UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD – SUITE 102
KING OF PRUSSIA, PA 19406-1415

December 9, 2025

EAF-RI-2025-0151

Pedro J. Torres
Administrator
Rio Piedras Sono-Nuclear Center
Calle Los Angeles #1028
Esq. de Diego
Rio Piedras, Puerto Rico 00923

SUBJECT: RIO PIEDRAS SONO-NUCLEAR CENTER - NRC – INSPECTION REPORT 03030140/2025002

Dear Pedro Torres:

This letter refers to the reactive inspection by the U.S. Nuclear Regulatory Commission (NRC) conducted remotely (i.e., email and telephone) between May 30, 2025, and June 26, 2025. The purpose of the inspection was an examination of activities related to NRC-licensed byproduct material. The inspection was initiated following the event notification you submitted on May 29, 2025, (EN 57735), regarding the loss of a vial containing 201 millicuries (mCi) of lutetium-177 (Lu-177) as documented in the 30-day report you submitted on June 26, 2025. The inspection consisted of a selected examination of representative records and interviews with personnel. The enclosed report presents the results of this inspection. A final exit briefing was conducted (telephonically) with you on December 2, 2025.

Based on the results of the inspection, the NRC identified one apparent violation which is being considered for escalated enforcement action in accordance with the NRC's Enforcement Policy. The current Enforcement Policy is included on the NRC's website at: https://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The apparent violation, which is described in the Enclosure, involves the apparent failure to dispose of licensed material only by transfer to an authorized recipient, decay in storage, or by release in effluents within the limits in Title 10 *Code of Federal Regulations* (10 CFR) Part 20 in accordance with 10 CFR 20.2001.

Since the apparent violation involves improper transfer for disposal of licensed material (201 mCi of Lu-177), the NRC is considering proposing imposition of a civil monetary penalty. Section 2.3.4, "Civil Penalty," of the NRC Enforcement Policy states that for violations where a licensee has lost required control of its regulated licensed material for any period of time, the NRC may exercise discretion and impose a civil penalty. The base civil penalty amount, as set out in Section 8.0, "Table of Base Civil Penalties," of the Policy, is based on approximately three times the expected average cost of authorized disposal; however, the NRC may exercise its discretion to mitigate or escalate a civil penalty amount based on the merits of a specific case.

Therefore, you may provide information regarding the actual expected cost of authorized disposal that you believe the NRC should consider in making a final enforcement decision.

However, NRC will not normally reduce the civil penalty to an amount below the lowest base civil penalty for such cases (i.e., $9,000).

Since the NRC has not made a final determination in this matter, a Notice of Violation is not being issued at this time. Please be advised that the characterization of the apparent violation described in the enclosed inspection report may change as a result of further review. You will be advised by separate correspondence of the results of our deliberations on this matter.

Before the NRC makes its enforcement decision, we are providing you with an opportunity to (1) respond to the apparent violation addressed in this inspection report in writing within 30 days of the date of this letter, (2) request a Pre-decisional Enforcement Conference (PEC), or (3) request Alternative Dispute Resolution (ADR) mediation. If a PEC is held, it will be open for public observation, and the NRC will issue a press release to announce the time and date of the conference. If you decide to participate in a PEC or pursue ADR, please contact **Monica Ford at 610-337-5214 or via email at Monica.Ford@nrc.gov within 10 days of the date of this letter**. A PEC should be held within 30 days and an ADR session within 45 days of the date of this letter.

If you choose to provide a written response, it should be clearly marked as a "Response to Apparent Violation in NRC Inspection Report (03030140/2025002); EAF-RI-2025-0151," and should include: (1) the reason(s) for the apparent violation, or, if contested, the basis for disputing the apparent violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved. Your response may reference or include previously docketed correspondence if the correspondence adequately addresses the required response. Additionally, your response should be sent to U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy mailed to Christopher Regan, Acting Director, Division of Radiological Safety & Security, U.S. Nuclear Regulatory Commission Region I, 475 Allendale Road, Suite 102, King of Prussia, PA, 19406, and emailed to R1Enforcement@nrc.gov within 30 days of the date of this letter. If an adequate response is not received within the time specified or an extension of time has not been granted by the NRC, the NRC will proceed with its enforcement decision.

