Notice Pursuant to the National Cooperative Research and Production Act of 1993—PlantSTEP, Inc.

Notice is hereby given that, on March 10, 1995, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq* (''the Act''), PlantSTEP, Inc., has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing (1) the identities of the parties and (2) the nature and objectives of the venture. The notifications were filed for the purpose of invoking the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Pursuant to section 6(b) of the Act, the identities of the parties are Autodesk, Inc., Sausalito, CA; Bechtel Corporation, San Francisco, CA; Bentley Systems, Houston, TX; Black & Veatch, Overland Park, KS; CADCentre, Inc., Houston, TX; Computervision Corporation, Bedford, MA; Dassault Systems of America, Burbank, CA; Eastman Chemical Company, Kingsport, TN; E.I. DuPont & Co., Inc., Wilmington, DE; H.B. Zachry Company, San Antonio, TX; Intergraph Corporation, Huntsville, AL; Jacobus Technology Inc., Gaithersburg, MD; John Brown E&C, Houston, TX; and Sunland Fabricators, Inc., Walker, LA.

The nature and objectives of this joint venture are to undertake and develop a standard, computer-intelligible product data exchange specification.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 95–18156 Filed 7–24–95; 8:45 am]

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NUCLEAR REGULATORY COMMISSION

Report to Congress on Abnormal Occurrences January–March, 1995 Dissemination of Information

Section 208 of the Energy Reorganization Act of 1974, as amended, requires NRC to disseminate information on abnormal occurrences (AOs) (i.e., unscheduled incidents or events that the Commission determines are significant from the standpoint of public health and safety). During the first quarter of CY 1995, the following incident at an NRC licensed facility was determined to be an AO and is described below, together with the remedial actions taken. The event is also being included in NUREG–0090, Vol. 18, No. 1, (''Report to Congress on Abnormal Occurrences: January–March 1995''). This report will be available at NRC's Public Document Room, 2120 L Street NW. (Lower Level), Washington, DC, about three weeks after the publication date of this **Federal Register** Notice.

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

95–1 Medical Brachytherapy Misadministration at Welborn Memorial Baptist Hospital in Evansville, Indiana

One of the AO reporting guidelines notes that a therapeutic dose that is greater than 1.5 times the prescribed dose can be considered an abnormal occurrence.

Date and Place—November 18, 1994; Welborn Memorial Baptist Hospital, Inc.; Evansville, Indiana.

Nature and Probable Consequences—On November 18, 1994, a 73–year–old patient was prescribed to receive a brachytherapy treatment dose of 600 centigray (cGy) (600 rad) at the vaginal cavity using a GammaMed IIi high dose rate afterloading unit. However, because of a treatment error the patient received a 1250 cGy (1250 rad) dose instead of the prescribed dose.

The licensee identified the misadministration during a quality management review on November 21, 1994. The licensee reported the event to the NRC on November 22, 1994, and followed up with a written report on December 6, 1994. The referring physician was notified. The patient was notified on November 23, 1994, by the licensee's Radiation Safety Officer and was provided with a written report of the incident.

An NRC medical consultant was retained to evaluate the medical consequences of the misadministration. The medical consultant expressed concern that long term effects such as fibrosis or loss of blood supply may occur as a result of the 1250 cGy (1250 rad) treatment. The medical consultant also suggested that this case be considered for the U.S. Department of Energy (DOE), Office of Epidemiology and Health Surveillance long term medical study program. Information regarding the DOE program and a copy of the NRC medical consultant's report were provided to the referring physician.

Cause or Causes—NRC concluded that the cause of the misadministration was twofold: (1) The technologist failed to activate a button that automatically corrects for treatment time based on source decay, failed to notice a display indicating the treatment time correction that would have been entered automatically, reentered the treatment time instead, and failed to notice the error; and (2) the treatment software did not stop the technologist from proceeding after the initial error was made as it was supposed to because an integrated circuit containing the software code failed to operate.

Action Taken To Prevent Recurrence

Licensee—In order to prevent recurrence of the incident as of November 25, 1994, the licensee revised its internal ''Policy and Procedure for all HDRs'' to require both individuals operating the unit to verify the displayed time factor and compare it to the factor supplied by the manufacturer. Prior to this misadministration, the device operators were required to verify only operator entered data. Also, the unit was evaluated by the licensee's medical physicist and a GammaMed service representative. As a result of the evaluation, the printed circuit board (card) with the read-only-memory integrated circuits containing the defective software program was replaced with a card having the correct software program.

NRC—NRC conducted a safety inspection on November 30 and December 1, 1994. An interoffice review of the event was conducted through December 8, 1994, to review the circumstances of the misadministration. No violations of NRC requirements were identified. As a result of the incident, NRC contacted the manufacturer of the GammaMed IIi and sent a letter to all GammaMed IIi users to inform them of this potential problem and tell them how to test their software to prevent similar events.

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Dated at Rockville, MD, this 19th day of July, 1995.

For the Nuclear Regulatory Commission.

John C. Hoyle,

Secretary of the Commission.

[FR Doc. 95–18196 Filed 7–24–95; 8:45 am]

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[Docket Nos. 50–334 and 50–412]

Exemption

In the Matter of Duquesne Light Company; Ohio Edison Company; Pennsylvania Power Company; the Cleveland Electric Illuminating Company; and the Toledo Edison Company; (Beaver Valley Power Station, Unit Nos. 1 and 2).

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Duquesne Light Company, et al. (the licensee) is the holder of Facility Operating Licenses Nos. DPR–66 and NPF–73, which authorize operation of