If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment request involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemakings and Adjudications Staff may be delivered to the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, by the above date. A copy of the petition should also be sent to the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, and to R. Alexander Glenn, General Counsel, Florida Power Corporation, MAC–A5A, P.O. Box 14042, St. Petersburg, Florida 33733–4042, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the presiding Atomic Safety and Licensing Board that the petition and/or request should be granted based upon a balancing of the factors specified in 10 CFR 2.714(a)(1) (i)–(v) and 2.714(d).

For further details with respect to this action, see the application for amendment dated October 4, 1997, which is available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room, located at the Coastal Region Library, 8619 W. Crystal Street, Crystal River, Florida.

Dated at Rockville, Maryland, this 6th day of November 1997.

For the Nuclear Regulatory Commission.

L. Raghavan,

Sr. Project Manager, Project Directorate II–3, Division of Reactor Projects—I/II Office of Nuclear Reactor Regulation.

[FR Doc. 97–29889 Filed 11–12–97; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 030–31373; License No. 12–16559–01; EA 97–207]

In the Matter of Conam Inspection, Inc. Itasca, IL; Order Imposing Civil Monetary Penalty

I

Conam Inspection, Inc. (Conam or Licensee) is the holder of Byproduct Materials License No. 12–16559–01 issued by the Nuclear Regulatory Commission (NRC or Commission) on January 2, 1990. The license authorizes the Licensee to possess and use certain byproduct materials in accordance with the conditions specified therein at the Licensee's facilities in Columbus, Ohio; Gary, Indiana; Reading, Pennsylvania; Gallipolis, Ohio; and at temporary job sites anywhere in the United States where the NRC maintains jurisdiction for regulating the use of licensed material.

II

An inspection and investigation of the Licensee's activities were conducted between March 28, 1996 and November 12, 1996. The results of the inspection and investigation indicated that the Licensee had not conducted its activities in full compliance with NRC requirements. A written Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was served upon the Licensee by letter dated June 9, 1997. The Notice states the nature of the violations, the provisions of the NRC's requirements that the Licensee had violated, and the amount of the civil penalty proposed for three of the violations in the aggregate (Violations I.A, I.B, and I.C).

The Licensee responded to the Notice in a letter dated July 7, 1997. In its response, the Licensee denied Violations I.B and I.C, and requested remission or full mitigation of the civil penalty.

III

After consideration of the Licensee's response and arguments for mitigation contained therein, the NRC staff has determined, as set forth in the Appendix to this Order, that the Licensee did not provide an adequate basis for withdrawing Violations I.B and I.C, or mitigating the severity level of Violations I.A, I.B, and I.C in the aggregate, or mitigating the civil penalty associated with Violations I.A, I.B, and I.C. Therefore, a civil penalty in the amount of $16,000 should be imposed.

IV

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205, *it is hereby ordered that:*

The Licensee pay a civil penalty in the amount of $16,000 within 30 days of the date of this Order, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852–2738.

V

The Licensee may request a hearing within 30 days of the date of this Order. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made in writing to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission Washington, D.C. 20555, and include a statement of good cause for the extension. A request for a hearing should be clearly marked as a ''Request for an Enforcement Hearing'' and shall be addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission Washington, D.C. 20555, with a copy to the Commission's Document Control Desk, Washington, D.C. 20555. Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address and to the Regional Administrator, NRC Region III, 801 Warrenville Road, Lisle, IL 60532.

If a hearing is requested, the Commission will issue an Order designating the time and place of the hearing. If the Licensee fails to request a hearing within 30 days of the date of this Order (or if written approval of an extension of time in which to request a hearing has not been granted), the provisions of this Order shall be effective without further proceedings. If payment has not been made by that time, the matter may be referred to the Attorney General for collection.

In the event the Licensee requests a hearing as provided above, the issues to be considered at such hearing shall be:

(a) Whether the Licensee was in violation of the Commission's requirements as set forth in Violations I.B and I.C of the Notice referenced in Section II above, and

(b) Whether, on the basis of such violations and the additional violations set forth in the Notice of Violation that the Licensee admitted, this Order should be sustained.

For the Nuclear Regulatory Commission.

Dated at Rockville, Maryland this 5th day of November 1997.

James Lieberman,

Director, Office of Enforcement.

Appendix A—Evaluations and Conclusion

On June 9, 1997, the NRC issued to Conam Inspection, Inc., (Licensee or Conam) a Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the amount of $16,000 for violations identified during an NRC inspection and investigation conducted from March 28 through November 12, 1996. The Licensee responded to the Notice by letter dated July 7, 1997. With regard to the violations assessed a civil penalty, the Licensee admitted Violation I.A; denied Violations I.B and I.C; and requested remission or full mitigation of the civil penalty. The NRC's evaluations and conclusion regarding the Licensee's requests are as follows:

Restatement of Violation I.B

I.B 10 CFR 34.43(b) requires, in part, a licensee to ensure that a survey with a calibrated and operable radiation survey instrument is made after each radiographic exposure to determine that the sealed source has been returned to its shielded position. The survey must include the entire circumference of the radiographic exposure device and any source guide tube.

