent constitution.

3.4. Calibration, acceptance and tests of nuclear medicine equipment

Nuclear medicine quality assurance programs focus on image quality, radiopharmaceutical quality and patient dose optimisation.

The basic elements consist of:

(a) equipment acceptance testing;

(b) equipment constancy testing;

(c) radiopharmaceutical quality testing;

(d) record keeping;

(e) patient activity surveys; and

(f) keeping records of equipment unscheduled downtime and the reason for the failure.

Acceptance Testing of Nuclear Medicine Equipment

At initial installation, nuclear medicine equipment (e.g. radionuclide dose calibrators, gamma cameras, PET cameras, autogamma counters, laser film imagers) needs to undergo acceptance testing to ensure that the equipment performance complies with the manufacturer's specifications and also to establish a baseline against which future equipment performance can be evaluated. The results of the acceptance testing will need to be documented with a copy sent to the WHS unit, and be available for inspection by the relevant regulatory authority.

Any radionuclide sources used in performing accuracy checks of radionuclide dose calibrators will need to have a calibration traceable to a national or international standard.

3.5. Repair and maintenance of the nuclear medicine equipment

Nuclear medicine equipment must only be repaired / maintained by qualified service engineers who possess a current radiation licence covering the use of radioactive substances for quality assurance purposes.

Following calibration or repair (prior to clinical use), equipment performance must be assessed to demonstrate that it is at a level which equals or is better than that expected for routine performance of clinical work. This judgement would be made by comparison of the equipment performance to baseline or recent quality control assessments.

3.6. Nuclear medicine Quality Assurance, including radiopharmaceutical QA

Local QA programs should clearly define the:

- types of constancy tests;
- frequency of tests;
- tolerance of each parameter being monitored; and
- procedure for staff to follow when tolerance is exceeded and this procedure must include:
    - review of the results of constancy testing need to be a matter of routine, and
    - any anomalous results reported immediately to the Responsible Person, usually WHS.

Tests designed to assess the performance of the equipment must be conducted, taking into account:

(a) the likelihood of an equipment failure or a measured parameter falling outside an acceptable tolerance range; and

(b) the frequency of testing based on the consequences that follow when such an event occurs.

3.6.1. Gamma Cameras

Suggested gamma camera tests and frequencies are outlined in the document "Minimum Quality Control Requirements for Nuclear Medicine Equipment," prepared by the Technical Standards Committee of the Australian and New Zealand Society of Nuclear Medicine (ANZSNM) and available at:

https://www.anzsnm.org.au/resources/quality-and-technical-standards-committee/

3.6.2. PET Equipment

For PET equipment, the Technical Standards Committee of the Australian and New Zealand Society of Nuclear Medicine (ANZSNM) have produced the document "Requirements for PET Accreditation (Instrumentation & Radiation Safety)" which outlines Minimum performance parameters for the PET scanner in an accredited PET facility measured using NEMA NU2-2001 protocols.

This is available at:
https://www.anzsnm.org.au/resources/quality-and-technical-standards-committee/

Current required performance parameters are as follows:

Parameter	***Specification***
Transverse resolution at 1 cm radius	≤ 6.5 mm
Axial resolution at 1 cm radius	≤ 6.0 mm
Transverse (tangential) resolution at 10 cm radius	≤ 8 mm
Axial resolution at 10 cm radius	≤ 8 mm
System sensitivity	≥ 4.0 cps/kBq
Peak noise equivalent count rate (NEC_{peak}) at activity concentrations of ≤10 kBq/ml	≥ 30 kcps
Maximum count rate error over the central 80% of axial FOV (after dead time correction) at or below NEC_{peak}	≤ 10%

3.6.3. Testing of Dose Calibrators

For dose calibrators, the following tests shall be conducted at the frequency indicated below, and to the indicated tolerance:

(a) background – at least once each work day prior to the first assay of patient dosages or whenever contamination of the dose calibrator is suspected;

(b) constancy – at least once each work day prior to the first assay of patient dosages (±10 per cent);

(c) linearity – at installation and at least annually thereafter, and after repair or movement (±10 per cent);

(d) accuracy – at installation and at least annually thereafter, and after repair or movement (±10 per cent); and

(e) geometry independence – at installation and after repair or movement (±10 per cent).

Recommended testing frequencies for dose calibrator quality control procedures are as follows:

Quality Control Procedure	Testing Frequency
Constancy	Daily
Linearity	Annually
Accuracy	Annually
Geometry independence	At calibrator acceptance and then for any change in sample geometry

Repair, replacement, or arithmetic correction will need to be conducted if the dose calibrator falls outside the indicated tolerances.

Details of procedures that may be used to meet these test requirements are provided in *ARPANSA's Radiation Protection Series No. 14.2 Safety Guide Radiation Protection in Nuclear Medicine* and Code for Radiation Protection in Medical Exposure (2019) (RPS C-5

3.6.4. Testing Radiopharmaceutical Quality

The in vivo behaviour of a radiopharmaceutical is dependent upon its quality, which includes high standards of radionuclidic, radiochemical and chemical purity. The specifications and quality control testing for most of the currently used radiopharmaceuticals are given in the British Pharmacopoeia (BP) or other suitable Pharmacopoeia (e.g. USP). There should be written local procedures detailing all aspects of quality control testing that should be considered before the radiopharmaceutical is administered to the patient.

Technetium-99m Generator

A molybdenum-99 breakthrough measurement needs to be performed on all elutions from each technetium-99m generator and the following records kept of all generator elutions:

(a) dose calibrator setting where the isotope is manually dialled;

(b) reading of long-lived reference source;

(c) time of elution;

(d) volume of eluate;

(e) technetium-99m activity;

(f) molybdenum-99 activity; and

(g) radionuclidic purity.

The BP specification for molybdenum-99 impurities in sodium pertechnetate eluate is 0.1% or a limit of 1 MBq of molybdenum-99 per GBq of technetium-99m at the time of administration. If this level is exceeded, then the technetium-99m solution has failed quality control and is not to be used in the preparation of radiopharmaceuticals for patient use. (Note: The US pharmacopoeia limit of 0.15 MBq Mo-99 per GBq Tc-99m may also be used).

Aluminium ion breakthrough should also be checked on any eluate used to prepare products that are adversely affected by the presence of aluminium.

Technetium-99m cold kits.
The procedure for using technetium-99m prepared from cold kits shall include any appropriate radiochemical purity testing to be performed on the reconstituted kit prior to patient administration. Records of such testing are to be maintained and kept.

3.7. Use, Maintenance and Calibration of Radiation Measuring Instruments

3.7.1. Proper radiation survey meters must be used for each radiation survey required by this Plan. A survey meter is considered proper if it:

(a) has sufficient measurement range to measure ambient dose equivalent rates at least throughout the ranges of 0.5 μSv h^{-1}, or its equivalent, to 1 mSv h^{-1} (2 mSv h^{-1} for radiotherapy use) or its equivalent from the radioactive sources used.

(b) continues to indicate, either visibly or audibly, when radiation levels exceed the maximum reading in any measurement range; and

(c) indicates the measured quantity with a measurement uncertainty not greater than ± 25% inclusive of uncertainty due to response variation with energy over the range of energies of the radiation to be measured.

3.7.2. Radiation survey meters used for the purposes of completing 3.7.1 above must have an operational and calibration check performed:

(a) Prior to initial use;

(b) At intervals not exceeding 12 months; and

(c) Following damage or repairs.

4. VETERINARY RADIOLOGY QA

4.1. Quality Assurance Program

A quality assurance (QA) program approved by a CRE should be instituted and maintained with a copy sent to the WHS unit.

The program should ensure that consistent, optimum-quality images are produced so that the exposure of operator, staff and the general public to radiation satisfies the 'as low as reasonably achievable' principle.

QA procedures should be standardised and documented in a QA manual.

4.2. Ongoing Testing

The QA program should include checks and test measurements on all parts of the imaging system, as indicated in NSW Guideline 6 Part 4 and in ARPANSA RPS 17, at appropriate time intervals not exceeding one year.

The program should include daily step-wedge or equivalent quality control of the electronic output of X-ray film processors.

5. DOCUMENTATION

As described above

6. AUDIT

Every 2 years

7. REFERENCES

ARPANSA Code of Practice for Radiation Protection in the Medical Applications of Ionizing Radiation (2008), RPS14

ARPANSA Code of Practice for Radiation Protection in the Medical Applications of Ionizing Radiation (2019), RPS C-5

ARPANSA **Radiation Protection in Veterinary Medicine** (2009), RPS17

ARPANSA Safety Guide for Radiation Protection in Diagnostic and Interventional Radiology (2008), RPS14-1

ARPANSA Safety Guide for Radiation Protection in Nuclear Medicine (2008), RPS14-2

ARPANSA Safety Guide for Radiation Protection in Radiotherapy (2008), RPS14-3

ANZBMS Accreditation Guidelines for Bone Densitometry (2007)

ANZSNM Minimum Quality Control Requirements for Nuclear Medicine Equipment (2013)

ANZSNM Requirements for PET Accreditation (Instrumentation and Radiation Safety)

RANZCR,, Standards of Practice for Clinical Radiology (2020)

NSW Radiation Guideline 6 Registration requirements & industry best practice for ionising radiation apparatus used in diagnostic imaging.

ACPSEM Position Paper: Recommendations for a technical quality control program for diagnostic X-ray equipment, Aust Phys Eng Sci Med, 2008, 28:69-75

Craig AR et al, Recommendations for a mammography quality assurance program, Aust Phys Eng Sci Med, 2001, 24:107-131

8. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

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Aug 2014	Draft	William Bartolo, Bartolo Safety Management Service
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Mar 2017	Revision 6	K Ambrose, T Millar and W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

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RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, X-rays, radiology, medical imaging, radiotherapy, equipment management
SUMMARY	Procedures for the maintenance, disposal and reporting of faults of radiation apparatus.

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

Brief summary of the contents of the document	

INDEX – Section 12

1. BACKGROUND

This document provides procedures necessary to ensure compliance with this policy in relation to the management of equipment used in medical imaging, nuclear medicine and radiation monitoring. This is to ensure compliance with the current legislation as well as NSW Standard No.1, NSW Guideline No.6, ARPANSA RPS C-5, ARPANSA RPS 6, ARPANSA RPS 10, and ARPANSA RPS 17.

In addition to annual RSO and local assessments, random inspections of equipment registers and documentation will take place to ensure the necessary documentation and records are kept and maintained.

2. RESPONSIBILITIES

2.1. The University and Radiation Management Licence Holder

The University (the owner of the radiation apparatus) via the Radiation Management Licence (RML) Holder alone is responsible for: the disposal of radiation apparatus and for ensuring that records of disposal are maintained.

The University, via the Radiation Management Licence Holder, will ensure that:

(a) the repair, maintenance, disposal (records of disposal must be maintained).or sale of radiation apparatus comply with the NSW Protection from Harmful Radiation Regulation 2025.

(b) copies of all maintenance and inspection reports and summaries of QA tests undertaken on radiation apparatus, together with a copy of the registration certificate are kept with the apparatus and copies are sent to the S&W.

(c) annual and random inspections in regards to the management of this apparatus are conducted by the S&W with assistance of RSO,

Note: The records of disposal may be in hardcopy or electronic form.

Note: The records of disposal must be kept for at least 6 years and made available on request to an authorised officer of the EPA. They can only be disposed of after permission is granted from the State Director General.

2.2. The Radiation Management Licence Holder and the Chief Investigator

Both the RML Holder and Chief Investigators responsible for the instrument must ensure compliance with the following procedures relating to the repair, maintenance, disposal or sale of radiation apparatus. Normally, the process would occur jointly between these parties.

3. PROCEDURE

3.1. Repair and maintenance of radiation apparatus

Radiation apparatus must only be repaired and maintained by qualified service engineers who possess a current radiation licence and whose licence allows them to repair the specific radiation apparatus.

The S&W will be informed by the Chief Investigator using the instrument of intended maintenance, inspection or intended repair and the details of the person or company carrying out the work prior to the work taking place.

Whenever the repair and maintenance may have compromised the performance of the equipment or any of the radiation safety features, the relevant compliance tests must be repeated and passed before the equipment is reused either for research or clinically.
If an X-ray tube of a clinical unit is replaced, the full compliance tests must be performed by a CRE.

The S&W will be sent a report by the Chief Investigator responsible for the instrument that will include the date of completion and an overview of the maintenance, inspection or repair as soon as possible following the work. It will include the name of the person or company who carried out the work.

For repairs needing compliance tests, a Certificate of Compliance must be sent to the S&W and a copy maintained at the site of the unit.

Where the CRE has certified the apparatus as compliant, but has specified that minor repairs are necessary to satisfy all the registration requirements, the Chief Investigator responsible for the instrument must:

(a) inform the S&W of the need for these repairs and the specified timeframe.

(b) ensure that these repairs are carried out within the timeframe specified in the CRE's report; and

(c) adhere to any restrictions in the use or operation of this apparatus specified by the CRE until the apparatus is fully repaired.

(d) Inform the S&W in writing when the repairs have been completed

3.2. The reporting of faults that would compromise safety, diagnosis or analysis

3.2.1. The named person responsible for the instrument will:

(a) Report to the S&W any suspected problems with a unit of ionising equipment that have or may present a health hazard.

(b) notify the S&W within 2 days if the radiation apparatus:

i). fails or ceases to satisfy the requirements for registration;
ii). has an X-ray tube insert replaced; or
iii). is relocated (fixed units only).

3.2.2. The S&W will:

(a) Report to the RML holder any suspected problems with a unit of ionising equipment that have or may present a health hazard.

(b) notify the RML holder within 4 days if the radiation apparatus:

i). fails or ceases to satisfy the requirements for registration;
ii). has an X-ray tube insert replaced; or
iii). is relocated (fixed units only).

3.2.3. The RML holder will:

(a) Ensure that any suspected problems with a unit of ionising equipment that have or may present a health hazard are reported to the Therapeutic Goods Administration (TGA) or the EPA depending on the classification of the equipment.

(b) Ensure that the EPA is informed within 7 days if a radiation apparatus:

i). fails or ceases to satisfy the requirements for registration;
ii). has an X-ray tube insert replaced; or
iii). is relocated (fixed units only).

Note: Typical problems include deficiencies in labelling, instructions or packaging, defective components, performance failures, poor construction or design.

Note: Details of how to report the problem can be found at the TGA website.

3.3. Disposal of radiation apparatus

3.3.1. The named person responsible for the instrument will notify the S&W:

(a) of an intention to dispose of radiation equipment

(b) when the radiation apparatus has been rendered permanently inoperable (a condition of disposal) and “safe; and

(c) only dispose of the equipment following written approval by the S&W;

3.3.2. The S&W will notify the RML through Ethics Officer:

(a) the intention to dispose of radiation equipment.

(b) when the radiation equipment has been disposed

3.3.3. The RML holder will ensure that the EPA has been notified within 7 days

3.4. Trade of radiation apparatus

The RML Holder may trade radiation apparatus only if:

(a) the RML has a condition of licence to sell/possess radiation apparatus, or an appropriate licence to use the apparatus; and

(b) the EPA has been notified within 7 days

(c) The Radiation Equipment disposal has been appropriately authorised by S&W.

3.5. Transfer of registration

The RML Holder may transfer the radiation apparatus to another person only if:

(a) the purchaser holds a licence to sell/possess radiation apparatus, or an appropriate licence to use the apparatus;

(b) The EPA has been notified within 7 days, and,

(c) Disposal of the radiation equipment has been appropriately authorised.

4. DOCUMENTATION

The University Asset Disposal form (WN request)
EPA Disposal, transfer and sale forms

5. AUDIT

Six monthly audits of equipment registrations

6. REFERENCES

NSW Protection from Harmful Radiation Regulation 2025

7. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Sept 2014	Draft	William Bartolo, Bartolo Safety Management Service
Dec 2014	Draft 2	K Ambrose, T Millar & W Bartolo
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Mar 2017	Revision 6	K Ambrose, T Millar & W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Storage and Disposal of Radioactive Waste
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S13
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, radioactivity, radioactive waste
SUMMARY *Brief summary of the contents of the document*	Procedures for the safe storage and disposal of radioactive waste

INDEX – Section 13

1. BACKGROUND

This document describes appropriate methods for the storage and eventual disposal of waste radioactive material. Legislation requires that the RML Holder is responsible for radioactive material from time of acquisition to disposal (including appropriate storage of radioactive waste), and this responsibility cannot be delegated. The Chief Investigator that is responsible for the material locally or the project must ensure that the correct procedures are followed for storage and disposal of radioactive waste.

The International Commission on Radiological Protection (ICRP) has three waste concepts as follows:

- Delay and decay (applicable to radionuclides with short half-lives)
- Concentrate and contain (applicable to all radioactive waste)
- Dilute and disperse (possible, but discouraged and without great care could be in breach of the Regulatory Guidelines. Regulatory authorities may apply a limit of 1 Bq/L (above background) to the sewerage system, above which double delay tanks with other restrictions may be required.)

NOTE:

Half Life	Radionuclide
Five days or less:	Na-24, K-42, Cu-64, Tc-99m, Mo-99
Five days to two months:	P-32, Cr-51, Fe-59, 1-125, 1-131, Cs-131
Two months to one year:	S-35, Ca-45, Sc-46, Sn-113
Greater than one year:	H-3, C-14, Na-22, Cl-36, Co-57, Co-60, Cs-137

Note:

The EPA's ***Waste Classification Guidelines Part 3: Waste Containing Radioactive Material:****November 2014*, *(all procedures and requirements contained within)* must be adopted into the waste procedures. This document is enacted through the *Protection of the Environment Operations Act 1997.*

Note:

Radioactive Waste is classified as the following:

- Liquid or non-liquid wastes with a specific activity greater than 100 Bq/g and consisting of, or containing more than, the prescribed activity (see Appendix 13.1 of this Section) of a radioactive element in Schedule 1 of the Protection from Harmful Radiation Regulation 2025, whether natural or artificial, must be classified as ***hazardous*** **wastes**.

- For liquid or non-liquid wastes with a specific activity of 100 Bq/g or less and/or consisting of, or containing, the prescribed activity or less of a radioactive element in Schedule 1 of the Protection from Harmful Radiation Regulation 2025, whether natural or artificial, the *total activity ratio* and *specific activity ratio* must be calculated according to the mathematical expressions below:

Total activity ratio is calculated using the expression:

$$\text{Total activity ratio} = (A1 \times 10^{-3}) + (A2 \times 10^{-4}) + (A3 \times 10^{-5}) + (A4 \times 10^{-6})$$

where A1 to A4 are the total activity of radionuclides, as set out in Schedule 1 of the Protection from Harmful Radiation Regulation 2025 (see Appendix 1 of this Section).

Specific activity ratio is calculated using the expression:

$$\text{Specific activity ratio} = SA1 + (SA2 \times 10^{-1}) + (SA3 \times 10^{-2}) + (SA4 \times 10^{-3})$$

where SA1 to SA4 are the specific activity (of the material) of Group 1 to Group 4 radionuclides, as set out in Column 1 of Schedule 1 of the Protection from Harmful Radiation Regulation 2025.

Definition
'*Specific activity*' is defined in the *Code for the Safe Transport of Radioactive Material RPS C-2 (Australian Radiation Protection and Nuclear Safety Agency 2019)* as follows:

- 'Specific activity of a radionuclide shall mean the activity per unit mass of that nuclide.
- The specific activity of a material shall mean the activity per unit mass of the material in which the radionuclides are essentially uniformly distributed.'

Non-liquid wastes must be classified as *restricted solid waste* **unless**:

- other characteristics of the waste mean that it must be classified as *hazardous waste* (for example, it may be pre-classified as *hazardous waste* in accordance with Step 3 of Part 1 of the *Waste Classification Guidelines* [EPA 2014]

or

- it contains chemical contaminants that will lead to its assessment as *hazardous waste* (see Step 5 of Part 1 of the *Waste Classification Guidelines)*.

Where the *specific activity ratio* and *total activity ratio* are equal to or less than one, the waste must be classified according to its other characteristics in line with Part 1 of the *Waste Classification Guidelines*.

Definition:
Restricted solid waste

Currently, no wastes have been pre-classified by the EPA as 'restricted solid waste'. Restricted solid waste, therefore, only includes wastes assessed and classified as such in accordance with the procedures in Step 5 of EPA Waste Classification Guideline.

However the EPA may classify waste as restricted solid waste from time to time by a notice published in the *NSW Government Gazette*. All currently gazetted restricted wastes will be listed on EPA's website at www.environment.nsw.gov.au/waste/wastetypes.htm.

According to the Protection from Harmful Radiation Act 1990 No 13 and Protection from Harmful Radiation Regulation 2025 (and all subsequent amendments) for the Radiation Management Licence Holder to dispose of radioactive waste, they must have received written authority from the Director-General. To date, the D-G has not had any need to

give such authority to an institute and therefore to be compliant, the radioactive waste must be stored by the licence holder.

2. RESPONSIBILITIES

2.1. Generators of Radioactive Waste

Generators of radioactive waste (e.g. researcher, student, laboratory personnel) must:

- for a particular series of experiments, collect and store the radioactive waste such that has minimum and proper containment. The waste must be collected after each experiment or procedure that generates waste (Section 4.1);
- label waste containers with a University Radiation Waste Label (see Appendix 13.2 of this Section) that has been filled in with the information required.
- Complete all required documentation and local records (the same details as in on the waste label);
- When the waste container is full, or it is appropriate time for the waste to be processed by the University, complete the waste form and contact the University S&W

Note: Disposal will then be the responsibility of the Radiation Management Licence Holder who will delegate the management to the S&W (and the RSO) for final management and disposal (if possible).

