in any fiscal year are exempt from audit requirements.

B. Audit Costs

Although under OMB Circular A–128 audit costs are generally allowable charges under Federal grants, audit costs incurred at the grantee (State) level are determined to be an administrative expense.

C. Financial Status Report for States

Financial Status Reports (269A) are required from all State agencies. A Financial Status Report shall be submitted to the Office of the Comptroller for each calendar quarter in which the grant is active. This Report is due even though no obligations or expenditures were incurred. Financial Status Reports shall be submitted to the Office of the Comptroller, by the State, within 45 days after the end of each calendar quarter. Calendar quarters end March 31, June 30, September 30, and December 31. A Final Financial Status Report is due 90 days after the end of the VOCA grant, no later than December 31.

D. Termination of Advance Funding

If the State grantee receiving cash advances by Letter of Credit or by direct Treasury check demonstrates an unwillingness or inability to establish procedures that will minimize the time elapsing between cash advances and disbursement, OJP may terminate advance funding and require the State to finance its operations with its own working capital. Payments to the State will then be made by the direct Treasury check method, which reimburses the State for actual cash disbursements.

Monitoring

A. Office of the Comptroller/General Accounting Office/Office of the Inspector General

The Office of the Comptroller, the General Accounting Office, and the Office of the Inspector General conducts periodic reviews of the financial policies and procedures and records of VOCA States. Therefore, upon request, States must give authorized representatives the right to access and examine all records, books, papers, case files, or other documents related to the grant.

B. Office for Victims of Crime

Beginning with the FFY 1991 grant period, OVC implemented an on-site monitoring plan in which each State grantee is visited a minimum of once every three years. While on site, OVC personnel will review various documents and files such as (1) financial and program manuals and procedures governing the crime victim compensation grant program; (2) financial records, reports, and audit reports for the State grantee; (3) the State's compensation application, procedures, and guidelines for awarding compensation benefits; (4) a random sampling of victim compensation claim files; and (5) all other applicable State records and files.

Suspension and Termination of Funding

If, after notice and opportunity for a hearing, OVC finds that a State has failed to comply substantially with VOCA, the M7100.1D (effective edition), the Final Program Guidelines, or any implementing regulation or requirement, OVC may suspend or terminate funding to the State and/or take other appropriate action. At such time, States may request a hearing on the justification for the suspension and/or termination of VOCA funds.

Approved by:

Aileen Adams

Director, Office for Victims of Crime, Office of Justice Programs.

[FR Doc. 95–4417 Filed 2–22–95; 8:45 am]

BILLING CODE 4410–18–P

NATIONAL INDIAN GAMING COMMISSION

Fee Rates

AGENCY: National Indian Gaming Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given, pursuant to 25 CFR 514.1 (a)(3), that the National Indian Gaming Commission has adopted a preliminary annual fee rate of 0.6% (.006) for calendar year 1995. The rate shall apply to all assessable gross revenues (tier 1 and tier 2) from each class II gaming operation regulated by the Commission.

FOR FURTHER INFORMATION CONTACT: Cindy Altimus, National Indian Gaming Commission, 1850 N Street, NW., Suite 250, Washington, DC 20036; telephone 202/632–7003; fax 202/632–7066 (these are not toll-free numbers).

SUPPLEMENTARY INFORMATION: The Indian Gaming Regulatory Act established the National Indian Gaming Commission which is charged with, among other things, regulating Class II gaming on Indian lands.

The regulations of the Commission (25 CFR Part 500) provide for a system of fee assessment and payment that is self-administered by the Class II gaming operations. Pursuant to those regulations, the Commission is required to adopt and communicate assessment rates; the gaming operations are required to apply those rates to their revenues, compute the fees to be paid, and report and remit the fees to the Commission on a quarterly basis.

The regulations of the Commission and this rate are effective for calendar year 1995. Therefore, all Class II gaming operations within the jurisdiction of the Commission are required to self-administer the provisions of these regulations and report and pay any fees that are due to the Commission before the end of the first quarter of 1995 (March 31), and quarterly thereafter.

Harold A. Monteau,

Chairman, National Indian Gaming Commission.