Contrary to the above, on February 27, 1996, at Eli Lilly, Indianapolis, IN, a Licensee radiographer did not perform an adequate survey after each radiographic exposure to determine that the sealed source had been returned to its shielded position, in that the survey did not include the entire circumference of the radiographic exposure device and the source guide tube.

Summary of Licensee's Response to Violation I.B

The Licensee, in its response, denies Violation I.B and states that on February 28, 1996, the day following the incident, the radiographer expressly stated to the Licensee's Radiation Safety Officer (RSO) that he had performed a full 360-degree circumferential survey of the radiographic exposure device.

NRC Evaluation of Licensee's Response to Violation I.B

The specific issue addressed in Violation I.B is whether the radiographer performed the required survey to determine that the source had completely been withdrawn into the radiographic exposure device. This requires, among other things, that the radiographer be aware of the results of the survey, especially the dose rate measured at the exit port (front) of the radiographic exposure device. As noted on page 7 of the Licensee's reply to the Notice, the Licensee states (regarding the radiographer's survey) that: ''He then failed to properly read his survey meter when he performed a radiation survey in a 360-degree motion around the camera.'' The fact that the radiographer improperly read the survey meter means that he failed to properly determine: (1) Whether the source had been completely withdrawn into the radiographic exposure device; and (2) the radiological conditions and potential hazards incident to use of radioactive material.

In addition, during the investigation conducted by the NRC's Office of Investigations, the radiographer stated that he surveyed the radiographic exposure device, but only on the sides. He also stated to the investigator that because of the position of the radiographic exposure device, he did not survey the front part. This conflicts with the information provided by the radiographer to the Licensee's RSO, but appears to be more in line with the facts of the case given the elevated exposure result to the radiographer's film badge.

In either case, whether the radiographer improperly read the survey meter or whether the radiographer failed to survey the front part, the NRC concludes that Violation I.B occurred as stated in the Notice.

Restatement of Violation I.C

I.C 10 CFR 20.1201(a)(1)(i) requires, with exceptions not applicable here, that a licensee control the occupational dose to individual adults to an annual dose limit of 5 rems total effective dose equivalent.

Contrary to the above, the Licensee did not limit the annual occupational dose to an adult radiographer to 5 rems, total effective dose equivalent. Specifically, the individual received a radiation dose of a minimum of 6 rems, total effective dose equivalent, during an event on February 27, 1996.

Summary of Licensee's Response to Violation I.C

The Licensee, in its response, denies Violation I.C, states that the NRC's methodology in determining the total effective dose equivalent is flawed, and does not agree with the intent of the regulations. The Licensee contends that using conventional dose assessment models, consensus industry standards, and the NRC's own definitions, the maximum likely Total Effective Dose Equivalent (TEDE) incurred by the radiographer during the event was 2.9 rems, based upon the radiographer's *description* of time and motion.

As a basis for its argument, the Licensee asserts that while the Licensee's consultant calculated a dose to the right thigh of 9.369 rems, this dose does not constitute the TEDE. The Licensee states that the dose limits are based on the 1976 [1977] recommendations of the International Commission on Radiological Protection (ICRP), which states that there is a predictable relationship between irradiation of the whole body and biological effects. The Licensee argues that the dose to the radiographer's thigh is not an appropriate predictor of biological effects, and thus should not be compared to the primary dose limit in 10 CFR 20.1201.

The Licensee asserts that the ICRP recommendations should take precedence in determining how the TEDE is computed. As such, in calculating the TEDE, the Licensee uses weighting factors for each tissue area which are derived from ICRP Publication 26. The Licensee believes this is an acceptable approach because the Statements of Consideration for the issuance of the revised 10 CFR Part 20 included, as reasons for the revision, the need to incorporate updated scientific information, to reflect changes in the basic philosophy of radiation protection, and to put into practice recommendations from ICRP 26 and subsequent ICRP publications. The Licensee asserts that sections 10 CFR 20.1003, which defines the TEDE, and 10 CFR 20.1201(a), which specifies exposure limits, conform with ICRP 26 recommendations.

The Licensee maintains that the NRC's guidance on interpretation of 10 CFR 20.1201(c) permits use of external dose weighting factors. However, the Licensee argues that the language in 10 CFR 20.1201(c): (1) Conflicts with the definition of deep-dose equivalent provided in 10 CFR 20.1003; (2) is inconsistent with the ICRP recommendations; and (3) deviates from the fundamental principles underlying the dose limits in 10 CFR Part 20.

