✓ Broadening Participation: Selected Programs of the NSF Directorate for Education and Human Resources
✓ The NSF Broadening Participation Report
✓ The Legal History of CEOSE
✓ Completion of Unfinished Business

Dated: May 20, 2008.

Susanne Bolton,

Committee Management Officer.

[FR Doc. E8–11553 Filed 5–22–08; 8:45 am]

BILLING CODE 7555–01–P

NUCLEAR REGULATORY COMMISSION

Sunshine Federal Register Notice

DATES: Week of May 26, 2008.

PLACE: Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS: Public and Closed.

ADDITIONAL MATTERS TO BE CONSIDERED:

Week of May 26, 2008

Wednesday, May 28, 2008

9:25 a.m.—Affirmation Session (Public Meeting) (Tentative)

a. AmerGen Energy Company, LLC (Oyster Creek Nuclear Generating Station), Docket No. 50–219–LR, Citizens' Petition for Review of LBP–07–17 and Other Interlocutory Decisions in the Oyster Creek Proceeding (Tentative)

b. Oyster Creek, Indian Point, Pilgrim, and Vermont Yankee License Renewals, Docket Nos. 50–219–LR, 50–247–LR, 50–286–LR, 50–293–LR, 50–271–LR, Petition to Suspend Proceedings (Tentative)

c. U.S. Department of Energy (High Level Waste Repository: Pre-Application Matters), Docket No. PAPO–00 '' The State of Nevada's Notice of Appeal from the PAPO Board's January 4, 2008 and December 12, 2007 Orders and The State of Nevada's Motion to File a Limited Reply (Tentative)

This meeting will be Web cast live at the Web address—*http://www.nrc.gov*.

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* The schedule for Commission meetings is subject to change on short notice. To verify the status of meetings call (recording)—(301) 415–1292. Contact person for more information: Michelle Schroll, (301) 415–1662.

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ADDITIONAL INFORMATION: Affirmation of ''a. AmerGen Energy Company, LLC (Oyster Creek Nuclear Generating Station), Docket No. 50–219–LR, Citizens' Petition for Review of LBP–07–17 and Other Interlocutory Decisions in the Oyster Creek Proceeding (Tentative)'' and ''b. Oyster Creek, Indian Point, Pilgrim, and Vermont Yankee License Renewals, Docket Nos. 50–219–LR, 50–247–LR, 50–286–LR, 50–293–LR, 50–271–LR, Petition to Suspend Proceedings (Tentative)'' tentatively scheduled for Friday, May 16, 2008, at 8:55 a.m. have been tentatively rescheduled on Wednesday, May 28, 2008, at 9:25 a.m.

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The NRC Commission Meeting Schedule can be found on the Internet at: *http://www.nrc.gov/about-nrc/policy-making/schedule.html*.

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This notice is distributed by mail to several hundred subscribers; if you no longer wish to receive it, or would like to be added to the distribution, please contact the Office of the Secretary, Washington, DC 20555 (301–415–1969). In addition, distribution of this meeting notice over the Internet system is available. If you are interested in receiving this Commission meeting schedule electronically, please send an electronic message to *dkw@nrc.gov*.

Dated: May 20, 2008.

Rochelle C. Bavol,

Office of the Secretary.

[FR Doc. 08–1295 Filed 5–21–08; 10:25 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Report to Congress on Abnormal Occurrences, Fiscal Year 2007; Dissemination of Information

Section 208 of the Energy Reorganization Act of 1974 (Pub. L. 93–438) defines an abnormal occurrence (AO) as an unscheduled incident or event which the U.S. 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. 104–68) requires that AOs be reported to Congress annually. During Fiscal Year 2007, eleven events that occurred at facilities licensed or otherwise regulated by the NRC and/or Agreement States were determined to be AOs. The report describes five events at NRC-licensed facilities. The first NRC-licensee event involved radiation exposure to an embryo/fetus. The other four NRC-licensee events were medical events, as defined in Title 10, Part 35, of the Code of Federal Regulations (10 CFR part 35). All five NRC-licensee events occurred at medical institutions. The report also describes six events at Agreement State-licensed facilities. [Agreement States are those States that have entered into formal agreements with the NRC pursuant to Section 274 of the Atomic Energy Act (AEA) to regulate certain quantities of AEA licensed material at facilities located within their borders.] Currently, there are 34 Agreement States. All six events that occurred at Agreement State-licensed facilities were medical events, as defined in 10 CFR Part 35, and occurred at medical institutions. As required by Section 208, the discussion for each event includes the date and place, nature and probable consequences, the cause or causes, and the actions taken to prevent recurrence. Each event is also being described in NUREG–0090, Vol. 30, ''Report to Congress on Abnormal Occurrences: Fiscal Year 2007.'' This report is available electronically at the NRC Web site *http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/*.

