

# NMSS Licensee Newsletter



**U.S. Nuclear  
Regulatory  
Commission**

**Office of Nuclear  
Material Safety  
and Safeguards**

**NUREG/BR-0117  
No. 00-3  
Sept-Oct 2000**

## DISCRIMINATION TASK GROUP

On July 27, 2000, the U.S. Nuclear Regulatory Commission (NRC) established a management-level review group to evaluate the NRC processes used in the handling of discrimination allegations and violations of employee protection standards. The Discrimination Task Group's overall objective is to develop recommendations for possible changes to regulatory requirements, the Agency Enforcement Policy, or other guidelines, as appropriate. Another of the group's primary objectives is to promote active and frequent involvement of internal and external stakeholders in the development of recommendations for changes to the process.

The group's preliminary schedule is to begin work in September 2000, to evaluate current NRC processes and develop recommendations for process improvements. The Task Group plans to complete its work by June 30, 2001. Specific activities being considered include interaction with other agencies, conduct of internal and external stakeholder meetings to solicit input, and consideration of issues raised in a Petition for Rulemaking regarding requiring training of supervisors on their responsibilities in implementing the employee protection regulations.

Over the next several months, the Task Group plans to hold several internal stakeholder meetings in the regional offices, and public stakeholder meetings in various areas of the country. These public meetings will be held at the NRC Headquarters offices; Chattanooga, TN; San Luis Obispo, CA; and in the vicinity of the Milestone Nuclear Power Plant; the Chicago area; and the Paducah Gaseous Diffusion Plant. With the input from these meetings, the Task Group will begin to develop recommendations for process improvements.

The Task Group Charter and other pertinent documents related to the group's activities will be periodically posted and updated on the NRC Office of Enforcement WEB site homepage [<http://www.nrc.gov/OE/>]. Any questions about the group should be directed to Mr. Barry Westreich, telephone number: 301-415-3456, or e-mail: [bcw@nrc.gov](mailto:bcw@nrc.gov).

(Contact: Barry Westreich, 301-415-3456, e-mail: [bcw@nrc.gov](mailto:bcw@nrc.gov)).

## NRC STAFF COMPLETES DECOMMISSIONING STANDARD REVIEW PLAN

In July 1998, the U.S. Nuclear Regulatory Commission (NRC) directed the staff to develop a Standard Review Plan (SRP) for evaluating information to support the decommissioning of nuclear facilities. The goal of the SRP is to allow NRC staff to evaluate information submitted by licensees, in a timely, efficient, and consistent manner, to determine if the decommissioning can be conducted, such that the public health and safety are protected and the facility can be released in accordance with NRC's requirements. The staff has completed development of the SRP and is making it available to interested individuals for use in developing Decommissioning Plans (DPs) and other information to support the decommissioning of nuclear facilities.

The SRP describes a risk-informed, iterative approach developed by the staff, and provides guidance on the information that should be included in a DP, including evaluation and acceptance criteria for reviewing the information, and suggestions on the format and content of the information. It also provides NRC staff with a description of the contents of specific decommissioning plan modules, as well as evaluation and acceptance criteria for use in reviewing decommissioning plans and other information

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(September–October 2000)**

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**NRC STAFF COMPLETES  
DECOMMISSIONING STANDARD  
REVIEW PLAN (continued)**

submitted by licensees to demonstrate that their facilities are suitable for release in accordance with NRC requirements. To obtain input from the regulated community on issues that needed to be addressed in the SRP, NRC staff held a series of workshops on dose modeling surveys, demonstrating as low as is reasonably achievable, and restricted use/alternate criteria in 1998–2000. In addition, as draft SRP modules were completed, they were posted on the NRC Website.