The Licensee does note that the specific use of weighting factors other than 1.0 for all organs was not approved by 10 CFR Part 20; rather, 10 CFR 20.1003 states that ''[f]or the purpose of weighting the external whole-body dose (for adding it to the internal dose), a single weighting factor, Wt=1.0, has been specified. The use of other weighting factors for external exposures will be approved on a case-by-case basis until such time as specific guidance is issued.'' The Licensee notes that the NRC has not yet issued specific

guidance in interpreting this issue; however, since the American National Standards Institute (ANSI) has issued N13.41, ''Criteria for Performing Multiple Dosimetry,'' the Licensee believes that it should be able to use this methodology in computing its TEDE value. This guidance was utilized and the resulting TEDE was 2.9 rems.

The Licensee asserts that in light of the conflicting regulatory language in 10 CFR Part 20 regarding non-uniform exposure of the whole body, and the fact that 10 CFR 20.1003 allows weighting factors to be considered, the dose determined for the radiographer using ANSI N13.41 protocol was appropriate and consistent with the rationale underlying the occupational dose limits.

NRC Evaluation of Licensee's Response to Violation I.C

The specific issue addressed in Violation I.C is whether the radiographer's total effective dose equivalent *as defined in the regulations* exceeded the regulatory limits. The Licensee's use of ICRP 26 and ANSI N13.41 (i.e., use of a compartmentalization methodology to sum the effective dose equivalents for various areas of the whole body) was neither approved by the NRC nor in accordance with NRC requirements, for the reasons described below.

1. NRC Basis for Violation I.C

As noted in the Notice, 10 CFR 20.1201(a)(1)(i) requires, in part, that a licensee control the occupational dose to individual adults to an annual dose limit of 5 rems total effective dose equivalent. In addition, 10 CFR 20.1201(c) requires, in part, that the assigned deep-dose equivalent must be for the part of the body receiving the highest exposure and that the deep-dose equivalent may be assessed from surveys or other radiation measurements for the purpose of demonstrating compliance with the occupational dose limits, if the individual monitoring device was not in the region of highest potential exposure. As defined in 10 CFR 20.1003, Whole body means: ''for purposes of external exposure, head, trunk (including male gonads), arms above the elbow, or legs above the knee.'' [1]

Based on the findings in the NRC inspection report dated November 18, 1996, the NRC concluded, as described in the Notice, that the radiographer received a TEDE of 6 rems. The conclusion was based on: (1) Measurements of time and distances as re-enacted by the radiographer and the Licensee's film badge dose; and (2) the dose to the part of the body receiving the highest exposure (i.e., upper left thigh), given that the individual monitoring device was not in the region of highest potential exposure, the dose field from the radiographic exposure device was non-uniform, and the position of the radiographer and his film badge in relationship to the radiographic exposure device.

2. The Licensee's Use of ICRP 26 and ANSI N13.41

The NRC agrees that the dose limits in 10 CFR Part 20 are based on the ICRP 26 recommendations and acknowledges that the radiographer's thigh may not be an appropriate predictor of biological effects. However, the Licensee's use of ICRP 26 and the draft ANSI N13.41 for calculating the radiographer's whole-body dose is inappropriate in this case.

While the ICRP 26 recommendations in principle permit the use of external weighting factors, no specific recommendations were included concerning the use of weighting factors for external dose because there are practical problems with such use. The application of weighting factors also entails calculation of organ doses instead of whole-body doses from external radiation. One component of this calculation is the estimation of radiation attenuation as a function of the depth in the body. Therefore, as noted in the NRC's Statement of Consideration for 10 CFR Part 20 (56 FR 23369), the Commission decided that ''application of weighting factors for external exposures will be evaluated on a case-by-case basis until more guidance and additional weighting factors (such as for the head and the extremities) are recommended * * * The use of other weighting factors for external exposure *may be approved on a case-by-case basis upon request to the NRC.*'' (emphasis added). This means that, if a licensee proposes to use other weighting factors for external use, the licensee needs to develop the basis and technical justification for its request, submit the request to the NRC, and await approval of its request *before using* any modified weighting factors. To date, the Licensee has not submitted to the Commission such a request for an exemption of 10 CFR 20.1201.

With regard to ANSI N13.41, this is a *draft* standard that has been neither approved by ANSI, nor reviewed and approved by the Commission for use by NRC licensees. Moreover, ANSI N13.41 is not applicable because this case falls outside of the scope of that standard. This is evident from the standard itself, which states, under *Scope,* page 9, that ''this standard contains criteria applicable to *routine occupational activities* (emphasis added) for when and how to use multiple dosimeters to monitor the body and extremity of individuals exposed to sources of ionizing radiation.'' The next paragraph under this section goes on to state, ''Sudden or unexpected changes in the radiation environment *as might occur during accidents are beyond the scope of this standard''* (emphasis added).

