and Content of License Termination Plans for Nuclear Power Reactors.''

FOR FURTHER INFORMATION CONTACT: James C. Shepherd, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, *telephone:* 301–415–6712 or e-mail *James.Shepherd@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The U.S. Nuclear Regulatory Commission (NRC or Commission) is issuing a revision to an existing guide in the agency's ''Regulatory Guide'' series. This series was developed to describe and make available to the public information such as methods that are acceptable to the NRC staff for implementing specific parts of the agency's regulations, techniques that the staff uses in evaluating specific problems or postulated accidents, and data that the staff needs in its review of applications for permits and licenses.

Revision 1 of Regulatory Guide 1.179, ''Standard Format and Content of License Termination Plans for Nuclear Power Reactors,'' was issued with a temporary identification as Draft Regulatory Guide, DG–1228. This guide provides general procedures for the preparation of license termination plans for nuclear power reactors. Use of this regulatory guide will help to ensure the completeness of the information provided in a license termination plan, assist the staff of the NRC and others in locating pertinent information, and facilitate the review process. However, the NRC does not require conformance with the procedures, which are provided for guidance only.

II. Further Information

In August 2010, DG–1228 was published with a public comment period of 60 days from the issuance of the guide. The public comment period closed on October 11, 2010, no comments were received. Electronic copies of Regulatory Guide 1.179, Revision 1 are available through the NRC's public Web site under ''Regulatory Guides'' at *http://www.nrc.gov/reading-rm/doc-collections/* and through the NRC's Agencywide Documents Access and Management System (ADAMS) at *http://www.nrc.gov/reading-rm/adams.html,* under Accession No. ML110490419. The regulatory analysis may be found in ADAMS under Accession No. ML110490425.

In addition, regulatory guides are available for inspection at the NRC's Public Document Room (PDR) located at Room O–1F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852–2738. The PDR's mailing address is USNRC PDR, Washington, DC 20555–0001. The PDR can also be reached by telephone at (301) 415–4737 or (800) 397–4209, by fax at (301) 415–3548, and by e-mail to *pdr.resources@nrc.gov.*

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Dated at Rockville, Maryland, this 17th day of June, 2011.

For the Nuclear Regulatory Commission.

Thomas H. Boyce,

Chief, Regulatory Guide Development Branch, Division of Engineering, Office of Nuclear Regulatory Research.

[FR Doc. 2011–16270 Filed 6–28–11; 8:45 am]

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NUCLEAR REGULATORY COMMISSION

[NRC–2010–0321]

Notice of Issuance of Regulatory Guide

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of Issuance and Availability of Revision 2 of Regulatory Guide 1.107, ''Qualification for Cement Grouting for Prestressing Tendons in Containment Structures.''

FOR FURTHER INFORMATION CONTACT: Mekonen M. Bayssie, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, *telephone:* 301–251–7489 or e-mail *Mekonen.Bayssie@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The U.S. Nuclear Regulatory Commission (NRC or Commission) is issuing a revision to an existing guide in the agency's ''Regulatory Guide'' series. This series was developed to describe and make available to the public information such as methods that are acceptable to the NRC staff for implementing specific parts of the agency's regulations, techniques that the staff uses in evaluating specific problems or postulated accidents, and data that the staff needs in its review of applications for permits and licenses.

Revision 2 of Regulatory Guide (RG) 1.107 entitled, ''Qualification for Cement Grouting for Prestressing Tendons in Containment Structures,'' was issued with a temporary identification as Draft Regulatory Guide, DG–1196.

This guide describes a method that the staff of the U.S. Nuclear Regulatory Commission considers acceptable for the use of Portland cement grout as the corrosion inhibitor for prestressing tendons in prestressed concrete containment structures. This guide also provides quality standards for using Portland Cement grout to protect prestressing steel from corrosion.

The prestressing tendon system of a prestressed concrete containment structure is a principal strength element of the structure. The ability of the containment structure to withstand the events postulated to occur during the life of the structure depends on the functional reliability of the structure's principal strength elements. Thus, any significant deterioration of the prestressing elements caused by corrosion may present a potential risk to public safety. It is important that any system for inhibiting the corrosion of prestressing elements must possess a high degree of reliability in performing its intended function.

II. Further Information

In October 2010, DG–1196 was published with a public comment period of 60 days from the issuance of the guide. The public comment period closed on December 11, 2010. Electronic copies of Regulatory Guide 1.107, Revision 2 are available through the NRC's public Web site under ''Regulatory Guides'' at *http://www.nrc.gov/reading-rm/doc-collections/* and through the NRC's Agencywide Documents Access and Management System (ADAMS) at *http://www.nrc.gov/reading-rm/adams.html,* under Accession No. ML110550732. The Regulatory Analysis may be found in ADAMS under Accession No. ML110550743. Staff's responses to public comments on DG–1196 are available under ML110590058.

In addition, regulatory guides are available for inspection at the NRC's Public Document Room (PDR) located at Room O–1 F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852–2738. The PDR's mailing address is USNRC PDR, Washington, DC 20555–0001. The PDR can also be reached by telephone at 301–415–4737 or 800–397–4209, by fax at 301–415–3548, and by e-mail to *pdr.resources@nrc.gov.*

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Dated at Rockville, Maryland, this 17th day of June, 2011.