The SRP supersedes numerous existing Regulatory Guides, including Regulatory Guide 3.65, “Standard Format and Content of Decommissioning Plans for Licensees under 10 CFR Parts 30, 40, and 70,” and Policy and Guidance Directive FC 91–2, “Standard Review Plan: Evaluating Decommissioning Plans for Licensees under Parts 30, 40, and 70.” In addition, in recognition that similar information was being presented in the SRP and Draft Regulatory Guide DG–4006, “Demonstrating Compliance with the Radiological Criteria for License Termination,” staff has consolidated the guidance in the SRP and will not publish a final version of the Draft

Regulatory Guide. Comments submitted by interested individuals on DG–4006 were considered as the staff finalized the SRP.

Currently, NRC staff is preparing the SRP for publication as a NUREG. However, to allow interested individuals to begin using the SRP, the staff has placed it on NRC’s Decommissioning Website at: <http://www.nrc.gov/NMSS/DWM/DECOM/decomm.html>.

NRC staff will begin using the SRP to evaluate DPs and other information in September 2000, and all interested individuals are urged to review the SRP before they begin developing DPs and other information to support the decommissioning of their facilities.

(Contact: Nick Orlando, 301–415–6749; e-mail: [dao@nrc.gov](mailto:dao@nrc.gov))

**OKLAHOMA ASSUMES LICENSING  
AUTHORITY UNDER AGREEMENT WITH  
NRC**

Governor Frank Keating of the State of Oklahoma and Dr. Richard Meserve, Chairman of the U.S. Nuclear Regulatory Commission (NRC) signed an Agreement and, on September 29, 2000, Oklahoma became the 32nd Agreement State. The Agreement with Oklahoma allows Oklahoma to assume regulatory authority over 11e.(1) byproduct material; source material used to take advantage of its density and high-mass properties, where the use of the specifically licensed source material is subordinate to the primary specifically licensed use of either 11e.(1) byproduct material or special nuclear material; and special nuclear material in quantities not sufficient to form a critical mass. Oklahoma will also assume authority to regulate the disposal of low-level radioactive waste at a land disposal site as described in 10 CFR Part 61. With this agreement, approximately 235 NRC material licenses in Oklahoma were transferred to the State of

Comments, and suggestions you may have for information that is not currently being included, that might be helpful to licensees, should be sent to:

E. Kraus  
*NMSS Licensee Newsletter* Editor  
 Office of Nuclear Material Safety  
 and Safeguards  
 Two White Flint North, Mail Stop 8–A–23  
 U.S. Nuclear Regulatory Commission  
 Washington, D.C. 20555–0001

Oklahoma. Individuals who need to perform licensed activities, as listed above, in the State of Oklahoma, should contact Mike Broderick, Administrator, Oklahoma Department of Environmental Quality, Radiation Management Section, P. O. Box 1677, Oklahoma City, OK 73101-1677. The Department of Environmental Quality's phone number is 405-702-5155.

(Contact: Anthony Gaines, Region IV, 817-860-8252, e-mail: adg1@nrc.gov)

## **DOMESTIC LICENSING OF SPECIAL NUCLEAR MATERIAL; POSSESSION OF A CRITICAL MASS OF SPECIAL NUCLEAR MATERIAL**

The U.S. Nuclear Regulatory Commission (NRC) has amended its regulations, in 10 CFR Part 70, governing the domestic licensing of special nuclear material (SNM) for certain licensees authorized to possess a critical mass of SNM.

The amendments establish performance requirements that require the affected licensees to perform an integrated safety analysis (ISA). An ISA is a systematic analysis that identifies:

1) plant and external hazards and their potential for initiating accident sequences; 2) the potential accident sequences and their likelihood and consequences; and 3) the items relied on for safety to prevent or mitigate potential accidents at a facility. The amendments also require the implementation of measures to: (a) ensure that the items relied on for safety are available and reliable to perform their functions when needed; (b) require the safety bases to be maintained and report changes to NRC; (c) allow licensees to make certain changes to their safety program and facilities without prior NRC approval; (d) require reporting of certain events; and (e) require NRC to perform a backfit analysis under specified circumstances.

