that infringe claim 1 of U.S. Letters Patent 5,418,752 during the course of the Commission's investigation.

ADDRESSES: The complaint and motion for temporary relief, except for any confidential information contained therein, are available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street, S.W., Room 112, Washington, D.C. 20436, telephone 202–205–1802. Hearing-impaired individuals are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on 202–205–1810.

FOR FURTHER INFORMATION CONTACT: John M. Whealan, Esq., Office of Unfair Import Investigations, U.S. International Trade Commission, telephone 202–205–2574.

Authority: The authority for institution of this investigation is contained in section 337 of the Tariff Act of 1930, as amended, and in section 210.10 of the Commission's Final Rules of Practice and Procedure, 19 CFR 210.10. The authority for provisional acceptance of the motion for temporary relief is contained in section 210.58, 19 CFR 210.58.

Scope of Investigation

Having considered the complaint and the motion for temporary relief, the U.S. International Trade Commission, on February 20, 1996, ORDERED THAT—

(1) Pursuant to subsection (b) of section 337 of the Tariff Act of 1930, as amended, an investigation be instituted to determine whether there is a violation of subsection (a)(1)(B) of section 337 in the importation into the United States, the sale for importation, or the sale within the United States after importation of certain flash memory circuits and products containing same by reason of infringement of claims 1, 2, 3 or 4 of U.S. Letters Patent 5,418,752 or claims 27, 32, or 44 of U.S. Letters Patent 5,172,338, and whether there exists an industry in the United States as required by subsection (a)(2) of section 337.

(2) Pursuant to section 210.58 of the Commission's Final Rules of Practice and Procedure, 19 CFR 210.58, the motion for temporary relief under subsection (e) of section 337 of the Tariff Act of 1930, which was filed with the complaint, be provisionally accepted and referred to the presiding administrative law judge for investigation.

(3) For the purpose of the investigation so instituted, the following are hereby named as parties upon which this notice of investigation shall be served:

(a) The complainant is—SanDisk Corporation, 3270 Jay Street, Santa Clara, California 95054.

(b) The respondents are the following companies alleged to be in violation of section 337, and are the parties upon which the complaint and motion for temporary relief are to be served:

Samsung Electronics Company, Ltd., Samsung Main Building, 10th Floor, 250, 2–ka Taepyung-Ro Chung-Ku, Seoul, Korea

Samsung Semiconductor, Inc., 3655 North First Street, San Jose, California 95134–1707

(c) John M. Whealan, Esq., Office of Unfair Import Investigations, U.S. International Trade Commission, 500 E Street, S.W., Room 401P, Washington, D.C. 20436, shall be the Commission investigative attorney, party to this investigation; and

(4) For the investigation and temporary relief proceedings instituted, the Honorable Sidney Harris is designated as the presiding Administrative Law Judge.

Responses to the complaint, the motion for temporary relief, and the notice of investigation must be submitted by the named respondents in accordance with sections 210.13 and 210.59 of the Commission's Final Rules of Practice and Procedure, 19 CFR 210.13 and 210.59. Pursuant to 19 CFR 201.16(d), 210.13(a) and 210.59 of the Commission's Final Rules of Practice and Procedure, such responses will be considered by the Commission if received not later than 10 days after the date of service by the Commission of the complaint, the motion for temporary relief, and the notice of investigation. Extensions of time for submitting responses to the complaint will not be granted unless good cause therefor is shown.

Failure of a respondent to file a timely response to each allegation in the complaint, in the motion for temporary relief, and in this notice may be deemed to constitute a waiver of the right to appear and contest the allegations of the complaint, the motion for temporary relief, and this notice, and to authorize the administrative law judge and the Commission, without further notice to the respondent, to find the facts to be as alleged in the complaint, motion for temporary relief, and this notice and to enter both an initial determination and a final determination containing such findings, and may result in the issuance of a limited exclusion order or a cease and desist order or both directed against such respondent.

Issued: February 20, 1996.

By order of the Commission.

Donna R. Koehnke,

Secretary.

[FR Doc. 96–4223 Filed 2–23–96; 8:45 am]

BILLING CODE 7020–02–P

NUCLEAR REGULATORY COMMISSION

Report to Congress on Abnormal Occurrences July–September 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 third 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. 3 (''Report to Congress on Abnormal Occurrences: July–September 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.

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

95–7 Medical Brachytherapy Misadministration at Marshfield Clinic in Marshfield, Wisconsin

One of the AO reporting guidelines notes that administering a therapeutic dose from a sealed source such that the calculated total treatment dose differs from the prescribed total treatment 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—June 8, 1995; Marshfield Clinic; Marshfield, Wisconsin.

Nature and Probable Consequences—A patient was prescribed a dose of 1640 centigray (cGy) (1640 rad) for a low dose rate brachytherapy treatment of the cervix using cesium-137 sources.

After the sources were implanted, but prior to completion of the treatment, the physician entered the wrong date for removal of the sources into the final treatment plan. Because of this error the treatment was extended for an additional day. As a result, the calculated administered dose was 2440 cGy (2440 rad) which was

approximately 50 percent greater than the prescribed dose.