2.2. Chief Investigators

Chief investigators that are responsible for projects and procedures that generate radioactive waste must:

- inform and obtain permission from the RSO or the S&W before storing or disposing of radioactive waste;
- ensure compliance with current legislation regarding storage and disposal of radioactive waste;
- ensure that others involved with the project or procedure comply with the current legislation regarding storage and disposal of radioactive waste;
- ensure that themselves or others who generate radioactive waste record the nature and storage of such radioactive waste in the logbook provided in the facility or storage area;
- ensure that all dealings with radioactive waste storage or procedures are kept in a written form (could be electronic) and the records are stored for at least 6 years and destroyed only if permission is gained from the Director-General of the EPA; and
- ensure that personnel involved with the project or procedure are properly trained and wear personal protective equipment (PPE), appropriate to the hazard.

2.3. The Central Radiation Store Management

The person responsible for the central radiation store will ensure:

- that the storage area or facility complies with legislation; and
- a logbook of stored radiation material is available and kept in the storage area or facility.

2.4. Radiation Management Licence Holder

Radiation Management Licence Holder must ensure that:

- all radioactive waste is stored or disposed of in accordance with the current legislation;
- all dealings with radioactive waste storage or procedures are kept in a written form (could be electronic) and documents stored for at least 6 years and destroyed only if permission is gained from the Director-General of the EPA; and
- a store or storage area for radioactive sources within the premises is constructed of durable materials, is lockable and secure.

NOTE: Requirements for an approved radiation waste store or storage area
From the EPA Radiation Guideline 7 Radiation shielding design assessment and verification requirements, the shielding plan must ensure that any member of the general public occupying the adjoining areas (including above and below) is not exposed to more than the general public design constraint of 20 µSv per week.

All storage facilities must meet the appropriate requirements of the legislation and ARPANSA RPS11. Sealed sources and premises that are registered under the Radiation Management Licence, must meet the conditions of their registration, in addition to the requirements of this procedure.

2.5. Radiation Safety Officer

Radiation Safety officer (acting as the delegate of the RML holder) must:

- ensure that logbook, labels and records of transfer documentation are correct;
- ensure that the package(s) are verified in terms of dose rate (activity and specific activity); and
- sign off that the records pertaining to all of the radioactive waste are correct and up-to-date.

3. PROCEDURE

3.1. Storage Procedures (identification, location, record keeping)

3.1.1. Radioactive waste must

(a) have appropriately shielded and labelled waste containers dedicated to the project

(b) NOT be mixed with waste from other projects

(c) be stored in appropriately shielded and labelled containers in an area approved for storage of radioactive material

(d) be clearly identified with the University Radioactive Waste Label (see Appendix 2 of this Section)

(e) NOT be stored with explosive, combustible or corrosive material

3.1.2. Sharps (e.g. needles or needles with syringes attached) which may be contaminated with radioactivity must be stored in a trefoil labelled sharps container. The sharps containers must not be overfilled and labelled with the University Radiation Waste Label.

3.1.3. If the radioactive waste includes another type of hazardous waste (e.g. biological waste), then storage must comply with the conditions for radioactive waste storage and for the storage conditions for the other hazardous waste.

Note: Mixed waste is defined as a waste that is both radioactive and contains a non-radioactive contaminant that is itself considered a hazardous material, such as biological waste. Such wastes are subject to regulation for both hazards, which adds to their complexity when dealing with them. For this reason, mixed wastes should be avoided, but with research and teaching this is often unavoidable.

3.2. Scintillation Fluids

Used scintillation vials are not to be decanted of their contents before disposal. The used vials should be stored in a plastic pail of no more than 15 litres. This is to reduce the risk of manual handling problems and to minimise the time required dealing with used scintillation vials. The pail should be labelled as per 4.1.1 and have a lid that will seal the pail. DO NOT OVERFILL these pails: the lid must properly close and seal the container.

Once the pail is filled, the chief investigator of the project will organize for the consultant RSO to measure the activity and determine the disposal or storage procedure to be followed.

3.3. Waste Material Destined for the University Radioactive Store (Conditioning/packaging and storage of radioactive waste for long-term storage)

The RML holder or and his/her delegate will adhere to the principles associated with Annex E of the Safety Guide entitled Predisposal Management of Radioactive Wastes

(RPS 16) for management of medical and laboratory radioactive waste (Appendix 13.3 of this section). This will be done in consultation with the RSO.

3.4. Disposal Procedures

User licence personnel shall follow the following steps:

(a) If a waste container is full, or it is appropriate time for the waste to be processed by the University, or a project is completed (whichever the sooner), then the generator of the waste will contact the S&W to approve or confirm procedures for waste storage or disposal;

(b) Complete all necessary disposal and transfer forms;

(c) Once the assessment as per the guidance in the Background Section is completed for all radioactive waste then refer to Part 1 of the EPA Guidelines for the documentation and procedures required for notification and disposal. Note: the classification of the waste type (e.g. hazardous, industrial and non-radioactive) must be clearly indicated in the documentation; and

(d) The University S&W in conjunction with the University RSO will determine the action and the transfer to the University Central Radioactive Waste Store.

NOTE: The type of waste generated can take the following forms:

- airborne wastes such as radioactive gases, vapours, or particulate material;
- liquid radioactive wastes: These include animal excreta and aqueous solutions of radionuclides or suspensions of radioactive material in water or water-miscible liquid(s). Another category of liquid wastes is that of organic solvents which, because they are flammable or toxic, usually require special methods of disposal such as incineration in an approved incinerator (currently no Environmental Permit or Licence has been issued to a waste facility for such purposes);
- solid wastes include liquid in solid containers, sealed sources and rubbish. Sealed sources are generally in the form in which they were originally purchased; whilst rubbish includes contaminated packing materials, laboratory glassware, pipette tips, plastic vials and trays, paper tissues, used syringes, etc; and
- radioactive animal carcasses (from research activities) need special consideration. Carcasses of small animals such as mice and rats, and excised organs of larger animals, will need to be kept frozen until such time as the carcass and the associated radioactive contamination is deemed acceptable for disposal. The nature and quantity of radioactivity involved should be taken into account in selecting the appropriate option. Larger animals contaminated with radioactive materials are definitely a major problem. Please contact the WHS unit and the University BRSC while in the planning stages for this work.

3.5. Sealed Source Disposal

Sealed source disposal is difficult. There should have been an agreement as part of the purchase contract that at end of working life the source was to be returned to the supplier for disposal or re-use. See the relevant sections of RMP-S16.

Generally the following are to be applied:

- Return to supplier
- Store indefinitely until the source is deemed to be non radioactive
- Dispose if deemed to no longer radioactive.

The guidelines for disposal under the POEO legislation are mandated. Please contact the S&W and the RSO for further advice.

Sources cannot be transferred to another licensee unless the source is identified a serial number or identification code, plus the identity of the radionuclide and its activity and preferably a calibration date.

Once a sealed source has reached a point where it can be disposed, the following is required:

(a) all identifying marks and signs need to be removed, and

(b) the source checked by the RSO to ensure compliance with relevant legislation.

3.6 Decayed Source Disposal

Radioactive waste which has decayed to a safe level (below 100 Bq/g and meeting the other legal requirements such as the total activity and specific activity ratios) can be disposed of as chemical or clinical/biological waste.

4. DOCUMENTATION

Registers of radioactive substances

Waste storage and disposal records

5. AUDIT

Every 2 years

6. REFERENCES

None

7. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Sept 2014	Draft	William Bartolo, Bartolo Safety Management Service
Dec 2014	Revised Draft	K Ambrose, T Millar, & W Bartolo
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Nov 2016	Revision 5	BRSC comments, K Ambrose, T Millar, & W Bartolo
April 2017	Revision 6	BRSC comments, K Ambrose, T Millar, & W Bartolo
Oct., 2018	REvision 7	K Ambrose, T Millar, & W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

Appendix 13.1

NSW Prescribed activity of a radioactive substance

Column 1								Column 2
Group 1								
Ac227	Am241	Am243	Cf249	Cf250	Cf252	Cm242	Cm243	40 kilobecquerels
Cm244	Cm245	Cm246	Np237	Pa231	Pb210	Po210	Pu238	
Pu239	Pu240	Pu241	Pu242	Ra223	Ra226	Ra228	Th227	
Th228	Th230	U230	U232	U233	U234			
Any alpha emitting radionuclide that is not included in any other Group in this Schedule								
Group 2								
Ac228	Ag110m	At211	Ba140	Bi207	Bi210	Bk249	Ca45	400 kilobecquerels
Cd115m	Ce144	Cl36	Co56	Co60	Cs134	Cs137	Eu152	
Eu154	Ge68	Hf181	I124	I125	I126	I131	I133	
In114m	Ir192	Mn54	Na22	Pa230	Pb212	Ra224	Ru106	
Sb124	Sb125	Sc46	Sr89	Sr90	Ta182	Tb160	Te127m	
Te129m	Th234	Tl204	Tm170	U236	Y91	Zr95		
Any radionuclide that is not alpha emitting and is not included in any other Group in this Schedule								
Group 3								
Ag105	Ag111	Ar41	As73	As74	As76	As77	Au196	4 megabecquerels
Au198	Au199	Ba131	Ba133	Be7	Bi206	Bi212	Br75	
Br76	Br82	Ca47	Cd109	Cd115	Ce141	Ce143	Cl38	
Co57	Co58	Cr51	Cs129	Cs131	Cs136	Cu64	Cu67	
Dy165	Dy166	Er161	Er169	Er171	Eu152m	Eu155	F18	
Fe52	Fe55	Fe59	Ga67	Ga72	Gd153	Gd159	Hf175	
Hg195m	Hg197	Hg197m	Hg203	Ho166	I123	I130	I132	
I134	I135	In111	In115	In115m	Ir190	Ir194	K42	
K43	Kr85m	Kr87	La140	Lu177	Mg28	Mn52	Mn56	
Mo99	Na24	Nb93m	Nb95	Nd147	Nd149	Ni63	Ni65	
Np239	Os185	Os191	Os193	P32	P33	Pa233	Pb203	
Pd103	Pd109	Pm147	Pm149	Pr142	Pr143	Pt191	Pt193	
Pt197	Rb81	Rb86	Re183	Re186	Re188	Rh105	Rn220	
Rn222	Ru103	Ru105	Ru97	S35	Sb122	Sc47	Sc48	
Se75	Si31	Sm151	Sm153	Sn113	Sn121	Sn125	Sr85	
Sr91	Sr92	Tc96	Tc97	Tc97m	Tc99	Te125m	Te127	
Te129	Te131m	Te132	Th231	Tl200	Tl201	Tl202	Tm171	
U239	V48	W181	W185	W187	Xe135	Y87	Y90	
Y92	Y93	Yb175	Zn62	Zn65	Zn69m	Zr97		

Column 1								Column 2
Group 4								
Ar37	C11	C14	Co58m	Cs134m	Cs135	Cu62	Ga68	40 megabecquerels
H3	H3	I129	In113m	Kr81m	Kr85	N13	Nb97	
Ni59	O15	Os191m	Pt197m	Pt197m	Rb87	Re187	Se73	
Se73	Sm147	Sr85m	Sr87m	Tc96m	Tc99m	Th nat	U nat	
U nat	U235	U238	Xe131m	Xe133	Y91m	Zn69	Zr93	

NOTE:
Many standards, codes and recommendations DO NOT use the NSW Scheduled levels, and may use current Radiotoxicity Groups, Exempted Levels or ALIs

Appendix 13.2

University Radiation Waste Label

WESTERN SYDNEY UNIVERSITY

RADIATION WASTE DISPOSAL
IDENTIFICATION LABEL

Waste Generator Information

Department: _____

Date: ____/____/____ Extension: _____

Name: _____

Supervisor (if applicable) _____

Isotope: _____

Description: _____

Precautions: _____

Activity: _____

Decay Date (disposal date): ____/____/____

Waste Register Number: _____

Waste Owner Signature: _____

RSO Signature: _____

WESTERN SYDNEY UNIVERSITY

RADIATION WASTE DISPOSAL
IDENTIFICATION LABEL

Waste Generator Information

Department: _____

Date: ____/____/____ Extension: _____

Name: _____

Supervisor (if applicable) _____

Isotope: _____

Description: _____

Precautions: _____

Activity: _____

Decay Date (disposal date): ____/____/____

Waste Register Number: _____

Waste Owner Signature: _____

RSO Signature: _____

Appendix 13.3
Extract of Annex E of the Safety Guide titled Predisposal Management of Radioactive Wastes (RPS 16)

PRETREATMENT

The first pretreatment operation should be to collect the radioactive waste and segregate items on the basis of radiological, physical, chemical and pathogenic properties. Waste containing predominantly short-lived radionuclides should not be mixed with long-lived waste.

Segregation is only worthwhile if the segregated wastes will be treated differently as they move through the waste management steps to disposal or if waste acceptance criteria for disposal are likely to be different.

Knowledge of the processes generating the waste may provide adequate knowledge of the radioactivity and radionuclides in the waste. If this is not sufficient the waste should be characterised. The initial characterisation could be based on knowledge of the process generating the waste and the radionuclides involved in the process, combined with dose rate and perhaps preliminary gamma spectroscopy. This initial characterisation could provide enough information to allow disposal or storage options to be determined.

Wastes of different types and radioactivity concentrations (or total radioactivity in the case of sources) may be segregated (Section 4.3) to facilitate waste management according to the overall waste management strategy and the available facilities.

Considerations for segregation include:
- radioactivity concentration: higher radioactivity waste separated from lower radioactivity waste;
- radioactive decay: waste containing long-lived alpha emitters should be separated from waste with no alpha emitters;
- form: solid, gaseous and liquid wastes are treated separately;
- combustible or non-combustible;
- compressible or non-compressible;
- metallic or non-metallic;
- fixed or non-fixed surface contamination;
- materials and objects that are pyrophoric, explosive, chemically reactive or otherwise hazardous;
- items containing free liquids or pressurized gases;
- waste containing infectious agents or is regulated as medical waste; and
- animal carcasses and putrescibles materials.

A more definitive characterisation should be undertaken prior to any treatment and/or conditioning. This characterisation should be sufficiently comprehensive to provide adequate information for assessing treatment steps and demonstrating compliance with the Code for the Safe Transport of Radioactive Material (ARPANSA 2019)) and disposal waste acceptance criteria.

If all radionuclides in a waste package have half-lives less than about a year, consideration should be given to storing the waste in a storage facility approved by the regulatory authority until radioactivity has decayed to exemption levels.

Other actions undertaken in pretreatment could be to adjust the characteristics of the waste to make it more amenable to further processing and to reduce or eliminate certain hazards posed by the waste owing to its radiological, physical, chemical or pathogenic properties.

Larger items with limited contamination can sometimes be decontaminated to reduce the volume of waste. Mechanical, chemical and electrochemical methods can be used to remove surface contamination from a large item. The decontamination process should be planned to ensure that the characteristics of the secondary waste are compatible with the requirements for future management. The assessment as to whether to undertake decontamination should take into account the total amount of waste that will be generated by the decontamination (including any plastic sheeting, cleaning equipment, and liquid waste) and doses to workers from the decontamination.

Some items can be disassembled to remove smaller radioactive components or contaminated items from a larger volume of non-radioactive material.

Waste acceptance criteria for disposal are likely to contain exclusions for PCBs, hazardous materials, infectious waste, putrescible waste and explosive materials; and limits on some combustible materials, lead and lead compounds, surfactants, flammable liquids, pressurised gases, chelating agents, organic liquids and free liquids. Estimates of these and similar hazardous and/or toxic components should be determined from process knowledge or direct measurement, and the information documented and stored with the inventory so that it is available when the waste is sent for storage and disposal.

[The following underlined text is not applicable to the University but is included for completeness] In the hospital environment, linen including bedding, towels and personal clothing which may be contaminated with radioactive materials should remain segregated from other linen and waste until it has been monitored. If found to be contaminated, the article should be stored for decay until the amount of radioactivity is below the exemption limit [Schedule 4 of the *National Directory for Radiation Protection* (ARPANSA 2004)] for the particular radionuclide. At that time the article can be laundered with other linen or disposed of as non-radioactive waste including return to the owner.

LIQUID WASTE

Liquid radioactive waste can be generated in laboratory or medical applications of radioactive materials. Limited quantities of aqueous liquids with low concentrations of radioactive material may be suitable for discharge to the sewer, under the requirements and limits for discharge of radioactive waste by the user proposed to be included in Schedule 8 of the *National Directory for Radiation Protection*. Liquid waste potentially containing radioactivity which would cause the discharge exemption limit to be exceeded should be collected and stored for decay or other treatment determined by the chemical, physical and biological hazards of the liquid including the radionuclide half life.

Where aqueous liquid radioactive waste is regularly produced in a laboratory at a level where the effluent from laboratory sinks may conceivably cause the discharge to the sewer to exceed the proposed exemption level, sinks should be connected to a holding or delay tank system and these sinks should be restricted to uses involving radioactive materials. Where the volume of liquid radioactive waste is small, a labelled screw top container in the working area may be adequate.

[The following underlined text is not applicable to the University but is included for completeness] Toilets used by inpatients being treated with radioiodine should be clearly marked and only used by those patients. Acknowledging that single rooms within hospitals are a valuable resource, such designated toilets when not in use by patients undergoing radioiodine therapy treatment may be safely used for other patients if monitored and decontaminated correctly. If the effluent from these toilets may cause the exemption limit for discharge of iodine-131 from the premises to the sewer to be exceeded, the relevant regulatory authority may require that the toilets be connected to a holding tank system. The radioactivity and volume of the tank contents should be monitored continuously. Sufficient time should be allowed for decay of stored iodine-131 to below the exemption level for discharge to the sewerage system before a tank is emptied.

Holding tanks for short-lived radionuclide wastes are usually constructed in sets of two or more, so that one may be filling while the contents of a full one may be discharged after sampling or elapse of a sufficient period for radioactive decay.

Tanks for temporarily holding liquid waste should:

- be leak-free;
- have visual indicators of the volume of the contents and warning devices to indicate when the tank is almost full;
- be enclosed in a secondary enclosure of sufficient volume to hold the contents if at any time there should be a loss of tank contents;
- have facilities to monitor the amount of radioactivity or to allow easy withdrawal of representative samples;
- have a means to allow inspection of build-up of deposits on the base or sides and to allow access for clearing (incorporation of mechanical agitators may reduce the incidence of deposits); and
- have sanitary controls and methane monitoring if the tank holds human or animal wastes.

Liquid waste should be characterised on the basis of process knowledge and preliminary measurement. Mixing liquid waste streams should be limited to those streams that are radiologically similar and chemically compatible. It is usually preferable to treat a small amount of more concentrated liquid waste rather than treat the large volume created when the more concentrated liquid is mixed into a larger volume of liquid with low or very low levels of radioactivity.

Aqueous liquid waste streams should not be mixed with organic liquid waste. Organic liquid waste may be flammable, and its collection and storage should incorporate provisions for adequate ventilation and fire protection.

The non-radiological characteristics of liquid waste should be assessed to determine if there are other hazardous components in the waste that limit the management options for the waste.

TREATMENT

Treatment of laboratory waste may include:

- volume reduction by compaction of solid waste, by disassembly of bulky waste components or equipment, and by incineration of combustible waste;
- concentration and collection of radionuclides from liquid and gaseous waste streams by evaporation or ion exchange for liquid waste streams and filtration of gaseous waste streams; and
- change of form or composition by chemical processes such as precipitation, flocculation and acid digestion as well as chemical and thermal oxidation.

In general, treatment of radioactive waste requires approval from the regulator before any treatment or conditioning is undertaken. In some cases, this could already be included under an existing licence; in others, specific approval will be required.

Compaction can be an effective method for reducing the volume of a compressible waste. The characteristics of the material to be compacted and the desired volume reduction should be well defined and controlled. Issues to be taken into consideration in assessing the safety of compaction should include:

- possible release of volatile radionuclides and other airborne radioactive contaminants as gases or dust;
- possible release of contaminated liquid during compaction;
- chemical reactivity of the material during and after compaction; and
- potential fire and explosion hazards due to pyrophoric or explosive materials or pressurized components.

Disassembly and other size reduction techniques may be used for waste that is bulky or oversized in relation to the intended processing. Processes for size reduction can include sawing, hydraulic shearing, abrasive cutting, plasma arc cutting and cutting with high temperature flames. Preventing the spread of particulate contamination should be considered in the choice of method and in the operation of the equipment.

Combustible solid waste and radioactive organic liquids may be incinerated, calcined or treated with other advanced oxidation techniques suitable for reducing the volume of waste and producing a stable waste form. After incineration, calcination or advanced oxidation, radionuclides from the waste are distributed between the residue, the products from cleaning the exhaust gases and any stack discharges. The distribution of radioactivity and other combustion products to each of these waste streams should be assessed for all normal and abnormal conditions. Any proposal for incineration, calcination or other advanced oxidation technique should be referred to the regulator for approval.

If the radioactive waste contains fissile material, the potential for criticality should be evaluated and eliminated by means of design features and administrative controls.

Used filters from treating gases at facilities using radioactivity are a solid radioactive waste. Care should be taken to ensure that radioactive materials trapped on filters are not dispersed during handling the filters or the subsequent treatment of filters. Many filters will have only low levels of radioactivity and it may be worth assessing whether the level of radioactivity is below the exemption levels given in the *National Directory for Radiation Protection* (ARPANSA 2004). Filters containing radioactivity can usually be compacted to reduce the volume of radioactive waste to be managed.