These amendments were in response to a Petition for Rulemaking (PRM)-70-7, submitted by the Nuclear Energy Institute (NEI), which was published on November 26, 1996 (61 FR 60057). The proposed rule was intended to grant the NEI PRM in part and would modify the petitioner's proposal. The majority of the proposed modifications to Part 70 were included in a proposed new Subpart H, "Additional Requirements for Certain Licensees Authorized to Possess a Critical Mass of Special Nuclear Material." These modifications were proposed to increase confidence in the margin of safety at the facilities affected by the rule.

During the rulemaking process, the staff used several methods to seek stakeholder participation and comment. All important documents and significant drafts of selected documents were posted on the NRC web site ([www.nrc.gov](http://www.nrc.gov), under "Rulemaking and Technical Conference"). These postings included postings providing revised rule and standard review plan language; staff comments on related issues; postings of comments received; and postings of the transcripts of public meetings. Potentially interested parties were e-mailed notifications when a new document was added to the site. In addition, between December of 1998 and September of 2000, the NRC staff held 10 public stakeholder meetings to discuss the rule and associated guidance documents.

Through extensive stakeholder involvement, the final rule was approved by the Commission on September 6, 2000, and is to be published in the *Federal Register* in mid-September. The staff continues to work with affected stakeholders to develop guidance documents that would implement the proposed requirements. (Contact: Heather Astwood, 301-415-5819, e-mail: hma@nrc.gov)

## **OPERATIONAL EXPERIENCE**

The U.S. Nuclear Regulatory Commission (NRC) is providing summaries of these events to inform licensees of conditions they may encounter and of actions that may be taken to deal with them.

### **1. Contamination Resulting from Use of Feeding Tube to Administer Radiopharmaceutical**

NRC is alerting licensees to the possibility of a contamination and exposure hazard when a feeding tube is used in the administration of radiopharmaceuticals. The following event involved the contamination of two individuals and a skin overexposure of 1 sievert (Sv) (100 rem) to one of the individuals.

A physician, assisted by a nuclear medicine technologist, was administering a dosage of 140 millicuries (mCi) of Iodine-131 (I-131) to a patient for thyroid ablation. The method of administration was by injection into an existing stomach tube. On completion of the administration/procedure, the patient coughed and caused some of the I-131 to spray from the tube, which contaminated the technologist and physician.

The physician was decontaminated, but after showering, the nuclear medicine technologist was still contaminated on the hands, neck, hair, and

torso. Within 2 hours of the event, the nuclear medicine technologist was administered a blocking dose of potassium iodide. A thyroid count showed an uptake of 81.4 becquerels (Bq) (0.0022 microcuries) of I-131, which would give an estimated thyroid dose of 35 millisieverts (35 millirem). The licensee estimated the skin dose to the nuclear medicine technologist to be 1 Sv (100 rem) over a period of 20 days.

(Contact: Roberto Torres, 301-415-8115; e-mail: rjt@nrc.gov)

## 2. Radiography Camera Model IR-100 Crank Assembly Malfunction

*Date and Place*—March 31, 2000; Naval Fuel Supply Depot; Jacksonville, FL.

*Nature and Probable Consequences*—On March 31, 2000, at approximately 6:00 p.m., the licensee—Space Science Service—reported that it was unable to fully retract a 1.81-terabecquerel (49-curie) Iridium-192 source into the shielded position of its radiography exposure device, an Industrial Nuclear Company, Inc. (INC) IR-100. The work was being conducted at the Navy Fuel Depot in Jacksonville, FL, under reciprocity with NRC. The radiographers isolated the area and controlled access while taking corrective actions. The radiographers disassembled the crank that drives the source in and out of the exposure device. They found that a piece of the crank internals had malfunctioned and jammed the crank gears. The radiographers contacted the Radiation Safety Officer (RSO) by telephone, who consulted with them as they attempted to retract and lock the source. One of the radiographers loosened the drive cable connection from the device and manually pulled the source back into the camera by the cable, to a fully retracted and locked position.

This radiographer received a whole-body exposure of 1.25 millisieverts (mSv) [125 millirem (mrem)] as measured by a self-reading pocket dosimeter, for the entire job during which the event occurred. Of this, 0.25 mSv (25 mrem) were attributed to actions taken to return the source to the camera.

