and scientific disciplines, such as nuclear power plant operations, nuclear engineering, mechanical engineering, electrical engineering, chemical engineering, metallurgical engineering, structural engineering, materials science, probabilistic risk assessment, and instrumentation and process control systems.

At this time, candidates are specifically being sought who have 15–20 years of specific experience, including graduate level education in either: Materials science; metallurgical/structural engineering; systems engineering and thermal-hydraulics modeling as applied to nuclear plant systems; or the application of risk methods to nuclear safety issues.

Criteria used to evaluate candidates include education and experience, demonstrated skills in nuclear safety matters, and the ability to solve problems. Additionally, the Commission considers the need for specific expertise in relationship to current and future tasks. Consistent with the requirements of the Federal Advisory Committee Act, the Commission seeks candidates with varying views so that the membership on the Committee will be fairly balanced in terms of the points of view represented and functions to be performed by the Committee.

Because conflict-of-interest regulations restrict the participation of members actively involved in the regulated aspects of the nuclear industry, the degree and nature of any such involvement will be weighed. Each qualified candidate's financial interests must be reconciled with applicable Federal and NRC rules and regulations prior to final appointment. This might require divestiture of securities issued by nuclear industry entities, or discontinuance of industry-funded research contracts or grants.

Copies of a résumé describing the educational and professional background of the candidate, including any special accomplishments, professional references, current address and telephone number should be provided. All qualified candidates will receive careful consideration. Appointment will be made without regard to such factors as race, color, religion, national origin, sex, age, or disabilities. Candidates must be citizens of the United States and be able to devote approximately 80–100 days per year to Committee business. Applications will be accepted until July 30, 1999.

Dated: June 2, 1999.

Andrew L. Bates,

Advisory Committee Management Officer.

[FR Doc. 99–14467 Filed 6–7–99; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Report to Congress on Abnormal Occurrences, Fiscal Year 1998, 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 Nuclear Regulatory Commission (NRC) determines to be 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 on an annual basis. During fiscal-year 1998, six events that occurred at facilities licensed or otherwise regulated by the NRC and the Agreement States 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, Volume 21, ''Report to Congress on Abnormal Occurrences, Fiscal Year 1998.'' This report will be available at NRC's Public Document Room, 2120 L Street N.W. (Lower Level), Washington, D.C., about three weeks after the publication date of this **Federal Register** Notice.

Fuel Cycle Facilities (Other Than Nuclear Power Plants)

98–1 Seismic Risk From Liquid Uranium Hexafluoride at the Withdrawal Facilities at the Paducah Gaseous Diffusion Plant, Paducah, KY

One of the AO criteria notes that a major condition or significant event not considered in the license/certificate that requires immediate remedial action will be considered for reporting as an AO.

Date and Place—February 18, 1998; Paducah Gaseous Diffusion Plant, a uranium enrichment plant, operated by Lockheed Martin Utility Services for the United States Enrichment Corporation (USEC) and located about 16 kilometers (10 miles) west of Paducah, Kentucky.

Nature and Probable Consequences—On October 31, 1997, USEC submitted a certificate amendment request that provided an updated Safety Analysis Report, containing a new accident analysis, for Paducah. The seismic accident analysis stated that equipment (piping, condensers, and accumulators) in the withdrawal facilities containing liquid uranium hexafluoride (UF_6) could fail at a 70-year return earthquake (0.05 gravitational acceleration (g) peak ground acceleration (pga)) rather than at the 250-year return design basis earthquake (0.15 g pga). However, the consequences of the accident analysis were noted as minimal because of the assumptions made in the accident analysis. The NRC's request for additional information (RAI) dated February 5, 1998, raised concerns about the conservative nature of assumptions for the seismic accident analysis. In response to the RAI, USEC confirmed that the seismic accident analysis assumption of no liquid UF_6 in the withdrawal facilities' accumulators underestimated the potential source term for the seismic accident analysis.

The accumulators are normally empty and serve only as a reservoir for liquid UF_6 when cylinders are changed after being filled, or during periods of equipment problems or surveillances. However, with no operational restrictions on the amount of liquid UF_6 in the accumulators, a seismic event could occur with the accumulators full. Consequences from a 0.05 g pga earthquake with full accumulators in the withdrawal facilities could involve onsite fatalities and significant offsite injuries from exposure to the released UF_6 and reaction products.

Cause or Causes—The cause of this event was an inadequate seismic design for the facility and an inadequate accident analysis that failed to consider the full range of allowable operations of the withdrawal facilities.