[FR Doc. 95–4463 Filed 2–22–95; 8:45 am]

BILLING CODE 7565–0–M

NUCLEAR REGULATORY COMMISSION

Abnormal Occurrence Report; Section 208 Report Submitted to the Congress

Notice is hereby given that pursuant to the requirements of Section 208 of the Energy Reorganization Act of 1974, as amended, the Nuclear Regulatory Commission (NRC) has published and issued another periodic report to Congress on abnormal occurrences (AOs), ''Report to Congress on Abnormal Occurrences: July-September 1994'' (NUREG–0090, Vol. 17, No. 3).

Under the Energy Reorganization Act of 1974, which created NRC, an AO is defined as ''an unscheduled incident or event that the Commission (NRC) determines is significant from the standpoint of public health or safety.'' NRC has made a determination that an incident or event involving an actual loss or significant reduction in the degree of protection against radioactive properties of source, special nuclear, and by-product material is an AO.

This report addresses five AOs at NRC-licensed facilities. One involved a medical brachytherapy misadministration, two involved medical teletherapy misadministrations, one involved a medical sodium iodide misadministration, and one involved a medical sodium iodide event. One AO report submitted by an Agreement State is included. It involved the loss of management and procedural control of a radioactive source.

The report also contains updates of six AOs previously reported by NRC licensees and three AOs previously reported by Agreement State licensees. Two ''Other Events of Interest''

concerning nuclear power reactors are also reported. One involved the fracture of a frozen pipe at Dresden Unit 1 with a consequent release of water, and the other involved the possible deliberate exposure of a contract laborer to radiation at Quad Cities Nuclear Power Station.

Section 208 of the Energy Reorganization Act of 1974, as amended, also requires NRC to provide a wide dissemination of information relating to these reported occurrences. Descriptions of the NRC licensee AOs for the third quarter of calendar year 1994, are provided below and have been reported to Congress in NUREG–0090, Vol. 17, No. 3.

NRC Material and Medical Licensees

(Industrial Radiographers, Medical Institutions, Industrial Users, etc.)

94–15 Sodium Iodide Event at Welborn Memorial Baptist Hospital in Evansville, Indiana

The following information pertaining to this event is also being reported concurrently in the **Federal Register.** Appendix A (see General Criterion 1) of this report notes that a moderate exposure to, or release of, radioactive material licensed by or otherwise regulated by the Commission can be an abnormal occurrence.

Date and Place—March 9, 1994; Welborn Memorial Baptist Hospital, Inc.; Evansville, Indiana.

Nature and Probable Consequences—On May 16, 1994, the licensee reported to NRC that a pregnant patient was administered 185 megabecquerel (MBq) (5 millicurie [mCi]) of sodium iodide-131 (I–131) on March 9, 1994, as prescribed in the written directive for the treatment of Graves' disease (hyperthyroidism). The licensee did not know that the patient was pregnant at the time of the administration. On May 10, 1994, the licensee was informed by a private practice physician that the patient was 22-weeks pregnant at the time of treatment. As a result, the patient's fetus received an unintended radiation dose.

The patient was referred to the licensee with possible hyperthyroidism. To confirm the suspect condition, the licensee administered a 440.3 kilobecquerel (11.9 microcurie) I–131 capsule of the patient on March 7, 1994, and measured an 82-percent thyroid uptake over the ensuing 25 hours. The licensee stated that prior to administering the I–131 diagnostic capsule on March 7, 1994, the patient was questioned and informed both the treating physician and the nuclear medicine technologist administering the capsule that she was not pregnant. The licensee diagnosed the patient's condition as Graves' disease and the treating physician perscribed a 185 MBq (5 mCi) I–131 therapy treatment. On March 9, 1994, a 185 MBq (5 mCi) I–131 capsule was orally administered by one of the licensee's nuclear medicine technologists, as prescribed. Prior to the treatment on March 9, 1994, the technologist questioned the patient once more and was again informed by the patient that she was not pregnant.

Oak Ridge Institute for Science and Education calculated the fetal whole body and thyroid doses at NRC request. The fetal dose to the thyroid was calculated as 7,000–12,000 centigray (cGy) (7,000–12,000 rad), and the fetal whole body dose was calculated as 0.55 cGy (0.55 rad). Based on the calculated fetal dose there are a range of possible consequences, the most likely being no significant harm to the fetus. At NRC request, the Radiation Emergency Assistance Center/Training Site in Oak Ridge, Tennessee, contacted the licensee to discuss the dose assessment and potential fetal effects.

