DEPARTMENT OF VETERANS AFFAIRS
Medical Center
University & Woodland Avenue
Philadelphia PA 19104

NOV 15 1996

In Reply Refer To: 642/001

James Lieberman, Director
Office of Enforcement
U.S. Nuclear Regulatory Commission
One White Flint North
11555 Rockville Pike
Rockville, MD 20852-2738

Re: Reply to a Notice of Violation - EA 96-182

Dear Mr. Lieberman:

This is in specific response to the Notice of Violation and Proposed Imposition of Civil Penalty of $8,000.00 issued by Region I of the Nuclear Regulatory Commission on September 18, 1996, to the Philadelphia, PA, Veterans Affairs Medical Center (hereinafter, "VAMC").

Moreover, this response is pursuant to the provisions of 10 C.F.R. §§ 2.201(a) and (b).

1. Admission or Denial of the Alleged Violation:

Admitted. In other words, the undersigned does not challenge the March 6, 1996, findings of the Department of Labor's Acting District Director referenced in Mr. Miller's letter dated September 18, 1996. Moreover, the VA concurs with the determination that the Radiation Safety Officer (RSO) was "chastised" by her supervisor for making the contact. By way of further answer, see Enforcement Conference Transcript; hereinafter, "EC Tr." page 135. VA also agrees with the Department of Labor's September 5, 1996, findings that the RSO's allegations of discrimination cannot be substantiated.

2. The Reasons for the Violation:

VA's explanation of the reasons for the violation are set forth in detail throughout the entire ten (10) page "Answer To A Notice of Violation" pursuant to 10 C.F.R. § 2.205 and included as an enclosure with exhibits herein.

3. The Corrective Steps That Have Been Taken and the Results Achieved:

VA's explanation of corrective steps is set forth in Answer, supra.

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4. The Corrective Steps That Will Be Taken to Avoid Further Violations:

The Philadelphia VAMC will continue to schedule training programs as has been done in the past and consistent with our excellent NRC compliance record.

5. The Date When Full Compliance Will Be Achieved:

The Philadelphia VAMC and the undersigned look forward to complying with any date established by the NRC and pledges full cooperation to effectuate same.

Very truly yours,

EARL F. FALAST
Director/Chief Executive Officer

Enclosure

cc: Regional Administrator
c/o Charles W. Hehl
Director
Division of Nuclear Materials Safety
Region I
Nuclear Regulatory Commission

ANSWER TO A NOTICE OF VIOLATION

Docket No. 030-14526
License No. 37-00062-07
EA 96-182

VA Medical Center
Philadelphia, PA

Pursuant to 10 C.F.R. 2.205, the Department of Veterans Affairs Medical Center in Philadelphia, PA, submits this Answer in response to the Nuclear Regulatory Commission's "Notice of Violation and Proposed Imposition of Civil Penalty" dated September 18, 1996.

CHRONOLOGY OF FACTS

By letter dated April 12, 1996, the Nuclear Regulatory Commission (NRC) required the Philadelphia VA Medical Center (VAMC) to respond to an allegation by the VAMC Radiation Safety Officer (RSO) that she had been discriminated against while in the performance of her duties as RSO and in violation of the Energy Reorganization Act. The letter advised that the Department of Labor (DOL) had conducted an investigation of the allegation and determined by letter dated March 6, 1996, that the RSO had been discriminated against in violation of the Act. The DOL letter specifically cited as the basis for this conclusion that after the RSO had contacted the NRC regarding maintaining her position as RSO during scheduled furloughs, she was "chastised" by her supervisor for contacting the NRC regarding this matter. VA did not challenge this DOL determination and does not disagree with the finding that the RSO was "chastised" by her supervisor for making the contact. However, VA believes that the NRC proposed action in this matter has failed to adequately take into consideration mitigating factors presented by the VA and failed to give proper weight to evidence presented to the NRC.

