publishes notice at least once monthly of certain Federal agency requests for records disposition authority (records schedules). Records schedules identify records of sufficient value to warrant preservation in the National Archives of the United States. Schedules also authorize agencies after a specified period to dispose of records lacking administrative, legal, research, or other value. Notice is published for records schedules that (1) propose the destruction of records not previously authorized for disposal, or (2) reduce the retention period for records already authorized for disposal. NARA invites public comments on such schedules, as required by 44 USC 3303a(a).

DATES: Request for copies must be received in writing on or before January 11, 1996. Once the appraisal of the records is completed, NARA will send a copy of the schedule. The requester will be given 30 days to submit comments.

ADDRESSES: Address requests for single copies of schedules identified in this notice to the Records Appraisal and Disposition Division (NIR), National Archives and Records Administration, College Park, MD 20740. Requesters must cite the control number assigned to each schedule when requesting a copy. The control number appears in the parentheses immediately after the name of the requesting agency.

SUPPLEMENTARY INFORMATION: Each year U.S. Government agencies create billions of records on paper, film, magnetic tape, and other media. In order to control this accumulation, agency records managers prepare records schedules specifying when the agency no longer needs the records and what happens to the records after this period. Some schedules are comprehensive and cover all the records of an agency or one of its major subdivisions. These comprehensive schedules provide for the eventual transfer to the National Archives of historically valuable records and authorize the disposal of all other records. Most schedules, however, cover records of only one office or program or a few series of records, and many are updates of previously approved schedules. Such schedules also may include records that are designated for permanent retention.

Destruction of records requires the approval of the Archivist of the United States. This approval is granted after a thorough study of the records that takes into account their administrative use by the agency of origin, the rights of the Government and of private persons directly affected by the Government's activities, and historical or other value.

This public notice identifies the Federal agencies and their subdivisions requesting disposition authority, includes the control number assigned to each schedule, and briefly describes the records proposed for disposal. The records schedule contains additional information about the records and their disposition. Further information about the disposition process will be furnished to each requester.

Schedules Pending

1. Department of Health and Human Services, Administration for Health Care Policy and Research (N1–510–94–2). Hardcopy data collected for the Medical Treatment Effectiveness Program.

2. Department of Housing and Urban Development (N1–196–95–1). Public Housing Administration Legal Opinions, 1937–1971, relating to administrative matters.

3. Department of the Interior, Bureau of Reclamation (N1–115–94–4). General administrative records pertaining to the Bureau's research, testing, and technical program.

4. Department of State, Bureau of Population, Refugees, and Migration (N1–59–95–23). Routine, facilitative, and duplicative records.

5. Department of the Treasury, Internal Revenue Service (N1–58–95–4). Comprehensive schedule for the Martinsburg Computer Center.

6. Advisory Committee on Human Radiation Experiments (N1–220–95–9). Duplicative electronic records that do not meet the National Archives requirements for transfer.

7. Interstate Commerce Commission (N1–134–83–1). Public Dockets (a selection of which are designated for preservation).

8. President's Committee on Consumer Interests (N1–220–95–13). Consumer correspondence, 1969–1970.

Dated: November 8, 1995.

James W. Moore,

Assistant Archivist for Records Administrative.

[FR Doc. 95–28751 Filed 11–24–95; 8:45 am]

BILLING CODE 7515–01–M

NUCLEAR REGULATORY COMMISSION

Report to Congress on Abnormal Occurrences April-June, 1995; Dissemination of Information

Section 208 of the Energy Reorganization Act of 1974, as amended, requires NRC to disseminate information on abnormal occurrences (AOs) (i.e., unscheduled incidents or events that the Commission determines are significant from the standpoint of public health and safety). During the second quarter of CY 1995, the following incidents at NRC licensed facilities were determined to be AOs and are described below, together with the remedial actions taken. Each event is also being included in NUREG–0090, Vol. 18, No. 2, (''Report to Congress on Abnormal Occurrences: April-June 1995''). This report will be available at NRC's Public Document Room, 2120 L Street NW. (Lower Level), Washington, DC, about three weeks after the publication date of this Federal Register Notice.