If you choose to request a PEC, the conference will include an opportunity for you to provide your perspective on these matters and any other information that you believe the NRC should take into consideration before making an enforcement decision. The decision to hold a PEC does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference would be conducted to obtain information to assist the NRC in making an enforcement decision. The topics discussed during the PEC may include information to determine whether a violation occurred, information to determine the significance of a violation, information related to the identification of a violation, and information related to any corrective actions taken or planned. In presenting your corrective actions, you should be aware that the promptness and comprehensiveness of your actions will be considered in assessing any civil penalty for the apparent violations. The guidance in the enclosed excerpt from NRC Information Notice 96-28, "Suggested Guidance Relating to Development and Implementation of Corrective Action," may be helpful in preparing for your response.

In lieu of a PEC or written response, you may request ADR with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflicts using a neutral third-party. The technique that the NRC has decided to employ is mediation: a voluntary, informal process in which a trained neutral (the "mediator") works with

parties to help them reach resolution. If the parties agree to use ADR, they select a mutually agreeable neutral mediator who has no stake in the outcome and no power to make decisions. Mediation gives parties an opportunity to discuss issues, clear up misunderstandings, be creative, find areas of agreement, and reach a final resolution of the issues. Additional information concerning the NRC ADR program can be obtained at https://www.nrc.gov/about-nrc/regulatory/enforcement/adr/post-investigation.html. The Institute on Conflict Resolution (ICR) at Cornell University has agreed to facilitate the NRC program as a neutral third party. Please contact ICR at 877-733-9415 within **10 days** of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

In accordance with 10 CFR 2.390 of the NRC's "Agency Rules of Practice and Procedure," a copy of this letter, its enclosure, and your response, if you choose to provide one, will be made available electronically for public inspection in the NRC Public Document Room and from the NRC's Agencywide Document Access and Management System (ADAMS), accessible from the NRC website at http://www.nrc.gov/reading-rm/adams.html. To the extent possible, your response should not include any personal privacy or proprietary information so that it can be made available to the public without redaction.

If you have any questions regarding this matter, please contact Monica Ford of my staff at 610-337-5214, or via electronic mail at Monica.Ford@nrc.gov.

Sincerely,

Ferdas, Marc signing on behalf
of Regan, Christopher
on 12/09/25

Christopher M. Regan, Acting Director
Division of Radiological Safety and Security
Region I

Docket No. 030-30140
License No. 52-24937-01

Enclosure:
1. Inspection Report
2. Excerpt from NRC Information Notice 96-28, "Suggested Guidance Relating to Development and Implementation of Corrective Action"

SUBJECT: RIO PIEDRAS SONO-NUCLEAR CENTER NRC INSPECTION REPORT 03030140/2025002 DATED DECEMBER 9, 2025

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U.S. NUCLEAR REGULATORY COMMISSION
REGION I

INSPECTION REPORT

Inspection No.	03030140/2025002
Docket No.	03030140
License No.	52-24937-01
EA No.	EAF-RI-2025-0151
Licensee:	Rio Piedras Sono-Nuclear Center
Address:	1028 Los Angeles St. Urbanizacion del Carmen, Rio Piedras, Puerto Rico, 00926
Inspection Dates:	May 30, 2025 – June 26, 2025
Exit Meeting	December 2, 2025
Inspector:	Kelli Trotter Health Physicist Medical and Licensing Assistance Branch Division of Radiological Safety and Security
Approved By:	Farrah Gaskins, Acting Chief Medical and Licensing Assistance Branch Division of Radiological Safety and Security

EXECUTIVE SUMMARY

Rio Piedras Sono-Nuclear Center
NRC Inspection Report No. 03030140/2025002

The licensee was authorized for 10 CFR 35.100, 35.200, 35.300 and 10 CFR 31.11. The licensee had a previous inspection on March 5, 2025, through April 15, 2025. The inspection exited with five severity level IV violations. The licensee notified the NRC Headquarters Operation Officer (HOO) on May 29, 2025, because of lost licensed material which was inadvertently disposed of via a shared waste stream. The licensee identified the missing licensed material on Thursday morning, May 29, 2025. The NRC reached out to the licensee on Friday, May 30, 2025, for more information regarding the timeline and to inquire about the current actions of the licensee. The licensee met the reporting requirements of 10 CFR 20.2201 by submitting a 30-day report on June 26, 2025 [ML25181A041]. This report included a summary of the events and corrective actions taken by the licensee. The inspector conducted a preliminary debrief on August 12, 2025, with the facility manager and the radiation safety officer liaison. A formal exit meeting was held telephonically on December 2, 2025.