*Cause or Causes*—The INC examined the crank assembly and found that the inner lining of the drive cable, which is a Teflon tube, had pulled out of the outer drive cable housing and fed into the cranking mechanism between the gears, causing the malfunction. The exposed inner Teflon tube end was stretched and frayed.

The NRC staff contacted INC on June 4 and 6, 2000, regarding its investigation of the incident.

The INC informed the NRC staff that it examined the failed component. The outer drive cable housing was measured for stretch and was found to be the correct length of 7.6 meters (25 feet). The inner Teflon tube was examined and found to be in the original condition, at the crank end, but it was pulled back 12.7 centimeters (5 inches) from the source connector end.

The manufacturer of the cable housing, Universal Metal Hose, was unable to determine the cause and stated that this type of failure had never occurred before.

Based on the NRC staff's review of the case, improper handling of the radiography camera most likely caused the failure. Specifically, the operator probably pulled or lifted the camera by the drive cable. The cable stretched and returned to its original length. When the inner Teflon tube was stretched, it pulled loose from the outer drive cable housing. Before jamming, cranking of the source probably became more difficult as the inner Teflon tube moved into the drive cable housing connector. It is not clear why the operator seemed to ignore this problem and did not report it to the RSO or management.

### *Actions Taken to Prevent Recurrence*

*Licensee*—The licensee's corrective actions include installing a backup drive cable and modifying its quarterly maintenance check to include the removal of the cover plate of the crank assembly, to inspect and service the drive cable and gears.

*NRC*—The NRC staff reviewed the INC's investigation on this incident and determined that this is not a generic issue for the following reasons:

- (1) The control sheath is designed to withstand  $112.5 \pm 0.5$  pounds of tensile force for 30 seconds per cycle through 10 cycles. NRC's endurance tests, conducted by the Savannah River Technology Center (Page J-4 of NUREG/CR-6652) indicated that INC cameras did perform well within the specifications similar to other manufacturers' cameras.
- (2) The crank assembly jam would not have occurred if the company's maintenance procedures, as well as daily and quarterly inspection procedures, were followed properly.
- (3) There are no similar incidents reported either for INC cameras or for cameras of other manufacturers.

No actions are recommended because this failure is a single occurrence. However, the licensees

should follow the manufacturer's maintenance and inspection procedures.  
(Contact: Seung Lee, 301-415-5787; e-mail: sjl@nrc.gov)

### 3. Electronic Pocket Dosimeters

Both Siemens and MGPI have issued a "Customer Notification" on their electronic pocket dosimeters (EPDs). Siemens model Mk2 EPD occasionally has a software bug when configured with the EasyEPD2 program. This bug appears only when the "Intermittent Single Slow" alarm type is used. MGPI's model DMC 100 EPD may not function as expected when used incorrectly with the personal external alarm (PEA)-100. The problem occurs when the interface back jumper configuration is incorrect.

A software bug has been identified when an EasyEPD2 program (version 1.5 or earlier) is used to configure the Siemens EPD Mk2. The bug can sometimes cause EPDs, written by the batch method, to have an incorrect setting in relation to that defined by the stored batch write file. Specifically, if the alarm tone type "Intermittent Single Slow" is used for any alarm, the alarm may be set in the EPD to the "Off" condition and therefore inactive. To correct this problem, the user can first read a sample EPD, then open the stored batch file. After performing this procedure, the settings in the file will overwrite the screen values, and subsequent EPDs will have the same settings as those specified in the batch parameters.

The PEA-100 is designed to provide audible, visual, and tactile alarms in high-noise environments when connected to MGPI's model DMC-100 EPD. The PEA is also designed to alert the user if its plug becomes partially removed from the dosimeter's interface back. If the interface back jumper configuration is incorrect, the PEA-100 will not perform as expected in the case that the PEA-100 plug becomes partially removed. MGPI's customer notification outlines the correct jumper configuration and warns customers of problems arising from jumper misconfigurations. This information is also available at the MGPI web site <http://www.mgpi.com>.