The physician informed the patient of the misadministration both verbally and in writing. The licensee evaluated the consequences of the misadministration and determined that there would be no adverse health effects.

An NRC medical consultant evaluated the consequences of the misadministration and agreed with the licensee's conclusion.

Cause or Causes—The licensee failed to notice that the planned explant time documented in the final treatment plan did not represent the prescribed treatment time documented in the written directive. Also, the licensee's written directive/low dose rate brachytherapy log form, used to record events occurring during low dose rate brachytherapy treatments, did not contain a location to document the prescribed time for source removal.

Actions Taken To Prevent Recurrence

Licensee—The licensee revised its written directive/low dose rate brachytherapy log form to include documentation of the actual implantation time, and the time for the prescribed and actual removal of sources. Additionally, the revised form will include verification of such times by a licensee staff member.

NRC—NRC conducted an inspection and reviewed the circumstances surrounding the misadministration. NRC also retained a medical consultant to review the case. A Confirmatory Action Letter was issued which confirms that the licensee will verify that its authorized users meet training and experience requirements. A Notice of Violation was issued with five Severity Level IV violations.

* * * * *

95–8 Medical Brachytherapy Misadministration at Providence Hospital in Southfield, Michigan

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—July 25, 1995; Providence Hospital; Southfield, Michigan.

Nature and Probable Consequences—A patient was prescribed a dose of 1230 centigray (cGy) (1230 rad) for a palliative manual brachytherapy treatment of the brain using an iridium-192 seed.

After implantation, confirmatory x-rays were taken but could not confirm the location of the seed and the treatment was terminated about 31 hours after implantation. The licensee determined that the seed was implanted about 4 centimeters (1.57 inches) from the intended treatment site of the brain. Consequently, the wrong treatment site received an unintended radiation dose of about 739 cGy (739 rad) and the tumor received only about 72 cGy (72 rad).

The licensee determined that no adverse health effects would result from the misadministration. An NRC medical consultant has reviewed the case but has not yet submitted a report to NRC. The licensee notified the referring physician and the patient about the misadministration.

Cause or Causes—The licensee said that the seed became detained at the elbow of the applicator during implantation and changed direction. The physician consequently encountered resistance while inserting the source and assumed that it reached the intended treatment site. A confirmatory x-ray taken at the time of insertion did not show the location of the source. (The licensee had used a fluoroscope [real time imaging] during simulation of the treatment, but a fluoroscope was not used to observe the actual seed implantation.)

Actions Taken To Prevent Recurrence

Licensee—The licensee reported that when using this type of applicator in the future, fluoroscopy will be used to assure proper implantation of radioactive material.

NRC—NRC conducted an investigation to review the circumstances surrounding the misadministration. The NRC staff is currently reviewing the inspection results for possible violations, and enforcement action is pending.

* * * * *

95–9 Ingestion of Radioactive Material by Research Workers at the National Institutes of Health in Bethesda, Maryland

One of the AO reporting guidelines notes that a moderate exposure to, or release of, radioactive material licensed by or otherwise regulated by the Commission can be an abnormal occurrence.

Date and Place—June 28, 1995; National Institutes of Health (NIH); Bethesda, Maryland.

Nature and Probable Consequences—A pregnant research employee became internally contaminated with phosphorus-32 (P–32) and was sent to a local hospital for treatment.

NRC formed an Augmented Inspection Team (AIT), which included a medical consultant, to review the incident. The medical consultant stated, based on the licensee's initial report, that there would not be any adverse health consequences to the researcher or the fetus. Also, an NRC scientific consultant at the Oak Ridge Institute for Science and Education's Radiation Internal Dose Information Center was consulted. An independent assessment was also performed by Lawrence Livermore National Laboratories.

The licensee subsequently found that 26 individuals (in addition to the pregnant researcher) were also contaminated. The Federal Bureau of Investigation (FBI), the NRC's Office of Investigations (OI), and the NIH Police Department are currently investigating the event. The AIT has concluded its inspection efforts. OI continues to work with the FBI.

Cause or Causes—Because of the ongoing investigation, NRC has not reached a final conclusion as to the cause of the event.

Actions Taken to Prevent Recurrence

Licensee—The licensee continues to investigate the incident. The licensee performed bioassay sampling to identify the isotope, calculate preliminary estimates of intake, and determine the scope of the contamination. In addition, the licensee will take actions to enhance security for handling radioactive materials.

NRC—In addition to forming an AIT, NRC subsequently conducted a special inspection to determine the effectiveness of NIH security over radioactive materials.

NRC also issued two Confirmatory Action Letters. The first confirmed the actions that the licensee would take to reduce the possibility of further ingestion and to determine the extent of the contamination. The second confirmed the actions that the licensee would take in response to the special inspection that reviewed the NIH security policy for handling radioactive materials.

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Dated at Rockville, MD, this 20th day of February 1996.

For the Nuclear Regulatory Commission.

John C. Hoyle,

Secretary of the Commission.

[FR Doc. 96–4227 Filed 2–23–96; 8:45 am]

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