REPORT DETAILS

1. Organization and Scope of the Program

a. Inspection Scope

On May 29, 2025, the licensee notified the NRC of a loss of licensed material by telephone notification to the HOO. A remote inspection was performed between May 30, 2025 – June 26, 2025, to establish a timeline of the event, understand the details of the loss of material, and to determine if a violation of NRC requirements occurred. The scope of the inspection was to examine licensed activities as they relate to public health and safety and to the NRC's rules and regulations. Within these areas, the inspection consisted of a selected examination of written procedures and representative records, and interviews with personnel.

b. Observations and Findings

The licensee was authorized for nuclear medicine related activities encompassing 10 CFR 35.100, 35.200, 35.300 and 31.11. The licensee's last routine inspection was conducted March 5, 2025, through April 15, 2025 [ML25106A106]. Five severity level IV violations were issued at the time of this inspection.

The licensee's initial report summarized that the licensee received two doses of Pluvicto (lutetium-177 (Lu-177)) on May 27, 2025. Each dose was approximately 200 mCi and was in its own shielded vial. The two vials were packaged in a single shipping container; one was at the bottom of the box with a Styrofoam separator on top and the other was on top of the Styrofoam.

On May 28, 2025, the first dose was administered to a patient without incident. The second dosage was left in the original shipping container to decay for approximately 24 hours for a target dose of 5.92 GBq (160 mCi). The next day the nuclear medicine technologist (NMT) stripped the original shipping container of all radioactive material labels, forgetting about the second dose that was in the bottom portion of the box and placed the shipping container outside the hot laboratory to be discarded as regular trash. The janitorial staff then picked up the box, believing it to be trash, and discarded it in a dumpster which had a trash compactor attachment. This dumpster was a shared waste stream with a neighboring hospital, which does not have a license for radioactive materials.

One apparent violation of NRC requirements was identified resulting from the findings of the remote inspection. Details of the apparent violation are described in Section 2.c below.

2. Review of Licensed Activities

a. Inspection Scope

The licensee is authorized for 10 CFR 35.100, 35.200, 35.300 and 10 CFR 31.11. The licensee had an inspection March 5, 2025, through April 15, 2025 (2025001). The 2025 routine inspection [ML25106A106] inspection exited with five severity level IV violations.

On May 29, 2025, the NRC was notified of a loss of licensed material by the licensee at 10:10 AM by telephone notification to the HOO. The initial report summarized that the licensee received two doses of Pluvicto (lutetium-177 (Lu-177)) on May 27, 2025. Each dose was in its own shielded vial. The two vials were packaged in a single shipping container; one was at the bottom of the box with a Styrofoam separator on top and the other was on top of the Styrofoam. The picture depicts the top layer of how a box is typically packaged. This picture is not the actual box of concern but is a similar box.

On May 28, 2025, one dose was administered to a patient without any incident. The NMT then cut the radioactive labels from the surface of the box, obliterated the labels, and left the box outside of the hot lab to be discarded with the regular trash. The unused dose, inside of its lead pig, was still inside the box. The janitorial staff picked up the box between 3 PM and 5 PM. The box was then put into a waste compactor that was at the end of the parking lot of the San Francisco Hospital, a facility that was not licensed by the NRC to possess, use, or store licensed material.

On the morning of May 29, 2025, the NMT remembered that the second dose was sitting to decay but could not find the box. At about 7:10 AM, the NMT informed the administrator, who called the quality control manager, to explain what was happening. The administrator and quality control manager called the radiation safety officer (RSO) and the RSO gave instructions for the NMT to take surveys of the compactor and to contact the NRC. The licensee searched for the box in other places to ensure it was not left out. At 9:00 AM, the NMT and quality control manager survey around and inside the compactor. People cannot gain full-body access to the compactor but can reach in with an arm and take readings (see the picture below). Both readings on May 29, 2025, were reading background radiation.