Actions Taken To Prevent Recurrence

Licensee/Certificate Holder—Immediate corrective actions included restricting operations in the withdrawal facilities to limit the amount of liquid UF_6 available for release. Long-term corrective actions were to install seismic modifications that will allow the withdrawal facilities' equipment to withstand a design-basis earthquake. The modifications have been completed as directed by the NRC.

NRC—An immediately effective ''confirmatory order modifying certificate'' to incorporate the immediate and long-term corrective actions was issued on April 22, 1998.

* * * * *

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

98–2 Multiple Medical Brachytherapy Misadministrations by José N. De León, M.D., in Rio Piedras, PR

One of the AO criteria notes that a medical misadministration that results in a dose that is: (1) Equal to or greater than 1 gray (Gy) (100 rad) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1000 rad) to any other organ and that represents a dose or dosage that is at least 50 percent greater than that prescribed in a written directive will be considered for reporting as an AO.

Date and Place—Between April 27, 1995, and June 26, 1996; private medical office of José N. De León, M.D., Rio Piedras, Puerto Rico.

Nature and Probable Consequences—Nine patients were treated after surgery for non-malignant eye growths with a strontium-90 (Sr-90) eye applicator, at Dr. De León's private medical office. Each of the nine patients received a dose of 4000 centigray (cGy) (4000 rad) instead of the intended dose of 2000 cGy (2000 rad). The NRC staff identified this event during Fiscal Year 1998.

On June 1, 1994, Dr. De León submitted to NRC a Quality Management Program (QMP) indicating that his 4.625 gigabecquerel (125 millicurie) Sr-90 eye applicator device would deliver to a patient a dose of 2000 cGy (2000 rad) in 26 seconds. In April 1995, Dr. De León hired a health physics consultant to calculate a decay correction for the surface dose rate of the Sr-90 eye applicator. In April 1995, Dr. De León submitted a revised QMP to the NRC, incorporating the surface dose rate corrections performed by the consultant, stating that the Sr-90 eye applicator device would deliver a 2000 cGy (2000 rad) dose in 60 seconds.

On December 11, 1997, the NRC conducted a special inspection of Dr. De León's licensed activities. During this inspection, the NRC determined that in April 1995, Dr. De León's consultant had made a calculation error. Without verifying the consultant's calculations, Dr. De León had adjusted the treatment time from 26 seconds to 60 seconds.

When Dr. De León became aware of this error, he indicated that: (1) All patients or next of kin were notified, (2) a free examination was offered to all patients, which was declined, and (3) there were no problems or complications reported by patients associated with the misadministrations. Dr. De León also indicated that it is unlikely for patients to develop any harmful effects as a result of the misadministration.

The NRC hired a medical consultant to review the medical aspects of the misadministration. The NRC's medical consultant reviewed the information obtained from the NRC, Dr. De León, and Ryder Memorial Hospital, and concluded that: (1) The range for a single fraction for eye radiation treatments, recommended by the medical community using a Sr-90 applicator, is about 1800–3000 cGy (1800–3000 rad), (2) the highest single dose, using a Sr-90 applicator, recommended in published medical reports is 3000 cGy (3000 rad), and (3) the patients treated by Dr. De León are at a higher risk for harmful effects because of the high doses given in single fractions.

Cause or Causes—Dr. De León's consultant made a calculation error in correcting the surface dose rate of the Sr-90 applicator for radioactive decay and Dr. De León failed to verify or question the consultant's calculation before using the revised surface dose rate in patient treatments.

Actions Taken To Prevent Recurrence

Licensee—Dr. De León has retired; he has properly transferred the Sr-90 eye applicator to a foreign user and he has obtained from NRC a termination of his license.

NRC—The NRC's Advisory Committee on the Medical Use of Isotopes will be recommending courses of action to the NRC. NRC will perform additional inspections of NRC licensees authorized to possess and use Sr-90 eye applicators to confirm the use of proper decay corrections and source calibrations. In addition, the NRC staff will review this case with the Secretary of Health of the Commonwealth of Puerto Rico for possible action.

* * * * *

98–3 Multiple Medical Brachytherapy Misadministrations at Ryder Memorial Hospital, in Humacao, PR

One of the AO criteria notes that a medical misadministration that results in a dose that is: (1) Equal to or greater than 1 gray (Gy) (100 rad) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1000 rad) to any other organ and that represents a dose or dosage that is at least 50 percent greater than that prescribed in a written directive will be considered for reporting as an AO.

Date and Place—Between April 22, 1995, and February 21, 1996; at Ryder Memorial Hospital; Humacao, Puerto Rico.

