January 2019 Update from our Health & Safety Update

Ionising Radiations Regulations IRR 2017, Update

A year ago I raised the matter of Ionising Radiation in the workplace from Radon. We have recently had a number of Care organisations in the Cardiff area written to by a superintendent radiographer asking them to register that they are working with radioactive materials.

This relates to patients come out of hospital following certain treatments and scans. I have written to the HSE Health and Social care team, who have raised the issue with their Radiation specialist, as I feel it may not be appropriate, and there is a financial cost.

I asked the following questions:

- Is registering care homes under IRR regs the right course of action?
- If the Patient is sent home with radioactive material inside them, how can managers know how it will be excreted, passed or the level of radioactivity and duration?
- Should the hospital chart this and notify the care company of consequences and the risk?
- If it is radioactive enough to affect others - should the patient be let out of hospital?
- If it is correct that Care homes register under the act, there are huge gaps in protecting the wider care sector -
- What about domiciliary care workers, or housing officers, who may not even know the patient is Radioactive and they could very often be providing close personal support
- What duty of care should lie with the Hospital when sending out a radioactive patient?

Advice from James Taylor: HSE
Employers working with radioactive materials above certain quantities, and this would include most patients who have been administered with radioactive materials, have to register with the HSE prior to commencing work.
Provided the hospital provides the correct information to the care home, they do not have to police the latter's compliance with the IRR17.
Some employers have said that this is major change from the IRR99. It isn't. Under the old regulations the care home still had to notify the HSE and comply with the regulations. All that is now different is that they have to register rather than notify.
If a patient is returned home they are usually given written instructions about close contact with relatives and friends, what toilet facilities they should use and how, and any other instructions relevant to the reducing exposures to radiation.

On this basis Care Homes should check with Hospitals and if a patient has been treated by a number of Radiological methods then you will have to register and this is going to cost you £25.00, you will need to check if this is per home or per organisation when you register- and make sure you get information from the hospital.

I am still pursuing further clarification on how supported living and Domiciliary care workers can be protected and if Domiciliary care providers and supported living providers need to register.

Hospital Fine for failing to protect a young teenager (From SHP on Line 14/01/2019)

The Priory healthcare group is facing a fine of millions of pounds for breaching health and safety laws after a 14-year-old girl with a history of suicide attempts died in its care. A criminal investigation was launched by the Health and Safety Executive into the private mental healthcare group after the death of Amy El-Keria, who was treated at its Ticehurst House psychiatric hospital in 2012, Brighton Magistrates' Court was told.

The company indicated at a hearing in Brighton that it would be admitting a health and safety breach when the case goes to crown court later this year. Prosecutor Sarah Le Fevre said the fine imposed would be at least £2.4m.

Brighton Magistrates' Court heard that The Priory would be pleading guilty to the charge of failing to discharge its duty as an employer to ensure people were not exposed to risk. It is due to be sentenced at Lewes Crown Court on 6 February.

Outside court, Amy's mother Tania El-Keria said her daughter's welfare should never have been "in the hands of a company whose priority was placing profit over her safety".

The magistrates' court was told that Amy, who had a "known and recent history" of suicide attempts, was admitted to the hospital in August 2012. She was left with unsupervised access and the means to carry out another suicide attempt.

On 11 November that year, she was found injured in her bedroom. She died in hospital the following day.

An inquest in 2016 heard staff had not been trained in resuscitation and had not called 999 quickly enough.

The jury said Amy died of unintended consequences of a deliberate act, contributed to by neglect, and that staffing levels at the Ticehurst centre were inadequate.

It could be worth you reviewing your resuscitation and emergency contact procedures, to avoid a similar delay.