product, or undertake an objective examination of all relevant evidence; further, the Government of Japan alleges that the captive production provision itself, section 771(7)(c)(iv) of the Tariff Act of 1930, as amended, is inconsistent with these articles of the Antidumping Agreement.

Other allegations include:

8. The United States' allegedly biased approach to the investigation, including with respect to the critical circumstances determination, the application of ''facts available,'' and the determination of injury, was inconsistent with Article X:3 of GATT 1994;

9. The above laws, regulations, and rulings are not in conformity with obligations under the WTO agreements, and so are inconsistent with Article XVI:4 of the Marrakesh Agreement and Article 18.4 of the Antidumping Agreement.

Public Comment: Requirements for Submissions

Interested persons are invited to submit written comments concerning the issues raised in this dispute. Comments must be in English and provided in fifteen copies to Sandy McKinzy at the address provided above. A person requesting that information contained in a comment submitted by that person be treated as confidential business information must certify that such information is business confidential and would not customarily be released to the public by the submitting person. Confidential business information must be clearly marked ''BUSINESS CONFIDENTIAL'' in a contrasting color ink at the top of each page of each copy.

Information or advice contained in a comment submitted, other than business confidential information, may be determined by USTR to be confidential in accordance with section 135(g)(2) of the Trade Act of 1974 (19 U.S.C. 2155(g)(2)). If the submitting person believes that information or advice may qualify as such, the submitting person—

(1) Must so designate the information or advice;

(2) Must clearly mark the material as ''SUBMITTED IN CONFIDENCE'' in a contrasting color ink at the top of each page of each copy; and

(3) Is encouraged to provide a non-confidential summary of the information or advice. Pursuant to section 127(e) of the URAA (19 U.S.C. 3537(e)), USTR will maintain a file on this dispute settlement proceeding, accessible to the public, in the USTR Reading Room: Room 101, Office of the United States Trade Representative, 600 17th Street, NW., Washington, DC 20508. The public file will include a listing of any comments received by USTR from the public with respect to the proceeding, the U.S. submissions to the panel in the proceeding, the submissions, or non-confidential summaries of submissions, to the panel received from other parties in the dispute, as well as the report of the dispute settlement panel, and, if applicable, the report of the Appellate Body. An appointment to review the public file (Docket WTO/DS–184, ''Hot-Rolled Steel Products—Japan'') may be made by calling Brenda Webb, (202) 395–6186. The Reading Room is open to the public from 9:30 a.m. to 12 noon and 1 p.m. to 4 p.m., Monday through Friday.

A. Jane Bradley,

Assistant U.S. Trade Representative for Monitoring and Enforcement.

[FR Doc. 00–14208 Filed 6–5–00; 8:45 am]

BILLING CODE 3190–01–M

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Notice of Application for Approval of Discontinuance or Modification of a Railroad Signal System or Relief From the Requirements of Title 49 Code of Federal Regulations Part 236

Pursuant to Title 49 Code of Federal Regulations (CFR) Part 235 and 49 U.S.C. 20502(a), the following railroads have petitioned the Federal Railroad Administration (FRA) seeking approval for the discontinuance or modification of the signal system or relief from the requirements of 49 CFR Part 236 as detailed below.

[Docket No. FRA-2000–6924]

Applicant: CSX Transportation, Incorporated, Mr. E.G. Peterson, Assistant Chief Engineer, Design and Construction, 4901 Belfort Road, Suite 130 (S/C J–350), Jacksonville, Florida 32256.

CSX Transportation Incorporated seeks approval of the proposed discontinuance and removal of the manual block system (DCS Operating Rules), on the single secondary track, between Swamp, milepost 0.0 and Wharf, milepost 12.0, near Fall River, Massachusetts, Fall River Subdivision, Albany Service Lane, and redesignation of the secondary track to an industrial track.

The reason given for the proposed changes is that density of traffic no longer warrants this type of train operation.

Any interested party desiring to protest the granting of an application shall set forth specifically the grounds upon which the protest is made, and contain a concise statement of the interest of the Protestant in the proceeding. Additionally, one copy of the protest shall be furnished to the applicant at the address listed above.