The dose calculated by the consultant to the radiographer's right thigh was 9.369 rems. As noted in the Licensee's response, the footnote attached to 10 CFR 20.1003 specifies that a single weighting factor, Wt=1.0, be used for external exposures.

However, rather than using this weighting factor, the Licensee applied the factors provided in ANSI N13.41 (which are less than 1.0) to calculate exposures of portions of the whole body to arrive at the overall dose determination. The Licensee's use of weighting factors (on the basis that the NRC has not issued new weighting factors) without prior NRC approval is contrary to NRC requirements. Given the above, the Licensee's method for calculating the radiographer's exposure is incorrect.

3. Arguments Concerning Deep-Dose Equivalent

10 CFR 20.1201(c) requires, in part, that the assigned deep-dose equivalent must be for the part of the body receiving the highest exposure. 10 CFR 20.1003 defines deep-dose equivalent as the dose equivalent at a tissue depth of 1 cm (1000 mg/cm^2) [regardless of the part of the whole body that is exposed]. Given that ICRP 26 did not include specific recommendations concerning the use of weighting factors for external dose, and the fact that there are practical problems in using weighting factors to assess external exposure as noted above, the NRC disagrees with the Licensee's argument that 10 CFR 20.1201(c) is inconsistent with the ICRP recommendations and that 10 CFR 20.1201(c) deviates from the fundamental principles underlying the dose limits in 10 CFR Part 20.

4. Use of the Consultant Results and Part 20 Weighting Factors

The NRC bases its enforcement actions on its regulations as codified in Title 10, Code of Federal Regulations. In this case, 10 CFR 20.1003 defines the weighting factor for the whole body as 1.0. As noted in the Licensee's response, the NRC has not approved the use of

[1] The NRC's definition is based, in part, on the fact that these portions of the whole body contain blood-forming organs.

other weighting factors for external exposures nor has the NRC issued specific guidance on the use of other weighting factors. The regulations do allow for the use of a different methodology, but only after review and prior approval by the NRC. In this case, such approval was not obtained by the Licensee. Because the thigh (right or left) is an area of the body meeting the definition for whole body, the appropriate weighting factor per the regulations is 1.0. Therefore, if the Licensee chooses to use the consultant's results in conjunction with the Part 20 weighting factors, the radiographer's TEDE for the event would be:

Dose to right thigh (9.369 rems) × weighting factor (1.0) = 9.369 rems

The Licensee correctly notes that the limit for whole-body exposure in 10 CFR 20.1201(a)(1)(i) is a TEDE of 5 rems. 10 CFR 20.1003 defines the TEDE as the sum of the deep-dose equivalent (external exposure) and committed effective dose equivalent (internal exposure). In this case, the TEDE can be considered to be equal to the deep-dose equivalent, because there was no internal exposure involved.

The circumstances surrounding the exposure, as described in the inspection report and by the radiographer during the conduct of the NRC's investigation, demonstrated that the radiographer's body was between the radiographic exposure device and the radiographer's film badge. As noted in the radiographer's and RSO's description of the Licensee's time-motion study, no props were used—the event was discussed at a table with the radiographer describing to the RSO what occurred. During this time-motion discussion, it was not clear that the radiographer's film badge was at the point nearest the source. It was clear that the beam from the exit port of the radiographic exposure device would be very directional and non-uniform. Later, on April 11, 1996, a re-enactment of the event by the radiographer in the presence of the Licensee's RSO and NRC personnel was performed and appropriate props were used. The radiographer was asked to demonstrate his activities at the time the exposure occurred. This re-enactment provided information that the Licensee had not obtained during its verbal time-motion discussion, namely, that the radiographer's leg was significantly closer to the source than was his film badge. For the sake of argument, the NRC has chosen to utilize the Licensee's dose calculation based on its verbal characterization, and the resulting dose obtained to the right thigh. If the Licensee chooses to use the consultant's results (which utilized variables from the NRC's re-enactment) in conjunction with the Part 20 weighting factors, the radiographer's TEDE for the event would be:

Dose to left thigh (42.075 rems) × weighting factor (1.0) = 42.075 rems

10 CFR 20.1201(c) states that ''the assigned deep-dose equivalent and shallow-dose equivalent must be for the part of the body receiving the highest exposure. The deep-dose equivalent, eye dose equivalent and shallow-dose equivalent may be assessed from surveys or other radiation measurements for the purpose of demonstrating compliance with the occupational dose limits, if the individual monitoring device was not in the region of highest potential exposure, or the results of individual monitoring are unavailable.'' In this case, the individual monitoring device was not in the region of highest potential exposure, given the non-uniform nature of the dose field from the radiographic exposure device and the position of the radiographer and his film badge in relationship to the radiographic exposure device. Therefore, per this requirement, the assigned deep-dose equivalent must be for the right thigh (using the Licensee's computation), as it is part of the whole body. This results in an assigned deep-dose equivalent of 9.369 rems. As noted above, the TEDE consists of the sum of the deep-dose equivalent and committed effective dose equivalent. In this case, it is equal to the deep-dose equivalent, 9.369 rems, a value that is in excess of the limit specified in 10 CFR 20.1201(a)(1)(i).