Nuclear Power Plants

95–2 Reactor Coolant System Blowdown at Wolf Creek Nuclear Generating Station

One of the AO reporting guidelines notes that major deficiencies in design, construction, use of, or management controls for licensed facilities or material can be considered an AO.

Date and Place—September 17, 1994; Wolf Creek Nuclear Generating Station, a Westinghouse-designed pressurized water reactor nuclear power plant, operated by Wolf Creek Nuclear Operating Corporation and located about 5.63 kilometers (3.5 miles) northeast of Burlington, Kansas.

Nature and Probable Consequences—An inadvertent blowdown of approximately 34,868 liters (9200 gallons) of reactor coolant through the residual heat removal (RHR) system to the refueling water storage tank (RWST) occurred because of incompatible, concurrent RHR valve manipulations. At the time of the event, the reactor had been shutdown for 28 hours and was on RHR cooling (2413 kPa gauge and 149 C [350 psi gauge and 300 F]). The event was successfully terminated in 1 minute by operator intervention. There was only minimal interruption to heat removal processes, and no core damage or fission product release occurred. However, if the blowdown continued, the licensee estimated that RHR cooling could have failed in about 3.5 minutes, the RWST header could have filled with steam in about 6 minutes, and uncovering of the core could have begun in about 30 minutes.

All of the emergency core cooling system (ECCS) pumps take their suction from the RWST header line. If the ECCS pumps were started to mitigate the blowdown after the RWST header filled with steam, a common-mode failure of all ECCS pumps could have occurred as a result of steam binding. The ECCS pumps could also have failed as a result of pressure pulses caused by cold RWST

water collapsing the steam in the RWST and RWST header. If they failed, successful mitigation of such an event would depend on the control room operators' cognitive abilities to establish core heat removal via the steam generators.

If core damage did occur, then a possibility for a significant offsite release existed because the blowdown path in place at the time bypassed the reactor containment.

Cause or Causes—This event was attributed to the following three causes:

(1) *Unrecognized design vulnerability*—An RHR-RWST connecting line was designed to provide operational convenience for refilling the RWST after a refueling outage, but not for safety purposes. The inappropriate use of this line while on RHR cooling could result in a rapid blowdown event and a subsequent common-mode failure of all ECCS pumps.

(2) *Inappropriate use of the RHR-RWST connecting line*—The licensee inappropriately used the RHR-RWST connecting line to increase the boron concentration of the RHR train. (Other boration paths existed that would not have resulted in an inadvertent blowdown.)

(3) *Inadequate work control*—The licensee was deficient in the control of maintenance and operational evolutions by allowing incompatible activities to occur simultaneously. The control room crew had ample warning of the potential adverse effects of these activities just prior to the event, but failed to limit the concurrent manipulation of selected RHR valves.

The licensee also had previous warnings of blowdown events from its experience at Wolf Creek and from the following NRC Information Notices: 90–55, ''Recent Operating Experience on Loss of Reactor Coolant Inventory While in a Shutdown Condition''; and 91–42, ''Plant Outage Events Involving Poor Coordination Between Operations and Maintenance Personnel During Valve Testing and Manipulations.'' The licensee's response to these warnings was that its administrative controls adequately addressed the concerns.

Actions Taken to Prevent Recurrence

Licensee—The licensee implemented the following actions: (1) Chain locked the isolation valve in the RHR-RWST connecting line, and made the plant manager and operations manager solely responsible for access to this valve; (2) removed the use of the RHR-RWST connecting line from the RHR boration procedures; and (3) approached the Westinghouse Owners Group to address the issue generically.

NRC—NRC issued Information Notice No. 95–03, ''Loss of Reactor Coolant Inventory and Potential Loss of Emergency Mitigation Functions While in a Shutdown Condition,'' to inform all reactor licensees of the circumstances and potential consequences associated with the Wolf Creek event.