There are currently no known Nuclear Material Safety and Safeguards licensees that use either of these EPD models, but it is important that the licensees be aware that this EPD problem exists. All current users of the previously mentioned EPDs, which consist of six nuclear power plants, have been notified of the problem. The U.S. Nuclear Regulatory Commission considers the

actions taken by Siemens and MGPI appropriate corrective measures.  
(Contact: Brian Smith, 301-415-5723; e-mail: bws1@nrc.gov)

## SIGNIFICANT ENFORCEMENT ACTIONS

Detailed information about these enforcement actions can be accessed via the U. S. Nuclear Regulatory Commission's (NRC's) homepage <http://www.nrc.gov/OE/>. Click on "Enforcement Actions." Cases are listed alphabetically. To access the complete enforcement action, click on the highlighted text after the name of the case.

### Gauge Licenses

**Bass Energy, Inc., Bruceton Mills, West Virginia** EA 00-118. A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$8800 was issued June 30, 2000. The action was based on failures: (1) to obtain written consent from NRC, before transferring control of licensed material to unlicensed companies, on two occasions; (2) to secure, or maintain constant surveillance of, licensed material, from unauthorized access; and (3) to provide information to NRC that was complete and accurate in all material aspects.

**Burning Rock Coal Company, Daniels, West Virginia** EA 00-119. A Notice of Violation was issued June 30, 2000, based on a violation involving the deliberate operation of a fixed gauging device containing 740 megabecquerels (mBq) [20 millicuries (mCi)] of cesium-137 and 11.1 gigabecquerel (300 mCi) of americium-241, without a specific or general license issued by NRC. Specifically, between July 8 and August 10, 1999, Burning Rock Coal Co. possessed and used byproduct material by operating a coal ash analyzer located at Bass Energy, Inc.'s Deep Coal Mine No. 1, without a specific or general license from NRC authorizing the use or possession of such a device.

**Caribbean Quality Control Services, Inc., St. Croix, U.S. Virgin Islands** EA 00-090. A Notice of Violation was issued on May 31, 2000, based on a violation involving the transfer of a portable moisture-density gauge containing licensed material to Alton A. Adams, Jr., Inc., a person who was not authorized to possess or use such byproduct material. During the time in which the non-licensed entity had possession of the gauge, an untrained technician was allowed to operate it.

**David Blackmore & Associates, Inc., Pottstown, PA** EA 00-124. A Notice of Violation was issued May 17, 2000, based on the failure to control and maintain constant surveillance of licensed

materials. Specifically, a portable nuclear density gauge containing 370 mBq [10 millicuries (mCi)] of cesium-137 and 5.15 mBq (150 mCi) of americium-241 was left unattended for a short period of time. During that time, the gauge was run over by a construction vehicle and was crushed.

### Medical

**Glendive Medical Center, Glendive, Montana** EA 00-076. A Notice of Violation and Proposed Imposition of Civil Penalty, in the amount of \$2750, was issued June 29, 2000. The action was based on the failure to secure molybdenum-99/technetium-99m generators from unauthorized removal or access. During the inspection it was discovered that during certain weekends the generators were delivered to the nuclear imaging room where they remained unsecured for several hours.

**Clara Maass Medical Center, Belleville, NJ** EA 99-257. A Notice of Violation was issued April 26, 2000, based on a violation involving the treatment of patients with a high-dose-rate (HDR) afterloading brachytherapy unit, after the source was replaced, without first checking to ensure that the source strength was consistent with the value provided by the manufacturer. The facility's procedures require a check of the source strength after each installation. Although some quality assurance checks were performed on the HDR unit before use, the medical physicist was unable to verify the manufacturer's source strength certification because the dosimetry system used to verify the source unit was not available.