Given the above, the NRC concludes that: (a) The Licensee has not provided a basis to substantiate that the radiographer's TEDE was below 5 rems; and (b) Violation I.C occurred as stated in the Notice.

Summary of Licensee's Request for Remission or Mitigation and Reconsideration of Severity Level

The Licensee offered several arguments in support of its request for remission or mitigation of the proposed penalty. Below is a summary listing of the Licensee's arguments that are related to its request for remission or mitigation, some of which have been consolidated. The NRC's evaluation follows each argument.

Appendix A

1. Licensee's Argument

The Licensee asserts that violations cited in Section I of the Notice should not be considered willful, for the following reasons:

- Based on the Licensee's discussion of the event on February 28, 1996, between the RSO and the radiographer, the Licensee concluded that the radiographer was negligent in failing to rotate the selector ring from the ''operate'' to the ''lock'' position and failing to depress the plunger mechanism of the radiographic exposure device.
- This act was not the result of deficiencies in the Licensee's Radiation Safety Program, nor did it follow other incidents of a similar nature. As evidence for its argument, the Licensee notes that seven prior unannounced NRC inspections had not identified any violations of applicable regulations.
- The Licensee disputes the fact that it was a ''typical'' practice of Conam radiographers to rely upon the automatic locking mechanism of their radiographic exposure devices rather than locking them in the manner required by the Licensee's radiation safety procedures.
- The Licensee believes that ''[b]ecause the NRC's conclusion that a ''willful'' violation has occurred is influenced by its erroneous conclusion that a violation of the occupational exposure limit occurred, its characterization of the violation as ''willful'' is flawed.''

NRC Evaluation

In its Notice, the NRC did not conclude that the violations in Section I were willful; rather, the NRC concluded that only Violation I.A was willful. In this regard, Section IV.C of the NRC Enforcement Policy defines willful violations to encompass not merely deliberate acts but acts of careless disregard as well. As part of the NRC's evaluation of this event, an investigation was conducted by the NRC's Office of Investigations (OI). That investigation concluded that the Licensee's radiographer willfully failed to follow the Licensee's procedures while operating the radiographic exposure device. The radiographer, who was knowledgeable of the requirement but failed to perform it due to being ''lax,'' demonstrated careless disregard for NRC requirements, a condition that clearly meets the NRC's definition of a willful violation.

Given the results of the OI investigation, the problem with failing to follow procedures was not isolated. As noted both in the November 18, 1996 inspection report and during the subsequent Predecisional Enforcement Conference, the Licensee's policy for performing field audits did not

encompass multiple exposures or other situations where the potential existed for a radiographer to fail to properly rotate the selector ring and depress the plunger. A single radiographic shot was often used, where this act would be performed prior to moving the radiographic exposure device. As such, the Licensee was unaware of the problem until it manifested itself in the exposure event that occurred on February 27, 1996, although a better field auditing technique may have allowed the Licensee to identify the problem prior to the February event. Therefore, the Licensee's arguments (i.e., lack of deficiencies in its radiation safety program and the lack of NRC findings during prior unannounced NRC inspections) do not alter the NRC's conclusion concerning the willful act of the radiographer.

When questioned by the OI investigator, approximately 25% of the Licensee's radiographers at the Gary, Indiana facility, including the radiographer associated with the event, admitted that on or prior to February 28, 1996, they failed on occasion to rotate the selector ring from the ''operate'' to the ''lock'' position and failed to depress the plunger mechanism as required by the Licensee's operating procedures. They stated to the investigator that they had been ''lax,'' but that they were knowledgeable of the requirement. They also stated that after the memo was issued by the RSO discussing the event and the need to follow procedures, they no longer violated this requirement.

In determining whether the radiographer willfully failed to lock the radiographic exposure device, the NRC based its conclusion on interviews with the radiographer as noted above. The Licensee's belief that the NRC's conclusion concerning willfulness was influenced by whether a violation of the occupational exposure limit occurred is simply incorrect.

2. Licensee's Argument

The Licensee asserts that the NRC improperly denied identification and corrective action credit under the terms of the NRC Enforcement Policy, Section VI.B.2.b and c, by ignoring essential facts. The Licensee asserts that while the incident was identified through an event, this fact does not preclude identification credit where the problem arose from a single incident of negligence by a radiographer in violation of well-publicized Conam safety procedures, where the Licensee's quarterly radiation safety compliance audit program was demonstrably adequate, and where there were no prior deficient occurrences to identify the problem.