I. For All Licensees

A. Human Exposure to Radiation From Licensed Material

During this reporting period, one event at an NRC-licensed and regulated facility was significant enough to be reported as an abnormal occurrence (AO).

NRC07–01 Human Exposure to Radiation at Washington University Medical Center in St. Louis, Missouri

Date and Place—May 29, 2007, St. Louis, Missouri.

Nature and Probable Consequences—Washington University Medical Center (the licensee) reported that cancer treatment to a 22 year old patient using iodine-131 resulted in a dose to an embryo/fetus. On May 29, 2007, the treatment was conducted at Barnes Jewish Hospital, the affiliated teaching hospital of Washington University School of Medicine, using 4.64 GBq (126 mCi) of iodine-131. Prior to that

treatment, the patient saw her prescribing physician on May 22, 2007, for a related consultation. In addition, because hospital procedures require a pregnancy test within 1 week before the therapy is administered, the licensee conducted a pregnancy test on the patient on the same day. That test yielded a negative result and the patient was advised not to get pregnant prior to the treatment. Moreover, before treatment on May 29, 2007, the patient signed a statement that, to the best of her knowledge, she was not pregnant. However, on May 30, 2007, the patient performed a home pregnancy test, which yielded a positive result. Consequently, the licensee performed another pregnancy test the same day, and the results indicated that the patient had been pregnant for 4–5 weeks at the time of the iodine-131 administration. The patient and the referring physician were informed of this event. As an approximation for the dose equivalent received by the embryo/fetus, the licensee's staff calculated an annual total effective dose equivalent to the patient's uterus, which was estimated to be 250–340 mSv (25–34 rem).

The NRC-contracted medical consultant confirmed the licensee's dose estimate and determined that the most likely result would be delivery of a normal infant (with regard to thyroid function) because the iodine-131 was administered at such an early stage in the pregnancy; however, the risk of childhood cancer may be slightly increased. The possible effects of the event have been discussed with the patient.

Cause(s)—The causes of this event were the false negative pregnancy test and the patient's lack of awareness that she might be pregnant.

Actions Taken To Prevent Recurrence

Licensee—Because the causes of this event were beyond the licensee's control, the licensee determined that no corrective action was necessary to prevent recurrence.

NRC—There were no violations identified by the NRC.

II. Commercial Nuclear Power Plant Licensees

During this reporting period, no events at commercial nuclear power plants in the United States were significant enough to be reported as AOs.

III. Events at Facilities Other Than Nuclear Power Plants and All Transportation Events

C. Medical Licensees

During this reporting period, four events at NRC-licensed or regulated facilities and six events at Agreement State-licensed facilities were significant enough to be reported as AOs.

NRC07–02 Medical Event at St. Luke's Hospital of Kansas City, Missouri

Date and Place—October 23–26, 2006, Kansas City, Missouri.

Nature and Probable Consequences—On October 27, 2006, St. Luke's Hospital of Kansas City (the licensee) notified the NRC of a medical event that occurred during a high dose-rate (HDR) remote afterloader, using a 144 GBq (3.9 Ci) iridium-192 source, brachytherapy procedure to treat breast cancer.