Nature and Probable Consequences—Twelve patients treated with a strontium-90 (Sr-90) eye applicator at the Ryder Memorial Hospital received a dose of 4000 cGy (4000 rad) instead of the intended dose of 2000 cGy (2000 rad). Two patients received a second treatment dose of 4000 cGy (4000 rad) to the same eye. These treatments were performed by Dr. José De León, who, in addition to his private practice in Rio Piedras in Puerto Rico, was authorized by NRC to practice at the Ryder Memorial Hospital in Humacao, Puerto Rico. The NRC staff identified this event during Fiscal Year 1998.

On June 28, 1994, Ryder Memorial Hospital notified the NRC that it had canceled the authorization given to the ophthalmologists named on their license to use Sr-90 at its facility, and a Quality Management Program was not needed for this activity. However, during a routine inspection of Ryder Memorial Hospital, conducted between November 17 and December 11, 1997, the NRC staff learned that Dr. De León had used his Sr-90 eye applicator at the Ryder Memorial Hospital without authorization from the hospital. NRC was unable to determine whether Dr. De León had been told by Ryder Memorial Hospital that his authority was canceled for the use of Sr-90 eye applicator.

On December 11, 1997, the NRC conducted a special inspection of Dr. De León's licensed activities. During this inspection, the NRC determined that in April 1995, Dr. De León's consultant had made a calculation error. Without verifying the consultant's calculations, Dr. De León adjusted the treatment time from 26 seconds to 60 seconds.

Ryder Memorial Hospital representatives and Dr. De León, notified the patients or next of kin of the misadministrations. The information presented by Ryder Memorial Hospital describing the effects on patients from misadministrations was based on the information submitted by Dr. De León. Specifically, Dr. De León indicated that the delivered dose of 4000 cGy (4000 rad) falls within the dose range used by the medical community to prescribe these treatments and no adverse effects were expected.

The NRC medical consultant reviewed the information obtained from the NRC, Dr. De León, and Ryder Memorial Hospital, and concluded that: (1) The range for a single fraction for eye radiation treatments, recommended by the medical community using a Sr-90 applicator, is about 1800–3000 cGy (1800–3000 rad), (2) the highest single dose, using a Sr-90 applicator,

recommended in published medical reports is 3000 cGy (3000 rad), and (3) the patients treated by Dr. De León are at a higher risk for harmful effects because of the high doses given in single fractions.

Cause or Causes—Dr. De León's consultant made an error in calculating the surface dose rate of the Sr-90 applicator, and Dr. De León failed to verify the consultant's calculation before incorporating the revised surface dose rate in patient treatments. In addition, Dr. De León performed ophthalmic brachytherapy using his Sr-90 eye applicator device at Ryder Memorial Hospital under Ryder Memorial Hospital's NRC license, without the hospital's authorization.

Actions Taken To Prevent Recurrence

Licensee—Ryder Memorial Hospital reiterated its withdrawal of Dr. De León's authority to use the Sr-90 eye applicator device at Ryder Memorial Hospital and does not intend to authorize future use of the Sr-90 eye applicator for ophthalmic brachytherapy. In addition, Dr. De León has retired; he has properly transferred the Sr-90 eye applicator to a foreign user and he has obtained from NRC a termination of his license.

NRC—The NRC's Advisory Committee on the Medical Use of Isotopes will be recommending courses of action to the NRC. NRC will perform additional inspections of NRC licensees authorized to possess and use Sr-90 eye applicators to confirm the use of proper decay corrections and source calibrations. In addition, the NRC staff will review this case with the Secretary of Health of the Commonwealth of Puerto Rico for possible action.

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98–4 Iodine-131 Medical Misadministration at Virginia Beach General Hospital, in Virginia Beach, VA

One of the AO criteria notes that a medical misadministration that results in a dose that is: (1) Equal to or greater than 1 gray (Gy) (100 rad) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1000 rad) to any other organ and represents a dose or dosage that is at least 50 percent greater than that prescribed in a written directive will be considered for reporting as an AO.

Date and Place—November 21, 1997; Virginia Beach General Hospital; Virginia Beach, Virginia.

Nature and Probable Consequences—A patient was administered a dosage of 199.8 megabecquerel (MBq) (5.4 millicurie (mCi)) of iodine-131 (I–131) for a thyroid procedure instead of an 11.1 MBq (0.300 mCi) dosage of iodine-123 (I–123). As a result, the patient's thyroid received a dose of 4000 centigray (cGy) (4000 rad), instead of the intended dose of 2.0 cGy (2.0 rad).

