National Radiation Protection Office Update 12th June 2025

Radiation safety incidents reported on the National Incident Management System (NIMS) Q1 2025

This report details the radiation safety incidents reported on the NIMS from January to March 2025. The figures listed below do not include incidents related to ultrasound, MRI or issues with extravasation of contrast from a peripheral vascular catheter.

1. Category of radiation safety incident

Category of incident	Radiology	Radiotherapy
Harm	11	
Near miss	160	5
No harm	171	70
Total number of reports	**342**	**75**

2. Category of person affected by the radiation safety incident

Category of person	Radiology	Radiotherapy
Adult patient / service user	305	74
Staff member	29	1
Member of the public	8	

3. Details of the process involved in the incidents.

Radiology incidents reported on the NIMS in Q1 2025						
Process	**Severity Rating**					**Total**
	Extreme	**Major**	**Moderate**	**Minor**	**Negligible**	
Checking patient identification					36	**36**
Clinical details on referral					99	**99**
Documentation / records					27	**27**
Communication / consent issues					5	**5**
Equipment failure					30	**30**
Performing procedure			2		64	**66**
Pregnancy status					5	**5**
Not applicable / unknown					74	**74**

One report categorised as moderate harm related to a missed diagnosis; and the second was a delayed diagnosis due to a failure to follow local policy when preparing the patient for the procedure.

The 74 reports categorised as ‘not applicable’ or ‘unknown’ refer mainly to equipment failures, poor referral practices and staff exposure related issues. These included, for example, high personal dosimetry readings, staff declining to wear appropriate personal protective equipment and staff entering a room when a radiation exposure was in progress.

Radiotherapy incidents reported on the NIMS in Q1 2025						
Process	**Severity Rating**					**Total**
	Extreme	**Major**	**Moderate**	**Minor**	**Negligible**	
Documentation / Records					16	**16**
Communication / Consent					1	**1**
Equipment Failure					9	**9**
Performing Procedure					45	**45**
Unknown / Not applicable					4	**4**

The 4 reports categorised as 'unknown / not applicable' refer to two issues with treatment protocols; one issue with patient transport arrangements; and one report where a delivery driver repeatedly used a restricted radiation area for convenience in order to deliver pharmaceuticals to the hospital, despite being advised not to by staff.

4. The problems recorded in the incidents.

Radiology incidents reported on the NIMS in Q1 2025						
Problem	**Severity Rating**					**Total**
	Extreme	**Major**	**Moderate**	**Minor**	**Negligible**	
Diagnostic exposure greater than intended					23	**23**
General exposure related issue					58	**58**
Failure / malfunction			1		33	**34**
Wrong body part / side /site					81	**81**
Wrong patient (>1mSv)						**13**
Wrong patient (<1mSv)						**38**
Wrong process / treatment / procedure			1		40	**41**
Other / Unknown					54	**54**

The 54 reports categorised as 'other' or 'unknown' refer mainly to poor referral practices; incorrect patient details recorded on either the referral or the IT system; and radiation equipment or software failures.

Radiotherapy incidents reported on the NIMS in Q1 2025						
Problem	**Severity Rating**					**Total**
	Extreme	**Major**	**Moderate**	**Minor**	**Negligible**	
Failure / malfunction					3	
Wrong process / treatment / procedure					12	
Other					60	

The 60 reports categorised as 'other' refer mainly to treatment planning and delivery issues, patient positioning and issues with equipment.