**Virginia Commonwealth University, Richmond, VA** EA 00-040. A Notice of Violation, issued April 24, 2000, involved the failure to control and maintain constant surveillance of a 321.16-mBq (8.68-millicurie) strand of Iridium-192, and the failure to immediately report, by telephone, to NRC, the loss of licensed materials. The strand was lost in the bed linen during a brachytherapy treatment. The licensee found the strand at an off-site commercial laundry within 4 hours of identifying the loss. A civil penalty was not proposed because the facility has not been the subject of escalated action within the last two inspections. Credit was warranted for corrective action which included: (1) in-service refresher training provided to all nursing staff from the unit where the incident occurred; (2) posting nursing instructions on patients' doors and in their charts; (3) reminding laboratory personnel of correct waste disposal procedures; and (4) reviewing pertinent sections of Title 10 of the *U.S. Code of*

*Federal Regulations* regarding regulatory reporting requirements

### Radiography

**Hayes Testing Laboratory, Inc., Louisville, KY** EA 00-089. A Notice of Violation was issued June 9, 2000, based on a violation involving the performance of radiography in areas of NRC jurisdiction without filing an NRC Form 241, the failure to file revisions, and the failure to clarify a May 4, 1999, NRC Form 241, to identify new job sites and to include dates, for performing radiography, that were not previously submitted.

### Other

**Mallinckrodt, Inc., St. Louis, Missouri** EA 00-143. A Confirmatory Order Modifying License was issued June 9, 2000, to Mallinckrodt, Inc. The order was to resolve certain concerns NRC had with recently identified exposures in excess of the regulatory limits in 10 CFR Part 20 and with radiation practices at Mallinckrodt, Inc.

**Syncor International Corporation, Woodland Hills, California** EA 00-060. A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$2750 was issued June 28, 2000. The action was based on an apparent failure to properly block and brace a package of radioactive material that fell from a Syncor vehicle on July 9, 1999, and an apparent failure to ensure that the door-locking mechanisms on a Syncor vehicle were adequate to meet NRC security requirements when radioactive material in a vehicle is left unattended.

(Contact: Sally Merchant, OE, 301-415-2747; e-mail: slm2@nrc.gov)

### SELECTED FEDERAL REGISTER NOTICES (July 1, 2000–August 31, 2000)

NOTE: U.S. Nuclear Regulatory Commission (NRC) contacts may be reached by mail at the U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001.

### PROPOSED RULES

"List of Approved Spent Fuel Storage Casks: FuelSolutions™ Addition," July 11, 2000, 65 FR 42647.

Contact: Richard Milstein, 301-415-8149, e-mail: rim@nrc.gov.

"Licensing Proceedings for the Receipt of High-Level Radioactive Waste at a Geologic Repository: Licensing Support Network, Design

Standards for Participating Websites,” 65 FR 50937, August 21, 2000.  
Contact: Francis X. Cameron, 301-415-1642, e-mail: fxc@nrc.gov.

## OTHER NOTICES

“Major Revision to 10 CFR Part 71: Compatibility with ST-1—The IAEA Transportation Safety Standards—and Other Transportation Safety Issues, Issues Paper, and Notice of Public Meetings,” 65 FR 44360, July 17, 2000.  
Contact: Naiem S. Tanious, 301-415-6103, e-mail: nst@nrc.gov.

“Consolidated Guidance about Materials Licenses: Program-Specific Guidance about Well Logging, Tracer, and Field Flood Study Licenses” (NUREG-1556, Vol. 14), 65 FR 45116, July 20, 2000.  
Contact: Carrie Brown, 301-415-8092, e-mail: cxb@nrc.gov.

“Consolidated Guidance about Materials Licenses: Guidance about Administrative Licensing Procedures” (draft NUREG-1556, Vol. 20), 65 FR 45116, July 20, 2000.  
Contact: Carrie Brown, 301-415-8092, e-mail: cxb@nrc.gov.

“Revision of Policy Statement on Medical Use of Byproduct Material,” 65 FR 47654, August 3, 2000.”  
Contacts: Thomas Young, 301-415-5795, e-mail: tfy@nrc.gov  
Marjorie U. Rothschild, OGC, 301-415-1633, e-mail: mur@nrc.gov.