On May 10, 1994, a physician specializing in maternal fetal medicine, not affiliated with the licensee, discussed the incident with the licensee. The patient was informed of the exposure and possible consequences to the fetus by the material fetal specialist.

NRC Region III learned the patient was aware that she was being administered radioactive materials, and subsequent to the administration she realized she was pregnant. It should be noted that since this was not a misadministration, there was no requirement to notify the patient.

Cause or Causes—The principal cause for the event was licensee reliance on the patient's assurance of non-pregnancy. Licensee procedures do not require determination of pregnancy status through serum testing, or other appropriately documented means, for all female patients of child bearing age. The patient was apparently unaware of her pregnancy status at the time of I–131 administration on March 9, 1994.

Action Taken To Prevent Recurrence

Licensee—The licensee is in the process of developing internal policies which will address options for pregnancy status determination including serum pregnancy testing or suitable written proof, such as evidence of a hysterectomy. The legal implications and options for written proof of non-pregnancy are being evaluated by the licensee. Until policies have been finalized, the licensee plans to administer pregnancy tests to all female patients of child bearing age, unless appropriate proof of non-pregnancy is available as determined by the authorized user. For patients unwilling to undergo pregnancy testing, radiopharmaceuticals will not be administered and the authorized user will be consulted for the appropriate course of action.

NRC—NRC Region III conducted a safety inspection from May 18 through June 8, 1994, to review the circumstances surrounding the event and to evaluate aspects of the licensee's radiopharmaceutical Quality Management Program (Reg. 1). No regulatory violations associated with the event were identified. The licensee's procedure appears to have been followed in this specific case. NRC regulations do not include requirements for patient pregnancy verification prior to administration of radiopharmaceuticals. However, NRC is in the process of developing regulations which will address the administration of radiopharmaceuticals to breast feeding and pregnant patients.

94–16 Teletherapy Misadministration at Medical Center Hospital in Chillicothe, Ohio

The following information pertaining to this event is also being reported concurrently in the **Federal Register.** Appendix A of this report notes that a therapeutic dose that results in any part of the body receiving unscheduled radiation can be considered an abnormal occurrence.

Date and Place—July 21 and 22, 1994; Medical Center Hospital; Chillicothe, Ohio.

Nature and Probable Consequences—On July 27, 1994, the licensee reported that a patient received a radiation dose of approximately 300 centigray (cGy) (300 rad) to an unintended treatment site using a cobalt-60 teletherapy unit.

A patient was scheduled to receive 1400 cGy (1400 rad) in a series of seven treatments for cancer of the esophagus. Each of the treatments was to consist of two radiation exposures of 100 cGy (100 rad) each delivered from different angles. The first treatment was performed on July 21. Following the first of the to exposures during the second treatment on July 22, the technologist found inconsistencies in the angles of treatment documented in the written directive and in the patient simulation sheet. Upon further review, the licensee determined that the wrong treatment angles had been used during the first treatment and part of the second treatment.

As a result of the incorrect angles of exposure, the treatment site received only part of the prescribed dose and adjacent tissue received a higher does than intended. The licensee estimates a dose of 300 cGy (300 rad) to the unintended site. Under normal conditions, the unintended site would have received approximately 20–50 cGy (20–50 rad).

The treatment angles were corrected on the patient's chart, and the radiation dose was modified to compensate for the reduced dosage delivered in the initial treatments. The patient was informed and no adverse medical effects are expected.

The patient was notified verbally on July 26, 1994 and in writing as required by 10 CFR 35.33. According to the medical consultant, there will be no medical consequences as a result of the misadministration.

Cause or Causes—The error occurred because the simulated gantry angles had not been converted to the treatment unit gantry angles, and gantry angle conversion factors were not included in the licensee's treatment chart checks conducted by the technologists.

The root causes of the problem were discussed with the licensee on September 1, 1994, during an Enforcement Conference. The causes appeared to be the following: (1) Written procedures were not developed to address gantry angle conversions; (2) the technologists did not have an adequate understanding of the informal gantry angle conversion procedures; (3) the informal gantry angle conversion procedure was not part of the licensee's annual refresher training program; (4) technologists did not fully understand their responsibilities to resolve discrepancies in a treatment plan; and (5) gantry angle conversion factors were not included in the licensee's treatment chart checks conducted by the technologists.