The authorized user physician developed a written directive that prescribed 10 fractionated doses, to be administered to the patient's left breast using a balloon catheter technique, with each dose consisting of 3.4 Gy (340 rad), for a total dose of 34 Gy (3,400 rad). The first fractionated dose was administered to the patient on October 23, 2006. On October 26, 2006, after the seventh fraction and prior to administering the eighth fraction to the patient, the chief physicist noted a discrepancy. The investigation into the discrepancy revealed that the catheter length entered into the treatment planning computer was 93.0 cm (36.6 in), rather than 95.0 cm (37.4 in). This error resulted in delivering an unplanned dose of 100 Gy (10,000 rad), 1.0 cm (0.4 in) from the treatment site and proximal from the balloon. The area proximal from the balloon would have received an intended dose of 24.5 Gy (2,450 rad), had the treatment been delivered as prescribed by the authorized user physician. Moreover, because the prescribed dosage was not delivered to the correct location, the patient also received an under dosage to the distal side of the balloon. Specifically, the area intended to be treated received a dose in the range of 7 Gy to 10 Gy (700 rad to 1,000 rad) rather than the prescribed dosage of 34 Gy (3,400 rad). The patient and the referring physician were informed of this event. The authorized user physician did not expect any acute adverse medical effects to the patient as a result of the medical event, but indicated that surgery may be required in the future. The authorized user physician discontinued further treatments and plans to follow-up on the patient clinically.

The NRC-contracted medical consultant expects some necrosis to fatty tissue in the overexposed region of the breast, within 2–4 months.

Cause(s)—The medical event was caused by the dosimetrist's failure to enter the correct catheter length in preparing the treatment plan parameters for the HDR brachytherapy treatment. In addition, the licensee's written procedures for implementing HDR treatment plans did not require verification of the treatment plan parameters to ensure that they were correct.

Actions Taken To Prevent Recurrence

Licensee—The licensee initiated several immediate and long-term corrective actions to prevent recurrence. Specifically, those corrective actions included (1) Revising the procedures for HDR treatments to include verification of the catheter length and input to the treatment planning computer by both the medical physicist and the authorized user physician, (2) revising the treatment plan record to require that the authorized user physician and the medical physicist document the verification of the catheter length, and (3) conducting in-house training to ensure that staff are aware of the new procedural steps and to ensure that the prescribing authorized user physician and the medical physicist actively participate in the training.

NRC—On March 14, 2007, the NRC issued a Notice of Violation related to this event.

NRC07–03 Medical Event at Hackley Hospital in Muskegon, Michigan

Date and Place—January 8, 2007, Muskegon, Michigan.

Nature and Probable Consequences—On January 8, 2007, Hackley Hospital (the licensee) notified the NRC of a medical event that occurred during a brachytherapy seed implant procedure to treat prostate cancer. The written directive prescribed a total dose of 120 Gy (12,000 rad) to the patient's prostate using 41 iodine-125 seeds as permanent implants. According to the licensee, because the patient moved, only 7 of the prescribed 41 seeds were delivered to the prostate (the intended site), and the other 34 seeds were delivered to an unintended site located approximately 4 cm (1.6 in) inferior to the prostate. As a result, the prostate received a dose of approximately 13 Gy (1,300 rad) rather than the prescribed dose of 120 Gy (12,000 rad) (~90% less than the prescribed dose). In addition, the unintended site received a dose of approximately 110 Gy (11,000 rad) and the patient's skin around the

unintended site received a dose of approximately 2.4 Gy (240 rad). The patient and the referring physician were informed of this event. The patient will require further treatment via external beam therapy in order to deliver the appropriate dose to the prostate.

The NRC-contracted medical consultant agreed with the licensee's dose estimate and concluded that the risk for impotence is somewhat increased by the additional radiation dose to the unintended site as a result of the medical event. There may also be some risk of perineal tissue fibrosis and skin irritation, although the risk may not be significant enough to cause clinical concerns.

Cause(s)—The licensee determined the root cause of the event was a failure to identify the patient's movement before continuing with the procedure. In addition, the NRC inspector determined that the licensee failed to develop adequate written procedures to provide high confidence that each brachytherapy administration was in accordance with the authorized user physician's written directive, as required by 10 CFR 35.41. Specifically, the licensee's procedures did not include appropriate steps or guidance to ensure that radioactive sources were positioned in the patient in accordance with the written directive and treatment plan.

Actions Taken To Prevent Recurrence

Licensee—The licensee's corrective actions to prevent recurrence included revising its written procedure to ensure that sources are positioned in the patient in accordance with the written directive, and ensuring that the staff implements those revisions.