At 10:10 AM, the facility administrator called the HOO and reported the loss of material. More surveys were conducted by the licensee at 11:25 AM on the same day and the readings were still background.

On Friday, May 30, 2025, the NRC reached out to the licensee through the RSO liaison and the facility manager. The inspector asked the licensee where the trash was and if the compactor was still being used, to which the licensee was unsure and was verifying by the end of the day. The licensee was told to contact the waste company who picked up the dumpster to prevent them from coming into possession with the licensed material. The licensee was not able to get into contact with the company over the weekend since this was outside of business hours.

On Monday, June 3, 2025, the NRC had reached out to the waste company and was told that the dumpster with the unused dose had been picked up before 7 AM on Friday, May 30, and that the contents of the dumpster had been put into a landfill before noon on that same day. A transfer or disposal to an unauthorized individual is a violation of 10 CFR 20.2001(a), which requires, in part, a licensee shall dispose of licensed material only by transfer to an authorized recipient or decay in storage.

b. Interviews and Records Review

On May 30, 2025, the inspector contacted the facility manager and the RSO liaison. Both interviews provided the inspector with a timeline of the event as well as the understanding of the RSO's role in the event. The RSO was able to be reached by phone when the dose was found to be missing and instructed the facility manager and NMT on what to do with the surveys. No other instructions were given at this time.

The inspector requested the shipping intake records, which showed that the licensee received both Pluvicto doses on May 27, 2025, with 546 mCi of Lu-177 between the two doses. The licensee verified through surveys that the two doses were received without contamination of the box.

A second inspector reached out to the waste company to gain more information about their waste pick up routine to better understand the timeline of when the licensee's waste was taken into their possession. Through this conversation, it was found that the licensee's waste was picked up Friday morning before the first inspector contacted the licensee and the same waste bin was returned to the licensee by the time the survey was completed later that day.

The inspector interviewed the RSO liaison, facility manager, and RSO. The RSO liaison and the facility manager were both involved with the identification of the lost material, and follow-up actions. The consultant RSO directed the on-site staff to take the surveys of the compactor, areas around the compactor, and was involved with the dose estimates which were included in the 30-day report. The majority of the contact with the licensee was with the facility manager, who provided the timelines, pictures of the reference boxes, pictures of the survey meter readings, and information regarding the licensee's process and procedures. The HOO report described the root cause of the event as human error with the NMT not remembering the second dose being in the box prior to defacing and discarding for the janitorial staff. The licensee submitted a report meeting 10 CFR 20.2201 requirements on June 26, 2025 [ML25181A041].

c. Apparent Violation

One apparent violation of NRC requirements was identified and appears as follows:

10 CFR 20.2001 requires, in part, that a licensee shall dispose of licensed material by transfer to an authorized recipient or by decay in storage.

Contrary to the above, the licensee failed to dispose of licensed material by transfer to an authorized recipient or by decay in storage. Specifically, on May 28, 2025, the licensee disposed of the unused lutetium-177 dose into regular trash, and it was picked up by the waste company on May 30, 2025.

d. Conclusions

The NRC inspection identified one apparent violation regarding the failure to dispose of licensed material by transfer to an authorized recipient or by decay in storage. Since the incident, the licensee has reviewed and expanded upon the protocol to clarify that packages, prior to being disposed of, should be double checked and additional survey measurements will be done to the shipping boxes that were used for Lu-177 doses. The licensee submitted a report stating that on May 30, 2025, the RSO and the Quality Control supervisor reviewed the procedures for waste disposal and decay-in-storage with the technologist involved in the incident. The same review was given to the other technologists on June 4, 2025.

