motion picture, and television cameras during the meeting may be limited to selected portions of the meeting as determined by the Chairman. Information regarding the time to be set aside for this purpose may be obtained by contacting Dr. Sher Bahadur prior to the meeting. In view of the possibility that the schedule for ACRS meetings may be adjusted by the Chairman as necessary to facilitate the conduct of the meeting, persons planning to attend should check with Dr. Sher Bahadur if such rescheduling would result in major inconvenience.

In accordance with Subsection 10(d) Public Law 92–463, I have determined that it is necessary to close portions of this meeting noted above to discuss proprietary information per 5 U.S.C. 552b(c)(4), to protect national security information per 5 U.S.C. 552b(c)(1), and to protect safeguards information per 5 U.S.C. 552b(c)(3).

Further information regarding topics to be discussed, whether the meeting has been canceled or rescheduled, the Chairman's ruling on requests for the opportunity to present oral statements, and the time allotted therefor can be obtained by contacting Dr. Sher Bahadur (telephone 301–415–0138), between 7:30 a.m. and 4:15 p.m., EDT.

ACRS meeting agenda, meeting transcripts, and letter reports are available through the NRC Public Document Room at *pdr@nrc.gov*, or by calling the PDR at 1–800–397–4209, or from the Publicly Available Records System (PARS) component of NRC's document system (ADAMS) which is accessible from the NRC Web site at *http://www.nrc.gov/NRC/ADAMS/index.html.*

Videoteleconferencing service is available for observing open sessions of ACRS meetings. Those wishing to use this service for observing ACRS meetings should contact Mr. Theron Brown, ACRS Audio Visual Technician (301–415–8066), between 7:30 a.m. and 3:45 p.m., EDT, at least 10 days before the meeting to ensure the availability of this service. Individuals or organizations requesting this service will be responsible for telephone line charges and for providing the equipment and facilities that they use to establish the videoteleconferencing link. The availability of videoteleconferencing services is not guaranteed.

Dated: April 18, 2002.

Andrew L. Bates,

Advisory Committee Management Officer.

[FR Doc. 02–9993 Filed 4–23–02; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Report to Congress on Abnormal Occurrences Fiscal Year 2001 Dissemination of Information

Section 208 of the Energy Reorganization Act of 1974 (Pub. L. 93–438) identifies an abnormal occurrence (AO) as an unscheduled incident or event that the U.S. Nuclear Regulatory Commission (NRC) determines is significant from the standpoint of public health or safety. The Federal Reports Elimination and Sunset Act of 1995 (Pub. L. 104–66) requires that AOs be reported to Congress annually. During fiscal year 2001, two events, one at a facility licensed by the NRC and the other at a facility licensed by an Agreement State were determined to be AOs. These events are discussed below. As required by Section 208, the discussion for each event includes the date and place, the nature and probable consequences, the cause or causes, and the action taken to prevent recurrence. Each event is also being described in NUREG–0090, Vol. 24, ''Report to Congress on Abnormal Occurrences, Fiscal Year 2001.'' This report will be available electronically at the NRC Web site *http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/.*

Nuclear Power Plants

None of the events that occurred at U.S. nuclear power plants during this reporting period was significant enough to be reported as an AO.

Fuel Cycle Facilities (Other Than Nuclear Power Plants)

None of the events that occurred at fuel cycle facilities during this reporting period was significant enough to be reported as an AO.

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

01–1 Occupational Overexposure at Southeast Missouri State University in Cape Girardeau, Missouri

Date and Place—June 13–16, 2000, Southeast Missouri State University (the university), Cape Girardeau, Missouri. The information available to the staff prior to the publication of the FY 2000 report was not sufficient to determine if this event met the AO criteria.

Nature and Probable Consequences—In 1970, the university was licensed by the Atomic Energy Commission, NRC's predecessor, to possess and use up to 185 megabecquerel (MBq) [5 millicurie (5 mCi)] of americium-241 (Am-241) in unsealed form. The authorized user of the Am-241 died in 1980. In 1991, the university requested and received an amendment to its NRC license to remove authorization to possess and use certain radionuclides, including Am-241. The university disposed of some radionuclides in its possession but inadvertently kept the unsealed Am-241.

On February 16, 2000, a routine NRC inspection at the university found that the radiation program had deteriorated significantly. Specifically, since August 1, 1999, the university had been without a radiation safety officer (RSO), and the university officials were not sure whether they had radioactive materials in their possession or what materials they were authorized to possess. They did not know the general terms and conditions of their license. During the inspection, the licensee and an NRC inspector found an apparently empty vial labeled as containing 185 MBq (5 mCi) of Am-241 in a safe, located in the basement of the university, along with additional unauthorized material.

After the discovery of the unauthorized material, the university hired a consultant to characterize the material in the safe, and assess contamination in and around the area. On April 19, 2000, the consultant inventoried the contents of the safe and found elevated radiation levels in the room where the safe was located. On June 13, 2000, the consultant began to perform surveys and decontamination activities and identified loose Am-241 contamination.

Inadequate radiological surveys and poor handling techniques used by the consultant resulted in contamination in a number of areas in the basement.

On June 21, 2000, the NRC initiated a special inspection in response to a report from the university on loose Am–241 contamination. NRC surveys independently confirmed the Am–241 contamination.

The licensee restricted access to all contaminated areas, interrupted the decontamination process, and performed internal dose assessments of individuals potentially exposed to Am–241 contamination. These assessments indicated that the consultant received a calculated committed dose equivalent to the bone surface of 2630 millisievert (263 rem). The consultant has seen a doctor, had one therapeutic medical treatment, and no adverse health effects are expected. The licensee hired a second consultant to complete the decontamination process.