In addition, the Licensee argues that its corrective actions were also prompt and comprehensive and should result in credit. The Licensee believes that the incident was promptly and comprehensively addressed and corrected by the Licensee's RSO through his analysis of the film badge, his issuance of a February 29, 1996, memorandum reminding all Conam radiographic personnel of the proper procedure for operating radiographic exposure devices, his withdrawal of the radiographer from further radiographic duties, and the suspension of the radiographer without pay for one week.

The Licensee disagrees with the NRC's position, as described in the Notice, that credit should not be given because the Licensee did not confirm that each radiographer had received the February 29, 1996, memorandum from the RSO, nor had the Licensee instituted any monitoring/auditing program to evaluate the effectiveness of the memorandum. The Licensee states that there is no evidence that the radiographers did not receive the memorandum, and that there has been no repetition of the problem since the February event's occurrence. The Licensee believes that the NRC's dismissal of credit for identification and corrective action ignores the fact that the February event was the only one of its kind against a record of no violations whatsoever during seven prior NRC inspections, and no that subsequent violations since the event have been identified by NRC inspections.

NRC Evaluation

The NRC Enforcement Policy, Section VI.B.2.b, discusses the criteria to be considered when deciding if a licensee should be given credit for actions related to identification. These circumstances include: (i) Whether the problem requiring corrective action was NRC-identified, licensee-identified, or revealed through an event; and (ii) for a problem revealed through an event, the ease of discovery, the licensee's self-monitoring effort, the degree of licensee initiative in identifying the problem requiring corrective action, and whether prior opportunities existed to identify the problem (Section VI.B.2.b(2)(ii) of the Enforcement Policy).

The NRC and the Licensee both agree that the problem requiring corrective action was revealed through an event. Therefore, the criteria in Section VI.B.2.b(2)(ii) of the Enforcement Policy are applicable in this case. Regarding the ease of discovery, as well as the Licensee's self-monitoring effort, the radiographer involved in the incident reported the problem to the Licensee's RSO; and the problem was not identified through any self-monitoring action of the Licensee's RSO or management, such as an audit. Regarding the degree of licensee initiative in identifying the problem requiring corrective action, the Licensee's initiative does not deserve credit, as described below. Regarding the existence of prior opportunities to identify the problem, as stated earlier, the OI investigation revealed that approximately 25% of the Licensee's radiographers and assistant radiographers at the Gary, Indiana facility admitted that on or prior to February 28, 1996, they on occasion failed to rotate the selector ring from the ''operate'' to the ''lock'' position and failed to depress the plunger mechanism as required by the Licensee's operating procedures. Thus, the problem with failing to follow procedures was not isolated. The Licensee performs quarterly field audits of its radiographers. As noted in the inspection report and during the Predecisional Enforcement Conference, the Licensee's policy for performing field audits did not encompass multiple exposures or other situations where the potential existed for a radiographer to fail to properly rotate the selector ring and depress the plunger. Therefore, numerous prior opportunities existed to identify the problem, yet the problem was not identified prior to the February 27, 1996 incident. Thus, credit for identification is not warranted.

The NRC Enforcement Policy, Section VI.B.2.c, discusses the criteria to be considered when deciding if a licensee should be given credit for prompt and comprehensive corrective actions. These criteria include: (i) The timeliness of the corrective action, (ii) the adequacy of the licensee's root cause analysis for the violation, and (iii) the comprehensiveness of the corrective action. As stated in the inspection report, the NRC acknowledges the Licensee's prompt action in issuing a memorandum to all radiation safety supervisory personnel advising all radiography staff to complete a full and accurate survey of the radiographic exposure device, collimator, guide tube, and connector after each exposure and to secure the source assembly in accordance with the Licensee's procedures. However, although the issuance of the memorandum was timely, it does not constitute a comprehensive corrective action.

Specifically, after the Licensee received the vendor's report indicating the radiographer's dose, the Licensee

did not perform an exact time-motion study at the scene of the event to determine the locations of the whole body, film badge and radiographic exposure device exit port. Photographs of the scene that were obtained later did not include the position of the radiographer. In addition, the Licensee could not confirm that each radiographer had received the memorandum, nor had the Licensee instituted any monitoring/auditing program to evaluate the effectiveness of the memorandum. The Licensee's argument that there is no evidence that the radiographers did *not* receive the memorandum is not persuasive; a comprehensive corrective action would ensure that each radiographer had received, reviewed, and understood the memorandum, and would monitor the radiographers' understanding of and compliance with the memorandum. Such comprehensive corrective actions were not implemented by the Licensee.

Finally, the fact that no violations had been identified during seven NRC inspections prior to the February 27, 1996 event, although commendable, is not relevant as far as credit for corrective action is concerned. Further, in accordance with Section VI.B.2.c of the NRC Enforcement Policy, the adequacy of a licensee's corrective actions is judged at the time of the enforcement conference, not on the basis of whether subsequent violations following the event have been identified by the NRC. Given the above, the NRC concludes that while the Licensee took some timely actions, on balance, such actions did not address the root cause of the violations and were not comprehensive. Thus, credit for prompt and comprehensive corrective actions is not warranted.