NRC—On June 20, 2007, the NRC issued a Notice of Violation related to this event.

* * * * *

NRC07–04 Medical Event at Kennedy Memorial Hospital in Turnersville, New Jersey

Date and Place—October 25, 2006 (identified on December 8, 2006), Turnersville, New Jersey.

Nature and Probable Consequences—Kennedy Memorial Hospital (the licensee) reported that a patient was prescribed a brachytherapy treatment of 145 Gy (14,500 rad) to the prostate gland for prostate cancer using 104 iodine-125 seeds, but instead received a dose of 145 Gy (14,500 rad) to an unintended treatment site. The brachytherapy seeds were implanted under ultrasound guidance; however, a post-treatment computed tomography scan showed that the implanted seeds were displaced inferior to the intended position, resulting in a dose of approximately 8 Gy (800 rad) delivered to the intended treatment site. The patient and the referring physician were informed of this event, and additional external beam radiation treatment was recommended.

The NRC staff conducted a reactive onsite inspection on December 12, 2006. The NRC-contracted medical consultant reviewed the case and agreed with the licensee's analysis and conclusions, stating that no significant adverse health effect to the patient is expected.

Cause(s)—The medical event was caused by the licensee's failure to accurately identify the position of the prostate during the intraoperative ultrasound guidance procedure.

Actions Taken to Prevent Recurrence

Licensee—The licensee revised its procedures, including the use of a contrast medium in the Foley catheter balloon to more clearly identify the bladder/prostate interface, and use of fluoroscopic imaging to confirm anatomical positioning and verify seed placement.

NRC—There were no violations identified by the NRC.

NRC07–05 Medical Event at the University of Virginia at Charlottesville, Virginia

Date and Place—February 2–4, 2007, Charlottesville, Virginia.

Nature and Probable Consequences—University of Virginia at Charlottesville (the licensee) reported that a patient was prescribed a brachytherapy treatment of 30 Gy (3,000 rad) for treatment of cancer of the cervix using cesium-137 sources. Instead, the patient received 7.7 Gy (770 rad) to the cervix and small volumes of the rectum and vaginal mucosa received doses greater than intended, ranging from 14.14 Gy to 26.77 Gy (1,414 rad to 2,677 rad). Upon removal of the implant, the licensee discovered that the applicator had been loaded with a plastic radioactive source carrier insert that was approximately 4 cm (1.6 in) shorter than the intended 24 cm (9.5 in) insert, which caused the sources to be displaced from the intended position. The patient and the referring physician were informed of this event, and additional external beam radiation treatment was recommended.

The NRC staff conducted a reactive onsite inspection on February 12, 2007. The NRC-contracted medical consultant reviewed the case and agreed with the licensee's analysis and conclusions, stating that no significant adverse health effect to the patient is expected.

Cause(s)—The medical event was caused by the licensee's failure to ensure that the insert was of the correct length before preloading the cesium-137 sources.

Actions Taken To Prevent Recurrence

Licensee—The licensee revised its procedures, including measuring the length of the insert before loading the source, and limiting the supply of inserts in the source loading room to inserts of the length used for standard applicator treatments. The licensee also implemented additional staff training.

NRC—On May 7, 2007, the NRC issued a Notice of Violation related to this event.

AS07–01 Medical Event at St. James Hospital and Health Center in Olympia Fields, Illinois

Date and Place—November 29, 2006—December 20, 2006, Olympia Fields, Illinois.

Nature and Probable Consequences—St. James Hospital and Health Center (the licensee) reported that a 75-year-old female patient received a dose to an unintended area of approximately 4 cm^2 (0.6 in^2) of 20 Gy (2,000 rad), which was prescribed to supplement surgery and external radiation treatments for cancer of the uterus. The treatment used a high dose-rate (HDR) afterloader containing an iridium-192 source with an activity of 370 GBq (10 Ci). The source stopped 20 cm (7.9 in) short of the intended position; thus, the patient received none of the prescribed dose to the correct location. The patient and the referring physician were informed of this event. Over the next 4 weeks, the patient was treated for wet desquamation on both of her inner thighs, surrounded by a halo of erythema and the licensee continues to monitor the patient.