Following VA's receipt of the NRC's letter of April 12, 1996, VA responded in writing as directed by the NRC by letter dated May 21, 1996. By letter dated July 5, 1996, the NRC scheduled an Enforcement Conference to review this matter. Also in early July the RSO submitted a second complaint to the DOL alleging continuing discrimination and asserting that "I am still being harassed by my employer and forced to work in a hostile environment because of my engagement in a protected activity on 11/16/95." The Enforcement Conference was held on August 26, 1996, at the regional offices of the NRC. Utilizing a

team of 10 persons, including the VAMC Director and VAMC RSO, VA presented evidence regarding the alleged discrimination.

By letter dated September 5, 1996, to the RSO, DOL issued its findings regarding the RSO's second complaint regarding continuing harassment which she alleged stemmed from the same set of circumstances as her first complaint. The DOL findings, based upon a second investigation, were that, "Our investigation did not verify that discrimination was a factor in the actions comprising your complaint." Additionally, the DOL letter stated that it had found that VA had complied with all terms and conditions of remedies outlined by DOL regarding the RSO's first complaint.

By letter dated September 18, 1996, the NRC issued its Notice of Violation and Proposed Imposition of Civil Penalty. This letter indicated that it was based upon (1) the DOL's determination on the RSO's first complaint and (2) information provided at the Enforcement Conference. Notwithstanding the fact that the RSO's allegations regarding continuing harassment were discussed at length in the Enforcement Conference, the NRC's September 18, 1996, letter does not mention the DOL's September 5, 1996, findings on continuing harassment and appears not to take these DOL findings into consideration in the NRC's ultimate conclusions. To reiterate, the NRC apparently did not consider these September 5th findings despite Mr. Charles W. Hehl's (Region I Director of Division of Nuclear Materials Safety) assertion at page 137 of the Enforcement Conference Transcript; hereinafter, "EC Tr.", that "... [W}e {the NRC] use the <u>same criteria</u> essentially as the Department of Labor with regard to the Atomic Energy Act..." (Emphasis supplied). A copy of the September 5, 1996, DOL letter is attached hereto as Exhibit 1.

The NRC letter concluded that the NRC regulation entitled "Employee Protection" (10 C.F.R. 30.7) had been violated. It also categorized the violation at Severity Level II because "...the discriminatory actions in this case involved the RSO's immediate supervisor who was in a position above first line supervision (Chief of Engineering)." The base civil penalty for this severity level is $4,000.00. The letter then concluded that no credit should be given VA for Identification or Corrective Action. In fact, the base penalty was escalated 100% to $8,000.00 because the NRC found that VA had failed to take prompt and comprehensive corrective actions. The letter allowed VA 30 days to respond. By letter dated October 16, 1996, the NRC allowed VA until November 18, 1996, to respond.

<u>VA'S RESPONSE</u>

While VA does not challenge the NRC finding that there was a violation of the NRC regulation on Employee Protection, VA believes that the Severity Level

and civil penalty proposed for this violation are disproportionate to the facts of this situation. VA's contention is predicated upon the following rationale.

1. NRC Has Failed to Give Adequate Weight to VA's Mitigating Evidence:

VA does not challenge the DOL finding that the RSO's supervisor, Mr. Hatsis, "chastised" her for telephoning the NRC. However, the NRC determination does not mention that he chastised the RSO, Ms. Lovell, not just for telephoning the NRC, but because she failed to first inform him of the problem. No one has contended that speed in notifying the NRC was critical in this situation, nor that informing him of the information that she had on this matter before telephoning the NRC and allowing him to take appropriate action based upon that information would have in any way created a safety problem or violated any NRC regulation. It is a critical maxim of effective management that in order for a supervisor to be able to effectively manage, that supervisor must be kept informed of all critical and relevant information so that the supervisor can make appropriate and informed decisions. If a subordinate fails to keep his/her supervisor informed of such information, the supervisor is deprived of the ability to take appropriate action, and effective management is undermined.