All communications concerning this proceeding should be identified by the docket number and must be submitted to the Docket Clerk, DOT Central Docket Management Facility, Room PI–401, Washington, DC 20590–0001. Communications received within 45 days of the date of this notice will be considered by the FRA before final action is taken. Comments received after that date will be considered as far as practicable. All written communications concerning these proceedings are available for examination during regular business hours (9 a.m.–5 p.m.) at DOT Central Docket Management Facility, Room PI–401 (Plaza Level), 400 Seventh Street, SW, Washington, DC 20590–0001. All documents in the public docket are also available for inspection and copying on the internet at the docket facility's Web site at *http://dms.dot.gov.*

FRA expects to be able to determine these matters without an oral hearing. However, if a specific request for an oral hearing is accompanied by a showing that the party is unable to adequately present his or her position by written statements, an application may be set for public hearing.

Issued in Washington, DC on May 25, 2000.

Grady C. Cothen, Jr.,

Deputy Associate Administrator for Safety Standards and Program Development.

[FR Doc. 00–14055 Filed 6–5–00; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Emergency Medical Equipment

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of decision.

SUMMARY: This notice is issued pursuant to the Aviation Medical Assistance Act of 1998, which requires the Federal Aviation Administration to determine whether or not to require automatic external defibrillators at airports. To carry out this mandate, the agency reviewed data on the medical capability at the airports most used by passengers to respond to cardiac events. Based

upon this review, the Administrator of the Federal Aviation Administration has determined that it is unnecessary to propose a regulation to require automatic external defibrillators at airports.

FOR FURTHER INFORMATION CONTACT: Robert E. David, AAS–300, Airport Safety and Operations Division, Office of Airport Safety and Standards, Federal Aviation Administration, 800 Independence Avenue, SW, Washington, DC 20591, telephone (202) 267–3085.

SUPPLEMENTARY INFORMATION: On April 24, 1998, the Aviation Medical Assistance Act of 1998 (the Act), Pub. L. 105–170, 49 U.S.C. 44701 was enacted. The Act requires the Administrator of the Federal Aviation Administration to make decisions on whether or not automatic external defibrillators (AED's) should be required:

- On passenger aircraft operated by the air carriers and/or
- At airports.

The act specifies that the decisions shall be made in one of the following three forms:

- A notice of proposed rulemaking requiring AED's, or
- A recommendation to Congress requiring AED's, or
- A notice in the **Federal Register** that AED's should not be required.

Background

The following information has been reported recently in various medical journals and the press:

- Cardiac arrest (the stopping of effective pumping of blood by the heart) reportedly strikes over 350,000 Americans every year, typically those 41 to 65 years old.
- The most common form of treatable cardiac arrest (a substantial portion of all cardiac events) is caused by an abnormal heart rhythm called ''ventricular fibrillation'' (where the heart is still beating, although ineffectively pumping blood.) Ventricular fibrillation is treatable with defibrillation, electric shocks that stimulate the heart to resume beating normally.
- Survival of individuals undergoing ventricular fibrillation can be as high as 90 percent in some circumstances, if defibrillation is provided during the first minute following collapse and subsequent cardiac care is rapidly provided.
- For every minute that defibrillation is delayed, survival is reported to fall about 10 percent, dropping below 50 percent after 6 minutes.
- By providing early electrical correction of ineffective heart pumping, therapeutic defibrillation is more effective than CPR in sustaining life and function in certain situations.

A defibrillator, when place on the chest of a person suffering from ventricular fibrillation, can shock that person's heart back into proper rhythm. Originally defibrillators were bulky and complex units that were designed to be used by specially trained medical personnel, such as doctors or paramedics. These manual-style defibrillators were used as part of an Advanced Life Support (ALS) system.

Defibrillator technology has progressed with the introduction AED's. AED's are lightweight, compact, virtually maintenance-free, simple to use, and can deliver repeated, high-amperage shocks that stun the heart cells long enough to give the heart an opportunity to restore its normal rhythm if possible. Because these battery-powered systems voice-prompt step-by-step guidance, non-medical personnel may use them fairly confidently to assist in certain, especially treatable cardiac emergencies. In fact, both the American Red Cross and the American Heart Association include instruction on these devices in their basic cardiopulmonary resuscitation (CPR) classes. AED's currently cost approximately $3,500 per unit, AEDs have been placed in many public and private buildings and AEDs have been issued to non-medical personnel such as police and firefighters.