3. Licensee's Argument

The Licensee asserts that the NRC Enforcement Policy should find, at worst, that the February 27,1996 incident involved two non-willful Severity Level III violations which, with appropriate identification and corrective action credit, do not justify any civil penalty. The Licensee asserts that to aggregate the violations cited in Section I of the Notice and assign a Severity Level II ''problem'' to this collection is not consistent with the NRC's Enforcement Policy published in 60 FR 34381 (June 30, 1995). The Licensee believes that the NRC's Notice compounds that error by determining that the Severity Level II problem was willful, and on that basis justifying a 100% escalation of the $8,000 Severity Level II base penalty.

NRC Evaluation

As described above, the NRC has determined that Violation I.A was willful, that Violations I.A, I.B, and I.C occurred as described in the inspection report, and that credit for identification and corrective action is not warranted. The NRC Enforcement Policy, Section IV.A, states, in part, that the purpose of aggregating violations is to focus the licensee's attention on the fundamental underlying causes for which enforcement action appears warranted and to reflect the fact that several violations with a common cause may be more significant collectively than individually and may, therefore, warrant a more substantial enforcement action. As noted in the Notice, in consideration of the willfulness involved, the relationship of these violations to a single incident, and the fact that two safety barriers were breached, the violations are of very significant regulatory concern. Therefore, consistent with Section IV.A of the Enforcement Policy, the violations in Section I of the Notice were combined to reflect that, collectively, they are more significant than individually and, therefore, warrant a more substantial enforcement action.

As to the Licensee's argument concerning escalation of the $8,000 base penalty, the NRC did not escalate the civil penalty on the basis of a willful violation. The base amount for a Severity Level II problem is $8,000. Credit was not warranted for the identification and corrective action factors. Therefore, in accordance with the civil penalty assessment process described in Section VI.b.2, the civil penalty for the Severity Level II problem is twice the base amount (i.e., $16,000).

NRC Conclusion

The NRC concludes that the Licensee did not provide an adequate basis for withdrawing Violations I.B and I.C, for mitigating the severity level of Violations I.A, I.B, and I.C in the aggregate, or for mitigating the civil penalty associated with Violations I.A, I.B, and I.C. Therefore, the proposed civil penalty in the amount of $16,000 should be imposed by order.

Appendix B Evaluation of Violations Not Assessed a Civil Penalty

Of the violations not assessed a civil penalty, the Licensee admitted violation II.B and denied Violation II.A.

Restatement of Violation II.A

II.A 10 CFR 20.2203(a)(2)(i) requires, in part, that a licensee submit a written report within 30 days after learning of a dose in excess of the occupational dose limits for adults as defined in 10 CFR 20.1201.

Contrary to the above, on April 11, 1996, the Licensee learned of an event that caused an adult radiographer to receive a total effective dose equivalent of more than 5 rems total effective dose equivalent and did not submit a written report within 30 days as required.

Summary of Licensee's Response to Violation II.A

The Licensee, in its response, denies Violation II.A and states that, because the radiographer was not exposed to a dose in excess of 5 rems, total effective dose equivalent, no reporting obligation arose under applicable regulations.

NRC Evaluation of Licensee's Response to Violation II.A

The specific issue raised by Violation II.A was whether the Licensee was required to submit a report to the NRC after learning of a dose in excess of the occupational dose limits for adults as defined in 10 CFR 20.1201. In this case, the Licensee's evaluation of the circumstances did not appear to be adequate in that the Licensee did not complete an exact time/motion study at the scene of the event to determine the locations of the whole body, film badge, and radiography exposure device. As a result, the Licensee did not conclude that an exposure in excess of the dose limits occurred.[2]

By letter dated June 23, 1997, the Licensee did submit the report required by 10 CFR 20.2203(a)(2)(i), but solely on the basis that the NRC's letter transmitting the Notice of Violation and Proposed Imposition of Civil Penalty specifically stated that the Licensee was required to make such a report. As noted above, the Licensee still contends that an exposure in excess of regulatory limits did not occur based on the Licensee's unapproved methodology it used to compute the TEDE.

Given that the Licensee did not learn that the radiographer's exposure was in excess of regulatory limits, and that, after being informed by the NRC of the radiographer's exposure, the Licensee submitted a report per the requirements of 10 CFR 20.2203(a)(2)(i), the NRC concludes that Violation II.A should be withdrawn.

NRC Conclusion

The NRC staff concludes that the Licensee provided an adequate basis for

[2] For details concerning the Licensee's evaluation, see Summary of the Licensee's Response to Violation I.C and the NRC's Evaluation of the Licensee's Response to Violation I.C.

withdrawing Violation II.A. Therefore, Violation II.A should be withdrawn.