95–3 Previously Unidentified Path for the Potential Release of Radioactivity at Millstone Nuclear Power Station Unit 2

One of the AO reporting guidelines notes that a loss of plant capability to perform essential safety functions, such that a potential release of radioactivity in excess of 10 CFR Part 100 guidelines could result from a postulated transient or accident (e.g., loss of emergency core cooling system, loss of control rod system), can be considered an AO.

Date and Place—December 6, 1994; Millstone Nuclear Power Station Unit 2, a Combustion Engineering-designed pressurized water reactor nuclear power plant, operated by Northeast Nuclear Energy Company and located about 5.15 kilometers (3.2 miles) west-southwest of New London County, Connecticut.

Nature and Probable Consequences—While the plant was in a refueling outage, a systems engineer employed by the licensee identified a condition that established a potential unfiltered release path to the atmosphere that could have resulted in offsite doses in excess of 10 CFR Part 100 guidelines in the event of a postulated loss-of-coolant accident (LOCA). The licensee immediately declared the enclosure building inoperable and promptly reported the condition to NRC.

The Millstone Unit 2 design includes an Enclosure Building around the reactor Containment Building to collect all leakage out of the containment during a postulated LOCA. The Enclosure Building Ventilation System contains a charcoal bed filtration unit to remove radioactive iodine prior to discharging the Enclosure Building air out of the 114.4-meter (375-foot) high Unit-1 stack. The condition identified on December 6, 1994, was that the ventilation system associated with the Hydrogen Analyzer cabinet and waste gas sample hood fan, located within the East Electrical Penetration Room of the Enclosure Building, would not isolate in the event of a LOCA. During a postulated accident, this ventilation system, which does not contain a charcoal filter unit, would draw Enclosure Building air (contaminated with any containment leakage) from the East Penetration Room and discharge it through the 45.8-meter (150-foot) high Unit 2 vent. The lack of a charcoal filter and the lower release point would significantly increase the potential of a thyroid dose in excess of the 10 CFR Part 100 guideline at the exclusion area boundary.

The Technical Specifications for Millstone Unit 2 require that the Enclosure Building integrity be maintained to ensure that the Enclosure Building Ventilation System limits the site boundary doses to within 10 CFR Part 100 guidelines following a postulated design basis accident. NRC performed a design basis dose calculation which took into account the lack of charcoal filtration and the lower elevation release path which would result from the noted design deficiency. This calculation indicated that an exclusion area boundary dose to the thyroid greater than the 10 CFR Part 100 guideline of 3000 millisievert (mSv) (300 rem) would occur. It also indicated that the whole body dose would not exceed the 250 mSv (25 rem) 10 CFR Part 100 guideline. The NRC calculation was very conservative in that it assumed that all of the designed allowable containment leakage, following the design basis accident, would be through the penetrations in the East Electrical Penetration Room and released from the Enclosure Building through the Hydrogen Analyzer Ventilation system.

Cause or Causes—The cause of this condition was an original design deficiency of the hydrogen analyzer cabinet exhaust system.

Actions Taken to Prevent Recurrence

Licensee—The licensee modified the design to route the exhaust path from the hydrogen analyzer cabinet into the enclosure building ventilation system, thereby going through the appropriate filtration, in order to reduce any post-LOCA radioactive release to below 10 CFR Part 100 guidelines. The waste gas sample sink was relocated from the enclosure building to the auxiliary building. This design modification was implemented prior to the start up of Millstone Unit 2.

NRC—On February 16, 1995, NRC exercised enforcement discretion and did not issue a violation. In accordance with the ''General Statement of Policy and Procedure for NRC Enforcement Actions,'' (Enforcement Policy) then set out at 10 CFR Part 2, Appendix C, this design deficiency would normally be categorized as a Severity Level III violation and enforcement action would normally be considered because it involved a violation of the Technical Specifications and could have resulted in 10 CFR Part 100 guidelines being exceeded in the event of a LOCA. However, the exercise of discretion for the apparent Severity Level III violation

was determined to be warranted in this instance because: (1) The condition was identified by the licensee's staff as a result of a questioning attitude by a system engineer and was promptly reported to the NRC; (2) the condition, which existed since initial startup, was difficult to discover and such identification was not likely by routine inspection, surveillance and quality assurance activities; (3) comprehensive corrective actions were taken within a reasonable time period that involved an adequate root cause determination and a review for failures caused by similar root causes; and (4) the condition was caused by an old performance failure that is not reasonably linked to present performance.