On November 20, 1997, the referring physician prescribed a thyroid function procedure, which, at Virginia Beach General Hospital, required the administration of about 11.1 MBq (0.300 mCi) of I–123. Due to poor communication between the referring physician and her staff (a staff nurse), the patient was scheduled for a whole-body thyroid scan, which required the administration of approximately 185 MBq (5 mCi) of I–131. On November 21, 1997, the technologist who was to perform the procedure attempted to contact the referring physician to ask questions about the requested procedure. However, the referring physician was not available, and the staff nurse who had originally taken the request from the referring physician and scheduled the procedure confirmed that the physician wanted an I–131 scan. The technologist, without a written directive, decided to proceed with the procedure and administered the dosage of 199.8 MBq (5.4 mCi) of I–131 to the patient. The misadministration was identified on November 24, 1997, when the patient returned for a 72-hour whole-body scan.

The licensee stated that no adverse health effects are expected from the misadministration. The NRC's medical consultant determined that the impact of the misadministration on the patient's health should be negligible, with no expected long-term disability.

Cause or Causes—This event was caused by the licensee's failure to prepare a written directive before the administration of the I–131 dosage and inadequate follow-up by the technologist involved in the I–131 procedure.

Actions Taken To Prevent Recurrence

Licensee—New procedures were initiated that required all I–131 procedures to be scheduled through the Nuclear Medicine Department, and additional quality management measures were implemented. The licensee also initiated changes to the computerized scheduling system and provided retraining of the staff.

NRC—An inspection was conducted to review the circumstances of the misadministration. A Notice of Violation was issued for failure of the licensee to prepare a written directive before the administration of I–131.

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98–5 Exposure to a Minor from a Radiopharmaceutical Therapy Event at Western Pennsylvania Hospital in Pittsburgh, PA.

One of the AO criteria notes that any unintended radiation exposure to any minor (an individual less than 18 years of age) resulting in an annual total effective dose equivalent (TEDE) of 50 mSv (5 rem) or more will be considered for reporting as an AO.

Date and Place—July 28, 1998; Western Pennsylvania Hospital; Pittsburgh, Pennsylvania.

Nature and Probable Consequences—A female patient was prescribed a whole-body iodine-131 (I–131) thyroid scan following a thyroidectomy. The technologist asked the patient if she was breast-feeding but she did not reply and was administered a dosage of 111 megabecquerel (3 millicurie) of I–131. Two days later, while the thyroid scan was being performed, the patient said that she had breast-fed her 4-year-old son during the past few evenings. The licensee performed a bioassay on the child on August 3, 1998, and determined that the TEDE for the child based on the International Commission on Radiological Protection calculations was 89.5 millisievert (8.95 rem), and the dose to the thyroid was about 184 centigray (cGy) (184 rad).

The NRC medical consultant evaluated the event and estimated that the dose to the child's thyroid using the Medical Internal Radiation Dose calculations was about 128 to 152 cGy (128 to 152 rad) and presented a discussion of potential clinical consequences.

The hospital was notified of the consultant's findings and was given a copy of the consultant's report. The child has been examined by a pediatric endocrinologist and the hospital continues to monitor the patient and her child.

Cause or Causes—The patient failed to answer the technologist's question regarding breast feeding and the hospital failed to receive an answer to the question before dose administration.

Action Taken To Prevent Recurrence

Licensee—The licensee developed a new response form for women aged between 10 and 50 years for: (1) Asking them if they are nursing, (2) informing them of the harm to a child if they are breast-feeding after I–131 administration, and (3) obtaining a signed statement before administering them radioactive material.

NRC—NRC sent a letter to the licensee requiring it to prepare a plan describing how to prevent similar

events. The licensee responded on October 8 and 12, 1998, listing adequate actions to prevent recurrence of similar events.

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Agreement State Licensees

AS 98–1 Medical Brachytherapy Misadministration at Tuomey Regional Medical Center in Sumter, SC

One of the AO criteria notes that any unintended radiation exposure to an adult (any individual 18 years of age or older) resulting in an annual total effective dose equivalent (TEDE) of 250 millisievert (mSv) (25 rem) or more; or an annual sum of the deep dose equivalent and committed dose equivalent to any individual organ or tissue other than the lens of the eye, bone marrow, and the gonads of 2500 mSv (250 rem) or more will be considered for reporting as an AO.

Date and Place—September 23, 1997; Tuomey Regional Medical Center; Sumter, South Carolina.