At the Enforcement Conference, Mr. Hatsis stated that he was angry with the RSO and chastised her because she had failed to keep him properly apprised, as was her duty as a subordinate, of information she had received on the subject that she ultimately called the NRC about (EC Tr. p. 47). Mr. Hatsis held a meeting with his subordinates on November 14 advising them of the furlough schedule, including the RSO (EC Tr. p. 51). The RSO received a memorandum from VA Health Physics Headquarters staff advising that RSO's were not to be furloughed through Dr. Zloty on November 15 (EC Tr. p. 73). The RSO telephoned the NRC on November 16 and inquired about whether she could volunteer to work during a furlough (EC Tr. p. 57). The RSO transmitted an E-Mail message to Mr. Hatsis on the evening of November 16, informing him for the first time of the VA Health Physiscs memorandum. Mr. Hatsis read the E-Mail the next day, November 17, after which he became angry with the RSO for not informing him of the VA directive before calling the NRC (EC Tr. p.64). Mr. Hatsis stated that had he been informed of the VA memorandum directing that RSOs were not to be furloughed prior to Ms. Lovell's call to the NRC, he would have taken appropriate action to remove her name from the list of those to be furloughed, and there would have been no need for the RSO to call the NRC (EC Tr. p. 47). In effect, the RSO's failure to promptly inform her supervisor of the relevant information undermined Mr. Hatsis' ability to make appropriate management decisions that would have prevented any violation of NRC requirements. In order for a supervisor to maintain effective control over his/her area of responsibility, the supervisor must communicate that it is imperative that subordinates promptly and adequately inform him/her of evolving potential problems and reinforce that understanding periodically. Had Mr. Hatsis not at

least reminded Ms. Lovell that she was failing in her responsiblity to keep him informed, Mr. Hatsis would have been sending a signal to all his subordinates that keeping him abreast of breaking situations was not an imperative of his management style, thus undermining his ability to effectively manage.

The NRC's proposed fine in this case sends the wrong message to NRC licensees and employees. Rather than encouraging employees to work closely with management to avoid violations of requirements, it disregards such a duty of subordinates and tacitly undermines management's ability to properly manage so as to avoid regulatory violations. On the contrary, we believe that a true concern of the NRC should be to encourage licensees to maintain the integrity of their managerial procedures so as to be able to effectively manage and avoid regulatory violations.

2. "Chastisement" Was One-Time Occurrence Resulting from Extenuating Circumstances

Although VA does not contest that Mr. Hatsis "chastised" Ms. Lovell on November 17, 1995, for failing to promptly apprise him of the VA directive regarding the furloughing of RSO's prior to calling the NRC, we believe that the NRC has failed to give adequate weight to the mitigating fact that Mr. Hatsis' over-reaction was at least partly due to the unique and highly-stressed situation in which it occurred. It should also be noted that Mr. Hatsis stated that he later apologized to Ms. Lovell for his over-reaction (EC Tr. p.53). The week in which this event occurred was one in which all VA personnel, up to and including the Hospital Director, were being subjected to the threat of being furloughed, possibly without pay, for an indefinite period of time (EC Tr. pp.10-11). Not only was such a situation unique, but it produced a heightened level of anxiety and stress in VA personnel, while they were expected to continue to meet the primary objective of their employment - the providing of medical care to veterans. Mr. Hatsis and Ms. Lovell were not unlike other VA employees in this respect. It was in this environment that Mr. Hatsis "chastised" Ms. Lovell, instead of merely reminding her of her responsiblity to keep him informed of developing problems.

Furloughs of VA employees is not a routine occurrence. In fact, the extended furloughs and threats of furloughs during the period of late 1995 and early 1996 has no comparable situation in recent Federal Government history. Consequently, VA believes that the November 17, 1995, "chastisement" of Ms. Lovell was a one-time occurrence prompted, at least in part, by a unique and probably never to occur again situation. VA believes that it would be a totally incorrect interpretation of this situation to conclude that the chastisement was symptomatic of a work environment in which employees were afraid to take all appropriate actions to fulfill their job responsiblities.