[FR Doc. 97–29886 Filed 11–12–97; 8:45 am]
BILLING CODE 7590–01–P

PENSION BENEFIT GUARANTY CORPORATION

Proposed Submission of Information Collection for OMB Review; Comment Request; Allocating Unfunded Vested Benefits

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Notice of intention to request extension of OMB approval.

SUMMARY: The Pension Benefit Guaranty Corporation (''PBGC'') intends to request that the Office of Management and Budget (''OMB'') extend approval, under the Paperwork Reduction Act, of a collection of information in its regulation on Allocating Unfunded Vested Benefits (29 CFR Part 4211) (OMB control number 1212–0035; expires February 28, 1998). This notice informs the public of the PBGC's intent and solicits public comment on the collection of information.

DATES: Comments should be submitted by January 12, 1998.

ADDRESSES: Comments may be mailed to the Office of the General Counsel, suite 340, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4026, or delivered to that address between 9 a.m. and 4 p.m. on business days. Written comments will be available for public inspection at the PBGC's Communications and Public Affairs Department, suite 240 at the same address, between 9 a.m. and 4 p.m. on business days.

FOR FURTHER INFORMATION CONTACT: Deborah C. Murphy, Attorney, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4026, 202–326–4024. (For TTY and TDD, call 800–877–8339 and request connection to 202–326–4024).

SUPPLEMENTARY INFORMATION: Section 4211(c)(5)(A) of the Employee Retirement Income Security Act of 1974 (''ERISA'') requires the PBGC to prescribe by regulation a procedure whereby multiemployer pension plans can change the way they allocate unfunded vested benefits to withdrawing employers, subject to PBGC approval. Approval of a change is to be based on a determination that the change will not significantly increase the risk of loss to plan participants or the PBGC.

The PBGC's regulation on Allocating Unfunded Vested Benefits (29 CFR Part 4211) includes, in § 4211.22, rules for requesting the PBGC's approval of an amendment to a plan's allocation method. Section 4211.22(d) prescribes information that the PBGC needs to identify the plan and evaluate the risk of loss, if any, posed by the amendment (and, hence, determine whether it should approve the amendment). Section 4211.22(e) requires the submission of other information that the PBGC may need to review the amendment. (The regulation may be accessed on the PBGC's home page at http://www.pbgc.gov.)

The collection of information under the regulation has been approved by OMB under control number 1212–0035 through February 28, 1998. The PBGC intends to request that OMB extend its approval for another three years. The PBGC estimates that it receives five submissions from plan sponsors annually under the regulation; that virtually all submissions are prepared by outside consultants; that the total annual hour burden of engaging the services of such consultants is one hour; and that the total annual cost burden of having the submissions prepared is $1,575.

The PBGC is soliciting public comments to—

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Issued in Washington, DC, this 7th day of November, 1997.

David M. Strauss,

Executive Director, Pension Benefit Guaranty Corporation.

[FR Doc. 97–29880 Filed 11–12–97; 8:45 am]
BILLING CODE 7708–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 35–26774]

Filings Under the Public Utility Holding Company Act of 1935, as amended (''Act'')

November 6, 1997.

Notice is hereby given that the following filing(s) has/have been made with the Commission pursuant to provisions of the Act and rules promulgated thereunder. All interested persons are referred to the application(s) and/or declaration(s) for complete statements of the proposed transaction(s) summarized below. The application(s) and/or declaration(s) and any amendments thereto is/are available for public inspection through the Commission's Office of Public Reference.

Interested persons wishing to comment or request a hearing on the application(s) and/or declaration(s) should submit their views in writing by December 1, 1997, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549, and serve a copy on the relevant applicant(s) and/or declarant(s) at the address(es) specified below. Proof of service (by affidavit or, in case of an attorney at law, by certificate) should be filed with the request. Any request for hearing shall identify specifically the issues of fact or law that are disputed. A person who so requests will be notified of any hearing, if ordered, and will receive a copy of any notice or order issued in the matter. After said date, the application(s) and/or declaration(s), as filed or as amended, may be granted and/or permitted to become effective.

New England Electric System, et al. (70–9143); Notice of Proposal to Amend Articles of Incorporation and Authorize Registered Holding Company to Acquire Preferred Stock of Utility Subsidiaries; Order Authorizing Solicitation of Proxies

New England Electric System (''NEES''), a registered holding company, and its wholly-owned public utility subsidiaries, New England Power Company (''the Power Company''), Massachusetts Electric Company (''Mass Electric''), and the Narragansett Electric Company (''Narragansett''), all located at 25 Research Drive, Westborough, Massachusetts 01582, have filed an application-declaration under sections 6(a), 7, 9(a), 10, 12(c), 12(d) and 12(e) of