The type of AED most commonly used can monitor a person's cardiac function and administer a shock if indicated. The machine determines whether, and when, an individual needs an electric shock. If defibrillation is needed and is successfully performed, further medical interventions may be necessary to stabilize a stricken passenger. Both AED's and manual-style defibrillators produce the same medical results when used on a person experiencing ventricular fibrillation.

Airports Considered

Under Title 14 of the Code of Federal Regulations (CFR) part 139, operators of airports having scheduled air carrier service with aircraft having more than 30 seats are required to have an airport operating certificate issued by the FAA. While not all airports are certificated, the airports most frequently used by passengers are certificated. Part 139 covers all aspects of airport safety for the prevention and mitigation of aircraft accidents; it does not cover passenger medical matters in the airport passenger terminal building or in the aircraft on the ground at the airport. (In general passenger medical care, as opposed to safety, especially on the ground, is within state, not federal, jurisdiction). The drafters of the Act recognized the differences in the environment presented by an aircraft and an airport for an individual experiencing a medical event. In an aircraft, individuals experiencing medical events are isolated by flight from the usual emergency care and must rely on the medical resources in the aircraft. In an airport, individuals experiencing medical events have available to them the usual emergency medical care plus potentially can rely on the full spectrum of modern medicine.

The drafters of the Act provided that the decision regarding requiring AEDs for airports and air carriers could be in different forms. As a result the FAA decided to undertake separate, but parallel and coordinated, efforts in gathering and analyzing information for airports and air carrier aircraft. The decision published here applies only to airports. A decision regarding AEDs on air carrier aircraft will be issued separately.

The report from the Committee on Transportation and Infrastructure that accompanied the Act stated that the FAA should consider the size of the airports in determining if AEDs should be required. The Committee also expressed their expectation that the FAA would take a judicious approach in drawing the line with respect to airports. In view of the Committee report language, FAA decided to focus its effort on airports with an average of 275 or more daily enplanements (100,000 annual enplanements.) In simple terms, an enplanement is counted for each passenger who begins a trip or changes planes at an airport. There are 215 airports that have scheduled air carrier service with an average of 275 or more daily enplanements.

There is quite a variance in the number of enplaned passengers between individual airports. For example, 83 airports have 1 million or more annual enplanements and account for 92 percent of all enplanements. At the top end of this group there are Atlanta's Hartsfield and Chicago's O'Hare that each have more than 30 million annual enplanements. At the other end of the spectrum are airports like Syracuse-Hancock International and Albany International, that each just exceed 1 million annual enplanements.

Similarly, there are 72 airports certificated under part 139 that have more than 250,00 but less than 1 million annual enplanements. These airports account for 5.4 percent of the total annual enplanements.

There are another 60 airports certificated under Part 139 that have more than 100,000 but less than 250,000 annual enplanements. These airports account for 1.5 percent of the total annual enplanements.

The preceding 215 airports (83 + 72 + 60) account for 98.9 percent of total annual enplanements. The remaining airports certificated under Part 139 have less than 100,000 annual enplanements and are part of the airports that comprise the remaining 1.1 percent of annual enplanements.

Airports having this type of scheduled air carrier service are usually owned and operated by units of state or local government. Some of these airports have medical doctors located on the premises; others have units staffed with paramedics located on the airport; while others have the primary emergency medical response in the community respond to medical situations at the airport.

Under Part 139 airports serving scheduled air carrier aircraft with more than 30 seats are required to provide for basic emergency medical care during the operations of these aircraft. This medical care is part of the Aircraft Rescue and Firefighting response to airfield incidents; however, emergency personnel used to meet this requirement frequently respond to medical emergencies throughout the entire airport although this is not required by part 139.