Action Take To Prevent Recurrence

Licensee—The licensee's corrective actions included: (1) Revising the simulation data form to include a specific location to document the converted gantry angles; (2) initialing all angle conversions by the person performing the conversion, and having a second individual independently verify the conversions prior to treatment; (3) instructing the technologists to review all treatment information and to resolve any discrepancy prior to continuing treatment; (4) performing all future gantry angle conversions by the licensee rather than by the licensee's simulation contractor; and (5) conducting a review of past treatment plans back to 1988, with emphasis on those which did not identify any additional errors.

NRC—NRC Region III conducted an inspection on August 1, 1994, to review the circumstances surrounding the misadministration (Ref. 2). NRC also retained a medical consultant to review the case. An Enforcement Conference was held on September 1, 1994, to discuss the inspection findings and actions taken by the licensee. On September 20, 1994, NRC Region III issued a Notice of Violation with a Severity Level III (Severity Levels I through V range from the most significant to the least significant) violation with no civil penalty assessed. The licensee's corrective and preventive actions will be reviewed during the next NRC inspection of the licensed program.

94–17 Sodium Iodide Misadministration at St. Joseph Mercy Hospital in Pontiac, Michigan

The following information pertaining to this event is also being reported concurrently in the **Federal Register**. Appendix A of this report notes that administering a diagnostic dose of a radiopharmaceutical differing from the prescribed dose by more than 50 percent in which the event results in adverse health effects worse than expected for the normal range of exposures prescribed for the diagnostic procedure can be considered an abnormal occurrence.

Date and Place—July 26, 1994; St. Joseph Mercy Hospital; Pontiac, Michigan.

Nature and Probable Consequences—On July 27, 1994, the licensee reported to NRC that a misadministration occurred involving a patient receiving the wrong radiopharmaceutical for a diagnostic procedure.

The patient's referring physician requested a thyroid scan which involves administration of a standard prescription at St. Joseph Mercy Hospital of a 9.25 megabecquerel (MBq) (0.25 millicurie [mCi]) sodium iodide–123 (I–123) capsule. However, the licensee administered a 92.5 MBq (2.5 mCi) I–131 capsule. The amount of activity that was administered is normally used following removal of the thyroid to examine a patient for the spread of cancer from the thyroid through the body.

NRC retained a medical consultant to review the case. The medical consultant concluded that the resultant unnecessary dose to the patient's thyroid would result in a low, but finite, probability of hypothyroidism developing in the future. Also, there is a lifetime probability of developing radiation-induced thyroid cancer of 10 percent, including a risk of fatal thyroid carcinoma of approximately 1 percent. The licensee has arranged for the patient to be seen by a endocrinologist, and for repeat thyroid imaging with I–123 to be performed several months after the misadministration.

The patient was notified in person by the Radiation Safety Officer on July 27, 1994. Subsequently, the patient was also given a written report that was dated August 5, 1994.

Cause or Causes—Part of the cause of the misadministration was the lack of the treating physician's involvement in the patient's examination prior to the I–131 administration. The administrative staff and technologists failed to have the examination clarified by a treating physician with the referring physician prior to administration of the I–131. Causal factors for this event also included the failure of licensee management to ensure implementation of the licensee's written Quality Management Program. Contributing factors also appear to include deficiencies in training, and a failure to follow through on matters.

Action Taken To Prevent Recurrence

Licensee—The licensee took the following corrective actions: (1) Held a training session which included the Radiation Safety Officer, treating physicians and technologists; (2) instituted a limit on the number of individuals who will be involved in the use of I–131; and (3) required a written directive to be filled out and signed by a treating physician.

NRC—NRC Region III conducted an inspection on August 1, 1994, to review the misadministration (Ref. 3). A Conformatory Action Letter (CAL) was issued to the licensee on August 2, 1994, which described the commitments made by the licensee as to which actions will be taken prior to the administration of I–131. An Enforcement Conference was held on August 24, 1994, to discuss the inspection findings and actions taken by the licensee in response to the CAL.