3. Exit Meeting

The inspector conducted a preliminary debrief on August 12, 2025, with the facility manager and the radiation safety officer liaison. A formal exit meeting was held telephonically on December 2, 2025, with Brenda Manich, Radiation Safety Officer, Pedro Torres, Facility Manager and Administrator, and Sylvia Rodriguez, Quality Control Supervisor.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Pedro Torres, Administrator and Facility Manager

INSPECTION PROCEDURES USED

MD 8.3, "NRC Incident Investigation Program"

LIST OF ACRONYMS USED

10 CFR	*Code of Federal Regulations*
ADAMS	Agencywide Document Access and Management System
ADR	Alternative Dispute Resolution
HOO	Headquarters Operation Officer
NMT	Nuclear Medicine Technologist
NRC	Nuclear Regulatory Commission
PEC	Pre-decisional Enforcement Conference
RSO	Radiation Safety Officer

NOTE: The following information is an updated excerpt from NRC Information Notice 96-28 issued in 1996.

NRC INFORMATION NOTICE 96-28

UNITED STATES
NUCLEAR REGULATORY COMMISSION
OFFICE OF NUCLEAR MATERIAL SAFETY AND SAFEGUARDS
WASHINGTON, D.C. 20555
May 1, 1996

NRC INFORMATION NOTICE 96-28: SUGGESTED GUIDANCE RELATING TO DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION

Addressees

All material and fuel cycle licensees.

Purpose

The U.S. Nuclear Regulatory Commission (NRC) is issuing this information notice to provide addressees with guidance relating to development and implementation of corrective actions that should be considered after identification of violation(s) of NRC requirements. It is expected that recipients will review this information for applicability to their facilities and consider actions, as appropriate, to avoid similar problems. However, suggestions contained in this information notice are not new NRC requirements; therefore, no specific action or written response is required.

Background

On June 30, 1995, NRC revised its Enforcement Policy, to clarify the enforcement program's focus by, in part, emphasizing the importance of identifying problems before events occur, and of taking prompt, comprehensive corrective action when problems are identified. Consistent with the revised Enforcement Policy, NRC encourages and expects identification and prompt, comprehensive correction of violations. In many cases, licensees who identify and promptly correct non-recurring Severity Level IV violations, without NRC involvement, will not be subject to formal enforcement action. Such violations will be characterized as "non-cited" violations as provided in Section VI.A of the Enforcement Policy. Minor violations are not subject to formal enforcement action.

Nevertheless, the root cause(s) of minor violations must be identified and appropriate corrective action must be taken to prevent recurrence. If violations of more than a minor concern are identified by the NRC during an inspection, licensees will be subject to a Notice of Violation and may need to provide a written response, as required by 10 CFR 2.201, addressing the causes of the violations and corrective actions taken to prevent recurrence. In some cases, such violations are documented on Form 591 (for materials licensees) which constitutes a notice of violation that requires corrective action but does not require a written response. If a significant violation is involved, a pre-decisional enforcement conference may be held to discuss those actions.

The quality of a licensee's root cause analysis and plans for corrective actions may affect the NRC's decision regarding both the need to hold a pre-decisional enforcement conference with the licensee and the level of sanction proposed or imposed.

Discussion

Comprehensive corrective action is required for all violations. In most cases, NRC does not propose imposition of a civil penalty where the licensee promptly identifies and comprehensively corrects violations. However, a Severity Level III violation will almost always result in a civil penalty if a licensee does not take prompt and comprehensive corrective actions to address the violation. It is important for licensees, upon identification of a violation, to take the necessary corrective action to address the noncompliant condition and to prevent recurrence of the violation and the occurrence of similar violations. Prompt comprehensive action to improve safety is not only in the public interest, but is also in the interest of licensees and their employees. In addition, it will lessen the likelihood of receiving a civil penalty. Comprehensive corrective action cannot be developed without a full understanding of the root causes of the violation. Therefore, to assist licensees, the NRC staff has prepared the following guidance, that may be used for developing and implementing corrective action. Corrective action should be appropriately comprehensive to not only prevent recurrence of the violation at issue, but also to prevent the occurrence of similar violations. The guidance should help in focusing corrective actions broadly to the general area of concern rather than narrowly to the specific violations. The actions that need to be taken are dependent on the facts and circumstances of the particular case.