For any waste management process that potentially leads to airborne emissions, stack discharges should be monitored to ensure that the concentrations and amounts of radionuclides discharged are within the limits specified by the regulatory body and are consistent with the parameters modelled in the safety assessment.

Animal carcass waste might be incinerated or treated with lime and absorbent. Specific absorbents are available for dealing with biological material, and the specific instructions should be followed.

TREATMENT OF LIQUIDS

Long-lived liquid radioactive waste requiring storage should be converted to solid form as soon as practicable. Solid waste is easier to store safely and, as shown in Annex G, a repository for waste disposal is likely to only accept solid waste with limits on the amount of free liquid.

Treatment of organic liquid waste, e.g. contaminated oil, depends on the organic liquid involved so relevant advice on treatment options should be sought. Methods for converting radioactive aqueous liquid waste to a solid form include:

- chemical precipitation, for example precipitating the radioactive component as hydroxide by raising pH;
- evaporation of liquid and management of the residue as solid radioactive waste;
- incorporation into a matrix, e.g. added to a sand cement mortar, bitumen polymer, ceramics or glass;
- adsorption of radioactivity onto a solid, e.g. alum followed by centrifuging to separate the solids from the liquid;
- the use of ion exchange resin; and
- filtration, ultrafiltration and reverse osmosis.

Chelating agents, organic liquids or oil and salt content in liquid waste may also be of concern in some conditioning processes.

CONDITIONING

Conditioning laboratory waste may include the conversion of the waste to a solid waste form, enclosure of the waste in containers, and, if necessary, provision of an overpack. Conditioning could also be encapsulation of contaminated items in an inert matrix, such as a cement or mortar.

Twenty litre, 60 litre and 205 litre steel drums are the preferred package sizes for laboratory radioactive waste. Galvanised or stainless steel drums have greater resistance to corrosion and may be preferred. A safety assessment should be performed to ensure that the drum selected is suitable for the particular waste type. Other sized packages or type of package should be used if the safety assessment demonstrates a significant advantage in doing so. A generator producing small amounts of radioactive waste might use smaller packages, but the smaller packages selected should be able to be packed into larger drums for ease of subsequent handling. If larger packages are indicated, future transport and handling requirements should be considered before deciding to use larger packages. Consideration should be given to cutting larger items to fit into a 205 litre drum.

The dose rate on the outside of the package containing radioactive waste should be measured to ensure the package is suitable for the storage facility and the proposed mode of transport. Some waste may need to be encapsulated in cement mortar to reduce the contact dose rate on the outside of the package. Alternatively, additional temporary shielding and control procedures could be used to control access to areas with higher dose rates.

Waste packages produced by conditioning should satisfy the criteria for transport, storage and disposal. To the extent practicable, conditioning of radioactive waste should produce a waste package with the following characteristics and properties:

- physical and chemical properties of the waste are compatible with any matrix materials and the container;
- low voidage;
- low permeability and leachability;
- chemical, thermal, structural, mechanical and radiation stability will be maintained for the required period of time;
- resistant to chemical substances and organisms;
- suitable for retrieval at the end of the storage period;
- suitable for transport to and handling at a disposal facility; and

- [The following underlined text is not applicable to the University but is included for completeness] meets waste acceptance criteria of the disposal facility, or if the disposal facility is not yet established, meets the generic waste acceptance criteria in the *Code of Practice for Near-Surface Disposal of Radioactive Waste in Australia* (NHMRC 1992).

Some materials require specific assessment before being encapsulated in concrete. Aluminium, magnesium and zirconium are known to react with the alkaline water of a cement slurry or water diffused from a concrete matrix to produce hydrogen.

The container may also need to provide radiation shielding. The selection of materials for the container and its outer surface finish should consider the ease of decontamination. An additional container or an overpack may be needed to meet the acceptance criteria if the container does not meet the relevant criteria for transport, storage or disposal. Any such package should be designed to maintain integrity and containment of the radioactivity for an extended period of storage if there could be a significant delay before an acceptable disposal route becomes available.

DISPOSAL

[The following underlined text is not applicable to the University but is included for completeness] Most laboratory and medical radioactive wastes have a sufficiently low radionuclide concentration to be accepted at a near-surface disposal facility.

[The following underlined text is not applicable to the University but is included for completeness] Other disposal options include delay/decay to below exemption levels for clearance or disposal in accordance with Schedule 8 of the NDRP (ARPANSA 2004).

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Radiation shielding and facility design
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S14
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University Consultant RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation shielding, facility design, building construction
SUMMARY *Brief summary of the contents of the document*	Shielding and facility design procedures to limit radiation risk to staff and members of public.

INDEX – Section 14

1. BACKGROUND

The University uses radiation for various scientific and medical purposes. Such activities require radiation shielding, facility design and storage of radioactive materials such that they comply with the requirements of NSW *Radiation Guideline 7 – Radiation Shielding Design Assessment and Verification Requirements.*

This means that all areas where radiation is to be used need to be assessed to determine if shielding is required and to ensure that the shielding is adequate for the particular use. Shielding should be a central part of design from the earliest stages of facility and project planning.

This process also includes the need to reconsider the adequacy of shielding in existing radiation facilities when building modifications or increased building occupancy result in changes to previously unoccupied space adjacent to radiation facilities or sources.

2. DEFINITION

Facility is the building, room or space where the activity occurs and any adjacent spaces that could be affected by the activity or sources. Laboratory is defined as an area where scientific endeavour occurs.

3. RESPONSIBILITIES

3.1. TRTS Technical Coordinator/Leader or Facilities Manager

The persons responsible for a facility will ensure that:

- The Radiation Safety Officer is consulted prior to development of any new facility;
- the Radiation Safety Officer is consulted prior to any modifications to existing buildings and facilities which incorporate radiation sources;
- records of the consultation regarding shielding and facilities design are kept. These records will include recommendations from the RSO or other professional consultants and the actions taken regarding the recommendations; and
- records of consultation are submitted to the S&W of the University within two weeks of any such meetings.

3.2. Radiation Safety Officer

The RSO will have suitable qualifications and experience in shielding design for the particular type of facility involved, or else an expert with qualifications and experience in shielding design for the particular type of facility involved must be consulted.

The RSO will assess the advice from consultants for accuracy and verify (via a professional consultant if necessary) that the shielding is implemented correctly during and after construction.

3.3. Chief Investigator

The Chief Investigator will be responsible to ensure that the facility has adequate shielding and storage facilities for the activity being undertaken before commencing the project.

4. PROCEDURE

4.1. Project Planning

(a) Arrange radiation activities within a facility to reduce the amount of shielding required.

(b) Consult with RSO from earliest planning stages.

(c) Consider the type of analysis being undertaken.

(d) On advice from the RSO, an independent Consulting Radiation Expert (CRE) specialising in shielding will be engaged as part of the design team.

(e) If a health physicist is responsible for the operation of a facility, then they should be part of the design team from the earliest stages.

(f) Shielding must comply with NSW EPA guideline *Radiation Guideline 7 – Radiation Shielding Design Assessment and Verification Requirements*.

4.2. Design Considerations To Comply With Dose Constraints

To not exceed dose limits for the members of the public and occupationally exposed persons as described in Schedule 4 of the NSW Protection from Harmful Radiation Regulation 2025, the shielding design:

- should ensure that radiation levels in facilities do not give rise to an equivalent dose greater than 100 µSv per week for occupationally exposed persons from all sources of exposure
- **must** ensure that radiation levels in facilities do not give rise to an equivalent dose greater than 20 µSv per week for members of the general public.

4.3. Planning of Radiology Facilities

General considerations for the planning of radiology facilities (including X-ray analysis, diagnostic X-ray apparatus) include:

(a) predicted number of volunteers/patients at maximum workflow;

(b) the type of clinical examinations to be undertaken; or

(c) the type of analysis being undertaken.

Further design and shielding assessments should be undertaken when:

(a) the intended use of a room changes; and/or

(b) X-ray equipment is upgraded.

NOTE: Further details of specific shielding requirements for medical applications can be found in NSW EPA EPA *Radiation Guideline 6 – Registration requirements and Industry best practice for ionising Radiation apparatus used in diagnostic imaging*.

NOTE: The literature (NCRP 2004, BIR 2000) should be referred to for advice on structural shielding issues.

NOTE: As a general requirement, RPS C-5 requires that barriers should:

- be at least two metres high; and
- have all penetrations and joints arranged so that they are equally as effective in shielding radiation.

(a) Any viewing windows need to have at least the same lead equivalence as the minimum shielding specifications for the shielded barrier in which they are located.

(b) Due consideration should be given to the provision of floor and or ceiling shielding when rooms immediately below and above the X-ray installation respectively are occupied.

(c) Where estimating shielding for CT installations, the Qualified Expert (Shielding Physicist) should insist that the equipment suppliers provide radiation scatter contour maps around the scanner as part of the documentation accompanying the equipment.

(d) Appendix C of NSW EPA *Radiation Guideline 7* should be consulted for further technical details relating to shielding of diagnostic X-ray facilities.

(e) All shielded barriers must be labelled with the details of the shielding as per EPA Radiation Guidelines 6 and 7. These labels should preferably be provided by the company constructing or providing the shielding and must specify the lead equivalent of the shield and the energy at which that lead equivalence is defined.

(f) When dictated by Radiation Guideline 7 an independent CRE should ensure that a radiation survey is undertaken to confirm the shielding meets the relevant requirements.

(g) A documented record of this assessment must be kept as part of the facility commissioning records. Radiation Guideline 7 should be consulted for the essential elements required in this record.

4.4. Planning of Unsealed Source Facilities

Consult with the RSO to confirm the facility and laboratory grading (low, medium, or high) as described by AS2243.4 and follow the general guidelines found in AS2982 and AS2243.4

For high level facilities, security arrangements may be required to be incorporated into the design.

4.4.1. Low-level laboratories

In low-level laboratories, fittings and finish shall be chosen so that they may be readily, cleaned and shall incorporate features as follows:

(a) Joints shall be sealed and made waterproof and be located away from sources of contamination (e.g. not near sinks or under edges of benches).

(b) Seamless PVC flooring is recommended. Painted or carpeted surfaces are not acceptable.

(c) Walls should be smooth, finished with a washable high gloss or semi-gloss paint and reasonably free of exposed electrical conduits, and water and gas pipes.

(d) Benchtops must have a smooth, waterproof, chemically resistant covering that is easy to clean: Melamine, seamless vinyl, cast epoxy resin and stainless steel are recommended. Painted surfaces are not acceptable.

(e) Drainage shall be arranged so that it is isolated and so that other building areas cannot become contaminated if the drainage system becomes blocked.

(f) Secure storage facilities, which may include refrigerators and freezers, shall be provided for stocks of radionuclides. Shielding of the storage facility shall be provided if recommended by the RSO.

(g) The advice of the RSO shall be sought to determine if a fume cupboard is necessary for handling small quantities of non-volatile radionuclides that are of low radiotoxicity class (see AS 2243.4).

(h) Stainless steel sinks are required.

(i) A hand washbasin with automated action, or knee- or foot-operated taps, should be available immediately adjacent to the entrance doorway.

(j) A hand-held shower on a flexible hose and an eye wash facility.

4.4.2. Medium-Level laboratories

A high degree of cleanliness is essential in medium-level laboratories, and finishes and fittings shall be chosen to assist its achievement. In addition to meeting the requirements of 4.4.1 above, the laboratory shall comply with the following:

(a) The floor is strong enough to support the weight of any shielding while maintaining its smooth decontaminable continuous surface.

(b) Where welded PVC floor covering is used, a polyvinyl chloride content in excess of 76% by weight is to be used for ease of decontamination.

(c) The floor covering is coved up to and be sealed to walls and vertical surfaces to aid cleaning.

(d) Benches are to be strong enough to support the weight of any shielding likely to be used. The front and side edges of the benchtop is to be slightly raised and the back coved up to the wall or reagent shelf, so that the benchtop acts as a shallow tray to help contain spills.

(e) Joins between bench surfaces are to be designed and constructed so that they do not leak or trap contamination.

(f) A hand washbasin be provided and the taps shall be operated automatically, or be operated by knee or foot.

(g) Drainage systems shall be self-contained and be appropriately labelled at accessible locations. Polyethylene and PVC pipes and fittings are recommended because they are resistant to most chemicals and are less likely than metal pipes to become internally contaminated.

(h) If glove-boxes are to be used, each shall have its own exhaust air filter. Discharge of the exhaust air shall comply with the requirements of AS/NZS 2243.8.

(i) Laboratory ventilation requires careful design with outdoor fresh air quantities increasing as the quantity of radioactivity proposed for use increases. Table 9.1 provides a practical guide to the supply of outdoor air requirements for laboratories assuming a floor area of 10m^2 per person and a ceiling height of 2.4 m.

NOTE: The RSO shall advise on recirculation of laboratory air within radioisotope laboratories. Fume cupboard exhaust air shall not be recirculated. Radioisotope laboratories shall be maintained at a negative pressure with respect to adjacent spaces. An alarm system that is automatically activated in the event of failure of the ventilation system shall be installed.

NOTE: The RSO shall determine whether overshoes and barriers are required.

NOTE: Laboratories of a medical or biological nature, where sterility of products also has to be maintained, will present special design difficulties. In such cases the RSO will need to resolve the different requirements of the radioisotope codes and standards, the sterility standards for cleanrooms and the Australian Code of Good Manufacturing Practice for Therapeutic Goods. In addition, for product and operator protection, laminar flow biological safety cabinets complying with AS 2252.2 may be required.

- Ceilings are to be smooth and decontaminable as for walls. Flush light fittings shall be used in preference to suspended fittings which trap dust.

- Laboratories, in the upper part of the medium-level classification or above, shall have ceilings coved to the walls to aid cleaning.
- For medium-level laboratories in which higher levels of radioactivity are used, consideration shall be given to the provision of delay tanks for collection of the effluent before discharge to the sewer. The advice of the RSO, regulatory authority and waste water authority shall be sought when considering the need for, and design of, such a system.
- At least one fume cupboard in accordance with AS/NZS 2243.8 shall be provided. Appropriate exhaust air filters are desirable and provision shall be made to fit them at a later date even if they are not required in the first instance. Provision shall be made for exhaust air sampling. The base of the fume cupboard shall be capable of carrying 0.5 kg/cm^2 (0.5 MPa) averaged over the whole area of the base.

4.5. Decommissioning of Radiation Facilities

When a radiation facility, whether it be an X-ray, unsealed or sealed source facility, is being decommissioned whether it is for refurbishment, no longer required or being moved, there is a proper procedure to be conducted. This procedure will involve the Chief Investigator, facilities management and the RSO.

The University has a documented procedure that requires compliance by all of the University; and this document is attached as an appendix at the end of this section; in addition there is a “Termination of Laboratory Work checklist” available.

5. DOCUMENTATION

In accordance with NSW EPA Guideline 7, the following will be kept at the facility and a copy sent to the WHS unit:

(a) Shielding plans as per requirements of NSW EPA Guideline 7.

(b) Shielding CRE reports showing all details of assumptions made regarding workloads, energies, dimensions and occupancies etc.

(c) Shielding assessment reports by independent CRE or local physicist as per requirements of NSW EPA Guideline 7.

(d) Engineering drawings of facilities “as constructed” detailing any shielding including lead equivalence or HVL of each barrier as well as any pipes or ducting that may carry radioactive materials (waste or otherwise).

6. AUDIT

Every 2 years

7. REFERENCES

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NSW EPA - Protection from Harmful Radiation Regulation 2025

8. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Oct 2014	Draft	William Bartolo, Bartolo Safety Management Service
Dec 2014	Revised Draft	K Ambrose, T Millar, W Bartolo
Mar 2015	Draft V3	K Ambrose, T Millar, W Bartolo
Mar 2016	Draft 4	K Ambrose, T Millar, W Bartolo
Dec 2016	Draft 5	K Ambrose, T Millar, W Bartolo + BRSC + stakeholders
Apr 2017	Revision 6	K Ambrose, T Millar, W Bartolo
July 2018	Revision 6b	K Ambrose, T Millar, W Bartolo
Oct., 2018	Revision 7	K Ambrose, T Millar, W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

Appendix 14.1

Procedure for Decommissioning a Radiation Laboratory and Associated Facilities

1. **SUMMARY:**
When laboratories and associated facilities are vacated, any radioactive (as well as chemical or biological) contamination must be dealt with and all of these materials must be removed and disposed of properly.

2. **SCOPE:**
This Guideline applies to any researcher moving out of a laboratory or a laboratory being shut down. These moves include: leaving the University, moving to another building on campus or relocating to another laboratory within the same building.

3. **DEFINITIONS:**
Decommission - the formal deactivation of a laboratory; assuring the safety of the space for further cleaning, renovation, or occupancy. The decommissioning process involves an inspection by S&W Laboratory Safety Specialist; and representatives from the Radiation Safety Officer (RSO).

4. **PROCEDURE**
Principal Investigators/Authorized Users notify School/Faculty/Facility Manager and S&Wwhen an investigator (laboratory based) will be leaving the University or relocating within the University.

Before removal of materials and equipment, the equipment must be checked for contamination and decontaminated if required.

Pack and remove all radiological materials and equipment.

Check the laboratory for contamination. Contact S&W for assistance with radiological site evaluations and decontamination. S&W will advise the Chief Investigator/Authorized User on precautions to be taken during decontamination and transfer of radioactive materials. Information regarding relocating laboratory hazardous materials is available upon request.

If radiological contamination is identified by S&W personnel, S&W will notify Chief Investigators/Authorized Users. Chief Investigators/Authorized Users will be responsible for all decontamination activities. The School/Faculty/Facility Management is responsible for any deficiencies not corrected by the Chief Investigator/Authorized User and any ensuing costs.

Divisions of Operations and Commercial will be notified by S&W after the decommissioning is complete.

NOTE: Divisions of Operations and Commercial will not service or clean laboratory facilities that have not been decommissioned by S&W.

4.1 Radiation Facilities

4.1.1 Prior to relocating to the new radioisotope facility, the facility must be approved by the RSO and The Biosafety and Radiation Safety Committee (BRSC) and registered with the EPA at this point or in the near future. S&W will notify the Authorized User of approval.

4.1.2 Compile a complete listing of all isotopes (including activities) previously used in the facility.

4.1.3 All radioactive waste containers not being transferred to a new facility must be relocated to the radiation storage facility organised through S&W.

4.1.4 Radioactive waste which has decayed to a safe level (below 100 becquerels per gram and meeting the other legal requirements such as the total activity and specific activity ratios) can be disposed of as chemical or clinical/biological waste. Contact S&W in regards to disposal.

4.1.5 Conduct a Radiation Contamination Survey

For surface contamination (including bench tops, sinks, taps, light switches, cupboards and handles, fridges, and possibly floors), a full contamination survey needs to be conducted.

It is important to first document what isotopes (and their characteristics) have been used over, say, the last five (5) years. From this list the type of survey (portable contamination meter or wipe test) can be determined. Soft Betas and some gammas will require a wipe test – eg ^{3}H, ^{14}C, ^{35}S, ^{125}I and possibly ^{32}P. For most others the use of a portable instrument will suffice.

Conduct the contamination survey and record the results.

An operational definition needs to be established as to the maximum amounts of such contamination that would be tolerable. Below are the two established levels or requirements:

AS2243.4 Contamination Levels		
Radiotoxicity Group	**Maximum levels within laboratory Bq/cm2**	**Maximum level on skin or items leaving the laboratory Bq/cm2**
Group 1	0.1	0.01
Group 2	1	0.1
Group 3a	10	1
Group 3b	100	10
Group 4	1000	100

Legislative Requirements (Section 21 of Regulations)		
Scheduled Level Group	**Alpha Radiation Maximum levels Bq/cm2**	**Beta or Gamma Radiation Maximum level Bq/cm2**
Group 1	0.04	0.4
Group 2	0.04	0.4
Group 3	0.4	0.4
Group 4	0.4	0.4

Decontamination Procedure

Once contamination levels have been determined the following is the decontamination process:

1. Loosely attached radioactive material on the bench top and floor may be removed by wiping with damp paper towelling. Again check the contamination levels (wipe test or instrument). If this does not achieve a reasonable result then the use of radiation decontamination detergent will be required.

2. Clean using one of the proprietary radiation decontamination detergents (used as described in the directions that come with the detergent). Again check the contamination levels (wipe test or instrument). Repeat the decontamination process and re-check levels).

3. Every effort should be made to eliminate it so that the activity indicated by the instrument or on the filter paper is finally zero or close to zero.

4. If contamination is persistent, and firmly attached, and activity still exceeds the above maximum figures, contact the S&W and the RSO.

4.1.6 All wipes used in cleaning should be placed in a radiation waste receptacle and the affected areas monitored. Decontamination should be carried out until no further reduction in radiation levels, as checked by the RSO, is being achieved, provided that the contamination level is then below the maximum permissible. After

completion of all operations, the area must be checked with radiation monitoring equipment or, in the case of 14C, 3H, 35S and 125/131I, with a swab which can then be counted in the Scintillation counter.

4.1.7 Decontamination of Radiation facilities must be organised through the RSO. Upon written notification by the Chief Investigator/Authorized User or the RSO that the facility has been cleaned and decontaminated, the RSO will conduct a radiological survey of the facility. In addition, RSO will verify that the equipment used to store or analyse radioactive materials is decontaminated. For information on equipment decontamination, contact RSO or refer to the Radiation Management Plan. Chief Investigators/Authorized Users will be notified of the results. If contamination is identified, laboratory personnel will be responsible for decontamination. The laboratory will be re-evaluated upon completion of decontamination efforts.