Cause(s)—The medical event was caused by human error. The licensee entered an incorrect initial value into the treatment system, and the treatment plan was not reviewed by an authorized medical physicist during the subsequent three weekly treatment sessions. The error was identified during a chart audit before the next similar HDR treatment was planned.

Actions Taken To Prevent Recurrence

Licensee—The licensee reviewed previous administrations to confirm that this event was an isolated incident. The licensee also developed new procedures requiring additional quality assurance steps, including the presence of a medical physicist during treatments. In addition, licensee personnel received additional training on the revised treatment procedures.

State—The State conducted an investigation on January 8, 2007, and

issued a Notice of Violation. On March 8, 2007, the NRC-contracted medical consultant investigated the matter for the State and supported the licensee's conclusions. The State accepted the licensee's corrective actions on April 12, 2007.

AS07–02 Medical Event at Aroostook Medical Center of Presque Isle, Maine

Date and Place—January 16, 2007, Presque Isle, Maine.

Nature and Probable Consequences—Aroostook Medical Center (the licensee) reported that a patient received 148 MBq (4 mCi) of iodine-131 for a whole body scan, instead of the prescribed 5.6 MBq (0.151 mCi) for a thyroid uptake scan. On March 6, 2007 during a follow-up visit with an endocrinologist, it was recognized that the wrong scan was performed. The patient and the referring physician were informed of this event. Using the methodology in NUREG–CR–6345, ''Radiation Dose Estimates for Radiopharmaceuticals'', the licensee estimated that the administration of 148 MBq (4 mCi) resulted in a thyroid dose of 51.22 Sv (153.7 rem). The licensee concluded that no significant adverse health effect to the patient is expected.

Cause(s)—The medical event was caused by human error. The licensee failed to verify the prescribed dosage for a specific patient directly with the referring physician. In addition, a written directive was not completed for this procedure.

Actions Taken To Prevent Recurrence

Licensee—Corrective actions taken by the licensee included revising procedures to improve communication with referring physicians, to allow the certified nuclear medicine technologist to speak directly with the referring physician or authorized user to confirm the type of test to be conducted. Also, written directives will be required for all administrations of iodine-131 in quantities greater than 1.11 MBq (30 μCi).

State—The State Radiation Control Program (RCP) performed an onsite investigation on May 24, 2007, and requested that the licensee take corrective actions to prevent recurrence. The RCP initially reviewed and accepted the licensee's proposed corrective actions during this investigation. The RCP issued a Notice of Violation on November 1, 2007, and awaits the licensee's response.

AS07–03 Medical Event in New York

Date and Place—March 7, 2007; (Licensee) New York.

Nature and Probable Consequences—The licensee reported a brachytherapy medical event to the New York State Department of Health. The event involved a 31-year-old female patient with a history of vaginal cancer. The treatment involved the use of both cesium-137 and iridium-192 seeds. Each ribbon contained 8 seeds with an activity of 1.855 milligram radium equivalent (118 MBq or 3.19 mCi). The patient was to be administered a total dose of 25 Gy (2,500 rad) via interstitial brachytherapy, to be delivered to the 0.5 Gy (50 rad) isodose line for a total treatment time of 50 hours.

On March 6, 2007, the iridium-192 seeds and the cesium-137 seeds were placed into the patient. Late in the morning of March 7, 2007, the medical physicist performed a manual check of the treatment plan calculations, and discovered that the hand calculations indicated a significantly higher dose rate than was generated using the treatment planning software. The ensuing investigations revealed that the original treatment plan was in error. On March 7, 2007, after 27 hours of treatment, the seeds were removed from the patient.

The patient received an estimated dose of 45.9 Gy (4,590 rad) to the treatment site, rather than the intended 25 Gy (2,500 rad). The rectal dose was 73 Gy (7,300 rad). The radiation oncologist disclosed that the patient is at risk for radiation cystitis, rectal proctitis, and more importantly, fistula formation between the rectum and the vagina. The patient and the referring physician were informed of this event. The patient will be monitored closely over the next year by both her gynecologic oncologist and the radiation oncologist. The patient is being treated with broad spectrum antibiotics, along with daily treatments in a hyperbaric oxygen chamber.