Data Gathering

In order to determine whether or not AED's should be required at airports, the FAA assessed the current capability of airports having scheduled service with air carrier aircraft having more than 30 seats to respond to medical events that an AED could possibly be used. The information sought by the FAA on an airport's capability consisted of answers to the following four questions:

1. Are AED's located on the airport?

2. Are manual-style defibrillators located on the airport?

3. If the answers to both questions 1 and 2 are ''No,'' is there an off-airport response available to cardiac events that occur on the airport?

4. If the answer to question 3 is yes, can the off-airport medical response reach the airport in 6 minutes or less?

(Question 4 is based upon the generally accepted medical guideline that it is necessary to start defibrillation within 6 minutes of the cardiac event; see Background above.)

Analysis of Data

Data were reviewed for 130 airports having 100,000 or more annual enplanements. Information was also collected on defibrillators in general.

A review of the data for the 83 the airports with more than 1 million annual enplanements revealed that all but four had AED's. Of these four, three had manual-style defibrillators. The remaining airport had an off-airport response within 6 minutes. These 83 airports that enplane 92 percent of the total annual enplanements appear to have the medical capability to address cardiac events in which AED's may be of assistance.

Data was collected for 27 of the 72 airports that have 250,000 or more but less than 1 million enplanements. This represents a 37 percent sample. Of the 27 airports, 17 (63 percent) had AED's. None of the remaining 10 airports had a manual-style defibrillator, but six of them had an off-airport response of less than 6 minutes. The remaining four also had an off-airport response but it exceeded 6 minutes. Including the six airports with an off-airport response of less than 6 minutes with the 17 airports that have AED's reveals that 85 percent of the airports in the sample of 27 airports appear to have the medical capability to address cardiac events in which AED's may be of assistance.

Data was collected for 20 of the 60 airports that have 100,000 or more but less than 250,000 enplanements. This represents a 33 percent sample. Of the 20 airports, nine (45 percent) had AED's. None of the remaining 11 airports had a manual-style defibrillator, but five of them had an off-airport response of less than 6 minutes. The remaining six also had an off-airport response but it exceeded 6 minutes. Including the five airports with an off-airport response of less than 6 minutes with the nine airports that have AED's reveals that 70 percent of the airports in the sample of 20 airports appear to have the medical capability to address medical events including those in which AEDs may be of assistance.

For the latter two data groups it would be statistically unreliable to extrapolate the results from the samples of 27 and 20 airports to remaining airports in the group, since neither sample would qualify as a random sample. However, both samples serve to confirm reports that AED's are becoming commonplace. For example, some airports that initially responded that they did not have AED's were contacted to obtain clarification about the availability of off-airport emergency response. In the ensuring months between the first response and the subsequent contact, three of these airports had acquired AED's.

In summary, data gathered on 130 airports indicates that 108 (83 percent) had defibrillators. Including the 11 airports that have an off-airport response rate of less than 6 minutes shows that 119 airports, or 91.5 percent, appear to have the medical capability to address medical events including those in which AEDs may be of assistance.

Decision

The majority of units of state and local government that operate certificate airports, having scheduled air carrier service with 100,000 or more annual enplanements, have already taken the necessary steps to provide for the medical capability to address cardiac events at their individual facilities. In addition, all available information indicates that local acquisition and availability of AED's in public places is increasing.

Finally, it is unclear as to whether the FAA has the authority to require AEDs in an airport. The regulation and the provision of medical care with a state are traditionally state functions that the states have vigorously monitored and controlled. Indeed, the airport serving the vast majority of passengers today have medical care available (including AEDs) without Federal regulation.

In view of the foregoing, the FAA has determined that no regulation will be proposed to require AEDs at airports.

Woodie Woodward,

Acting Associate Administrator for Airports.

[FR Doc. 00–14086 Filed 6–5–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Index of Administrator's Decisions and Orders In Civil Penalty Actions; Publication

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of publication.

SUMMARY: This notice constitutes the required quarterly publication of an index of the Administrator's decisions and orders in civil penalty cases. This publication represents the quarter ending on March 31, 2000. This publication ensures that the agency is in compliance with statutory indexing requirements.

FOR FURTHER INFORMATION CONTACT: James S. Dillman, Assistant Chief Counsel for Litigation (AGC–400),