April 3, 2001

COMMISSION VOTING RECORD

DECISION ITEM: SECY-01-0030

TITLE: REPORT TO CONGRESS ON ABNORMAL OCCURRENCES FOR FISCAL YEAR 2000

The Commission (with Chairman Meserve and Commissioners Diaz, McGaffigan, and Merrifield agreeing) approved the subject paper as recorded in the Staff Requirements Memorandum (SRM) of April 3, 2001. Commissioner Dicus disapproved the paper.

This Record contains a summary of voting on this matter together with the individual vote sheets, views and comments of the Commission.

Annette L. Vietti-Cook
Secretary of the Commission

Attachments:
1. Voting Summary
2. Commissioner Vote Sheets

cc: Chairman Meserve
Commissioner Dicus
Commissioner Diaz
Commissioner McGaffigan
Commissioner Merrifield
OGC
EDO
PDR

VOTING SUMMARY - SECY-01-0030

RECORDED VOTES

	APRVD	DISAPRVD	ABSTAIN	NOT PARTICIP	COMMENTS	DATE
CHRM. MESERVE	X				X	3/19/01
COMR. DICUS		X			X	3/15/01
COMR. DIAZ	X				X	3/15/01
COMR. McGAFFIGAN	X					3/7/01
COMR. MERRIFIELD	X				X	3/12/01

COMMENT RESOLUTION

In their vote sheets, Chairman Meserve and Commissioners Diaz, McGaffigan, and Merrifield approved the staff's recommendation and some provided additional comments. Commissioner Dicus disapproved the paper until various questions could be clarified. Subsequently, the comments of the Commission were incorporated into the guidance to staff as reflected in the SRM issued on April 3, 2001.

Commissioner Comments on SECY-01-0030

Chairman Meserve

I approve the issuance of the FY 2000 Abnormal Occurrences report, subject to the modifications identified by Commissioner Dicus in her vote. I also offer a number of minor edits to the report, reflected in the attached markup of the draft report.

In reviewing the Abnormal Occurrences report, I note that all of the non-reactor-related events classified as AOs occurred in the area of medical uses of radioactive materials, either in the production of radiopharmaceuticals or in the administration of medical therapy. Moreover, all of the events involved failures of what can be classified broadly as quality assurance (QA). This suggests that there may be a generic problem with QA programs associated with the manufacture and medical uses of radioisotopes. Accordingly, I suggest that the Advisory Committee on the Medical Uses of Isotopes (ACMUI) examine the issue of QA in this area, and provide recommendations, as appropriate, as to whether additional NRC regulatory oversight is required.

Commissioner Dicus

I disapprove of the issuance of the current draft of the REPORT TO CONGRESS ON ABNORMAL OCCURRENCES FOR FISCAL YEAR 2000. Various statements in the report raise questions or require clarification that should be addressed by NRC staff before the report is issued to Congress. These statements are identified below.

Abstract, Second Paragraph, Second and Third Sentences:

> The following additions are recommended to assist any congressman who would choose only to read the abstract:
>
> "...the second event resulted in overexposures of occupational workers at a radiopharmaceutical manufacturing plant, and the third event involved a medical brachytherapy misadministration. The report also discusses six medical AOs...."

Event 00-1, Nature and Probable Consequences, Second Paragraph

> Add the underlined phrase to the last sentence:
>
> "No radioactivity was measured off-site above normal background levels, and the event did not impact the public health and safety or the environment."

Event AS 00-1, Nature and Probable Consequences, Second Paragraph, Third Sentence

> The sentence states that the patient was treated with a dose that "was delivered inside the patient's skull, which was the wrong treatment site."

Since GSR treatments are always intended to be inside the patient's skull, perhaps the intent was to state that the dose was delivered at the wrong treatment site within the patient's skull.

Also, the report should clarify that intervention prevented a related misadministration for patient B, if this was the case.

Event AS 00-3, <u>Actions to Prevent Recurrence</u>

The report states that no action was taken by the licensee and that the State found no violations. In summary, no actions were taken to prevent recurrence. The inference is that since this type of event is expected to rarely occur, no corrective action is justified.

It would seem that any event reported as an AO should include corrective actions to prevent recurrence; otherwise, this kind of event can reasonably be expected to reappear in this report in the future.

APPENDIX C, OTHER EVENTS OF INTEREST, Page 20

The description of the first event, the unplanned high radiation field at the University of Missouri Research Reactor, states that the event resulted in unplanned high radiation levels in the basement floor level of the reactor containment, which triggered a radiation alarm, and that the calculated maximum dose rate at the opening in the shielding was 400 rem/hr for about 3 minutes. That is, if it were possible for anyone to be at that location, they would have received a 20 rem dose. Later the report states that radiation overexposures had not occurred and that the event did not affect members of the public.

Although the report clarifies that members of the public were not affected, questions arise regarding possible exposures to workers at the reactor:

Were there any workers in the basement floor level at the time of the event?

Did any of them receive radiation exposures, given the high levels reported? (It is clear from the report that no overexposures occurred; thus, if there were exposures they were less than 5 rems.)

NRC AND AGREEMENT STATE MATERIALS LICENSEES, Page 21

The first paragraph of this section states that there were 230 events resulting "in licensed material entering the public domain in an uncontrolled manner...." The report further states, "In some cases, the material caused radioactive contamination or radiation exposures." The report should be amplified to better describe the risk perspective on these events.

In the second sentence of the third paragraph, add the word "used." "Examples are (1) radioactive sources <u>used</u> in medical treatments...."

Loss of a Radioactive Camera Owned by Welding Testing X-Ray, Inc., Page 22

"State" is spelled incorrectly in the second line of the event description.

One sentence states, "The sheriff's department found the radiography camera by the fire department near Canyon Lake, Texas." This sentence is not clear. Region IV staff recalls that either fire department personnel or sheriff's personnel found the camera and reported it to the licensee.

Commissioner Diaz

I believe a final "scrub" of the report would be useful.

Commissioner Merrifield

Approved subject to minor technical edits.