In October 1994, NRC proposed an $8,000 fine against the licensee for violations of NRC requirements involved in a diagnostic procedure using radioactive iodine at the hospital. The violations involve: (1) Failure to have signed written directives by an authorized user prior to administration of I–131 in quantities greater than 1.11 MBq (0.03 mCi) on July 26, and in two previous instances where the I–131 was the intended radiopharmaceutical; (2) failure to have a clinical procedure for the proper administration of I–131 for

whole body scans; and (3) failure to provide proper instruction to the nuclear medicine staff. The licensee paid the civil penalty.

94–18 Multiple Teletherapy Misadministrations at Sinai Hospital in Detroit, Michigan

The following information pertaining to this event is also being reported concurrently in the **Federal Register**. Appendix A of this report notes that a therapeutic dose that results in any part of the body receiving unscheduled radiation can be considered an abnormal occurrence.

Date and Place—July 28 and August 3, 1994; Sinai Hospital; Detroit, Michigan.

Nature and Probable Consequences—On July 28, 1994, and August 3, 1994, misadministrations occurred on two separate patients when the licensee's therapists failed to verify correct teletherapy machine parameters prior to treatment.

Beginning on July 19, 1994, a patient was to received 4500 centigray (cGy) (4500 rad) in a series of 25 treatments to the left neck area. The first seven treatments were completed without incident. However, on the eighth treatment on July 28, one faction was set up using the wrong treatment angle. This resulted in a radiation dose of 90 cGy (90 rad) being received by the right shoulder and neck area instead of the left neck area.

Beginning July 5, 1994, another patient was to receive 5000 cGy (5000 rad) in a series of 25 treatments to the right shoulder area. The first 20 treatments were completed without incident. However, on the 21st treatment on August 3, the teletherapy unit was positioned using the wrong treatment angle. This resulted in a radiation dose of 100 cGy (100 rad) being received by the right lung area instead of the right shoulder area.

An NRC medical consultant reviewed both cases and concluded that no significant adverse side effects or tissue injury are expected.

Cause or Causes—The cause of both misadministrations was human errors by several of the licensee's therapists. The therapists failed to verify the collimator angle, the wedge setting, and the treatment site before administering the teletherapy dose to the patients.

Action Taken To Prevent Recurrence

Licensee—The corrective actions taken included: (1) Suspending all teletherapy treatments pending an internal investigation, and identification of appropriate corrective actions prior to re-start of the teletherapy treatments; (2) developing procedures which require independent verification of proper treatment parameters during patient set-up; and (3) installing a record-and-verify system on the teletherapy unit to ensure that all major treatment parameters are checked prior to a treatment.

NRC—NRC Region III conducted an inspection July 29 through August 12, 1994, to review the circumstances surrounding the two misadministrations (Ref. 4). NRC also retained a medical consultant to review the case. An Enforcement Conference was held on September 8, 1994, to discuss the inspection findings and actions taken by the licensee. On September 21, 1994, NRC Region III issued a Notice of Violation with a Severity Level III (Severity Levels I through V range from the most significant to the least significant) violation with no civil penalty assessed. The licensee's corrective and preventive actions will be reviewed during the next NRC inspection of the licensed program.

As required by 10 CFR 35.33(a), the licensee, for each misadministration, notified the referring physician and patient after the discovery of the incident and submitted a written report to the patient, including a statement that the report submitted to NRC Region III will be made available upon request.

94–19 Brachytherapy Misadministration Involving the Use of a Strontium-90 Eye Applicator at the University of Massachusetts Medical Center in Worcester, Massachusetts

The following information pertaining to this event is also being reported concurrently in the **Federal Register.** Appendix A (see Event Type 5 in Table A–1) of this report notes that a therapeutic dose that results in an actual dose less than 0.5 times the prescribed dose can be considered an abnormal occurrence. In addition, Criterion No. 11 under ''For All Licensees'' in Appendix A notes that a serious deficiency in management or procedural controls in major areas can be considered an abnormal occurrence.

Date and Place—July 29, 1994; University of Massachusetts Medical Center; Worcester, Massachusetts.