For the Nuclear Regulatory Commission.

Thomas H. Boyce,

Chief, Regulatory Guide Development Branch, Division of Engineering, Office of Nuclear Regulatory Research.

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NUCLEAR REGULATORY COMMISSION

[NRC–2011–0132]

Report to Congress on Abnormal Occurrences; Fiscal Year 2010; 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 that 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 2010, fifteen events that occurred at facilities licensed or otherwise regulated by the NRC and/or Agreement States were determined to be AOs.

This report describes eight events at NRC-licensed facilities. The first event involved radiation exposure to an embryo/fetus. The other seven events occurred at NRC-licensed or regulated medical institutions and are medical events as defined in Title 10, Part 35, of the *Code of Federal Regulations* (10 CFR part 35). The report also describes seven events at Agreement State-licensed facilities. Agreement States are the 37 States that currently 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. The first two Agreement State-licensee events involved radiation exposure to an embryo/fetus. The other five Agreement State-licensee events 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, the 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. 33, ''Report to Congress on Abnormal Occurrences: Fiscal Year 2010.'' This report is available electronically at the NRC Web site at *http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/*.

Three major categories of events are reported in this document—I. For All Licensees, II. For Commercial Nuclear Power Plant Licensees, and III. Events at Facilities Other Than Nuclear Power Plants and All Transportation Events. The full report, which is available on the NRC Web site, provides the specific criteria for determining when an event is an AO. It also discusses ''Other Events of Interest,'' which does not meet the AO criteria but has been determined by the Commission to be included in the report. The event identification number begins with ''AS'' for Agreement State AO events and ''NRC'' for NRC AO events.

I. For All Licensees

A. Human Exposure to Radiation From Licensed Material

During this reporting period, one event at an NRC-licensed or regulated facility and two events at Agreement State-licensed facilities were significant enough to be reported as AOs. Although these events occurred at medical facilities, they involved unintended exposures to individuals who were not patients. Therefore, these events belong under the criteria I.A, ''For All Licensees'' category as opposed to the criteria III.C, ''For Medical Licensees'' category.

AS10–01 Human Exposure to Radiation at Mohamed Megahy MD, Ltd in Maryville, Illinois

Date and Place—May 1, 2007 (reported on June 17, 2010), Maryville, Illinois.

Nature and Probable Consequences—Mohamed Megahy MD, Ltd (the licensee) indicated that on May 1, 2007, a patient was given 3,807 MBq (102.9 mCi) of iodine-131 as a treatment for the recurrence of thyroid cancer. On June 11, 2007, the licensee was contacted by the patient's obstetrician/gynecologist (OB/GYN) who advised them that the patient was 25–27 weeks (6 months) pregnant at the time of the iodine-131 administration. At the time of administration, the patient indicated to the licensee that she was not pregnant, and the licensee did not perform an independent test.

In June 2010, the Illinois Emergency Management Agency was contacted by the licensee and requested to make a dose estimate to a fetus as a result of administration of iodine-131 to a patient who was later found to be pregnant. When the Illinois Emergency Management Agency requested additional information to determine the appropriate parameters of the event, the licensee advised the Illinois Emergency Management Agency that the administration had occurred 3 years earlier. The Illinois Emergency Management Agency calculated an estimated dose to the fetus of 860 mSv (86 rem) and the fetal thyroid of over 1,000,000 mSv (100,000 rem). A full-term child was subsequently born in August 2007 without a thyroid. The child was immediately placed on replacement hormone therapy and continues such treatment.

Cause(s)—The cause of the event was found to be a combination of miscommunication and failure of the licensee to conduct an independent confirmatory pregnancy test.

Actions Taken To Prevent Recurrence

Licensee—The licensee has subsequently made procedural changes to the interview process for screening patients for iodine-131 treatment. This policy includes a confirmatory negative pregnancy test. In addition, the licensee identified the significant delay in reporting the event to the Illinois Emergency Management Agency as not knowing the reporting requirement for this type of event.

State—The Illinois Emergency Management Agency conducted an investigation of the event and issued a Notice of Violation (NOV) for the licensee's failure to report the event. The Illinois Emergency Management Agency is considering rulemaking to require the performance of testing to determine pregnancy prior to administration of iodine-131.

AS10–02 Human Exposure to Radiation at Mercy Medical Center in Durango, Colorado

Date and Place—March 16, 2010, Durango, Colorado.

Nature and Probable Consequences—Mercy Medical Center (the licensee) reported that a therapeutic dose of 1,110 MBq (30 mCi) of iodine-131 for hyperthyroidism resulted in a dose to an embryo of 80 mGy (8 rem) whole body. Prior to the treatment, the patient informed the licensee's staff that she was not pregnant and the licensee's staff administered a pregnancy test as a routine precaution. The pregnancy test yielded a negative result. Based on the negative pregnancy test results and the patient's interview responses, the licensee administered iodine-131 to the patient.

On April 26, 2010, the patient performed a home pregnancy test that resulted in a positive test result. The patient's pregnancy was confirmed with a positive blood serum pregnancy test on April 27, 2010. The patient's OB/GYN estimated that conception