Cause(s)—The primary cause was the use of an inappropriate Dose Rate Factor (DRF) in the treatment planning system. The value used corresponded to the DRF for air kerma, however, the seed strength entered was in milligram radium equivalent. Other causes and contributing factors included failure to check the treatment pre-plan before the seeds arrived although there was time to do so; failure to double-check the calculations either prior to the implant or shortly thereafter; use of a treatment planning system that underwent acceptance testing for cesium-137 and iodine-125, but not iridium-192; and lack of recent experience preparing a treatment plan using iridium-192. Neither the physicist nor the radiation oncologist had prepared a treatment plan using iridium-192 in 6 years.

Actions Taken To Prevent Recurrence

Licensee—The licensee changed its policy and procedures to require a check of calculations for any single-fraction brachytherapy treatment.

State—The State plans to follow-up on the licensee's implementation of their new procedures during the next regularly scheduled inspection.

AS07–04 Medical Event at Memorial Mission Hospital of Asheville, North Carolina

Date and Place—April 24, 2007, Asheville, North Carolina.

Nature and Probable Consequences—Memorial Mission Hospital (the licensee) reported that a 19-year-old female patient was prescribed a dose of 1.24 MBq (33.4 μCi) of iodine-131 for a diagnostic scan to assess the health of her thyroid, however, she was administered a dose of 1235.8 MBq (33,400 μCi) on April 24, 2007. The licensee discovered the event when the patient returned the next day for her uptake scan. The patient was placed on a gamma camera and given a whole body scan. The spectrum was identified as iodine-131 and the uptake was concentrated in the patient's neck area, consistent with a thyroid uptake. As a result, the patient received a dose to the thyroid of approximately 287.3 Gy (28,728 rad). The patient and the referring physician were informed of this event.

The patient received an ablative quantity of radioactive iodine and initially showed classic signs of thyroidoitis, including inflammation, swelling, pain, and difficulty swallowing. The patient has recently started taking a synthetic thyroid hormone.

Cause(s)—The radiopharmacy provided the hospital an incorrect and mislabeled dose. The hospital failed to conduct a proper and accurate receipt survey on the package when it arrived in the hospital's nuclear medicine department. The nuclear medicine technologist, who performed the package receipt survey, failed to investigate the higher-than-expected dose rate off the transport container to determine if anything unusual was present. The nuclear medicine technologist assigned to the patient failed to correctly and accurately assay the dose in the dose calibrator. A second nuclear medicine technologist who is supposed to perform a quality assurance (QA) check of the dose calibrator reading, taken by the nuclear medicine technologist assigned to the patient, failed to correctly and accurately read the dose calibrator. The nuclear

medicine technologist assigned to the patient failed to recognize that the number of counts obtained from the neck phantom used for the uptake scan baseline was unusually high for the quantity of radioactive material prescribed for the patient.

Actions Taken To Prevent Recurrence

Licensee—The licensee ceased purchasing radiopharmaceuticals from the radiopharmacy that provided the incorrect and mislabeled dose. The licensee set aside a designated area for receiving shipments of radiopharmaceuticals and posted a list of expected dose rates per shipment (based upon contents of the shipment). The licensee redesigned the patient administration log to serve as a check list for QA, instituted procedural changes to include a one-meter survey of each diagnostic capsule while it is being counted in the neck phantom prior to administration, and implemented updated training to acquaint all nuclear medicine technologists with these new policies.

State—The State radiation control agency conducted an investigation into this incident assisted by the State board of pharmacy. The licensee's actions to prevent recurrence will be inspected at their next regularly scheduled inspection.

AS07–05 Medical Event at University of Washington Harborview Gamma Knife of Seattle, Washington

Date and Place—November 16, 2006, Seattle, Washington.

Nature and Probable Consequences—University of Washington Harborview Gamma Knife (the licensee) reported that a patient who was prescribed to receive 18 Gy (1,800 rad) during a gamma knife treatment actually received 28 Gy (2,800 rad). The gamma knife contained 267.7 TBq (7,236 Ci) of cobalt-60. The patient and the referring physician were informed of this event. The licensee concluded that no significant adverse health effect to the patient is expected.