4.1.8 The registration will be surrendered upon completion of decommissioning of facility.

ATTACHMENT 1

Laboratory Equipment Listed for Disposal

Decontamination Certificate

Equipment to be relocated, removed for service or disposal is to be decontaminated prior to leaving a laboratory, in relation to its exposure to any hazardous material.

All equipment is to be decontaminated within the laboratory.

Hazardous material possibly exposed to:

☐ **biological**

☐ **chemical**

☐ **radioactive**

☐ **other (Please specify) ……..**

Equipment Description: ……..

Model number: ……..

Serial number: ……

Asset number: ……

Decontamination procedure(s) used must be specified below.

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Decontamination Declaration

I declare that the above equipment has been decontaminated as specified and is safe for removal.

Authorised Signature:Date:

Name (Printed): …… Position: ……

Note: A copy of this declaration is to be attached to the equipment.
A copy of this declaration is to be retained locally for a record.

ATTACHMENT 2

Laboratory/Facility Decontamination Certificate

Facility Description: .....

Building: .....

Room number/s: .....

Radiation Premises Registration number/s: .....

Radiation equipment licenses associated with this facility.....

Radiation source licenses associated with this facility.....

Facility Supervisor/Manager: .....

Facility is to be decontaminated in relation to all hazardous material previously handled.

Radiation

☐ Ionising (Sealed source) ☐ Ionising (Unsealed source)

☐ X-ray equipment etc ☐ Non-ionising (lasers)

Decontamination procedure(s) used must be specified below.

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☐ **Radiation waste (ionising) transferred to Radiation Storage Premises_____**

☐ **Unwanted x-ray equipment relocated to room_____**

☐ **Unwanted lasers relocated to room_____**

☐ **Sealed sources transferred to room_____ registration number_____/NA**

☐ **Unsealed sources transferred to room_____ registration number_____/NA**

☐ **X-ray equipment transferred to room_____ registration number_____**

☐ **Laser/s transferred to room_____**

☐ **Fume Hoods surface cleaned and maximo request submitted for decontamination**

☐ **All surfaces (benches, sinks, walls, floors) cleaned**

☐ **All surfaces wipe tested**

Decontamination Declaration

I declare that the above facility has been decontaminated as specified and is safe for use.

Authorised Signature:Date:

Name (Printed): .....Position:.....

Required Health and Safety Sign Off

☐ Radiation

Chief Investigator Name_____

Signature_____ Date_____

University Radiation Safety Officer_____

Signature_____ Date_____

☐ Health and Safety

Name_____ Signature_____

Date_____

Radiation Registration_____ cancelled date_____

FM notified decommission is complete date_____

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Safety with Sealed Sources
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S15
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University Consultant RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Sealed Sources, Sealed Source Devices
SUMMARY *Brief summary of the contents of the document*	Safety and management of sealed sources and sealed source devices.

INDEX – Section 15

1. BACKGROUND

The University utilises sealed sources and sealed sources devices for a number of field research, scientific and teaching purposes. As required by legislation and appropriate ARPANSA Codes of Practice , some sealed sources need a licence and registration, some registration only , and some are exempt. It is essential that sealed sources in each of these categories are identified so that proper steps can be taken to ensure maintenance of our legal requirements.

2. RESPONSIBILITIES

2.1. The University/Radiation Management Licence Holder

The University via the Radiation Management Licence Holder alone is responsible for the purchase, possession and disposal of radiation apparatus and for ensuring that all relevant records are maintained.

The University via the Radiation Management Licence Holder will be responsible for ensuring that

(a) the maintenance, disposal or sale of sealed sources comply with the NSW Protection from Harmful Radiation Regulation 2025.

(b) copies of all maintenance and inspection reports undertaken on sealed sources (and sealed source devices), together with a copy of the registration certificate if relevant are kept in the area where the sealed source is used and copies are sent to the S&W.

(c) annual and random inspections in regards to the management of these sealed sources are conducted by the WHS Unit.

Note: The records may be in hardcopy or electronic form.

Note: The records must be kept for at least 5 years and made available on request to an authorised officer of the EPA. They can only be disposed of after permission is granted from the State Director General.

2.2. The Radiation Management Licence Holder and the Chief Investigator

Both the RML holder and Chief Investigators using these sources must ensure compliance with the following procedures relating to the storage, maintenance, disposal or sale of these sources. Normally, the process would occur jointly between these parties.

The Chief Investigateor and the RML holder will ensure that the information that is to be contained in local and university inventory are the following details (NOTE: for many older sources and orphan sources the details may not be known, there was never a serial number or it has been worn off):

- Source serial number
- Isotope
- Date of calibration by supplier (or date of acceptance)
- Activity (in KBq or MBq)
- Storage location

3. SEALED SOURCES

A sealed source refers to radioactive material that is firmly bonded within metals or sealed in a capsule or similar container of adequate mechanical strength so that the active material cannot be dispersed into the environment under foreseeable conditions of use and wear. Typically, sealed sources are double encapsulated.

For more information on neutron gauges (soil moisture gauges, etc) see RMP Section 16.

Part of the legislative requirements for the registration of premises that store or use radioactive substances is the registration of sealed sources. The following is an extract of the current legislative requirements:

Protection from Harmful Radiation Act 1990 No 13 (2010)
:

6 Radiation management licences

(1) For the purposes of this Act each of the following persons is a person responsible for regulated material—

(a) the owner of the regulated material,

(b) any person who is storing, selling, consigning for transport, disposing of or giving away the regulated material,

(c) any person who has possession of the regulated material, other than—

(i) a person who is the holder of a radiation user licence in respect of the regulated material and who has possession of the regulated material only for the purposes of using the regulated material, or

(ii) a person who has possession of the regulated material only for the purposes of transporting the regulated material.

(2) A person responsible for regulated material must hold a radiation management licence in respect of the regulated material and must comply with any conditions to which the licence is subject.
Maximum penalty—1,500 penalty units in the case of a corporation or 250 penalty units or imprisonment for 2 years, or both, in any other case.

(3) The Authority may, by notice in writing given to a person, exempt the person from the requirement to hold a radiation management licence.

(4) The exemption may be granted unconditionally or subject to conditions and remains in force for the time specified in the notice or until cancelled by the Authority by giving further notice in writing, whichever occurs first.

(5) The Authority may seek, and take into consideration, the advice of the Council before making a decision in respect of the granting of an exemption under this section.

(6) Each person responsible for regulated material must ensure that the regulated material is not sold, leased or given to, or stored, possessed, consigned for transport, disposed of or used by, any other person unless that other person is the holder of an appropriate licence under this Part in respect of the regulated material.
Maximum penalty—1,500 penalty units in the case of a corporation or 250 penalty units or imprisonment for 2 years, or both, in any other case.

(7) In this section—
consign has the same meaning as in the Dangerous Goods (Road and Rail Transport) Act 2008.

Protection from Harmful Radiation Regulation 2025

Division 2 Conditions on radiation management licences—the Act, ss 13B(1A) and 40(3)(d1)

10 Obligations set out in adopted National Directory documents

(1) It is a condition of a radiation management licence that the person responsible for the regulated material to which the licence applies must comply with the obligations on a responsible person that—

(a) are set out in an adopted National Directory document, and

(b) relate to the person and the regulated material.

(2) The condition does not include—

(a) the obligations relating to safety assessments in the Code for Radiation Protection in Planned Exposure Situations, clause 3.1.19, or

(b) the obligations in the Code for the Disposal of Radioactive Waste by the User, or

(c) the obligations in the Security Code.

(3) If there is an inconsistency between an obligation imposed by the condition and a provision of this regulation, the provision of this regulation prevails to the extent of the inconsistency.

(4) In this section—

Code for Radiation Protection in Planned Exposure Situations means the document titled Code for Radiation Protection in Planned Exposure Situations published by the Australian Radiation Protection and Nuclear Safety Agency as in force from time to time.

11 Radiation management plans (RMP)

(1) It is a condition of a radiation management licence that the person responsible for regulated material to which the licence applies must ensure a radiation management plan for the regulated material is—

(a) prepared or adopted, and

(b) implemented.

(2) It is a condition of a RML that the RMP must comply, to the extent relevant, with the requirements for the preparation of a RMP contained in each adopted National Directory document other than the following—

(a) the Code for the Disposal of Radioactive Waste by the User,

(b) the Security Code.

(3) It is a condition of a radiation management licence that the person responsible for the regulated material to which the licence applies must—

(a) ensure a copy of the radiation management plan is available to—

(i) all persons who use the regulated material, and

(ii) all occupationally exposed persons employed by the person, and

(b) take all reasonable steps to ensure the procedures set out in the radiation management plan for the use of the regulated material are followed by—

(i) all persons who use the regulated material, and

(ii) all occupationally exposed persons employed by the person.

Division 3 Licence exemptions—the Act, s 39

Subdivision 1 Exemptions from licensing requirements generally

12 Radiation management licence exemptions for certain radioactive substances and ionising radiation apparatus

A person is exempt from the requirement to hold a radiation management licence under the Act, section 6 in relation to the following types of regulated material—

(a) radioactive substances and sealed source devices specified in Schedule 2, Part 2,

(b) ionising radiation apparatus specified in Schedule 2, Part 4.

13 Radiation user licence exemptions for certain radioactive substances and ionising radiation apparatus

A person is exempt from the requirement to hold a radiation user licence under the Act, section 7 in relation to the following types of regulated material—

(a) radioactive substances and sealed source devices specified in Schedule 2, Part 1 or 2,

(b) ionising radiation apparatus specified in Schedule 2, Part 3 or 4.

Since sealed sources not contained in a sealed source device are not excluded from registration, except as reference, teaching and training sources below 40 MBq, then all sealed sources not contained in a registered device must be inventoried and listed under the Radiation Management Licence.

In addition, any sealed sources that are deemed to be classed as a Security Enhanced Source must comply with the security requirements of the Legislation and the ARPANSA RPS11 Code in terms of security, storage and management. ***It is the responsibility of the principal investigator to determine the cost of any additional security required before purchase***

The following table gives the threshold levels for some of the sealed sources of concern, above which Security as per the legislation and necessitating a Security Plan is required:

Threshold activities for sealed radioactive sources

Radionuclide	Activity (GBq)	Element
Am-241	60	Americium
Am-241/Be	60	Americium/Beryllium
Au-198	200	Gold
Cd-109	20,000	Cadmium
Cf-252	20	Californium
Cm-244	50	Curium
Co-57	700	Cobalt
Co-60	30	Cobalt
Cs-137	100	Caesium
Fe-55	800,000	Iron
Gd-153	1,000	Gadolinium
Ge-68	700	Germanium
Ir-192	80	Iridium
Ni-63	60,000	Nickel
Pd-103	90,000	Palladium
Pm-147	40,000	Promethium
Po-210	60	Polonium
Pu-238	60	Plutonium
Pu-239/Be	60	Plutonium/Beryllium
Ra-226	40	Radium
Ru-106 (Rh-106)	300	Ruthenium (Rhodium)
Se-75	200	Selenium
Sr-90 (Y-90)	1,000	Strontium (Yttrium)
Tl-204	20,000	Thallium
Tm-170	20,000	Thulium
Yb-169	300	Ytterbium

For Security Assessment and requirements please contact WSU WHS unit.

3.1. Requirements of Australian Standard 2243.4

AS 2443.4 details safety considerations when working with sealed sources. These include:

(a) Sealed sources must be handled remotely (e.g. by using tongs or forceps) and for the minimum possible time.

(b) Locating shielding as close as practicable to the source of radiation. Precautions should be taken to protect laboratory workers and persons in adjacent areas from direct and scattered radiation.

(c) Every sealed source should be labelled with, and a record kept of the following:

i. the serial number or identification code.

ii. the nature of the source, its date of receipt, and its activity upon receipt.

iii. A record will be kept with the source and by S&W detailing where it is being stored, where it is being used and where to and when it is relocated.

iv. In addition S&W will keep a record of its date and details of disposal.

(d) When not in use, store sealed sources in secure and adequately shielded containment, which is labelled with the international radiation symbol and other relevant information.

(e) Where a source could potentially release a radioactive gas, the storage area must be adequately ventilated. Exhaust ventilation should be run for an adequate time before entering the area.

Sealed sources may be used in either an enclosed or open installation.

3.2. Safety Guidelines for Sealed Source Enclosed Installations

Permanent enclosures for any source of radiation and the materials being irradiated should be designed so that:

- No person can be within the enclosure during an irradiation.
- Interlocks prevent persons from entering the enclosure during an irradiation.
- Any person accidentally shut in an enclosure be able to leave by a suitable exit or be able to immediately enter an adequately shielded refuge.
- An irradiation is capable of being prevented or quickly interrupted from within a large enclosure. It should not be capable of being reset from outside the enclosure.
- Persons outside the enclosure are adequately protected.
- During operation, the dose rate at any accessible outside surface of any large enclosure should not, in any one hour, exceed 10μSv for occupationally exposed workers. If non-radiation workers have access to the outside area, the dose should not exceed 0.5μSv.
- When not in use, sealed sources should be placed into a secure and shielded housing. This will be carried out by remote control.
- Fail-safe interlocks and control systems shall be provided on all enclosed installations. If electrically operated, the system shall be rendered inoperative or non-hazardous in the event of loss of electrical power.

3.3. Safety Guidelines for Sealed Source Open Installations

In an open installation, the source of ionizing radiation and the materials being irradiated should be confined as far as possible within a specific area. The area should be outlined by suitable barriers, appropriate warning signs displayed, and follow the requirements of an enclosed installation as detailed above, so that:

- only authorised persons have access to the area.
- persons outside the area are not exposed to the source of radiation.

- authorised persons enter the area for the minimum time needed to make essential adjustments to the equipment.
- if possible, the apparatus be capable of adjustment by remote handling methods.

There are several NHMRC Documents that deal with sealed sources for medical applications that would be of use for developing safety procedures. Please note that some of these have been revised and are now listed as ARPANSA RPS documents and some are still in the process of being revised and replaced by the ARPANSA Radiation Protection Series.

3.4. Purchase of Sealed Sources

Before purchase, the Chief Investigator must ensure security costs and if a sealed source purchase is being contemplated please ensure the following:

(a) the purchase has as part of the contract return to the supplier when unwanted or decayed;

(b) If not possible or economic to return to supplier that there is a disposal pathway;

(c) That funds are allocated for any disposal of sealed sources;

(d) Please refer to RMP Section 13 for further guidance.

3.5. Sealed Sources Lacking Proper Identification or Lacking Disposal Pathway

Any person who detects or has a sealed source lacking proper identification or lacking disposal pathway at the time of purchase (e.g. purchases or acquisitions pre 2010) that needs to be disposed of should contact S&W.

In some cases the sealed source may still be highly radioactive. If this is the case, the following alternatives should be considered:

(a) return to the supplier;

(b) transfer to another user; or

(c) store in a suitable facility.

In all cases, S&W, the RSO and the Statutory Authority (EPA) should be notified of the decision to be taken.

3.6. Storage of Sealed Sources

When not in use the sealed source must be replaced into its shielded container (if it has one) and returned to its approved, designated storage facility that is kept under lock and key. There must be an inventory of all sources for this location and must be maintained on a regular basis.

As far as practicable and taking into account the ALARA principle, sealed sources should not be stored near regularly occupied or frequented areas. The dose rate at the surface of the storage facility is to be less than 5 µSv/hr if only occupationally exposed persons have access, or less than 0.5µSv/hr if accessible by the general public. Furthermore, sealed sources should not be stored in the same storage area as dangerous goods of the following Dangerous Goods Classes:

1 Explosives
2.1 Flammable gas
3 Flammable liquid
4.1 Flammable solid
4.2 Spontaneously combustible
4.3 Dangerous when wet
5.1 Oxidising agent
5.2 Organic peroxide
8 Corrosive

As radioactive materials are to be stored (in general) in a storage facility solely dedicated to radioactive storage, and designed for such storage, consideration needs to be given to ARPANSA and relevant Australian Standards documents, as well as legislative requirements (that is registration).

The name and contact details of the S&W or other relevant person, should be placed on the store in a conspicuous location.

3.7. Sealed Source Maintenance

It is expected that each sealed source is checked regularly by the person responsible for a approved designated storage area or their approved agent, either quarterly, six monthly or yearly to ensure that the sealing material maintains its integrity and that it is not degrading. The check involves examining for faults such as cracks or chips and conducting a surface ‘Wipe Test’ to ensure that the radioactive isotope is not “leaking”, by separating from the sealing compound and becoming a free agent. The ‘Wipe Test’ should be left to an expert familiar with sealed sources or equipment containing these sources.

Comprehensive records must be kept by the principal investigator for each sealed source, including results of wipe tests (Contamination Survey), visual inspections etc. The person responsible must send the results of such checks to the University S&W at least annually, or immediately if the integrity of the source is determined to have failed.

4. DOCUMENTATION

Records of use
Records of Storage, & Relocation
Records of Inspection and Maintenance of the source(s)

5. AUDIT

Every 2 years

6. REFERENCES

None

7. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Nov 2014	Draft	William Bartolo, Bartolo Safety Management Service
Feb 2015	Draft 2	William Bartolo, Bartolo Safety Management Service
Jun 2015	Draft 3	K Ambrose, T Millar & W Bartolo
Mar 2916	Draft 4	K Ambrose, T Millar & W Bartolo
Dec 2016	Draft 5	K Ambrose, T Millar & W Bartolo
Apr 2017	Revision 6	K Ambrose, T Millar & W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Safety with Neutron Gauges (soil moisture, soil density equipment)
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S16
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Soil moisture, neutron, soil density, neutron safety
SUMMARY *Brief summary of the contents of the document*	The basics from the mandated code of practice for the safe use of neutron gauge equipment.

INDEX – Section 16

1. BACKGROUND

Neutron gauges (soil moisture/density measuring equipment) are used for field research, scientific research and teaching purposes. These portable devices have radioactive sources. Their portability means that they are more readily lost or stolen and, therefore, the Commonwealth of Australia has special Acts and guidelines to control these devices. To ensure that the various Acts are abided by, a code of practice has been developed by ARPANSA Code of practice RPS 5 (*Code of Practice and Safety Guide for Portable Density/Moisture Gauges Containing Radioactive Sources (2004)*) and compliance with this code is a condition of the University Radiation Management Licence.

Note: due to the nature of the legislation, researchers purchasing or acquiring such a device should plan for a six month lag period between submission of the proposal to being able to purchase and use the equipment.

2. RESPONSIBILITIES

2.1. The Radiation Management Licence Holder

The Radiation Management Licence Holder will be responsible for ensuring that

(a) the purchase, storage, repair, maintenance, disposal or sale of radiation apparatus and sources comply with the NSW Protection from Harmful Radiation Regulation 2025

(b) copies of all maintenance and inspection reports undertaken on radiation apparatus, and sources, together with a copy of the registration certificate are kept with the apparatus and copies are sent to the S&W

(c) annual and random inspections in regards to the management of this apparatus and sources are conducted by the S&W and RSO.

Note: The records may be in hardcopy or electronic form.

Note: The records must be kept for at least 5 years and made available on request to an authorised officer of the EPA. They can only be disposed of after permission is granted from the State Director General.

2.2. The Radiation Management Licence Holder and the Chief Investigator

Both the RML Holder responsible for the equipment and chief investigators using the equipment must ensure compliance with the following procedures relating to the purchase or acquisition, storage, repair, maintenance, disposal or sale of radiation apparatus. In terms of purchase or acquisition please refer to Section 4 of the RMP. Normally, the processes would occur jointly between these parties.

The Radiation Management Licence holder has the recommendation to notify the

appropriate fire authority and police of the storage locations of each portable density/moisture gauge under their control if and when required by the authority. This maybe required for storage at permanent locations and is of particular importance when the gauge or gauges are stored at semi-permanent locations (as may be the case in field studies). The RML holder must ensure that all personnel receives appropriate radiation safety training by an accredited trainer, on the use of the gauge. It should be done as soon as practicable, preferably during initial staff induction. Refresher training should be undertaken at no more than 5 year intervals however, training may need to be more frequent where there have been changes to legislation or other safety requirements that are relevant to those personnel.

NOTE: NSW legislation requires that users are licensed (or students are exempted and under supervision during use of the gauge) and are suitably trained by an EPA approved trainer.

Every use of or project using ionizing radiation by a student, or staff member, of the University (please note: they must hold either an appropriate licence or an exemption) at any site, or the use by other persons at a University premise, requires prior project approval of the BRSC. Reporting details are included on this form. The ARPANSA document suggests that the review period is annual.

One of the licensee's responsibilities is to ensure the integrity of the sealed source, and a trained, experienced service technician should be employed for this purpose.

Service technicians involved with repair of portable density/soil moisture gauges might also need to be equipped with a suitable contamination monitor, particularly if they are performing wipe tests (*Note: wipe tests are not recommended by the industry or the EPA*). Contamination monitors should also be considered where there is a possibility that a source capsule can become ruptured.