Indeed, inasmuch as all VA employees were aware of and experienced the unique stress of this period, it would also be a misinterpretation to conclude that following the "chastisement" of November 17, 1995, VA employees perceived their ability to fully perform their job responsibilites, including contacting appropriate regulatory agencies, to be any less than before that date. This contention is reinforced by the fact that other VA personnel, one of whom was a peer to the RSO (VA Safety Manager), stated at the Enforcemenrt Conference that in fact she, as Safety Manager, did not perceive any chilling effect resulting from the events of November 17, 1995 (EC Tr. p.87). Indeed, she stated that her supervisor, Mr. Hatsis, has utilized, and continues to utilze, a style of management which grants to subordinates wide latitude and independnce in the performance of their duties; although, he expects to be kept informed of potential problems (EC Tr. p. 86). Additionally, the Safety Manager (who has worked for Mr. Hatsis since 1985) (EC Tr. p. 85), stated: He [Mr. Hatsis] has allowed me to operate independently with regard to contacting other regulatory agencies and safety and health professionals (EC Tr. p. 87). VA believes that it would be stretching credibility to conclude from these facts that the November 17, 1995, "chastisement" was anything other than an isolated incident.

3. Hospital Work Environment Does Not Deter Employees From Performing Their Responsibilities

As has been pointed out in the previous section, the November 17, 1995, "chastisement" occurred in a unique and stressful situation. This stress was experienced by all VA hospital employees at the time. Consequently, to assume that they would interpret the chastisment as a real attempt by hospital management to prevent them from carrying out their legitimate duties, including contacting regulatory authorities, is to also assume that these same employees did not experience, indeed were not even aware of, the special circumstances extant at the time.

The only information presented to the NRC staff that there has existed, and continues to exist, a hospital work environment hostile to employees being able to carry out their legitimate duties, including contacting regulatory agecnies, are the statements of the RSO. Ms. Lovell stated at the Enforcement Conference that VA employees are inhibited from calling the NRC because of their awareness of her "chastisement" on November 17, 1995 (EC Tr. pp. 110-111). She refused to identify the VA employees. She also points out in her statements that she perceives that she is being continually harassed in her position because of her previous action in her position (EC Tr. p. 111). This appears to refer to her allegations of continued harassment cited in her second complaint to the DOL.

As noted earlier, the DOL has rendered a determination on the RSO's second complaint to the effect that their investigation was unable to verify that discrimination was a factor in the actions comprising this complaint. Consequently, the only verified VA action that can be considered discrimination under the NRC regulations is the isolated and mitigated incident of the November 17, 1995, "chastisement." Notwithstanding the RSO's assertions to the contrary, the preponderance of the evidence is that VA employees at the Philadelphia hospital are encouraged to properly perform their duties, including contacting as appropriate regulatory agencies. At the Enforcement Conference, all those VA employees assigned , or previously assigned, to the Philadelphia hospital unequivocably stated that VA employees are encouraged to make appropriate contacts with regulatory agencies, such as the NRC (EC Tr., Chief of Nuclear Medicine and Chairman of the Radiation Safety Committee p. 23; former Radiation Safety Officer p. 17; Chief of Engineering Service p. 60; Safety Officer p. 87; Hospital Director p 111).

Consequently, the evidence is that there were two DOL investigations of the RSO's allegations of discrimination. The first investigation found that in fact there had been a chastisement of her on November 17, 1995. The DOL's second investigation found that her claims of further harassment were unverified. The statements of all other VA employees to the NRC have been that, contrary to the assertions of Ms. Lovell, VA employees are encouraged to properly perform their duties, including contacting regulatory agencies as appropriate. VA believes that assessing a fine, indeed an escalated fine, as is proposed in this case, is not consistent with the information presented to the NRC. The NRC's proposed action appears to rest on a finding that the RSO's assertions, even when unverified by a DOL investigation, warrant greater credibility than the statements of five other VA employees. Indeed, the VA hospital Director explicitly invited the NRC to conduct its own investigation to ascertain if in fact VA employees were deterred from contacting regulatory agencies. The response given was that the NRC does not typically conduct an investigation simultaneously with an ongoing DOL investigation (EC Tr. pp. 129-130).