This event was determined to be plant specific due to the unique design of the ventilation system.

Other NRC Licensees (Industrial Radiographers, Medical Institutions, Industrial Users, etc.)

95–4 Medical Brachytherapy Misadministration at the University of Virginia, in Charlottesville, Virginia

One of the AO reporting guidelines notes that a therapeutic exposure to any part of the body not scheduled to receive radiation can be considered an AO.

Date and Place—March 14, 1995; University of Virginia Medical Center; Charlottesville, Virginia.

Nature and Probable Consequences—A patient was prescribed a manual brachytherapy procedure using cesium-137 (Cs-137) sources loaded in an applicator, for a total gynecological treatment dose of 3000 centigray (cGy) (3000 rad).

During insertion of the applicator into the patient, one of the sources fell onto the patient's bed and was unnoticed by the licensee staff involved in performing the procedure. A nurse found the source in the bed on March 15 and removed it. The source was reloaded into the applicator and the physician revised the prescribed dose to 2500 cGy (2500 rad). The licensee estimated that the source remained at approximately 10 centimeters (4 inches) from the patient's foot for 18 hours and delivered a dose of about 13 cGy (13 rad) to the foot.

The licensee notified the referring physician and the patient of the misadministration. An NRC medical consultant was obtained who concluded that the patient was receiving appropriate follow-up care. In addition, the licensee and the medical consultant concluded that the patient will not experience any adverse health effects as a result of the misadministration.

Cause or Causes—The licensee's staff involved in the brachytherapy procedure were not familiar with handling of the applicator that contained the Cs-137 sources. Also, because of anatomic characteristics of the patient, the physician had difficulty inserting the source carrier into the applicator. The design of the afterloading device allows the source to slide out of the carrier if any unusual manipulation of source carrier is required. The difficulty experienced by the physician in inserting the source in the applicator and the design of the source carrier resulted in the source falling out of the carrier during the insertion process.

Actions Taken to Prevent Recurrence

Licensee—The licensee provided training for its staff, involved in brachytherapy procedures, concerning the precautions which must be taken when handling an applicator such as the one used in the subject procedure. Also, emphasis was placed on the need to be more attentive during the source insertion process in order to account for all prescribed sources.

NRC—NRC conducted a special inspection on March 23–24, 1995, to review the circumstances surrounding the misadministration. The inspection report was issued on May 2, 1995. Enforcement action will be taken as appropriate.

95–5 Medical Therapeutic Radiopharmaceutical Misadministration of Iodine-131 at Massachusetts General Hospital in Boston, Massachusetts

One of the AO reporting guidelines notes that administering a therapeutic dose of a radiopharmaceutical differing from the prescribed dose by more than 10 percent and the actual dose is greater than 1.5 times the prescribed dose can be considered an AO.

Date and Place—May 9, 1995; Massachusetts General Hospital; Boston, Massachusetts.

Nature and Probable Consequences—A patient was prescribed a 296 megabecquerel (MBq) (8 millicurie [mCi]) dosage of iodine-131 (I–131) for hyperthyroidism; however, a dosage of 1106.3 MBq (29.9 mCi) was administered.

Representatives of the hospital informed the referring physician and the patient of the misadministration. An NRC medical consultant was obtained to evaluate the event and stated that the higher dosage given to the patient will result in a more likely achievement of the intended therapeutic goal to eliminate the patient's hyperthyroidism. Additionally, the consultant determined that it is unlikely that the patient is at significant risk of experiencing long-term consequences from receiving the higher dosage beyond the risk associated with the prescribed dosage. Therefore, the impact on the patient's health is expected to be negligible with no expected long-term disability. (The intent of the prescribed dose was to ablate the portion of the thyroid remaining after surgery and then support the patient with thyroid supplement the rest of her life. This did not change with the administered dose.)