No testing is allowed unless all relevant authorisations (licences, permission from the land owner to access land for testing, etc) ***are to be obtained in writing before*** the testing is to be conducted;

2.3. User Responsibilities – The University Requirements

All users of soil density and moisture gauges shall:

(a) have a BRSC approval number for the project use of this equipment;

(b) hold a current radiation user's licence issued by the EPA (NSW), or hold a written exemption issued by an the RSO or BRSC;

(c) acquaint themselves with and obey all notices and all instructions issued to them for the safe use of these devices;

(d) refrain from careless or reckless practice or action likely to result in a radiation hazard to themselves or others;

(e) wear an appropriate personal monitoring device at all times when these instruments are in use or transporting equipment to pace of testing;

(f) not interfere with, remove, alter, damage or render ineffective any soil density and moisture gauge or radiation protective equipment provided;

(g) comply with any method or working procedure adopted to reduce radiation exposure;

(h) immediately report to the owner any difficulties with working procedures or defects in equipment which may have caused or are likely to cause a radiation hazard; and

(i) complete moisture gauge usage log records whenever the gauges are used, and store these log records together in a folder (close to the stored gauges) so that they are available for future radiation audits.

3. GUIDELINES FOR THE SAFE USE OF SOIL MOISTURE GAUGES

Only the Radiation Management Licence Holder (or their delegate) can purchase and possess such sealed source items. Therefore the requirement is that all ownership and use of such items is approved through the set University procedures. An important part of these procedures is having a path of disposal organised before the purchase of these items.

The following Procedures are in addition to any other requirements that are already listed in this Radiation Management Plan.

The following is based on the relevant sections of *Safety Guide: Portable Density/Moisture Gauges Containing Radioactive Sources, Radiation Protection Series No. 5 (May 2004)*.

3.1. Working Rules based on ARPANSA RPS 5

(a) All operators/users of the gauge are to be registered with the WHS Unit and are to be personally monitored with a Neutron Type TLD and possibly a standard TLD (both these dosimeters are to be a regulatory authority approved service):

i) the TLD is to be worn at the belt level
ii) The control monitor is not to be kept near the gauge at any time.

(b) The expected radiation levels around each portable density/moisture gauge are to be such that the dose received by the operator is kept at less than 60% of the annual dose limit for the occupationally exposed personand the dose rate 1 metre from the gauge should be no greater than the following:

i) When the source(s) is/are in the shielded position, the radiation levels from the gauge must not result in an ambient dose equivalent rate or directional dose equivalent rate, as appropriate, exceeding:
- 250 µSv/h at any point 0.05m from the gauge surface, and
- 10 µSv/h at any point 1m from the gauge surface.

(c) The gauge must be used as per the instruction manual (or the supplier/manufacturer's recommendations), safe methods for the use of the gauge are to be employed at all times. No more than 3 people are to involved in the direct use of the gauge at any time, all other persons are to be at least 3 metres from the instrument

(d) From (b) above the method(s) for conducting the survey, and any other safety tests are to be documented

(e) When not in use the gauge is to be housed in a secure and shielded storage facility that has

been approved by the S&W and RSO and this facility shall have the appropriate warning signs, and have a dose rate of less than 5 μSv/h at the surface of the facility;

(f) When soil testing is being conducted, no-one other than those directly operating the unit will be allowed within 3 m of the site. The use of appropriate signs such as the example in Annex A are to be displayed at the four compass points of the testing site. An individual from the testing team will be appointed as the site supervisor, so as to maintain safe distance, the appropriate use of signs and equipment as well as all safety records;

(g) Emergency Procedures approved by the S&W and an emergency kit kept near (but not with) the gauge at all times. **NOTE**: **Emergency kit** consists of: Portable neutron and radiation monitor/instrument; cones/poles and tape to demark the crisis area; communication device (mobile phone, radio, etc); and appropriate tools and utensils to deal with most envisaged situations.

(h) Unless in use, the gauge is to be kept in its transport packaging.

(i) All relevant authorisations (licences, permission to access land for testing, etc) are to be obtained in writing before the testing is to be conducted;

(j) During transport (see 3.6 below), and when in the field but not being used, the gauge is to be transported in its packaging as far from the driver and passengers as possible (preferably in the boot of the vehicle). The unit is to be secured within the vehicle to prevent theft and loss, and the source(s) kept locked in the shielded position when the unit is not in use. The unit is not to be left unsecured or uncontrolled at any time;

(k) The integrity of the gauge is to be maintained by regular servicing by an authorised service agent/company. This will also include calibration of the source on an annual or bi-annual time frame. Records of all services and calibrations are to be maintained;

(l) The emergency contacts are:

i) **Safety & Wellbeing , Ph: (02) 9852 5177,**

ii) **Campus Security After Hours, Ph 1300 737 003**

iii) **University RSO, Ph: 0415409467**

iv) **The Radiation Control Branch, EPA, Ph: 02 9995 5000 (only to be contacted by RSO or S&W)**

(m) The documentation to be maintained is as follows:

i) Storage Log Book, that is a record of the time the gauge is in the storage facility

ii) User/Use Log Book, that is a record of all use or display of the unit, when, where and by whom

iii) Service, Repair and Calibration Log Book

iv) Instrument Accident/Incident Records

3.2. Emergency Procedures

Written emergency procedures are to be developed and kept with the gauge at all times. Users of the gauge are to be familiar with the emergency procedures. The manufacturer's instructions should always be the first source of information for the development of these procedures.

(j) Storage of Gauges

When not in use, the gauge should be locked in its transport case.

(a) As far as practicable and taking into account the ALARA principle;

(b) portable density/soil moisture gauges should not be stored near regularly occupied or frequented areas;

(c) The dose rate at the surface of the storage facility is to be less than 5 μSv/hr if only occupationally exposed persons have access, or less than 0.5μSv/hr if accessible by the general public;

(d) Furthermore, portable density/soil moisture gauges should not be stored in the same storage area as dangerous goods of the following Dangerous Goods Classes:

1 Explosives
2.1 Flammable gas
3 Flammable liquid
4.1 Flammable solid
4.2 Spontaneously combustible
4.3 Dangerous when wet
5.1 Oxidising agent
5.2 Organic peroxide
8 Corrosive

The name and contact details of the University Work Health and Safety Unit, or other relevant person, should be placed on the store in a conspicuous location.

3.3. Transport of Gauges

(a) While in a vehicle, the case must not be visible to a passer-by

(b) The container cannot be transported in the passenger compartment

(c) When transported on roads, the gauge shall be locked in its original carry case/transport container

(d) The container shall be locked

(e) The container shall be fixed in location within the vehicle with the shutter mechanism facing away from the vehicle occupants or facing downwards

(f) The unit must be secured in such a fashion that theft is very difficult and loss from the vehicle during transport is not possible.

Gauges will not be transported with incompatible classes of dangerous goods unless written approval has been obtained from S&W.

The gauge cannot be transported across State borders without prior written approval from the S&W and the relevant regulatory authorities.

4. DOCUMENTATION

Storage Log Book, that is a record of the time the gauge is in the storage facility
User/Use Log Book, that is a record of all use or display of the unit, when, where and by whom
Service, Repair and Calibration Log Book
Instrument Accident/Incident Records

5. AUDIT

Every 2 years

6. REFERENCES

ARPANSA. CODE OF PRACTICE & SAFETY GUIDE: Portable Density/Moisture Gauges Containing Radioactive Sources (2004) Radiation Protection Series Publication No. 5

7. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Nov 2014	draft	William Bartolo, Bartolo Safety Management Service
Jan 015	Draft 2	K Ambrose, T Millar & W Bartolo
Jun 2015	Draft 3	K Ambrose, T Millar & W Bartolo
Dec 2016	Draft 5	K Ambrose, T Millar & W Bartolo
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Oct., 2018	Revision 7	K Ambrose, T Millar & W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

APPENDIX 16.1:

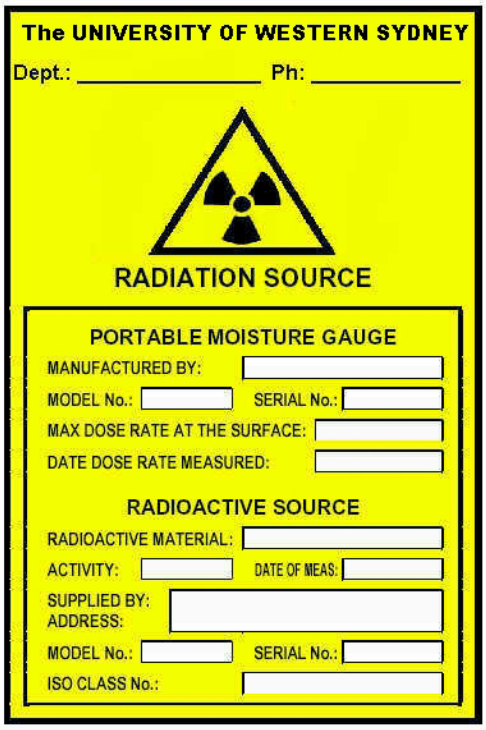
Radiation warning signs and labels

Radiation warning signs and labels, must conform to AS 1319 - 1994 *Safety signs for the occupational environment*, and AS 2342 - 1992 *Development, testing and implementation of information and safety symbols and symbolic signs*. Examples of suitable warning signs and labels are given below.

Colours for radiation warning signs and labels
Background: yellow
Marking and trefoil: black

EXAMPLE OF A SUITABLE WARNING SIGN FOR POSTING IN THE AREA ADJACENT TO PORTABLE DENSITY/SOIL MOISTURE GAUGE WHEN IN USE (55 x 22cm min size)

EXAMPLE OF A SUITABLE WARNING LABEL FOR ATTACHMENT TO A PORTABLE DENSITY/SOIL MOISTURE GAUGE CONTAINING A RADIOACTIVE SOURCE



The information included on this label should reflect the gauge's use (e.g. density only, moisture only (version depicted above) or combination) and its total radioactive contents (e.g. caesium only, ^{241}Am/Be only or both).

(NOTE: the lower part of this label may be unpainted metal with black lettering).

EXAMPLE OF A SUITABLE WARNING LABEL FOR DISPLAY ON A RADIATION STORE

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Handling, investigation and reporting of radiation incidents
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S17
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, incident, emergency, accident
SUMMARY *Brief summary of the contents of the document*	Procedures for the handling, investigation and reporting of radiation incidents

INDEX – Section 17

1. BACKGROUND

It is a legal requirement to report radiation incidents to the EPA if they meet the requirements outlined in point 1.2 of this document.

NOTE: Radiation incident – an unplanned or unexpected emission of radiation (including spillage or leakage of a radioactive substance or damage to radiation apparatus), or misuse of radiation apparatus or maladministration of a radioactive substance used for therapeutic or diagnostic purposes.

1.1 Possible types of incidents

Incidents can occur that result in one or more of the following events:

- Radiation exposure of a member of staff, student or visitor
- Incorrect radiation exposure of a volunteer
- Radioactive contamination of one or more persons and/or the environment
- Loss of a radioactive source (including suspected theft).
- Near misses are also included in this process in order to mitigate future radiation accidents.

1.2 Definitions of a radiation incident in the NSW Protection from Harmful Radiation Regulation 2025

The legislative definition of a radiation accident, now defined as an incident, as per the NSW Protection from Harmful Radiation Regulation 2025 is as follows:

Division 4 Radiation incidents—the Act, s 40(2)(a), (3)(h) and (3A)

56 Certain incidents taken to be radiation incidents

(1) For this regulation, a ***radiation incident*** is taken to have occurred if—

(a) there is an unplanned or unexpected emission of, or exposure to a person of, radiation, including as a result of—

(i) the spillage or leakage of a radioactive substance, or

(ii) damage to, or the malfunctioning of, an ionising radiation apparatus or sealed source device, and

(b) it is likely that—

(i) one or more persons have, or could have, received an effective dose of radiation of at least—

(A) for an occupationally exposed person—5 mSv, or

(B) otherwise—1 mSv, or

(ii) the premises or the environment may have become contaminated within the meaning of the Act, section 21(4).

(2) A radiation **incident** is also taken to have occurred if the use of a radioactive substance, ionising radiation apparatus or sealed source device for medical

purposes results in one or more of the following—

(a) the administration of a radioactive substance for diagnostic purposes at an activity that exceeds the activity prescribed by 50% or more,

(b) the administration of a radioactive substance for therapeutic purposes at an activity differing by 15% or more from the activity prescribed,

(c) the administration of radiation from an ionising radiation apparatus or a sealed source device for therapeutic purposes which differs from the total prescribed treatment dose by more than 10%,

(d) the administration of radiation from an ionising radiation apparatus for diagnostic purposes, other than in the course of delivering radiation therapy, in a quantity—

(i) of 50% or more of the initial intended dose, and

(ii) that results in a person receiving an effective dose of radiation of at least 1 mSv,

(e) the administration of radiation—

(i) to the wrong person or to the wrong part of a person's body, and

(ii) that results in a person receiving an effective dose of radiation of at least 1 mSv,

(f) the administration of a radiopharmaceutical—

(i) otherwise than as prescribed, and

(ii) that results in a person receiving an effective dose of radiation of at least 1 mSv,

(g) the administration of radiation for diagnostic or interventional purposes resulting in an unanticipated or unexpected observable acute radiation effect,

(h) the unplanned exposure of an embryo or foetus to radiation that results in the embryo or foetus receiving an absorbed dose of radiation of at least 1 mGy.

(3) In this section—

absorbed dose has the same meaning as in the 2007 ICRP recommendations

2. RESPONSIBILITIES

2.1. The Radiation Management Licence Holder

It is the ultimate responsibility of the RML holder to ensure that accidents and incidents are investigated and reported, and that all using radiation are fully trained and are cognisant of their responsibilities.

The RML holder has delegated this task to the WHS Unit and the BRSC.

2.2. The TRTS Technical Coordinator/Leader or Facility Manager

TRTS Technical Coordinator/Leader or Facility Manager

must ensure that any person using the facility has had training regarding a radiation accident and has demonstrated competency for the local conditions regarding possible incidents..

2.3. The Radiation User Licence Holder

The Radiation User Licence holder must follow the procedures detailed below, report the incident as soon as practicable and provide information to authorised officers (the University and/ or EPA) investigation the incident.

2.4. The Radiation Safety Officer

The RSO will assist in the response to the incident and will be responsible for ensuring that the incident and details of the radiation levels/exposures are reported to the RML Holder via the S&W Director

2.5. The Safety & Wellbeing Director

The WHS Unit Manager will be responsible for reporting all incidents to the Radiation Management Licence Holder and to the EPA, if required.

3. PROCEDURE

3.1. Immediately following an incident or accident

(a) Any person becoming aware of an incident or accident shall immediately:

i). Take steps to minimise further contamination, if safe to do so,

ii). Inform all people in the laboratory

iii). Inform the technical manager

iv). Inform the chief investigator

v). Inform the WHS Unit

(b) All persons not involved with the accident/incident should move to the designated assembly point.

(c) Persons suspected of being contaminated by radioactive material are not to leave the facility but are to move away from the site of contamination. If there is a risk of injury from fire, gas release or toxic materials (other than radiation), then the area is to be evacuated with those contaminated being isolated away from the site.

(d) If it is obvious that first aid is required, contact a first-aid officer.

(e) If it is an emergency dial 000

3.2 Typical protocol for Decontamination of Persons

The Designated Area Safety Coordinator must be involved in the following.

NONE OF THE FOLLOWING IS TO OCCUR WITHOUT FIRST CONSULTING THE RSO IF AVAILABLE.

Any obvious injuries should be treated immediately, taking care to avoid the spread

of contamination to wounds, eyes, nostrils or mouth.

Contaminated clothing should be removed and a contamination survey of the person should be performed. Personal decontamination should be undertaken according to the area(s) of the body contaminated, as follows:

(a) eyes should be irrigated with saline solution (a 0.9 % sodium chloride solution), or with distilled or mains water;

(b) hands should be washed with tepid water and mild soap or handwash solution (preferably neutral pH). If this is inadequate, repeat once or twice. Contaminated fingernails may be scrubbed lightly with a soft nail brush. For contamination that is difficult to remove, disposal rubber gloves may be worn for several hours to promote perspiration of the hands, which may assists in removing of contamination while preventing its spread to other surfaces;

(c) skin, other than that of the hands, should be swabbed gently with a cotton wool pad soaked in a mild soap or handwash solution (preferably neutral pH) and rinsed well. Do not vigorously scrub the skin or use detergents as this may affect the natural skin barrier and increase the risk of internal contamination;

(d) contaminated wounds should be washed under a fast running tap. If the wound is on the face, care should be taken not to contaminate the eyes, mouth or nostrils. Finally a gentle antiseptic and a waterproof dressing applied; and

(e) attempts to remove all contamination from skin may not be feasible or desirable. Some radioactivity may be trapped in the outermost layers and will remain until normal sloughing occurs (12-15 days). Personal decontamination should be continued until monitoring shows that less than 10% of the residual contamination is removed at each cycle, unless there is the risk of the contamination entering the bloodstream through the roughening or breaking of the skin.

3.3 Decontamination of surfaces or contaminated equipment

Consultation with the RSO is a necessary requirement before any decontamination is conducted.

See RMP Section 6 Radiation Safety and Monitoring in Laboratories, paragraph 4.1 for spill procedures.

3.4 Investigation and Reporting Requirements

All incidents should be investigated, including ‘near misses’, to minimise the likelihood of such incidents occurring again. The investigation should be aimed at:

(a) establishing what happened;

(b) identifying the failure;

(c) deciding on remedial action to minimise the chance of a similar failure; and

(d) estimating the likely radiation doses received by staff, student and/or member of the public.

3.4.1 All incidents including 'near misses', will be investigated by the RSO together with the TRTS Team Leader/Coordinator/Facility Manager and the chief investigator an incident report form (radiation) filled in and sent to the S&W within 24 hours of the incident. This form includes:

i). date, time and place of the incident and the period during which emission of radiation was uncontrolled;

ii). a description of the incident including particulars of the area over which any radioactive substances may have been dispersed;

iii). particulars of any steps taken at the time of the incident to rectify the accident;

iv). names, addresses, contact details of persons involved including witnesses

v). details of any injuries ; and

vi). estimation of the likely radiation doses received by staff, student and/or member of the public.

3.4.2 Any person accidentally irradiated must be informed by the S&W (through interpretation services if required) of the event in writing (includes electronically) and their likely exposure. Medical advice and independent counselling as to the likely implications of the unintended exposure will be offered.

3.4.3 The chief investigator in consultation with the S&W shall review the radiation safety processes and shall update the current risk assessment, control procedures, and document and organise additional training for staff or students to minimise the likelihood of a repeat of the incident.

3.4.4 The S&W will send a copy of the incident report to the chair of the BRSC to be evaluated executively and tabled at the next BRSC meeting.

3.4.5 The S&W Unit shall submit the incident report to EPA for addition to the National Register of Radiation Incidents.

3.4.6 The chief investigator will send to the BRSC any updated risk assessments, additional control procedures, and any additional training for staff or students as proposed amendments to their BRSC application for approval.

3.4.7 **Certain radiation incidents must be reported to the EPA**. The S&W in consultation with the RSO, shall decide whether a particular accident/event is classed as an incident and must be reported.

If a report to EPA is required:

i). The EPA shall be notified by the RML Holder or his delegate in writing within forty-eight hours of a radiation accident occurring. This is most easily achieved by sending an email to radiation@environment.nsw.gov.au.

ii). A copy of this notification must be sent to the RML holder.

The Faculty Dean/Director, S&W Director and the Radiation Management Licence Holder shall be notified immediately if the incident involves an injury or illness to workers to ensure appropriate Workers Compensation processes being taken in timely manner. The Safe Work NSW shall be notified within 24hrs by S&W Director if a radiation accident causes a fatality, serious injury or illness to workers or was immediately life threatening but without fatality or serious injury.

3.4.8 If an accident has been notified to EPA, a full report must be prepared for the EPA, following the accident investigation, which includes the following requirements (Section 57 of the Regulation):

- particulars of the accident, indicating, as far as possible, the place where it occurred and the period during which emission of radiation was uncontrolled;
- particulars of the area over which any radioactive substances may have been dispersed;
- particulars of any steps taken to rectify the incident;
- particulars of any personal injury or exposure that may have resulted;
- particulars of any assessment of the radiation dose to which any person may have been exposed as a result of the incident; and
- particulars of all measures put in place to prevent a recurrence of the accident.

This report must be sent to EPA within 10 days of the incident and a copy of this report must be provided to the Radiation Management Licence Holder, S&W Director, RSO and the Dean/Faculty/School Manager/Facility Director.

4 CONTACT DETAILS OF THE S&W UNIT AND THE RSO

		After Hours
the S&W Unit (Manager)	9852 5177	1300 737 003
the S&W Unit	9852 5176	1300 737 003
University RSO	0415409467	1300 737 003

The EPA Radiation control branch should only be contacted following consultation with the RSO.

EPA Radiation Control Branch	131 555

5 DOCUMENTATION

University Radiation Accident/Incident form

6 AUDIT

All Radiation incident reports are to be tabled and discussed at the BRSC
Every 2 years for a full audit of records

7 REFERENCES

NSW EPA Protection from Harmful Radiation Regulation 2025

8 REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Nov 2014	Draft	William Bartolo, Bartolo Safety Management Service
Dec 2014	Revised Draft	K Ambrose, T Millar and W Bartolo
Mar 2015	Draft 3	K Ambrose, T Millar and W Bartolo
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Apr 2017	Revision 6	K Ambrose, T Millar and W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Radiation Safety Training
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S18
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation Safety Training
SUMMARY *Brief summary of the contents of the document*	Requirements for training to ensure radiation safety at the University.

INDEX – Section 18

1. BACKGROUND

It is legal requirement that all individuals working with radioactive material are appropriately licenced and trained by an approved or accredited radiation safety trainer. The training records must be kept and maintain by S&W on behalf of the RML. Training is also required for those who are granted licence exemptions.