4. Categorization of Severity Level and Escalation Not Waranted

The NRC has categorized VA's action as a Severity Level II violation under the NRC's June 30, 1995, revised enforcement policy identified as NUREG-1600. VA believes that this categorization is excessive.

Unlike the NRC's previous enforcement regulations which allowed for five categories of severity level, NUREG-1600 allows for only four such categories. Category V of the older regulations, the least offensive of the severity levels, has been omitted from NUREG-1600. Severity Level I and II are for the most severe violations and "involve actual or high potential impact on the public." Severity

Level III violations "are cause for significant regulatory concern," and Severity Level IV violations are "of more than minor concern."

Supplement IV of NUREG-1600 lists seven examples of Severity Level II violations. Five of the seven examples involve actual exposures or actual releases of radioactive materials, one involves improper disposal, and one involves improper notification. As there was no actual exposure, release, or disposal of radioactive materials, or even the threat of such activity, on November 17, 1995, at the Philadelphia VA Medical Center; nor was notification an issue here, the examples in NUREG-1 600 for Severity Level II do not apply to the situation at the VA Medical Center. And the actual violation, the overreaction of the RSO's supervisor in "chastising" her, rather than merely reminding her of her responsibility to keep him informed of what was required and giving him the option of maintaining compliance before contacting the NRC, did not involve "actual impact on the public;" nor was there even the threat of potential impact on the public. The RSO was never actually furloughed. And even during the short period when there was uncertainty regarding whether she technically held the responsibilities of the RSO, those responsibilities were being double-covered by the Chief of Nuclear Medicine, who was well qualified to discharge those responsibilities since he had performed them previously (EC Tr.p. 26).

It also appears that the NRC's categorization of the RSO's "chastisement" as a Severity Level 11 violation fails to take into consideration the mitigating factors presented. Those factors were that the RSO's supervisor's over-reaction occurred during a unique and very stressful situation (furlouging of personnel), he had a legitimate reason for being upset with the RSO's action in that she failed to fulfill her duty as a subordinate to promptly inform him of what needed to be done to maintain compliance, he later apologized for his over-reaction (EC Tr. p. 53), and he was later told by the Hospital Director that his over-reaction with the RSO was unacceptable (EC Tr. p. 75).

The NRC has elected to impose, not only a base civil penalty of $4,000, but to escalate the penalty 100% because VA failed "to take prompt and comprehensive corrective actions." VA believes that the assessment of any penalty is unwarranted. It appears that the NRC's penalty assessment has failed to give adequate weight to a number of factors: (1) The mitigating factors involved in this situation described above. (2) The fact that the violation was a unique and very limited occurrence and not indicative of any chronic or programmatic difficulties.

(3) The fact that the Philadelphia VA Medical Center has an excellent history of NRC compliance. (4) The fact that VA acted promptly to fully comply with DOL directives after DOL determined that there had been a violation; even though the violation was only an over-reaction involving a legitimate managerial function.

It appears that the escalation is predicated upon VA's alleged failure to take "prompt and comprehensive corrective actions." However, VA believes that the RSO's supervisor's apology to the RSO after his over-reaction was quite prompt. Pending a determination from the DOL investigation into the RSO's first complaint, VA would have been premature to assume that further action was called for. When the DOL determination was issued, VA complied fully and promptly. Moreover, NRC Region I's July 5, 1996, letter announcing the Predecisional Enforcement Conference references same as a discussion pertaining to, inter alia, "corrective actions and the need for lasting and effective corrective action." VA interpreted this letter in part as an opportunity for VA to seek guidance. DOL's determination regarding the RSO's second complaint found that her allegations of continued harassment could not be verified. Consequently, there is no evidence that there has been, nor continues to be, any attempted intimidation of the RSO by VA management which requires remediation. The NRC notes that VA has not provided training to VA management regarding their responsibility to encourage open communication by subordinates with regulatory bodies, such as the NRC. VA believes this misses the point of the violation. It is not that the RSO's supervisor did not understand that the RSO had a legitimate responsibility and independent right to communicate with the NRC, his "chastisement" of her resulted from her failure to properly inform him of how to maintain compliance with applicable requirements. To the extent that he needed training, he received the ultimate training when he was chastised by his boss, the Hospital Director, for having over-reacted with the RSO and being informed by the Director that his subordinates should be allowed to perform their legitimate duties, including contacting regulatory bodies (EC Tr. p. 75).