The corrective action process should involve the following three steps:

1. Conduct a complete and thorough review of the circumstances that led to the violation.

   Typically, such reviews include: Interviews with individuals who are either directly or indirectly involved in the violation, including management personnel and those responsible for training or procedure development/guidance. Particular attention should be paid to lines of communication between supervisors and workers. Tours and observations of the area where the violation occurred, particularly when those reviewing the incident do not have day-to-day contact with the operation under review. During the tour, individuals should look for items that may have contributed to the violation as well as those items that may result in future violations. Reenactments (without use of radiation sources, if they were involved in the original incident) may be warranted to better understand what actually occurred.

   Review of programs, procedures, audits, and records that relate directly or indirectly to the violation. The program should be reviewed to ensure that its overall objectives and requirements are clearly stated and implemented. Procedures should be reviewed to determine whether they are complete, logical, understandable, and meet their objectives (i.e., they should ensure compliance with the **current** requirements). Records should be reviewed to determine whether there is sufficient documentation of necessary tasks to provide a record that can be audited and to determine whether similar violations have occurred previously. Particular attention should be paid to training and qualification records of individuals involved with the violation.

2. Identify the root cause of the violation.

Corrective action is not comprehensive unless it addresses the root cause(s) of the violation. It is essential, therefore, that the root cause(s) of a violation be identified so that appropriate action can be taken to prevent further noncompliance in this area, as well as other potentially affected areas. Violations typically have direct and indirect cause(s). As each cause is identified, ask what other factors could have contributed to the cause. When it is no longer possible to identify other contributing factors, the root causes probably have been identified. For example, the direct cause of a violation may be a failure to follow procedures; the indirect causes may be inadequate training, lack of attention to detail, and inadequate time to carry out an activity. These factors may have been caused by a lack of staff resources that, in turn, are indicative of lack of management support. Each of these factors must be addressed before corrective action is considered to be comprehensive.

3. Take prompt and comprehensive corrective action that will address the immediate concerns **and** prevent recurrence of the violation.

It is important to take immediate corrective action to address the specific findings of the violation. For example, if the violation was issued because radioactive material was found in an unrestricted area, **immediate** corrective action must be taken to place the material under licensee control in authorized locations. After the immediate safety concerns have been addressed, timely action must be taken to prevent future recurrence of the violation. Corrective action is sufficiently comprehensive when corrective action is broad enough to reasonably prevent recurrence of the specific violation as well as prevent similar violations.

In evaluating the root causes of a violation and developing effective corrective action, consider the following:

1. Has management been informed of the violation(s)?

2. Have the programmatic implications of the cited violation(s) and the potential presence of similar weaknesses in other program areas been considered in formulating corrective actions so that both areas are adequately addressed?

3. Have precursor events been considered and factored into the corrective actions?

4. In the event of loss of radioactive material, should security of radioactive material be enhanced?

5. Has your staff been adequately trained on the applicable requirements?

6. Should personnel be re-tested to determine whether re-training should be emphasized for a given area? Is testing adequate to ensure understanding of requirements and procedures?

7. Has your staff been notified of the violation and of the applicable corrective action?

8. Are audits sufficiently detailed and frequently performed? Should the frequency of periodic audits be increased?

9. Is there a need for retaining an independent technical consultant to audit the area of concern or revise your procedures?

10. Are the procedures consistent with current NRC requirements, should they be clarified, or should new procedures be developed?

11. Is a system in place for keeping abreast of new or modified NRC requirements?

12. Does your staff appreciate the need to consider safety in approaching daily assignments?

13. Are resources adequate to perform, and maintain control over, the licensed activities? Has the radiation safety officer been provided sufficient time and resources to perform his or her oversight duties?

14. Have work hours affected the employees' ability to safely perform the job?

15. Should organizational changes be made (e.g., changing the reporting relationship of the radiation safety officer to provide increased independence)?

16. Are management and the radiation safety officer adequately involved in oversight and implementation of the licensed activities? Do supervisors adequately observe new employees and difficult, unique, or new operations?

17. Has management established a work environment that encourages employees to raise safety and compliance concerns?

18. Has management placed a premium on production over compliance and safety? Does management demonstrate a commitment to compliance and safety?

19. Has management communicated its expectations for safety and compliance?

20. Is there a published discipline policy for safety violations, and are employees aware of it? Is it being followed?