Nature and Probable Consequences—On September 23, 1997, a patient was scheduled by a referring physician (urologist) for a palladium-103 (Pd-103) permanent prostate seed implant via transrectal ultrasound guidance. However, the referring physician had two patients with identical names and the wrong individual got the orders for the Pd-103 treatment. The patient was identified at the Medical Center by verbal means (asking the patient's name) and by checking the name on the patient's wristband. In addition, the patient had signed a consent in the chart stating he was at the hospital for seed implant for treatment of prostate cancer. The patient received 67 seeds of Pd-103 at 37 megabecquerel (MBq) (1 millicurie (mCi)) per seed, thus a total implant activity of 2479 MBq (67 mCi). On the basis of pre-implant dosimetry, the periphery of the prostate was to receive a maximum dose of 9000 centigray (cGy) (9000 rad). The posterior wall of the bladder and anterior wall of the rectum would receive approximately 4000 cGy (4000 rad) and the whole-body dose would be less than 1 cGy (1 rad). The procedure was performed without complication.

On September 25, 1997, the referring physician notified Tuomey Regional Medical Center that he had two patients with identical names and that the wrong individual had received the implant. On September 29, 1997, the authorized user met with the individual who had received the Pd-103 treatment and discussed the potential early and late side effects, and all necessary precautions.

The licensee stated that the early consequences from this type of implant usually are dysuria and possible hematuria, which, if they occur, resolve in several days. Late consequences could be an approximately 25 percent chance of impotence. Damage to the bladder and rectum occurs in fewer than 1 percent of patients.

Cause or Causes—The referring physician had two patients with identical names. The wrong individual arrived at Tuomey Regional Medical Center with orders from the referring physician for the Pd-103 seed implant. The patient who should have had these orders had been to Tuomey Regional Medical Center for a pre-operative interview. When the wrong individual presented for treatment at Tuomey Regional Medical Center with orders for the Pd-103 seed implant, the registration process failed to note that he was not the same individual who had undergone the pre-operative interview.

Actions Taken To Prevent Recurrence

Licensee—The licensee performed a comprehensive review of the patient identification process once the incident occurred. As a result, the patient identification system was revised on a hospital-wide basis in order to prevent recurrence of this type of event.

State Agency—The State agency investigated the event and a Notice of Violation and Enforcement Conference was held on February 10, 1998. A Notice of Noncompliance was issued for failure to meet the objective that each administration is done in accordance with a written directive. The licensee responded in writing and no additional actions were required.

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Dated at Rockville, Maryland this 2nd day of June, 1999.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. 99–14468 Filed 6–7–99; 8:45 am]

BILLING CODE 7590–01–P

RAILROAD RETIREMENT BOARD

Actuarial Advisory Committee With Respect to the Railroad Retirement Account; Notice of Public Meeting

Notice is hereby given in accordance with Public Law 92–463 that the Actuarial Advisory Committee will hold a meeting on June 15, 1999, at 10:30 a.m. at the office of the Chief Actuary of the U.S. Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois, on the conduct of the 21st Actuarial Valuation of the Railroad Retirement System. The agenda for this meeting will include a discussion of the assumptions to be used in the 21st Actuarial Valuation. A report containing recommended assumptions and the experience on which the recommendations are based will have been sent by the Chief Actuary to the Committee before the meeting.

The meeting will be open to the public. Persons wishing to submit written statements or make oral presentations should address their communications or notices to the RRB Actuarial Advisory Committee, c/o Chief Actuary, U.S. Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611–2092.

Dated: May 26, 1999.

Beatrice Ezerski,

Secretary to the Board.

[FR Doc. 99–14323 Filed 6–7–99; 8:45 am]

BILLING CODE 7905–01–M

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Filings and Information Services, Washington, DC 20549

Form F–6, SEC File No. 270–270, OMB Control No. 3235–0292

Regulation S–T, SEC File No. 270–375, OMB Control No. 3235–0424

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), the Securities and Exchange Commission (''Commission'') is soliciting comments on the collection of information summarized below. The Commission plans to submit these existing collections of information to the Office of Management and Budget for extension and approval.

The Commission under Section 19 of the Securities Act of 1933 established Form F–6 for registration of American Depositary Receipts (ADRs) of foreign companies. Form F–6 requires disclosure of information regarding the terms of the depository bank, fees charged, and a description of the ADRs. No special information regarding the foreign company is required to be prepared or disclosed, although the foreign company must be one which periodically furnishes information to the Commission. Such information is available to the public for inspection. The information is needed to ensure that investors in ADRs have full