Finally, VA believes that the assessment of a penalty in this situation is inconsistent with previous NRC enforcement actions. In NRC Docket No. 03028641, an Air Force sergeant received an unfavorable performance rating after cooperating with an NRC investigation into an Air Force coverup of an actual spill at Wright-Patterson Air Force Base. The NRC determined, after conducting its own investigation in 1990, that this was a violation of the Employee Protection provisions of the NRC regulations. A U.S. Senate committee investigated the situation.

Although the NRC determined that this was a Level 11 violation, it chose not to impose a fine for three reasons: (1) The Sergeant's performance rating was corrected, (2) The Sergeant's rater resigned, and (3) The Air Force had existing means and programs to review such activities and take appropriate action. There was no actual spill or exposure, or even threat of spill or exposure, at the Philadelphia VA Medical Center. The VA violation consisted of a verbal "chastisement" followed by a verbal apology. Also, there has been no continuing harassment. The RSO's supervisor has been chastised for his action by the Hospital Director. And the VA has implemented all directives issued by the DOL in this matter. VA believes that in comparing these two situations there is less basis for assessing a fine against VA than against the Air Force.

In NRC Docket No. 030-15269, the NRC determined, based upon its own investigation during 1992-1993, that there had been a violation of the NRC Employee Protection provisions at the North Chicago VA Medical Center. The Chief of Nuclear Medicine was found to have downgraded the performance appraisal of an employee for having pursued reporting an actual misadministration to the NRC. The NRC determined this to be a Level III violation not warranting any fine. The NRC indicated that it chose not to impose a fine for two reasons: (1) VA's corrective actions and (2) VA's good prior enforcement history. The corrective actions consisted of three things: (1) Establishing a written policy encouraging employees to bring safety matters to management attention and training employees in this matter, (2) Annually informing VA employees that they may contact outside regulatory agencies without fear of reprisal or authorization of VA management, (3) Correcting the downgraded performance appraisal and granting the employee a bonus.

VA believes that the situation at the Philadelphia VA Medical Center is less deserving of a fine than the situation at North Chicago. First, similar to Chicago, the Philadelphia VAMC has an excellent enforcement history. Second, VA at Philadelphia has an ongoing training program which includes instructing employees of their rights and duties to cooperate with regulatory authorities. Unlike the situation at Philadelphia, both North Chicago and Wright-Patterson involved actual misadministration or spills, involving real dangers to the public. Also, unlike Philadelphia, there were no justifying or mitigating circumstances surrounding the discrimination in the two cited cases.

Additionally, the NRC determination assessing the fine at Philadelphia erroneously fails to give VA credit for its ongoing safety training program. This program includes the distribution of a comprehensive Safety Training and Orientation Manual (that in fact the RSO helped prepare; namely, Section G on Hazardous Materials), a Medical Center Memorandum No. 138-36, "Reporting Unsafe/Unhealthful Working Conditions" which is presently in force despite an August 1996 expiration date until revisions are completed, and periodic training (See Exhibits 2, 3, and 4 respectively).

CONCLUSION

For the forgoing reasons, VA respectfully requests that the NRC reconsider its determination that the RSO's supervisor's "chastisement" constituted a Severity Level 11 violation of the NRC Employee Protection regulations warranting a fine of $8,000.

"For and in the absence of"

Margaret Bosler

Earl F. Falast
Medical Center Director

11/15/96
Date