The University uses radiation for research, scientific and teaching purposes. **All personnel involved with such activities must** have the appropriate training and ensure that:

(a) radiation training is current

(b) users have an understanding of the radiation that they are dealing with

(c) users have an understanding of record keeping procedures

(d) users have appropriate knowledge for handling, storage and disposal of radiation material (radioisotope, radiation source)

(e) exposure to radiation is mitigated

(f) users have an understanding of their responsibility regarding radiation to the University and the wider community

(g) users have appropriate knowledge to respond to an emergency.

2. RESPONSIBILITIES

2.1. The Radiation Management Licence Holder and the Safety &Wellbeing

Ensure that training occurs and that records of training are kept including copies of certificates issued to individuals.

2.2. Team Leaders/Coordinator and Facility Manager Faculty/School/Institute or Facility

Team Leaders/Coordinator and Facility Managers will ensure that all staff, students contractors, visitors entering radiation facilities, for whom they are responsible have appropriate training, professional qualifications and/or accreditations as required by their involvement in the radiation project before entering the facilities.

2.3. Chief investigator and/or user licence holder

Is responsible for ensuring that

- all radiation workers (and exempted students) identified on their approved project have the appropriate training, professional qualifications and/or accreditations
- all records of radiation use are maintained and kept

2.4. The radiation worker, exempted students, and contractors

Will ensure that they:

- Have the appropriate training, qualifications, accreditations, or licences to allow them to work safely within the designated radiation situation;

- are familiar with and comply with all local guidelines related to safe use, storage and disposal of their particular isotope and equipment in their facility;
- maintain and keep records of their radiation use.

2.5. Safety & Wellbeing and the Radiation Safety Officer

The WHS unit and the radiation safety officer will oversee and provide advice on radiation training for all personnel as required.

Note: legislation implies that training must be updated on a regular basis (5 year periods).

3. PROCEDURE

3.1. Radiation training for staff and students involved in the use of radiation

Chief investigator or equivalent will contact the:

- the Safety & Wellbeing to discuss training requirements for radiation usage.
- Facility manager to discuss training requirements for the specific facility usage

Note: A typical radiation safety training program includes:

- An outline of radiation physics basics
- Radiation interaction
- Detection and measurement
- Legal/ICRP dose limits
- The legal units
- Unsealed Source safety (if appropriate)
- Laboratory safety
- Sealed and X-ray analysis equipment safety (if appropriate)
- Current legal requirements.
- Record keeping and maintenance

Once radiation training is satisfactorily completed, the participant should receive appropriate certificate of completion which must be kept by chief investigator and facilities' manager where radiation work is performed. The individual also shall supply a copy of their certificate to the Safety & Wellbeing.

Note: Certificates typically include:

- the name of the individual
- type of training
- date
- level of achievement of the individual.
- A unique certificate number

Note: If applying for a user licence from the NSW Authority, do not send the original certificate (send a certified photocopy), as no material included in the application is returned to the applicant.

4. DOCUMENTATION

Records of staff training to be kept by the trained individual, chief investigator, facility manager and Safety & Wellbeing.
Local department induction training specific to particular equipment and local business rules to be documented and stored with review dates noted.

5. AUDIT

Every 2 years

6. REFERENCES

ICRP 2000a. *Avoidance of radiation injuries from medical interventional procedures*, ICRP Publication 85, Annals of the ICRP, 30 (2).

Wagner LK and Archer BR 2000. *Minimising risks from fluoroscopic X-rays*, 3rd Edition, Partners in Radiation Management, Woodlands, Texas.

ICRP 2000c. *Managing patient dose in computed tomography*, ICRP Publication 87, Annals of the ICRP, 30 (4).

ICRP 2007. *Managing patient dose in multi-detector computed tomography (MDCT)*, ICRP Publication 102, Annals of the ICRP, 37 (1).

NSW Government Protection from Harmful Radiation Regulation 2025

7. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Jan 2015	Draft	William Bartolo, Bartolo Safety Management Service
Jun 2015	Draft 3	K Ambrose, T Millar and W Bartolo
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Apr 2017	Revision 6	K Ambrose, T Millar and W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

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RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	**Radiation Safety Records**
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S19
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REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, ionising radiation, X-rays, radioactive substances, records
SUMMARY *Brief summary of the contents of the document*	Procedures to ensure that all records relating to radiation safety are maintained in compliance with the appropriate legislation

INDEX – Section 19

1. BACKGROUND

This procedure will list the legally mandated recordkeeping requirements with regard to radiation safety.

The storage of records, including records of staff occupational exposure:

- Records referred to in Points 3.1 – 3.6, 3.8 - 3.12, and 3.14 must be kept until such time as the Director-General of the EPA gives consent to dispose of them.
- All records referred to in Points 3.6, 3.8 – 3.10 must be kept at the site of the registered device, apparatus or premises for a period of 6 years after the event requiring documentation. Once a project is completed, the records are required to be transferred to the Safety & Wellbeing for archiving and keeping centrally for the University and the RML Holder.

2. RESPONSIBILITIES

2.1. Faculty/School/Facility Manager/Institute Director using radiation

The **Faculty/School/Facility Manager/Institute Director** will ensure that the following records are kept and maintained (those listed in points i). -ix). are required to have a copy forwarded to the University Safety & Wellbeing team every 6 months). The copy of the updated inventory with marked changes must be sent by email to Safety & Wellbeing team. If there has not been change since the last submission confirmation of no change to records must be sent by email to Safety & Wellbeing team

i). Register of User Licences

ii). Register of Student Exemptions

iii). Register of Personal Monitoring (sent to S&W when received)

iv). Inventory of Unsealed Sources

v). Inventory of Sealed Sources

vi). Inventory of X-ray equipment (all equipment that has an X-ray tube or X-ray capability)

vii). Register of Radioactive Waste

viii). Register of Portable and Non-portable radiation monitors and detectors

ix). Radiation Accident/Incident Reports **(**reported using University's reporting system within 12 h of occurrence)**)**

x). Register of Facilities (laboratories, radiation stores, etc)

xi). Record of use of facilities

xii). Record of Contamination and Area Monitoring

xiii). Register of Ionising Equipment Repairs, Calibrations and Certifications

xiv). Register of Clinical Equipment QA tests

xv). Register of Monitor and Detector repairs and calibrations

xvi). Register of Projects and Teaching involving Radiation including Approval Numbers (this is maintained by Research Engagement, Development and Innovation)

xvii). Register of Facilities Inspections

2.2. User Licence Holders

User Licence Holders are to keep and maintain all records regarding the usage, storage, waste, equipment maintenance, purchase, disposal, monitoring of radiation or radiation equipment associated with their project. They should be in accordance with the above list.

3. RECORDKEEPING

3.1. Register of User Licences

This register is to contain the following details:

(a) Name of the licencee

(b) Licence number

(c) Active/expired/terminated

(d) Date of expiration

(e) Licence details

(f) Radiation Safety Training Details

3.2. Register of Exemptions

This register is to contain the following details:

(a) Date of Issue of Exemption

(b) Name of Exempted Person

(c) Student details (Full student name, Student number, Course, Approved project number)

(d) Location of use of radiation

(e) Radiation details

(f) Name of User Licencee who is granting exemption and has the legal authority to do so and licence number

(g) Name of radiation supervisor who has the authority to supervise and licence number

(h) Copy of the written exemption for each person

3.3. Register of Personal Monitoring

Personal monitoring records for each person issued with a dosimeter must be kept and maintained. The record must contain the particulars from the Protection from Harmful Radiation Regulation 2025. The details are:

(a) the full name, sex and date of birth of the occupationally exposed person,

(b) the current home address of the occupationally exposed person or, if the person is no longer employed by the employer, the person's last known home address,

(c) the date of commencement of employment (and, if applicable, the date of cessation of employment) as an occupationally exposed person,

(d) the kind of work performed by the occupationally exposed person,

(e) details of the types of ionising radiation to which the occupationally exposed person may have been exposed in the course of employment with the employer, including information about radioactive substances in unsealed form (if any) to which the occupationally exposed person may have been exposed,

(f) details of any radiation accidents in which the person has been involved or by which the person may have been affected,

(g) details of the personal monitoring device worn by the occupationally exposed person, and

(h) the results of monitoring the levels of radiation exposure of the occupationally exposed person which will include date, type(s) of radiation, badge result, lifetime result and 5 year rolling average.

3.4. Inventory of radioactive sources and radiation apparatus

A documented inventory of all radioactive sources, substances and radiation apparatus must be kept and up to date. The specific requirements for the Unsealed and Sealed Source inventory are:

(a) Location and records of transfer of location including date of transfer

(b) Date of receipt

(c) Calibration date

(d) Sealed Source ID Number

(e) Isotope

(f) Chemical form and concentration

(g) Total activity

(h) Specific activity

(i) Date completely used or exhausted

The specific requirements for the ionising equipment inventory are:

(a) Date of receipt

(b) Calibration date and date of certification if clinical

(c) Registration number

(d) Equipment, equipment type, brand, model, serial number

(e) Location

(f) Date disposed, decommissioned or traded

3.5. Register of Radioactive Waste

The register is to contain sufficient detail so that University RSO and the WHS Unit can ascertain the ability of disposal. The details required are:

(a) Location and records of transfer of location including date of transfer

(b) Date of becoming waste

(c) Isotope(s)

(d) Concentration and details mixture

(e) Specific activity or total activity

(f) Chemical form (solid or liquid, chemical details)

(g) Signature of user of the material being declared as waste

3.6. Register of Facilities

All facilities (designated radiation areas, laboratories, radiation stores and radioactive waste stores) once inspected by the University RSO and the WHS Unit and certified will require a record of these facilities. This record will contain the following information:

(a) Type of facility

(b) Date of inspection and certification

(c) Date of annual inspection

(d) Registration number

(e) Location (includes site and room number)

3.7. Log of Facility Use

Each facility will have a book recording the use of that facility. The following details (as is relevant) will be recorded for each use:

(a) Date

(b) Time
(c) User(s)
(d) Purpose of use
(e) Isotope(s)
(f) Contamination and cleanup
(g) Signature

3.8. Record of Contamination and Area Monitoring

For radioisotope laboratories and facilities it is a legal requirement that contamination monitoring is conducted on a weekly basis. Area monitoring as is required and is usually expected to be at least once during a procedure. The following details are to be recorded:

(a) Location
(b) Date and time
(c) Name of person(s) doing the monitoring
(d) Contamination and area monitoring results
(e) Isotopes used at the time or are being tested for
(f) Decontamination required (Y/N)
(g) Signature of person doing monitoring

3.9. Register of Ionising Equipment Repairs, Calibrations and Certifications

It is a legal requirement that there is a documented record of all repairs, calibrations and certifications (where necessary for clinical use and registration). The information required will depend on the equipment, eg for clinical equipment as is detailed in NSW Guideline 6.

3.10. Register of Clinical Equipment QA tests

Records required are stipulated by the Code for Radiation Protection in Medical Exposure (ARPANSA 2019) or legislation. This will be a summary of all QA tests that are done for each item of equipment.

3.11. Register of Portable and Non-portable radiation monitors and detectors

Each School/Department/Centre must keep a record of their radiation monitors and detectors. This record will contain the following information:

(a) Location and records of transfer of location including date of transfer
(b) Date of purchase
(c) Instrument type, brand, model and serial number, and if allocated, the asset number.

3.12. Register of Monitor and Detector repairs and calibrations

This record could be combined with the previous register and would contain in addition to the above the following details:

(a) Location

(b) Instrument details

(c) Repair details (problem, symptom)

(d) Repaired by

(e) Calibration details

(f) Calibration results

(g) Signature

3.13. Register of Projects and Teaching involving Radiation including Approval Numbers

All work (research and teaching) in a School/Centre that involves radiation must be recorded for local information. The details to be recorded are:

(a) Dates of approval period

(b) BRSC record/approval number

(c) Project or teaching details

(d) Chief investigator

3.14. Record of Radiation Accident and Incidents

It is a legal requirement that there is a central record of all accidents and incidents that involve radiation. There needs to be a record both at the site/School and the WHS Unit. The legal minimum to be recorded is the following:

(a) particulars of the accident or incident, including where it occurred and the period during which there may have been uncontrolled emission

(b) names of any persons witnessing the event, or who may have been exposed

(c) an estimate of any potential exposure doses

(d) details of any medical examinations

(e) particulars of the area over which any radiation may have been dispersed

(f) the time at which the accident/incident was reported

(g) the probable cause of the accident

(h) particulars of the subsequent investigation/s

(i) the steps taken to minimise reoccurrence of a similar accident

At the local level (School, etc) points a), b), e), f), and g) are to be recorded.

3.15. Register of Facilities Inspections

In addition to the central record of inspections, each School, etc is to keep a simple register of inspections that may include:

(a) Date of inspection

(b) Type of inspection

(c) Name of the person conducting inspection

(d) Any necessary actions to be immediately addressed

4. DOCUMENTATION

The above records

5. AUDIT

Every 2 years

6. REFERENCES

Code for Radiation Protection in Medical Exposure (ARPANSA 2019)

NSW Protection from Harmful Radiation Regulation 2025

7. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Sept 2014	Draft	William Bartolo, Bartolo Safety Management Service
Dec 2014	Revised Draft	K Ambrose, T Millar, W Bartolo
Mar 2016	Revised Draft	
Mar 2016	Draft 4	K Ambrose, T Millar, W Bartolo
Dec 2016	Draft 5	K Ambrose, T Millar, W Bartolo
Apr 2017	Revision 6	K Ambrose, T Millar, W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	**Transport of Radioactive Substances**
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP – S20
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, transport, radiation, radioactive, dangerous goods.
SUMMARY *Brief summary of the contents of the document*	Procedures for the safe transport of radioactive substances.

INDEX – Section 20

1. BACKGROUND

As required by the Protection from Harmful Radiation Regulation 2025 (NSW) any transport of radioactive materials between, laboratories, hospitals, academic institutions, and other research establishments must be done according to safety standard and rules given by the Code of Practice for the Safe Transport of Radioactive Material; Radiation Protection Series No. C - 2 (RPS C-2) (2019),

The ARPANSA Safety Guide (SSG-26 & SSG-33) for the Safe Transport of Radioactive Material provides specific guidance on achieving the requirements set out in the Code of Practice by providing specific safety instructions for consignors, carriers and recipients; and providing information on minimising any radiation consequences in the event of a transport accident.

2. RESPONSIBILITIES

2.1. Responsible Person – Radiation Management Licence Holder

The Deputy Vice Chancellor – Research (RML Holder) is responsible to ensure that:

- all transport of radioactive material is done safely and according to legislation.
- Radioactive material is only transported with his/her authority

2.2. Safety & Wellbeing team

Safety & Wellbeing will be responsible for maintaining a record of transport of radioactive material associated with WSU between suppliers, institutions and facilities.

2.3. Radiation Safety Officer

The RSO is responsible for giving advice to all parties on the requirements for safe transport of radioactive materials.

2.4. The Consignor

The person initiating the transport of radioactive material (the consignor) is responsible for compliance with the current ARPANSA Code of Practice for the Safe Transport of Radioactive Material (RPS C-2).

2.5. Radiation User Licence Holder

The person that may have requested the materials or be transporting the materials as part of approved research or teaching project.

3. PROCEDURE FOR TRANSPORT BY ROAD

NOTE: The requirements for the safe transport of neutron gauges are included in Section 16 - Safety with Neutron Gauges.

WSU will adopt the transport guideline developed by NSW HURSOG for their members use. The following is the complete document.

In these guidelines, the words "*shall*", "*should*" and "*must*" have the following meanings associated with them:
shall – mandatory legal compliance, *should* – advisable, but not mandatory, *must* – although not legally mandatory, it is expected.

INTRODUCTION

The Code of Practice specifies a classification of "Excepted Packages". Packages in this classification

GUIDELINES FOR THE TRANSPORT OF RADIOACTIVE MATERIALS
BY ROAD BETWEEN HOSPITALS, UNIVERSITIES, RESEARCH AND OTHER MEDICAL ESTABLISHMENTS IN NSW

are exempt from many of the stringent requirements which otherwise must be followed.

If a package does not meet the "Excepted Packages" classification, then it must be transported as a "Type A" or "Type B" package (refer to Radiation Protection Series No. C - 2 (RPS C-2) for details of packaging classification).Transport of packages type A and B must meet various requirements as given by RPS C-2, therefore it is recommended that if a type A or type B package has to be transported the advice from University's RSO Radiation Safety Officer is obtained. Alternatively, Radiation Control Section of the NSW EPA should be contacted for directions.

The University's transport vehicle may be used to transport the package provided the driver is licenced (where required) and has been instructed in how to handle and secure the package in the vehicle and in the actions to be taken in case of an accident or an emergency. Written instructions must also be provided (see the kit in Appendix 20.2) Necessary placarding can be made as per figure 20.1 of Appendix 20.1 at the end of this document. The emergency procedure and kit must be in place as per Appendix 20.2 of this document,

Packages with activities lower than those given in the "Exempt Activity" column, of Table 1 in Appendix 20.1 are exempt from regulations. In NSW the "Activity" exempt from regulation is the "Prescribed Activity" of Schedule 1 of the NSW Protection from Harmful Radiation Regulation 2025 and is listed in brackets in the same column of Table 1 in Appendix 20.1. For compliance throughout Australia, the lower of the 2 values should be used.

Appendix 20.1 contains relevant extracts from the Transport Code of Practice.

Appendix 20.2 is a kit that may be used in conjunction with the Guidelines.

4. INSTRUCTIONS FOR THE TRANSPORT OF ALL PACKAGES

4.1. Sender

(a) All transportation of radioactive material must be approved in writing by the Safety & Wellbeing prior to transport.

(b) The material must be packaged appropriately:

i). A liquid must be contained in a sealed **labelled** vial.

ii). The vial or other source must be placed in a labelled shielded (lead etc) container with sufficient liquid absorber. The container will have a close fitting lid and be taped closed.

iii). The shielded container will be placed in a secondary sealable container, packed well with cushioning material, and be labelled radioactive and have a label with the name and activity of the compound, and the date.

iv). The sealed container will be placed within an outer transport box with cushioning material to prevent movement within the box. Seal and label the box.

v). The surface dose rate will be measured and recorded. Possible surface contamination must be checked by a wipe test.

vi). Determine whether the package can be classified as an "**Excepted Package**". See section 5 for excepted packages and Section 6 for non-excepted packages.

(c) Fill in the "**Dangerous Goods Declaration Form**".

(d) Label the package with the name and address of addressee. The package must also bear the sender's name and address.

4.2. Instructions to the person organising transport

(a) **No taxis, motorcycles, or public transport may be used to transport radioactive material.**

(b) A courier should be used to transport the package whenever possible.

(c) A University vehicle may be used to transport the package provided the driver approval from Safety & Wellbeing to transport such packages.

(d) Written instructions about emergency procedures must be in the transport vehicle (see kit Appendix 20.2).

(e) The package must be **addressed and handed to a specific licensed person** or their nominee. It must not be addressed generally to a "Department", nor delivered to some specified "area" or "front desk".

(f) The person to whom the package is to be delivered should be advised of the time of despatch and expected delivery time.

5. EXCEPTED PACKAGES

5.1. Instructions to Sender

(a) The activity must be less than the value listed in Table 1 of Appendix 20.1

(b) The radiation level at any point on the external surface must be less than 5 μSv/h.

(c) The removable radioactive contamination on any external surface must be less than 0.4 Bq/cm^2

(d) The package must bear the marking "**RADIOACTIVE**" on an internal surface in such a manner that a warning of the presence of radioactive material is visible on opening the package.

(e) The consignor shall include in the Dangerous Goods Declaration Form with each consignment, the United Nations Number **"2910"**, and for all items the proper shipping name and description of the substance or article being transported shall be included, i.e.:

"RADIOACTIVE MATERIAL, EXCEPTED PACKAGE
LIMITED QUANTITY OF MATERIAL"

5.2. Package Design

(a) The package must retain its contents under conditions likely to be encountered during routine transport.

(b) The package shall be so designed in relation to its mass, volume and shape that it can be easily and safely handled and transported. In addition, the package shall be so designed that it can be properly secured in or on the conveyance during transport.

(c) As far as practicable, the packaging shall be so designed and finished that the external surfaces are free from protruding features and can be easily decontaminated.

(d) As far as practicable, the outer layer of the package shall be so designed as to prevent the collection and the retention of water.

(e) Any features added to the package at the time of transport, which are not part of the package, shall not reduce its safety.

(f) The package shall be capable of withstanding the effects of any acceleration, vibration or vibration resonance which may arise under conditions likely to be encountered in routine transport without any deterioration in the effectiveness of the closing devices on the various receptacles or in the integrity of the package as a whole. In particular, nuts, bolts and other securing devices shall be so designed as to prevent them from becoming loose or being released unintentionally, even after repeated use.

(g) The materials of the packaging and any components or structures shall be physically and chemically compatible with each other and with the radioactive contents. Account shall be taken of their behaviour under irradiation.

(h) All valves through which the radioactive contents could otherwise escape shall be protected against unauthorised operation.

(i) For radioactive material having other dangerous properties the package design shall take into account those properties.

6. TYPE A OR TYPE B PACKAGES

(a) Type A or Type B packages must be packaged and labelled in accordance with the Code of Practice for the Safe Transport of Radioactive Material.