Nature and Probable Consequences—NRC Region I was notified on August 1, 1994, by the licensee of a brachytherapy misadministration involving the use of a strontium-90 (Sr-90) eye applicator. On July 29, 1994, a physician performed an ophthalmic treatment on a patient using a Sr-90 eye applicator without first removing the stainless steel mask from the source. Because of this oversight, the licensee estimated that the treatment site received 107 centigray (cGy) (107 rad) of radiation, rather than the 1250 to 2000 cGy (1250 to 2000 rad) that was intended. In addition, whereas the beta radiation from the eye applicator source only affects the surface of the eye, the bremsstrahlung radiation resulting from the interaction of the beta particles on the stainless steel mask is more penetrating. The patient returned on August 2, 1994, for the completion of the therapy to bring the total dose delivered within the originally prescribed range. The licensee expects that the clinical outcome of the misadministration will be inconsequential for the patient.

Cause or Causes—According to the licensee a combination of factors led to the misadministration: (1) Infrequent use of the ophthalmic applicator and the fact that its appearance with the mask is similar to its appearance with the mask removed; (2) the event occurred on a Friday afternoon and the stress of the week's work affected the alertness of the individuals involved; and (3) the most experienced physicists were not available, and a relatively inexperienced physicist prepared the source and was unaware that the source was equipped with a stainless steel mask.

Actions Taken to Prevent Recurrence

Licensee—The licensee is reviewing the feasibility of modifying the mask in some manner to make it more easily distinguished from the unmasked source. In addition, the licensee has employed two new radiation oncology physicians and a new chief physicist.

NRC—NRC conducted a special inspection on August 3, 1994. The inspector determined that the physician was assisted by a dosimetrist who had not previously been directly involved with the procedure. When the physician requested that the dosimetrist provide him with the eye applicator source in order to perform the treatment, the dosimetrist handed him the source with the stainless steel mask in place. The dosimetrist stated that she was unaware that the source was equipped with a mask and that the mask needed to be removed. The physician and other licensee staff stated that it is the assistant's responsibility, in this case the dosimetrist's responsibility, to remove the stainless steel mask from the source before handing the eye applicator to the physician. The treatment was administered by the physician with the mask in place. While cleaning the eye applicator later that same day, the licensee determined that the treatment had been performed with the mask in place. The licensee stated that the patient and the patient's physician were notified that there had been an

underdose and the patient returned on August 2, 1994, for the completion of the therapy. The patient was given a written report of the misadministration on August 9, 1994. The licensee submitted a report for the misadministration on August 10, 1994. NRC Region I has enlisted the services of a medical consultant to evaluate the clinical consequences of this misadministration and awaits his report.

A copy of NUREG–0090, Vol. 17, No. 3 is available for inspection or copying for a fee at the NRC Public Document Room, 2120 L Street NW. (Lower Level), Washington, D.C. 20037, or at any of the nuclear power plant Local Public Document Rooms throughout the country.

Copies of this report (or any of the previous reports in this series), may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Post Office Box 37082, Washington, DC 20013–7082. A year's subscription to the NUREG–0090 series publication, which consists of four issues, is also available.

Copies of the report may also be purchased from the National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161.

Dated at Rockville, MD this 16th day of February, 1995.

For the Nuclear Regulatory Commission.

John C. Hoyle,

Acting Secretary of the Commission.

[FR Doc. 95–4382 Filed 2–22–95; 8:45 am]

BILLING CODE 7590–01–M

[Docket Nos. 50–352 and 50–353]

In the Matter of: Philadelphia Electric Company (Limerick Generating Station, Units 1 and 2); Exemption

I.

Philadelphia Electric Company (the licensee), is the holder of Facility Operating License Nos. NPF–39 and NPF–85, which authorize operation of the Limerick Generating Station (LGS), Units 1 and 2. The licenses provide, among other things, that the licensee is subject to all rules, regulations, and orders of the Nuclear Regulatory Commission (the Commission) now and hereafter in effect. The facilities consist of two boiling water reactors located in Montgomery County, Pennsylvania.

