April 2020 through September 2020 Therapeutic and Diagnostic Machine Medical Reportable Events (MRE)	
Therapeutic	
1.	A patient was to receive Stereotactic Body Radiation Therapy (15Gy/fraction x 3 fractions) for her Medial Segment Left Lobe Liver Mass. During her 3rd fraction, the pump of the chiller failed while 16% (1598.32 MU/10115.54 MU) daily dose was delivered. The rest of the treatment was delivered within 48 hours. The part that broke is not prone to issues. Service was asked to pay special attention to this part during the next scheduled PM. (5/2020)
2.	Due to a treatment setup error for the initial 16 of 25 fractions, the delivered dose varied by more than 20% from prescribed for up to approximately 5% of the planning target volume (PTV). The therapist did not adequately review the prescription and the set-up sheet prior to each fraction. In addition, a substandard portal image that did not match the planned digitally reconstructed image was submitted for review and approved by physician. Radiation staff will be retrained. (6/2020)
3.	Patient was to receive first partial right breast treatment. The table was incorrectly positioned with a lateral coordinate set to -9.7 cm instead of +9.7 cm, resulting in a 19.4 cm error in the isocenter placement. The unintended dose to the left breast was approximately 45 cGy. The correct treatment was subsequently delivered without event. The therapists did not verify the light field or laser location. The couch coordinates were not captured during the dry run. There is not expected to be any harm to the patient. Therapists will be reminded to confirm treatment location by observing the light field or laser prior to beginning treatment. The current policy will be modified to explicitly state that the table coordinates must be captured during the dry run. (8/2020)
Diagnostic	
1.	An acute injury to a patient's skin was identified (8/06) through physical examination. The injury resulted from an interventional procedure (FGI) that took place on 7/14 in the Interventional Vascular Unit (IVU). At the conclusion of that exam, the RSO was notified by the IVU staff of the extensive fluoro time (74.6 minutes) and digital acquisition (CINE) runs (44), per policy. Patient is morbidly obese, which contributed greatly to the complications of the procedure, as well as causing the equipment to operate at, or near, maximum radiation output. The injury resulted from a complex medical procedure complicated by extreme body habitus. (7/2020)