(b) Type A packages must not have an activity greater than A_1 (for *special form material*, eg a capsule) or A_2 (for other forms - eg liquids and gases) of the radioactive material (see Table 2 in Appendix 20.1)

(c) If a package has an activity greater than A_1 or A_2, (Table 2) it must be packaged as a Type B package.

6.1. Placards

At least three placards (see figure 20.1 in appendix 20.1) must be displayed on the vehicle.

6.2. Category Labels

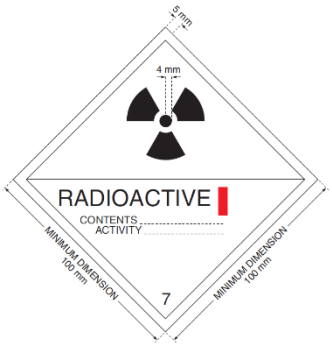
Type A packages have category labels attached to two opposite sides. The label to be used depends on the radiation dose rate at the surface and the transport index. The transport index is the maximum radiation dose rate at any point 1 metre from the surface of the package in μSv/h, divided by 10 and then rounded up to one decimal place.

Transport index	Maximum radiation level Category at any point on external surface	Category
0[a]	Not more than 5 μSv/h	I-WHITE
More that 0 but not more than 1	More than 5 μSv/h but not more than 500 μSv/h	II-YELLOW
More that 1 but not more than 10	More than 500 μSv/h but not more than 2000 μSv/h	III-YELLOW

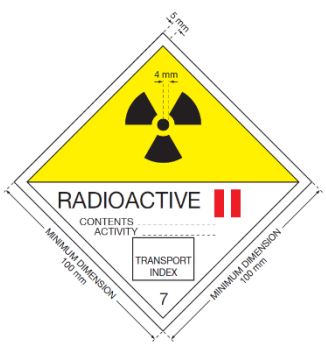
[a] *If the measured transport index is not greater than 0.05, the value quoted may be zero.*

***Note**: Both the transport index and the surface radiation level conditions are taken into account in determining the appropriate category. Where the transport index satisfies the condition for one category but the surface radiation level satisfies the condition for a different category, the package will be assigned to the higher category.*

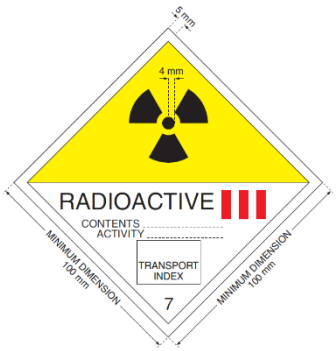
The category labels will need to indicate the radionuclide, its activity in becquerels and, for Category II and III, the transport index. The category signs appear as follows:



Category I-WHITE label



Category II-YELLOW label.



Category III-YELLOW label.

7. NOTES FOR CARRIERS

7.1. Check List For Carriers

The following checklist must be completed by carriers before material is accepted for transport. Tick off each item as checked.

WAYBILL OR CONSIGNMENT NOTE			**YES**	**NO**
1.	Consignor's name and address present;			
2.	Consignee's name and address present;			
3.	Note number of package(s) present;	Number =		
4.	Confirm whether consignment note states for instance “Dangerous Goods - Radioactive Substances”, see attached documents (Dangerous Goods Declaration Form).			
PLACARDS			**YES**	**NO**
	At least three placards must be available according to Figure 1 in Appendix 20.1			
EMERGENCY ROAD HAZARD SIGNS			**YES**	**NO**
	At least three Emergency Road Hazard Signs must be available in the vehicle.			
PACKAGES			**YES**	**NO**
1.	Correct number of packages are present;			
2.	Contents are packaged properly;			
3.	Packages are correct size and weight;			
4.	Packages are in good condition and seals are intact;			
5.	Check that labels agree with Consignor's Certificate (Dangerous Goods Declaration Form);			
6.	Check that information on transport index, radioactive substances, and activity given on the package label agree with the Consignor's Certificate (Dangerous goods Declaration Form);			
7.	A package containing liquid should have a '"THIS SIDE UP" label if appropriate; and			
8.	The class of the package(s) is marked (e.g. TYPE A, or B) as appropriate.			

DOCUMENTATION		YES	NO
Documentation and other requirements for the transport of radioactive substances by road are contained in the *Code of Practice for the Safe Transport of Radioactive Material.* The consignor must have all the following documents completed prior to commencement of the transport of the radioactive material.			
1.	Movement order or an equivalent document such as waybill, consignment note, or equivalent.		
2.	Consignor's Certificate (Dangerous Goods Declaration Form):		
	NOTE: A minimum of two copies is required. One is for the carrier and one, within a stout envelope, is to be firmly fixed to the outside of the package for inspection in transit. Where more than one carrier is involved, it may be necessary for each carrier to receive a copy of the Consignor's Certificate.		
3.	Package certification as required.		
4.	Special Form Certificate, if applicable, for sealed sources.		
5.	Competent Authority approval as required.		
6.	Information for carriers – a document which provides: i). any supplementary operational requirements for loading, transport, storage (away from persons, dangerous goods, livestock and films and for safe dissipation of heat), unloading and handling, or a statement that no supplementary operational requirements are necessary; and		
	ii). emergency arrangements specific to the package.		

7.2. Loading Procedures

(a) Ensure that details of consignment are entered on the carrier's consignment note or waybill. The consignment note should state that "Dangerous Goods - Radioactive Substances, see attached documents (Dangerous Goods Declaration Form)" are being carried.

(b) Use a vehicle that will allow several metres or more distance between the driver (and assistant(s)) and the packages; the greater the distance the better.

(c) The package must be secured on the vehicle. Small, light packages should be stored in a basket while larger, heavy packages should be properly blocked and braced.

(d) Restrictions on the loading of radioactive substances must be observed in regard to segregation from personnel, photographic film, livestock and any dangerous goods that need to be segregated.

(e) The sum of the transport indexes of packages loaded on the vehicle and into freight containers should not exceed 50 unless the material is Low Specific Activity (LSA) or unless other exclusive use conditions are applicable.

(f) Road vehicles, carrying packages, overpacks, tanks or freight containers, must display the placard made according to Figure 1 in Appendix 20.1 on each of:

i). at least two external lateral walls in the case of rail vehicles; and

ii). The two external lateral walls and the external rear wall in the case of a road vehicle.. Any placards, which do not relate to the contents, shall be removed. Placards on vehicles should not be obscured.

(g) No passengers are permitted to accompany the driver and his assistant(s) where packages other than those classified as "excepted" are carried.

(h) The vehicle's load should be securely locked or covered during transport.

8. DOCUMENTATION

Consignors Declaration for Dangerous Goods

9. AUDIT

Every 2 years

10. REFERENCES

NSW Protection from Harmful Radiation Regulation 2025.

ARPANSA Radiation Protection Series No. C-2 (rev.1) - Code of Practice for the Safe Transport of Radioactive Material (2019).

SSG-33 – Safety Guide for the Safe Transport of Radioactive Material (2008 Edition).ARPANSA Radiation Protection Series No. SSG-26 and SSG-33 – Safety Guide for the Safe Transport of Radioactive Material (2008 Edition).SSG-26 Advisory Material for the IAEA Regulation for the Safe Transport of Radioactive Material and SSG-33 Schedules of Provisions of the IAEA Regulations for the Safe Transport of Radioactive Material (rev.1) 2018

ARPANSA Radiation Protection Series No. 14.2 Safety Guide for Radiation Protection in Nuclear Medicine (2008)

ARPANSA Radiation Protection Series No. 14.3 Safety Guide for Radiation Protection in Radiotherapy (2008)

11. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Nov 2014	Draft	William Bartolo, Bartolo Safety Management Service
Feb 2015	Draft 2	K Ambrose, T Millar and W Bartolo
Mar 2016	Draft 3	K Ambrose, T Millar and W Bartolo
Dec 2016	Draft 5	K Ambrose, T Millar and W Bartolo
Apr 2017	Revision 6	K Ambrose, T Millar and W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

APPENDIX 20.1

ARPANSA RPS2

CODE OF PRACTICE

FOR THE SAFE TRANSPORT OF RADIOACTIVE MATERIAL, 2019

Packages with activities lower than those given in the "Exempt Activity" column, are exempt from regulations. In NSW the "Activity" exempt from regulation is the "Prescribed Activity" listed in brackets in the same column.

1.Regulations applying to "Excepted Packages"

- The radiation level at any point on the external surface of the package shall not exceed **5 μSv/h** (0.5 mrem/h).
- The non-fixed radioactive contamination on any external surface of the package shall not exceed **0.4 Bq/cm^2**.
- For radioactive material of *special form* (indispersible solid or sealed capsule), other solid forms and liquids the activity must not exceed the limits listed for the radionuclides in TABLE 1 below.

- The package must bear the marking "**RADIOACTIVE**" on an internal surface in such a manner that a warning of the presence of radioactive material is visible on opening the package.
- The documentation shall include the United Nations Number "**2910"**, and for all items the proper shipping name and description ie:

"RADIOACTIVE MATERIAL, EXCEPTED PACKAGE
LIMITED QUANTITY OF MATERIAL"

shall be included.

APPENDIX 20.1 (cont.)

TABLE 1
ACTIVITY LIMITS OF SELECTED RADIOISOTOPES FOR EXCEPTED PACKAGES

	Exempt Activity (Prescribed Activity NSW) (MBq)	Solids Special Form (MBq)	Solids Other Form (MBq)	Liquids (MBq)		Exempt Activity (Prescribed Activity NSW) (MBq)	Solids Special Form (MBq)	Solids Other Form (MBq)	Liquids (MBq)
Americium-241	0.01 (0.04)	10000	1	0.1	Iron-59	1 (4)	900	900	90
Bromine-82	1 (4)	400	400	40	Molybdenum-99	1 (4)	1000	600	60
Caesium-137	0.01 (0.4)	2000	600	60	Phosphorus-32	0.1 (4)	500	500	50
Carbon-14	10 (4)	40000	3000	300	Phosphorus-33	100 (0.4)	40000	1000	100
Chromium-51	10 (4)	30000	30000	3000	Radium-226	0.01 (0.04)	200	3	0.3
Cobalt-57	1 (4)	10000	10000	1000	Samarium-153	1 (4)	9000	600	60
Cobalt-60	0.1 (0.4)	400	400	40	Selenium-75	1 (4)	3000	3000	300
Fluorine-18	1 (4)	1000	600	60	Sodium-22	1 (0.4)	500	500	50
Gadolinium-153	10 (4)	10000	9000	900	Sodium-24	0.1 (4)	200	200	20
Gallium-67	1 (4)	7000	3000	300	Strontium-89	1 (0.4)	600	600	60
Gallium-68	0.1 (4)	500	500	50	Strontium-90	0.01 (0.4)	300	300	30
Germanium-68	0.1 (0.4)	500	500	50	Sulphur-35	100 (4)	40000	3000	300
Indium-111	1 (4)	3000	3000	300	Technetium-99m	10 (40)	10000	4000	400
Iodine-123	10 (4)	6000	3000	300	Thallium-201	1 (4)	10000	4000	400
Iodine-125	1 (0.4)	20000	3000	300	Tritium (H-3)	1000 (40)	40000	40000	4000
Iodine-131	1 (0.4)	3000	700	70	Xenon-133	0.01 (40)	20000	10000	1000
Iron-55	1 (4)	40000	40000	4000	Yttrium-90	0.1 (4)	300	300	30

For radionuclides not listed above, contact the Radiation Safety Officer.

Excepted packages may contain any quantity of natural uranium, depleted uranium or natural thorium, provided that the outer surface of the uranium or thorium is enclosed in an inactive sheath made of metal or some other substantial material.

APPENDIX 20.1 (cont.)

2. Regulations applying to Type A Packages

For radioactive material of *special form* (indispersible solid or sealed capsule) and all other forms the activity must not exceed the limits listed for the radionuclides in TABLE 2 below:

TABLE 2
ACTIVITY LIMITS OF SELECTED RADIOISOTOPES FOR TYPE A PACKAGES

	Special form A_1 (GBq)	Other form A_2 (GBq)		Special Form A_1 (GBq)	Other Form A_2 (GBq)
Americium-241	10000	1	Molybdenum-99	1000	600
Bromine-82	400	400	Phosphorus-32	500	500
Caesium-137	500	500	Phosphorus-33	40000	1000
Carbon-14	40000	3000	Samarium-153	9000	600
Chromium-51	30000	30000	Selenium-75	3000	3000
Cobalt-57	10000	10000	Sodium-22	500	500
Fluorine-18	1000	600	Sodium-24	200	200
Gadolinium-153	10000	9000	Strontium-89	600	600
Gallium-67	7000	3000	Strontium-90	300	300
Gallium-68	500	500	Sulphur-35	40000	3000
Germanium-68	500	500	Technetium-99m	10000	4000
Indium-111	3000	3000	Thallium-201	10000	4000
Iodine-123	6000	3000	Tritium (H-3)	40000	40000
Iodine-125	20000	3000	Xenon-133	20000	10000
Iodine-131	3000	700	Yttrium-90	300	300

For radionuclides not listed above contact the Radiation Safety Officer.

APPENDIX 20.1 (cont.)

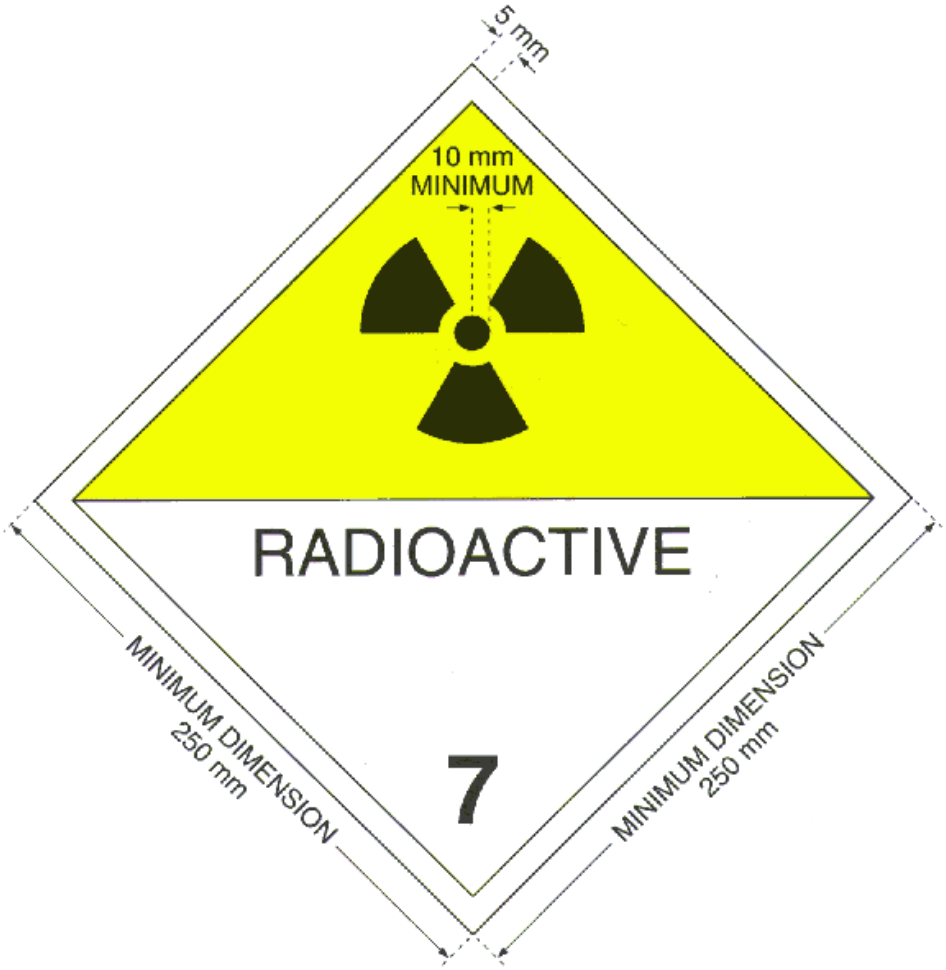
PLACARDS

Road vehicles, carrying packages, overpacks, tanks or freight containers, must display the placard made according to Figure 1 below, on each of the two external lateral walls and the external rear wall in the case of a road vehicle.

Any placards, which do not relate to the contents, shall be removed. Placards on vehicles should not be obscured.

FIGURE 20.1

PLACARDS. The number "7" shall not be less than 25 mm high. The background colour of the upper half of the placard shall be yellow and of the lower half white, the colour of the trefoil and the printing shall be black. The use of the word "RADIOACTIVE" in the bottom half is optional to allow the alternative use of this placard to display the appropriate United Nations number for the consignment.



APPENDIX 20.2

NSW H.U.R.S.O.G.
RADIOACTIVE MATERIAL TRANSPORT KIT AND EMERGENCY PROCEDURES GUIDE

To be read and carried by all transporters of radioactive materials

(*To be kept in the document holder in the driver's door or some place conspicuous in the driver's compartment*)

Transport of radioactive materials by public transport or taxis or motorcycles is NOT PERMITTED

Carry packages securely:

- in boot of car, or
- away from driver in vans and station wagons, and
- segregated from non-compatible dangerous goods

Do not leave packages unsecured at ANY time

For general radiation advice contact
Radiation Control Section
Environment Protection Authority
Department of Environment and Conservation
Telephone: 9995 5959 (business hours).

In an Emergency, contact:

HAZMAT Team
Telephone: 000 (All hours)

APPENDIX 20.2 (cont.)

INSTRUCTIONS

The following instructions must be followed by all transporters carrying labelled packages of radioactive materials:		YES	NO
1.	Check that a Radioactive Goods (consignment) form is attached to each package and that it has been completed with details of each radioactive material being delivered, destination and name of the addressee		
2.	Check that a "Shipping Document" for each package is issued to the driver/transporter		
3.	There are three placard signs in this kit. Put one placard on each side of the vehicle and one on the rear of the vehicle.		
4.	Transport the three Emergency Road Hazard Signs that are in this kit for use in an emergency.		
5.	Transport packages securely either: • in the boot of a car; or • away from the driver of a van or station wagon, and • segregated as per ADG code from other incompatible Dangerous Goods		
6.	Carry these instructions with you in the vehicle in the document holder.		
7.	Carry the appropriate safety equipment (personal protective, spill, etc) that the estimated risk of the consignment, and any other relevant requirements, deem necessary (for example, a Type A package would have negligible risk and as such no equipment is required).		
8.	Carry a mobile phone to be used in the event of an accident.		
9.	At each destination deliver the appropriate package together with its consignment form, to the addressee or their agent who should be a licencee. Adjust any "shipping documents" accordingly.		
10.	At your last destination remove the three yellow transport placards from the outside of the vehicle and replace them in this kit. It is illegal to display Dangerous Goods signs if Dangerous Goods are not in or on the vehicle.		
11.	Passengers are not to be carried at the same time as packages containing radioactive material. However, a licencee responsible for the radioactive material being carried may travel in the vehicle, or if two or more people are required for radionuclide procedures off site, they may all travel in the same vehicle.		
12	The vehicle must not be left unattended when carrying packages containing radioactive substances, except when delivering a package to its consignee.		

APPENDIX 20.2 (cont.)

ACCIDENT ACTION

In the event of an accident, **DON'T PANIC**. The packaging complies with international standard requirements and is designed to withstand accidents. If the package is not severely damaged, the radioactive material is most unlikely to be damaged, and its container is unlikely to leak. **So attend first to the needs of any injured persons.**

If a road vehicle transporting radioactive materials is involved in an accident that results in a dangerous situation (injury, road hazard, escape/leakage of materials, fire, vehicle immobilised, etc), the driver of the vehicle must:

- Notify Emergency Services “000” (Police, Fire Brigade, Hazmat, Ambulance);
- Notify the Institute’s RSO and/or the responsible head of school;
- Provide reasonable assistance to Emergency Services, or the responsible authority officer in charge.

In addition to the above, the routine in the event of such an accident is:

1. Leave vehicle (if possible) and assess the injury status of others involved in the accident;
2. At all times do not become another victim, if in doubt leave it to emergency services;
3. Assess the integrity of the radioactive packages, with minimal contact (or exposure);
4. With the results of the assessment in mind it may be necessary to complete the above actions of notification – i.e. notify Emergency Services, Institute’s WHS Unit, etc;
5. If possible, gain the assistance of passers-by to keep onlookers and other traffic at a safe reasonable distance;
6. Use the Emergency Road Hazard signs (three of these are to be carried in the vehicle at all times that radioactive materials are being transported – see APPENDIX 20.3 attachment for representation of sign);
7. Inform Emergency Services of any Environmental or Human hazards (fire, spill, etc);
8. Wait for and assist emergency services.