Charles T. Gallagher, Gammatron, Inc.; “Petition for Rulemaking,” 65 FR 49207, August 11, 2000.  
Contact: David L. Meyer, ADM, 301-415-7162 or, Toll-Free: 1-800-368-5642, e-mail: dlm1@nrc.gov.

“Notice of Availability and Request for Comments on NUREG-1556, Vol. 19, ‘Consolidated Guidance about Materials Licenses: Guidance for Agreement State Licensees about NRC Form 241 ‘Report of Proposed Activities in Non-Agreement States, Areas of Exclusive Federal Jurisdiction, or Offshore Water’ and Guidance for NRC Licensees Proposing to Work in Agreement State Jurisdiction (Reciprocity),’ ” 65 FR 49615, August 15, 2000.  
Contact: Carrie Brown, 301-415-8092, e-mail: cxb@nrc.gov.

“Notice of Formation of Rulemaking and Jurisdictional Working Groups; Uranium and Thorium,” 65 FR 52049, August 28, 2000.  
(Contact: Paul Goldberg, 301-415-7842, e-mail: pfg@nrc.gov)

## GENERIC COMMUNICATIONS ISSUED (July 1, 2000 – August 31, 2000)

Note that these are only summaries of U.S. Nuclear Regulatory Commission (NRC) generic communications. If one of these documents appears relevant to your needs and you have not received it, please call one of the technical contacts listed below. The Internet address for the NRC library of generic communications is—[www.nrc.gov/NRC/GENACT/GC/index.html](http://www.nrc.gov/NRC/GENACT/GC/index.html). Please note that this address is case-sensitive and must be entered exactly as shown.

### Information Notices (INs)

IN 2000-10, “Recent Events Resulting in Extremity Exposures Exceeding Regulatory Limits” was issued on July 18, 2000. This notice was issued to all material licensees who prepare or use unsealed radioactive materials, radiopharmaceuticals, or sealed sources for medical use or for research and development, to alert addressees to recent events that resulted in personnel receiving occupational extremity doses in excess of the 0.5-sievert (50-rem) shallow dose equivalent limit specified in 10 CFR 20.1201(a)(2)(ii).

Contacts: Jamnes L. Cameron, RIII/DNMS, 630-829-9833, e-mail: jlc@nrc.gov.  
Dr. Mohamed M. Shanbaky, RI/DNMS, 610-337-5209, e-mail: mms1@nrc.gov.

IN 2000-11, “Licensee Responsibility for Quality Assurance Oversight of Contractor Activities Regarding Fabrication and Use of Spent Fuel Storage Cask Systems” was issued on August 7, 2000. This notice was issued to all U.S. Nuclear Regulatory Commission (NRC) 10 CFR Part 50 and Part 72 licensees, and Part 72 Certificate of Compliance holders, to remind licensees that they retain responsibility for all aspects of their quality assurance program, even when portions of the program are delegated to contractors, subcontractors, agents or, consultants.

Contacts: Chet Poslusny, NMSS, 301-415-1341, e-mail: cxp1@nrc.gov.  
Charles Petrone, NRR, 301-415-1027, e-mail: cdp@nrc.gov.

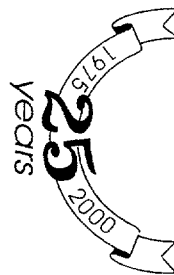
**Regulatory Issue Summaries (RIS)**

RIS 2000-10 (Erratum), "Technical Information to Facilitate Public Access to the U.S. Nuclear Regulatory Commission's Agencywide Documents Access and Management System (ADAMS)" was issued on August 7, 2000. This erratum to this summary was issued to all NRC licensees, to

correct a typographical error with an internet address published in the original summary.

Contact: NRC Public Document Room,  
202-634-3273 or 800-397-4209, e-mail:  
pdr@nrc.gov.

(General Contact: Mark A. Sitek,  
301-415-5799, e-mail: mas3@nrc.gov)



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001