Cause(s)—The cause of the incident was determined to be human error. The prescribing physician prescribed 18 Gy (1,800 rad) and erroneously entered 28 Gy (2,800 rad). The physician entered the prescribed value into the computer treatment planning system, rather than having the medical physicist enter the value as is the usual procedure, resulting in a failure to follow an established procedure.

Actions Taken To Prevent Recurrence

Licensee—Corrective actions taken by the licensee included a verification process to ensure that the prescribed treatment value is transferred from the treatment planning computer to the gamma knife computer prior to patient therapy. Also, a treatment plan signed by the treating oncologist, physicist, and neurosurgeon is now required. In addition, the treating oncologist and physicist will verify and initial the prescribed dose and isodose treatment parameters prior to patient therapy.

State—The State reviewed the licensee's corrective actions and determined that the procedures were adequate to ensure that this type of event should not happen in the future.

AS07–06 Medical Event at Physician Reliance of Fort Worth, Texas

Date and Place—August 22, 2007, Fort Worth, Texas.

Nature and Probable Consequences—Physician Reliance (the licensee, dba Texas Oncology at Klabzuba) reported that a patient who was being treated for lung cancer, with a high dose-rate (HDR) afterloader and an iridium-192 source, received 2,500 cGy (2,500 rad) during the first fraction, instead of the prescribed dose of 500 cGy (500 rad). The patient was prescribed to receive five fractions with 500 cGy (500 rad) per fraction over five weeks. The incident was discovered following an independent physicist's review of the treatment plan. The patient and the referring physician were informed of this event. The patient's pulmonologist concluded that no significant adverse health effect to the patient is expected.

Cause(s)—The incident occurred as a result of the incorrect isodose line being chosen and entered into the treatment planning system. The oncologist signed and approved the treatment plan and the radiation safety office performed a second calculation to check the treatment plan. The treatment planning system then normalized the calculations to the incorrect isodose line and delivered the resulting treatment. The calculation error was identified by an independent physicist prior to administration of the second fraction.

Actions Taken To Prevent Recurrence

Licensee—The licensee's corrective action was to change their procedure to include a second check by a licensed medical physicist of all treatment plans.

State—The State issued two violations related to this event: (1) A violation of 25 Texas Administrative Code (TAC) 289.256(p)(4)(A) and (B) was cited because the procedure as implemented was insufficient to ensure that a second check of the printed output of the treatment plan was performed to verify the accuracy of the planned treatment factors prior to treatment; and (2) a violation of 25 TAC 289.256(o)(1) and 289.256(p)(1) was cited because the instructions of obtaining the authorized physician's signed and dated written directive for each therapeutic administration were not followed. In addition, the State reviewed the licensee's corrective action of changing their procedures to include a second check by a licensed medical physicist of all treatment plans.

Dated at Rockville, Maryland, this 19th day of May 2008.

For the U.S. Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. E8–11666 Filed 5–22–08; 8:45 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–57829; File No. SR–Amex–2007–107]

Self-Regulatory Organizations; American Stock Exchange LLC; Order Approving Proposed Rule Change, as Modified by Amendment Nos. 3 and 4 Thereto, Relating to Section 31 Related Fees

May 16, 2008.

On October 2, 2007, the American Stock Exchange LLC (''Amex'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'' or ''SEC''), pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] a proposal to allow member firms to voluntarily submit, during a six-month period after the effective date of this proposal, funds previously accumulated by the member firms pursuant to Rule 393. In addition, the proposed rule change would allow the Exchange to use accumulated funds to pay its current section 31 fees or, to the extent of any surplus, offset other Exchange regulatory costs. The Amex filed Amendment No. 2 to the proposed rule change on March 19, 2008.[3] The Amex filed Amendment No. 3 to the proposed rule change on April 7, 2008.[4] The proposed rule change was published for comment in the **Federal**

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The Amex previously filed and withdrew Amendment No. 1 to the proposed rule change.

[4] Amendment No. 3 replaced all previous amendments in their entirety, added new effective dates of the proposed rule change, would eliminate non-substantive and extraneous text from proposed Commentary .01 to Rule 393.