II

Section 50.54(o) of 10 CFR Part 50 requires that primary reactor containments for water cooled power reactors be subject to the requirements of Appendix J to 10 CFR Part 50. Appendix J contains the leakage test requirements, schedules, and acceptance criteria for tests of the leak tight integrity of the primary reactor containment and systems and components which penetrate the containment. Sections II.H.4 and III.C.2 of Appendix J to 10 CFR Part 50 require leak rate testing of Main Steam Isolation Valves (MSIVs) at the calculated peak containment pressure related to the design basis accident, and Section III.C.3 requires that the measured leak rates be included in the combined local leak rate test results. The proposed deletion of the MSIV Leakage Control System (LCS), and proposed use of an alternate leakage pathway affects the description of an existing exemption which allows the leak rate testing of the MSIVs at a reduced pressure and the exclusion of the measured leakage from the combined local leak rate test results. The original exemption is contained in the LGS Safety Evaluation Report (SER) (NUREG–0991, and its Supplement 3).

By letter dated December 22, 1994, the licensee requested an exemption from the Commission's regulations. The subject exemption is from the requirements of 10 CFR Part 50, Appendix J, ''Primary Reactor Containment Leakage Testing for Water-Cooled Power Reactors,'' Sections II.H.4, III.C.2, and III.C.3, to allow alternative testing pressure and leakage limits for the MSIVs and to exclude MSIV leakage from the combined local leak rate test results after deletion of the LCS.

The staff issued for LGS, Units 1 and 2, the current exemption from 10 CFR Part 50, Appendix J, Sections II.H.4, III.C.2, and III.C.3, based on the conclusion that the LGS, Units 1 and 2, MSIV leak testing methods were acceptable alternatives to the requirements. This conclusion was included in the LGS SER (NUREG–0991, and its Supplement 3). The SER also described that in the event of a loss-of-coolant-accident (LOCA), the MSIV LCS will maintain a negative pressure between the MSIV and the effluent will be discharged into a volume where it will be processed by the standby gas treatment system before being released to the environment. The licensee had performed a radiological analysis based on an assumed leak rate limit of 11.5 standard cubic feet per hour (scfh), and the MSIVs were planned to be periodically tested to ensure the validity of the radiological analysis. The staff concluded that the current LGS testing procedure, where two valves on one steam line are tested simultaneously, between the valves, utilizing a reduced test pressure (i.e., half a peak containment pressure of 22 psig applied between the MSIVs) was acceptable. Also, the staff excluded the MSIV test leakage rate from the combined local leak rate because the MSIV leakage had been accounted for separately in the radiological analysis of the site.

By letter dated January 14, 1994, the licensee submitted a Technical Specifications (TS) amendment request for LGS, Units 1 and 2, which supports the planned modification to eliminate the MSIV LCS and utilize an alternate leakage pathway (main steam lines and condenser). This proposal is based on the Boiling Water Reactor Owners Group (BWROG) method summarized in General Electric Report NEDC–31858P, Revision 2, ''BWROG Report for increasing MSIV Leakage Rate Limits and Elimination of Leakage Control System.'' Therefore, the description of the MSIV LCS and the assumed MSIV leak rate are no longer accurate once the proposed TS modification is performed and implemented.

The licensee's January 14, 1994, TS (amendment) request states that a plant-specific radiological analysis has been performed in accordance with NEDC–31858P, Revision 2, to assess the effects of the proposed increase to the allowable MSIV leakage rate in terms of Main Control Room (MCR) and off-site doses following a postulated design basis LOCA. This analysis utilizes the hold-up volume of the main steam piping and condenser as an alternate method for treating MSIV leakage. The radiological analysis uses standard conservative assumptions for the radiological source term consistent with Regulatory Guide (RG) 1.3, ''Assumptions Used for Evaluating the Potential Radiological Consequences of a Loss-of-Coolant-Accident for Boiling Water Reactors,'' Revision 2, dated June 1974. The analysis results demonstrate that dose contributions from the proposed MSIV leakage rate limit of 100 scfh per MSIV, not to exceed 200 scfh for all four main steam lines, and considering the proposed deletion of the MSIV LCS, result in an acceptable increase to the LOCA doses previously evaluated against the regulatory limits for the off-site doses and MCR doses contained in 10 CFR Part 100, and 10 CFR Part 40, Appendix A, General Design Criteria (GDC) 19, respectively. The proposed calculated off-site and MCR doses resulting from a LOCA are the sum of the LOCA doses previously evaluated (currently described in the Updated Final Safety Analysis Report), and the additional doses calculated using the alternate MSIV leakage treatment method. The method of calculating the revised doses is conservative, since the LOCA doses