Cause or Causes—The licensee possessed radioactive material not authorized by the NRC license and failed to perform adequate radiation

surveys, including air sampling to measure airborne radioactivity present during the inventory and decontamination activities. The survey instruments were incapable of detecting alpha activity which is needed to identify the presence of Am–241. In addition, from August 1, 1999, to July 10, 2000, the licensee had no RSO to oversee and ensure implementation of an effective radiation protection program.

Actions Taken To Prevent Recurrence

Licensee—The licensee appointed a new RSO and revised its radiation safety program, with an emphasis on inventory control. Specifically, the university implemented new property control and surplus inventory policies and procedures that included: (1) Review and approval by the RSO of property transfers of potentially contaminated equipment, (2) surveys of surplused equipment for contamination control, and (3) training of personnel in the correct procedures for surplusing equipment containing radioactive material.

NRC—On September 13, 2001, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty against the university for the violation associated with the June 2000 radiation overexposure to the consultant. The fine was $11,000. The NRC also issued Information Notice 2001–01 to emphasize the importance of accurate inventory controls to prevent unauthorized possession of radioactive material.

This event is closed for the purpose of this report.

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Agreement State Licensees

AS 01–1 Industrial Radiography Occupational Overexposure at Quality Inspection Services, Inc., in Jacksonville, Florida

Date and Place—February 16, 2001, Quality Inspection Services, Inc., Jacksonville, Florida.

Nature and Probable Consequences—Based on discussions with the involved individuals, it was determined that a radiographer retracted a 2.15 terabecquerel (58 curie) iridium-192 source into what was thought to be a locked, shielded, and fully retracted position inside the radiography camera. In setting up for the next shot, the radiographers noticed that the source had not been secured in the off position after the previous shot and that their survey meters and their pocket dosimeters were off scale. The radiographers immediately retracted the source to its fully shielded position and exited the working area. Film badges belonging to the radiographers indicated exposures of 29 mSv (2.9 rem) and 392 mSv (39.2 rem). For the radiographer with the highest exposure, blood tests were normal and he declined further testing. No adverse health effects are expected.

Cause or Causes—The radiographers failed to perform an adequate survey of the radiography camera after performing radiographic operations. In addition, the alarming ratemeter worn by one of the radiographers was not turned on during radiography. The alarming ratemeter for the second radiographer had a low battery and did not produce an audible alarm.

Actions Taken To Prevent Recurrence

Licensee—The licensee conducted a reenactment of the event and, based on lessons learned, the training procedures were revised to prevent future incidents.

State Agency—The State of Florida Bureau of Radiation Control determined that the radiographer failed to follow procedures and took enforcement action against the licensee. The State reviewed and accepted the licensee's corrective actions, which included refresher training.

This event is closed for the purpose of this report.

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Dated at Rockville, Maryland this 18th day of April, 2002.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. 02–9995 Filed 4–23–02; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NUREG–1600]

NRC Enforcement Policy; Modification, Medical Use

AGENCY: Nuclear Regulatory Commission.

ACTION: Policy statement: Modification.

SUMMARY: In conjunction with a major revision of 10 CFR part 35, published in today's **Federal Register**, the Nuclear Regulatory Commission is amending its ''General Statement of Policy and Procedure for NRC Enforcement Actions,'' NUREG–1600 (Enforcement Policy). This change to the Enforcement Policy revises the examples of severity levels for violations associated with the requirements to use written directives for certain medical uses of byproduct material; and to develop, implement, and maintain certain procedures for medical uses that require a written directive (10 CFR 35.40 and 35.41). These examples are used in the enforcement process to provide guidance for determining the significance of a particular violation.

DATES: Consistent with the rulemaking to revise 10 CFR part 35, this action is effective November 25, 2002. Comments on this change to the NRC's Enforcement Policy should be submitted not later than 30 days following the effective date and will be considered by the NRC before the next revision of the Enforcement Policy.

ADDRESSES: Submit written comments to: Michael T. Lesar, Chief, Rules and Directives Branch, Division of Administrative Services, Office of Administration, Mail Stop: T6D59, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Hand deliver comments to: 11555 Rockville Pike, Rockville, Maryland, between 7:30 a.m. and 4:15 p.m., Federal workdays. Copies of comments received may be examined at the NRC Public Document Room, Public File area O–1F21, 11555 Rockville Pike, Rockville, Maryland.

FOR FURTHER INFORMATION CONTACT: Frank Congel, Director, Office of Enforcement, (301) 415–2741, E-mail: *fjc@nrc.gov* or John Lubinski, Office of Enforcement, (301) 415–2740, E-mail: *jwl@nrc.gov*.

SUPPLEMENTARY INFORMATION:

Background

In a separate action published in today's **Federal Register**, the NRC is revising its regulations in 10 CFR part 35 governing the medical use of byproduct material to make the requirements risk-informed and more performance-based. Before this revision, 10 CFR 35.32 required a quality management program to provide high confidence that byproduct material or radiation from byproduct material would be administered as directed by the physician who is the authorized user of the material under the NRC license. Among other things, the quality management program had to assure that, for certain medical uses, a written directive was prepared and signed by the authorized user. Before this revision to the regulations, the term ''misadministration'' was used to denote certain errors in administering byproduct material, or the radiation from byproduct material, to humans. The terms ''written directive'' and ''misadministration'' were defined in 10 CFR 35.2.