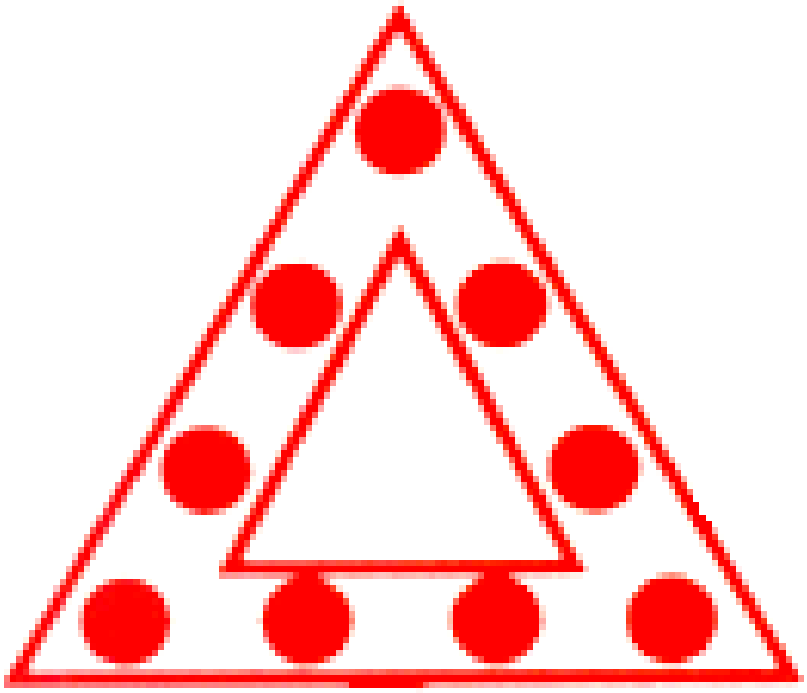
Other than that, if there is no risk from the radioactive materials leaking, or the packages are undamaged then the following applies:

- If the damage sustained by the vehicle does not have to be reported to the police and the vehicle can still be driven, deliver the parcel to the addressee, and tell them that the vehicle was involved in a minor accident on the way. Give a detailed report to the WHS Unit.

APPENDIX 20.3

The Road Hazard Sign

These are to be carried in the vehicle and used any time the vehicle is involved in an accident or becomes immobilised (breakdown, etc). These signs are to comply with Australian Standard AS3790.



INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Safety with Lasers
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S21
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Laser Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO & LSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Laser Safety, Laser Devices, Lasers
SUMMARY *Brief summary of the contents of the document*	Safety and management of Lasers and Las very devices.

INDEX – Section 21

1. BACKGROUND

Lasers can cause severe damage to the eyes and skin. Ocular damage during laser use is of particular concern, and therefore laser products are classified based on the maximum level of laser radiation that is accessible during normal operation. In increasing order of ocular hazard, the classes are: Class 1, “Class 1C”, Class 1M, Class 2, Class 2M, Class 3R, Class 3B and Class 4.

All Class 3B and Class 4 lasers must be registered with the WHS Unit. This includes Class 1 laser systems that have incorporated within them Class 3B or Class 4 lasers but excludes optical drives (e.g. CD and DVD drives).

Note: In Australia, a number of standards apply to laser products:

- AS/NZS IEC 60825.1:2014: Safety of laser products - Equipment classification and requirements
- AS/NZS IEC 60825.2:2022: Safety of laser products - Safety of optical fibre communication systems (OFCS)
- AS/NZS IEC 60825.14:2022: Safety of laser products - A user's guide.
- AS/NZ 4173 (2020): Guide to the Safe Use of Lasers in Health Care.

Definitions:

- Maximum permissible exposure (MPE): the level of laser radiation to which persons may be exposed without suffering adverse effects.
- Nominal ocular hazard distance NOHD: the maximum distance from the output aperture where the beam is above the ocular MPE.
- Nominal ocular hazard area NOHA

2. RESPONSIBILITIES

NOTE: This section excludes optical drives (e.g. CD and DVD drives) and most laser pointers

2.1. Safety & Wellbeing

Maintains an inventory of laser facilities, equipment, users and their eye health records

The following details about the laser are required:

(a) Manufacturer’s details

(b) Model & Serial Number

(c) Laser type(s) and rated power

(d) Enclosed or open

(e) Storage/usage location

(f) Date and nature of modifications to a laser and its associated checking and classification

2.2. Chief investigators

Chief investigators that are responsible for projects and procedures that involve class 3B and Class 4 lasers must:

(a) ensure compliance with current standards and codes of practice regarding operation and maintenance of lasers and the facilities in which they are located

(b) ensure that the project has been approved by the BRSC before commencing work

(c) ensure that others involved with the project or procedure have been trained to be competent to operate the laser or if they are not deemed competent (they must have been trained) are supervised by someone who has been trained and is competent to operate the laser

(d) ensure that those trained to operate the laser have eye-tests at the required intervals and these records are made available to the University WHS unit and will be kept for 50 years.

(e) ensure that records of laser maintenance and laser facility maintenance are kept in a written form (could be electronic) and stored for 30 years.

(f) inform and obtain permission from the laser safety officer or their delegate before disposing of a laser or decommissioning of a laser or its facility

(g) ensure that personnel involved with the project or procedure wear personal protective equipment (PPE), appropriate to the hazard

2.3. Users of class 3B and Class 4 lasers

Users of class 3B and Class 4 lasers (excluding optical drive but including class 1 that enclose class 3R, 3B, & 4) must:

- only use the laser or the facility to the extent of the scope of their documented training and competency
- only use the laser or facility beyond the scope of their documented competency but within their training when under the direct supervision of a person who has been trained and is competent at that level of usage
- have eyes tested if and as required by the University or in accordance with codes of practice

2.4. The Laser Safety Officer of the University (LSO)

The Laser Safety Officer of the University (LSO) (or RSO where one is not available) must:

- must provide advice about the installation, servicing, decommissioning, use and training with regards to lasers and laser facilities in the University.
- must provide reports on a needs be basis to the WHS unit, the BRSC, and the DVC Research
- be a contact point for questions about laser safety issues
- work with the Safety & Wellbeing team to audit laser facilities
- must actively provide advice to the university on changes to legislation, guidelines and standards regarding lasers and laser facilities
- must ensure that lasers built or modified and operated at the University or University controlled premises are checked and their classification confirmed.

3. ADMINISTRATIVE ARRANGEMENTS

Lasers used in the University are governed by the guidelines summarized in this document as approved by the WHS Unit and if appointed the appointed Laser Safety Officer (LSO). Administrative arrangements and responsibilities are specified in the Laser Safety Manual and encompass the following:

- Reading and becoming familiar with the contents of the University Laser Safety Manual and relevant Australian/New Zealand Standards.
- Reading safety instructions in relevant laser equipment operator's manuals and respective laboratory administrative, alignment and Standard Operating Practice while using and operating lasers. Familiarised yourself with all other aspects of the laser requirements and laboratory safety as directed by the LSO or Supervisor.
- Undertaking a risk assessment for the work to be performed and keeping the supervisor fully informed of any departure from established safety procedures. This includes notification of any accident or exposure incident immediately to a supervisor and completing a report using the the University incident reporting system.

4. USAGE OF LASERS (CLASSES 3R, 3B, & 4))

For establishing new laser facilities and using non-enclosed class 3R, 3B and 4 lasers, project applications must be approved by the BRSC before any work can take place.

LSO consultation and sign off by LSO and the Safety & Wellbeing may also be required.

5. RISK ASSESSMENT

All operators undertaking experiments involving Class 3B or Class 4 lasers must undertake a risk assessment of the procedure/process/experiment prior to starting the work. The risk assessment must be part of the project approval form that is to go to the BRSC before a project may commence.

In the case of undergraduate students, undergraduate lab managers and/or student supervisors will undertake a risk assessment of all experiments involving lasers and provide SOPs to all students undertaking these respective experiments.

6. DOCUMENTATION

Records of Laser Equipment.
Records of Approved Laser Users/Operators.
Records of Service, inspection and calibration

7. AUDIT

Every 2 years

8. REFERENCES

9. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Sept 2015	Draft	William Bartolo, Bartolo Safety Management Service
Jan 2016	Draft 2	William Bartolo, Bartolo Safety Management Service
Jan 2016	Draft 3	K Ambrose, T Millar and W Bartolo
Mar 2016	Draft 4	K Ambrose, T Millar and W Bartolo
Dec 2016	Draft 5	K Ambrose, T Millar and W Bartolo
Apr 2017	Revision 6	K Ambrose, T Millar and W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	Safety with UV Radiation
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Procedure
DOCUMENT NUMBER	RMP-S22
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	UWS Radiation Safety Manual
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service bartolo-safety@hotkey.net.au
REVIEWER & APPROVER *Position responsible for the document including email address*	Mr Simon Turner Western Sydney University RSO Radiation Safety Support Services Australia Simon@sensaweb.com.au
KEY TERMS	Radiation safety, Ultraviolet, transilluminators
SUMMARY *Brief summary of the contents of the document*	Procedures for the safe use of UV apparatus

INDEX – Section 22

1. BACKGROUND

UV radiation is invisible to the eye and it is non-ionizing form of radiation in the 100 nm to 400 nm wavelength region of the electromagnetic spectrum. UV radiation is arbitrarily divided into UV-A (315 nm to 400 nm), UV-B (280 nm to 315 nm), and UV-C (100 nm to 280 nm). UV lasers are not covered in this section; please refer to the laser safety section for safety issues related to lasers.

The ability of UV radiation to penetrate human tissue depends on wavelength. UV-A is the most penetrating among the UV groups and it can cause skin damage and cataract formation. UV-B is the most destructive form of UV, and it can cause erythema (sunburn) and corneal burn. The UV-B erythema threshold is 1,000 times lower than the erythema threshold of the UV-A, and it is much more effective in causing damage to live tissue then UV-A. UV-C cannot penetrate the dead layer of human skin; however, it can produce corneal burn. UV-C kills bacteria and it is used in germicidal lamps. Therefore, if any research projects involve the use or exposure to UV, special attention needs to be made to this in the risk assessments. For outdoor natural exposures to UV, refer to university policies Sun Protection Guidelines for Outdoor Workers and Sun Protection Policy.

ARPANSA RPS12 (2006) Tables 1 and 2 are in Appendix 22.1 of this Section and 2 attached to this section.

2. RESPONSIBILITIES

2.1. The Team Leader/Coordinator or Facility Manager

The **Team Leader/Coordinator or Facility Manager** will be responsible for monitoring and providing advice on UV safety within laboratories. They will have the authority to make immediate adjustments to procedures, or to immediately require a procedure to cease, or to shut down a facility if work involving UV light is not meeting safety standards.

2.2. The Radiation Safety Officer

Will provide a consultative role as required.

2.3. Chief Investigator

The chief investigator is responsible for ensuring that all projects involving UV have an approved risk assessment, that all procedures are performed safely, and personnel working on the project are appropriately trained.

2.4. Personnel working on the project

Is required to follow all work and safety procedures to ensure that UV exposure is minimised.

3. UV RADIATION EXPOSURE GUIDELINES

The University expects protection when using UV apparatus such that there are no direct exposed surfaces of the body with particular attention to protecting the eyes. ARPANSA Radiation Protection Series No. 12 **Occupational Exposure to Ultraviolet Radiation** and the associated supplementary documents in which safety recommendations and limits are given is the recommended reference for further information.

3.1. UV Control Measures

A risk assessment will be carried out and approved to ensure that appropriate control measures can be implemented to prevent UV exposure. Control measures should not create other safety hazards.

NOTE: Personal Protective Equipment - PPE is the least effective control in protection from UV and should be used in conjunction with engineering and administrative controls. Commonly used PPE against UV are polycarbonate UV safety goggles, polycarbonate UV face shields, long-sleeved, tightly-woven clothing that covers much of the body, and gloves. Application of sun-screen with high sun-protection factor (>15) against UV-A and UV-B may provide some protection. However, the use of UV skin blocks is considered inadequate for protection against the high irradiance of man-made UV radiation sources.

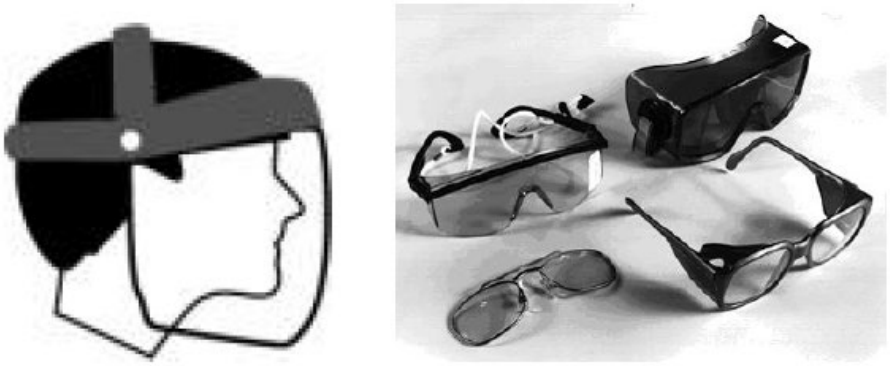


Figure 22.1. *UV personal protective equipment*

Protective eyewear must comply with Australian Standard AS/NZS 1067.1 and AS 1337 as a minimum.

3.2. Equipment And Area Labels

Any equipment that emits UV radiation and the area where the equipment is located must have appropriate UV warning labels posted (see fig. 22.2). There is no standard UV warning label.

Figure 22.2. *UV warning signs*

3.3. Training and Supervision

Workers who may be exposed to ultraviolet radiation must be trained in safe work practices regarding ultraviolet radiation and supervised when appropriate. They must also be trained about the controls in place to manage the potential ultraviolet radiation hazard. Management must maintain records of such staff training. There must be appropriate procedures in place, developed as part of a plan for the control of exposure to ultraviolet radiation, to ensure that the safe systems of work designed to prevent ultraviolet radiation exposure are utilised.

4. DOCUMENTATION

The following documentation is required to be kept in the facility and records maintained for a minimum of 5 years:

- UV Equipment Log Book
- UV User and Training Record

5. AUDIT

All UV incidents are to be reported to Safety & Wellbeing and discussed at the BRSC.

6. REFERENCES

ARPANSA. Occupational Exposure to Ultraviolet Radiation. RPS Publication No. 12. December 2006

ARPANSA. Management Plan for Artificial Sources.

Standards Australia, *AS 1337: Eye Protectors for Industrial Applications* (2010).

Standards Australia, *AS 1067.2*: *Sunglasses and Fashion Spectacles - Performance Requirements* (2016).

Standards Australia, *AS 1067.1: Sunglasses and Fashion Spectacles - Safety Requirements* (2016).

Standards Australia, *AS 2604: Sunscreen Products - Evaluation and Classification* (2021).

Standards Australia, AS 4399: *Sun Protective Clothing - Evaluation and Classification (2020)*

7. REVISION AND APPROVAL HISTORY *(state the author of the document, the date it was written, its revision number and approval history)*

Date	Revision No.	Author and Approval
Mar 2015	Draft	William Bartolo, Bartolo Safety Management Service
Jun 2015	Draft 2	T Millar, K Ambrose & W Bartolo
Mar 2016	Draft 3	T Millar, K Ambrose & W Bartolo
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Dec 2016	Draft 5	T Millar, K Ambrose & W Bartolo
Apr 2017	Revision 6	T Millar, K Ambrose & W Bartolo
July, 2026	Revision 8	S.Turner & D.Wojtalewicz

Appendix 22.1 ARPANSA Schedule 1 Tables

Table 1: Ultraviolet radiation exposure limits and Relative Spectral Effectiveness

Wavelength[a] (nm)	Exposure Limit ($J.m^{-2}$)	Exposure Limit ($mJ.cm^{-2}$)	Relative Spectral Effectiveness S_λ
180	2 500	250	0.012
190	1 600	160	0.019
200	1 000	100	0.030
205	590	59	0.051
210	400	40	0.075
215	320	32	0.095
220	250	25	0.120
225	200	20	0.150
230	160	16	0.190
235	130	13	0.240
240	100	10	0.300
245	83	8.3	0.360
250	70	7.0	0.430
254[b]	60	6.0	0.500
255	58	5.8	0.520
260	46	4.6	0.650
265	37	3.7	0.810
270	30	3.0	1.000
275	31	3.1	0.960
280[b]	34	3.4	0.880
285	39	3.9	0.770
290	47	4.7	0.640
295	56	5.6	0.540
297[b]	65	6.5	0.460
300	100	10	0.300
303[b]	250	25	0.120
305	500	50	0.060
308	1 200	120	0.026
310	2 000	200	0.015
313[b]	5 000	500	0.006

Table 1: Ultraviolet radiation exposure limits and Relative Spectral Effectiveness (continued)

Wavelength[a] (nm)	Exposure Limit ($J.m^{-2}$)	Exposure Limit ($mJ.cm^{-2}$)	Relative Spectral Effectiveness S_λ
315	1.0×10^4	1.0×10^3	0.003
316	1.3×10^4	1.3×10^3	0.0024
317	1.5×10^4	1.5×10^3	0.0020
318	1.9×10^4	1.9×10^3	0.0016
319	2.5×10^4	2.5×10^3	0.0012
320	2.9×10^4	2.9×10^3	0.0010
322	4.5×10^4	4.5×10^3	0.00067
323	5.6×10^4	5.6×10^3	0.00054
325	6.0×10^4	6.0×10^3	0.00050
328	6.8×10^4	6.8×10^3	0.00044
330	7.3×10^4	7.3×10^3	0.00041
333	8.1×10^4	8.1×10^3	0.00037
335	8.8×10^4	8.8×10^3	0.00034
340	1.1×10^5	1.1×10^4	0.00028
345	1.3×10^5	1.3×10^4	0.00024
350	1.5×10^5	1.5×10^4	0.00020
355	1.9×10^5	1.9×10^4	0.00016
360	2.3×10^5	2.3×10^4	0.00013
365[b]	2.7×10^5	2.7×10^4	0.00011
370	3.2×10^5	3.2×10^4	0.000093
375	3.9×10^5	3.9×10^4	0.000077
380	4.7×10^5	4.7×10^4	0.000064
385	5.7×10^5	5.7×10^4	0.000053
390	6.8×10^5	6.8×10^4	0.000044
395	8.3×10^5	8.3×10^4	0.000036
400	1.0×10^6	1.0×10^5	0.000030

[a] Wavelengths chosen are representative; other values should be interpolated at intermediate wavelengths.

[b] Emission lines of a mercury discharge spectrum.

Table 2: Limiting UV exposure durations based on EL

Duration of Exposure Per Day	Effective Irradiance E_{eff} ($W.m^{-2}$)	Effective Irradiance E_{eff} ($\mu W.cm^{-2}$)
8 Hr	0.001	0.1
4 Hr	0.002	0.2
2 Hr	0.004	0.4
1 Hr	0.008	0.8
30 Min	0.017	1.7
15 Min	0.033	3.3
10 Min	0.05	5
5 Min	0.1	10
1 Min	0.5	50
30 Sec	1.0	100
10 Sec	3.0	300
1 Sec	30	3 000
0.5 Sec	60	6 000
0.1 Sec	300	30 000

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

NAME OF DOCUMENT	RMP Attachment – The University RML Example
TYPE OF DOCUMENT *Policy, Procedure or Clinical Guideline*	Background Information for Radiation Users
DOCUMENT NUMBER	RMP-Attachment
DATE OF PUBLICATION	
RISK RATING	
LEVEL OF EVIDENCE	
REVIEW DATE *Documents are to be reviewed a maximum of five years from date of issue*	
FORMER REFERENCE(S) *Documents that are replaced by this one*	
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Western Sydney University BRSC
AUTHOR *Position responsible for the document including email address*	Mr William Bartolo – Consultant RSO; Bartolo Safety Management Service
REVIEWER *Position responsible for the document including email address*	Mr Simon Turner – Consultant RSO; Radiation Safety Support Services Australia Simon@SensaWeb.com.au
KEY TERMS	License
SUMMARY	Example of Current RML of 2018

INTERNAL ONLY

RADIATION MANAGEMENT PLAN COVER SHEET

WESTERN SYDNEY UNIVERSITY

Brief summary of the contents of the document	

This is an example of the Western Sydney University Radiation Management License

It is the 2018 version of the license and is replaced every year and updated as necessary.

Some details may be incorrect at the time of reading.

Regulated Material Pages have been omitted.

Some material has been redacted for security purposes.

RADIATION LICENCE EXEMPTION FORM

Reference: *[WSU Section 03 Procedure-Regulatory Requirements]*

The Radiation Control Act 1990 (NSW) and Protection from Harmful Radiation Regulation NSW 2025 impose restrictions on persons using radioactive substances, ionising radiation apparatus and certain types of non-ionising apparatus. Higher degree research students must be issued with an exemption approval prior to radiation use.

This completed form is to be sent to whs@westernsydney.edu.au and a copy displayed in the laboratory where the exempted person undertakes radiation work.

APPLICANT DETAILS — *ED2 Exemption (Students Only)*			
Title		**First Name**	
Middle Name		**Surname**	
Date of Birth		**Phone**	
Email		**Student ID**	

RADIATION TRAINING			
Course Name			
Training Organisation			
Date Completed		**Certificate No. (if applicable)**	

SUPERVISING LICENCE HOLDER — **must hold either G1 or "provide supervision"*			
Name		**Phone**	
Licence Number		**^Expiry Date**	

Licence Conditions: *(enter type and description of EPA user licence)*

☐ Specific Condition "provide supervision" ☐ Other:

APPROVING LICENCE HOLDER — *~must hold GE1*			
Name		**Phone**	
Licence Number		**^Expiry Date**	

Licence Conditions: *(enter type and description of EPA user licence)* ☐ Other:

Specifications of the Radioactive Substances / Radiation Apparatus to which the exemption relates:

Exemption Conditions: *include location where work will be undertaken and description of the task*			
Signature		**Date**	

ACCEPTANCE OF EXEMPTION DETAILS AND CONDITIONS

APPLICANT			
Signature		**Date**	
LAB SAFETY SPECIALIST — *from Safety & Wellbeing team*			
Name		**Signature**	
Date			
Exemption Approval Date		**Exemption Expiry Date (max 3 years)**	

S&W UNIT ONLY

Date entered into radiation database		**Entered by**	

^ Exemption is no longer valid if the Supervising / Approving Licence expires or if the status of the student changes (e.g. graduates).