Cause or Causes—The licensee stated that this event occurred because of a human error. The technologist involved in this procedure inadvertently switched the labeled lids on the vial shields containing the I–131 dosages prescribed for different patients. Additionally, the technician failed to check for the correct dosage on the vial label, and the wrong dose was administered to the intended patient.

Actions Taken to Prevent Recurrence

Licensee—The licensee instituted a procedure for checking the vial label before giving a dose. In addition, the licensee is obtaining a second dose calibrator which will be used in the out-patient dosing room of the Thyroid Clinic. Each dose will be re-assayed immediately before the I–131 is administered to the patient, rather than relying on the assay which was performed in the Thyroid Lab before the dose was transported to the out-patient dosing room.

NRC—NRC performed an inspection on May 12, 1995, to learn about the event and determined that it constituted a misadministration as defined in 10 CFR 35.2. NRC determined that this was an isolated violation of the licensee's Quality Management Program and issued a Notice of Violation at the Severity Level IV on June 26, 1995.

95–6 Multiple Medical Brachytherapy Misadministrations at Madigan Army Medical Center in Fort Lewis, Washington

One of the AO reporting guidelines notes that administering a therapeutic dose from a sealed source such that the treatment dose differs from the prescribed dose by more than 10 percent and the event (regardless of health effects) affects two or more patients at the same facility can be considered an AO.

Date and Place—February 1994 through May 1995; Madigan Army Medical Center (MAMC); Fort Lewis, Washington.

Nature and Probable Consequences—Four patients were prescribed brachytherapy procedures, using iridium-192 seeds of different source strengths, and received doses other than those prescribed because of the same computer input error. (The same computer input error could cause either underdoses or overdoses because the algorithm used was dose dependent.) Details of the misadministrations are as follows:

Patient A: The patient was prescribed a dose of 2800 centigray (cGy) (2800 rad) for a gynecological brachytherapy treatment, but received a dose of about 1680 cGy (1680 rad) instead.

Patient B: Event 1—The patient was prescribed a dose of 1600 cGy (1600 rad) for lung treatment, but received a dose of about 2128 cGy (2128 rad) instead.

Event 2—On another day, the same patient was prescribed a dose of 1500 cGy (1500 rad) for lung treatment, but received a dose of about 2350 cGy (2350 rad) instead.

Patient C: The patient was prescribed a dose of 3000 cGy (3000 rad) for gynecological treatment, but received a dose of about 5142 cGy (5142 rad) instead.

Patient D: The patient was prescribed a dose of 1500 cGy (1500 rad) for a biliary tract treatment, but received a dose of about 2050 cGy (2050 rad) instead.

The licensee does not expect the patients to experience any adverse health effects as a result of the misadministrations.

Cause or Causes—Based upon NRC's initial review of the misadministrations, it appears that the probable causes of the treatment errors were failures to: (1) independently review or check the data input to the computerized treatment planning system, and (2) perform an independent check of dose rate calculations generated by the treatment planning system.

Actions Taken to Prevent Recurrence

Licensee—The physics staff at MAMC promptly corrected the data entered into the computer treatment planning computer, recalculated the doses received by the patients, and took steps to ensure that appropriate data will be used for future treatment plans.

NRC—NRC initiated an inspection on June 6, 1995, to review the circumstances associated with the misadministrations and to review the licensee's corrective actions. (As of the date of this report, the inspection is ongoing.) An NRC medical consultant will review each case in order to provide an independent assessment of the potential consequences of the overdoses.

Dated at Rockville, MD this 20th day of November, 1995.

For the Nuclear Regulatory Commission.

John C. Hoyle,

Secretary of the Commission.

[FR Doc. 95–28835 Filed 11–24–95; 8:45 am]

BILLING CODE 7590–01–P

[Docket No. 030–31765–CivP EA 94–006 ASLBP No. 95–708–01–CivP]

Atomic Safety and Licensing Board; In the Matter of Oncology Services Corporation (Harrisburg, Pennsylvania, Byproduct Materials License No. 37–28540–01); Notice of Hearing (Staff Order Imposing Civil Monetary Penalties)

November 20, 1995.

Before Administrative Judges: G. Paul Bollwerk, III, Chairman, Dr. George C. Anderson, Dr. A. Dixon Callihan.

On April 24, 1995, the NRC staff issued an order imposing civil penalties in the amount of $280,000 on Oncology Services Corporation (OSC) for alleged regulatory violations relating to activities under Byproduct Materials License No. 37–28540–01. (60 Fed. Reg. 21,560.) That license authorized OSC to possess and use certain byproduct materials under specified conditions at six facilities in Pennsylvania.[1] The violations at issue were identified during a December 3–18, 1992 NRC inspection regarding a November 1992 misadministration incident at OSC's Indiana (Pennsylvania) Regional Cancer Center, and December 8, 1995 inspections of OSC facilities in Exton and Lehighton, Pennsylvania.

The April 1994 order provided that on or before May 24, 1995, OSC could submit a request for a hearing regarding the staff's civil penalty determination. On May 18, 1995, OSC filed a timely hearing request regarding the civil penalty order. The Commission referred OSC's submission to the Atomic Safety and Licensing Board Panel on May 25, 1995, for the appointment of a presiding officer to conduct any necessary proceedings. On May 30, 1995, the Acting Chief Administrative Judge of the Panel appointed this Atomic Safety and Licensing Board pursuant to the Commission's referral. (60 Fed. Reg. 29,901.) The Board consists of Dr. George C. Anderson, Dr. A. Dixon Callihan, and G. Paul Bollwerk, III, who will serve as Chairman of the Board.

Pursuant to the Board's June 12, 1995 initial prehearing order, on August 23, 1995, OSC and the staff submitted a prehearing report in which they individually or jointly identified some 259 ''central'' issues for litigation in this proceeding. Two days later, OSC filed a motion with the Board requesting that the proceeding be stayed pending the resolution of an open staff investigation of OSC, the termination of which OSC asserted could result in settlement of this proceeding. The staff opposed OSC's stay request. After entertaining party arguments on the motion during an October 11, 1995 prehearing conference, by unpublished memorandum and order issued October 30, 1995, the Board denied the stay request and established a schedule for filing prediscovery dispositive motions regarding the ''central'' litigation issues identified by the parties.

Please take notice that a hearing will be conducted in this proceeding. The parties to the hearing are the NRC staff and OSC. The hearing will be governed by the procedures set forth in 10 C.F.R. Part 2, Subpart G (10 C.F.R. 2.700–.790).

During the course of this proceeding, the Board may hold additional prehearing conferences or oral arguments, as provided in 10 C.F.R. 2.752, 2.755. The public is invited to attend any prehearing conference or oral argument, as well as any evidentiary hearing that may be held pursuant to 10 C.F.R. 2.750–.751. The Board will establish the schedules for such sessions at a later date, through notices to be published in the Federal Register and/or made available to the public at NRC Public Document Rooms.

In accordance with 10 C.F.R. 2.715(a), any person not a party to this proceeding may submit a written limited appearance statement setting forth his or her position on the issues in this proceeding. These statements do not constitute evidence but may assist the Board and/or the parties in the definition of the issues being considered. Written limited appearance statements should be sent to the Office of the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Service Branch. A copy of the statement also should be served on the Chairman of the Atomic Safety and Licensing Board. The Board will make a determination at a later date whether oral limited appearance statements will be entertained.

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[1] License No. 37–28540–01 was due to expire on August 31, 1995. On December 13, 1993, OSC requested that license be terminated and replaced with individual licenses issued to the facilities named as locations of use on that license. On August 24, 1994, License No. 37–28540–01 was terminated and the agency subsequently issued separate licenses for five of the six facilities. See *Oncology Servs. Corp.*, LBP–94–29, 40 NRC 123, 124 n.1 (1994).