U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Enforcement Conference Report No. 030-07022/90-004

Enforcement Action No. 89-80

Docket No. 030-07022 License No. 29-13613-02

Licensee: Process Technology North Jersey
108 Lake Denmark Road
Rockaway, New Jersey 07866

Enforcement Conference At: NRC Region I Office

Enforcement Conference Conducted: August 14, 1990

Prepared by: for Marlene J. Taylor, Health Physicist — 9/14/90 date

Approved by: John R. White, Chief, Nuclear Materials Safety Section C — 9/14/90 date

Summary: The findings of the NRC Office of Investigations (Case No. 1-89-006) concerning information provided and statements made during a previous Enforcement Conference (Enforcement Conference No. 30-07022/89-002) held in the NRC Region I office on April 26, 1989 were discussed, and the licensee described certain corrective actions taken or planned. The NRC's Enforcement Policy was explained.

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UNITED STATES NUCLEAR REGULATORY COMMISSION
REGION I

In re: RTI, INC.

An Enforcement Conference was held before Loretta B. Devery, Registered Professional Reporter and Notary Public at the Nuclear Regulatory Commission, Region I, 475 Allendale Road, King of Prussia, Pennsylvania, on Tuesday, August 14, 1990, commencing at 10:00 A.M.

PRESENT:

MALCOLM KNAPP, Director, Division of Radiation Safety & Safeguards
TIMOTHY MARTIN, Regional Administrator
JENNY M. JOHANSEN, Senior Enforcement Specialist, Office of Enforcement
DANIEL J. HOLODY, JR., Enforcement Officer, Region I
JOHN GLENN, Chief, Medical, Academic and Commercial Uses
JOHN R. WHITE, Division of Radiation Safety & Safeguards
KARLA SMITH, Regional Counsel, Region I
LEE BETTENHAUSEN, Chief, NMS Branch
JAMES LIEBERMAN, Director, Office of Enforcement
SUSAN CHIDAKEL, Senior Attorney, Office of General Counsel
ERNEST P. WILSON, Investigator, O.I., R.I.
KEITH D. BROWN, Health Physicist

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ORIGINAL

PRESENT: (Continued)

JOHN N. SCANDALIOS, President and CEO, RTI, Inc.
PAUL O. SHAPIRO, Vice President, RTI, Inc.
JOHN D. SCHLECHT, Plant Manager and RSO
MICHAEL J. SLOBODIEN, Independent Auditor
JAMES F. NICOLOSI, Manager, Special Projects,
Westinghouse SEG
BRADLEY W. JONES, ESQ., Outside Counsel
ROY P. LESSY, JR., ESQ., Outside Counsel
JOHN H. BUCK, Consultant

1 ---

2 DR. KNAPP: I would like to open this

3 enforcement conference between the Nuclear Regulatory

4 Commission and Process Technology of North Jersey or

5 RTI. We are here to discuss the Report of

6 Investigations 189006 and 189006 supplemental. I do

7 note that the meeting is being transcribed and so I

8 would ask that if you have view graphs to show or

9 other things which it would be appropriate to note as

10 part of the transcription, please do so.

11 I'd like to begin by introducing everyone

12 around the table. I know I don't recognize all the

13 faces. I'm Malcolm Knapp. I'm the Director of the

14 Division of Radiation Safety and Safeguards in NRC

15 Region I.

16 MR. GLENN: I'm John Glenn. I'm Chief of

17 the Medical Academic and Commercial Uses Safety Branch

18 in the Office of Nuclear Materials Safety and

19 Safeguards.

20 MR. MARTIN: Tim Martin, Regional

21 Administrator, Region I.

22 MR. HOLODY: My name is Dan Holody. I'm

23 the Enforcement Officer in Region I.

24 MS. JOHANSEN: My name is Jenny Johansen.

1 I'm an Acting Section Chief in Region I and normally
2 the Senior Enforcement Specialist in the Office of
3 Enforcement.
4 MR. JONES: I'm Brad Jones of the law
5 firm of Akin, Gump.
6 MR. SCHLECHT: John Schlecht, RSO. I'm
7 Plant Manager of Process Technology of North Jersey.
8 MR. SHAPIRO: Paul Shapiro, Corporate
9 Vice President, Corporate RSO, RTI.
10 MR. SCANDALIOS: John Scandalios,
11 President and CEO of RTI.
12 MR. SLOBODIEN: I'm Michael Slobodien. I
13 provide independent health and safety audits.
14 MR. NICOLOSI: I'm Jim Nicolosi. I'm
15 with Westinghouse SEG. I'm Manager of Special
16 Projects and consultant to RTI.
17 MR. LESSY: Roy Lessy, partner in the law
18 firm of Akin, Gump.
19 MR. BUCK: John Buck, consultant.
20 DR. BETTENHAUSEN: Lee Bettenhausen. I'm
21 Chief of the Nuclear Materials Safety and Safeguards
22 Branch.
23 MS. SMITH: Karla Smith, Regional
24 Counsel, Region I.

1 MR. WHITE: John White, Chief Nuclear
2 Materials Safety and Safeguards, Section C, Region I.
3 MR. WILSON: Ernest Wilson, Office of
4 Investigations, the investigator.
5 MR. BROWN: Keith Brown, Nuclear
6 Materials Safety and Safeguards, Section C.
7 DR. KNAPP: And I expect we would be
8 joined by two other people, James Lieberman, who is
9 the Director of Office of Enforcement, and Susan
10 Chidakel, who is from the Office of General Counsel.
11 They're coming from headquarters and we expect them
12 shortly.
13 What I would propose to do this morning
14 is I understand that you do have a presentation or
15 presentations for us. I'd like to make some
16 introductory remarks then we'd like to listen to the
17 presentation. We would then like to review the
18 various conclusions that have been reached in the O.I.
19 reports that I mentioned earlier, if we have
20 additional questions following the presentation, and
21 then I would have some summary remarks to make, and I
22 presume that you will have some to make. If that's
23 seems like a reasonable agenda to you --
24 MR. SCANDALIOS: Yes.

1 DR. KNAPP: Then I do have a few opening
2 remarks. First I'd like to talk just a little bit
3 about our enforcement policy and enforcement
4 conferences. I think you are aware that we have a
5 number of reasons for our enforcement policy. It's to
6 insure compliance with our regulations, to obtain
7 prompt correction where appropriate, to deter future
8 violations and to encourage improved licensing
9 performance. We hold a conference when there is
10 potential for an escalated enforcement. An escalated
11 enforcement would include such things as civil penalty
12 or fine or an order modifying the license. It can
13 change the license condition or it could go so far as
14 to suspend or revoke a license. And I would like to
15 repeat, potential, when potential for these things
16 occurs, then we have an enforcement conference such as
17 we are having today.
18 In that conference, what we want to do is
19 to assure that we have an accurate understanding of
20 the facts today, an accurate understanding of the
21 facts pertinent to the O.I. findings, and we'd like to
22 learn whether there are any mitigating or extenuating
23 circumstances that we should consider before we take
24 our next steps. And we would like to have you given

1 an opportunity to tell us of any changes that you have
2 made or changes that you plan to make that we should
3 consider as well in reviewing the report.
4 I would also like to say that we are well
5 aware of the meetings that John has had with a number
6 of senior NRC officials, and we take a very positive
7 view on this. This will result in increased
8 communication, and we commend that. We have also read
9 the document you provided to us last week, the Quality
10 Status and Improvement Plan. We consider that a
11 positive document. I'm particularly heartened by a
12 couple of the sections maintaining and improving
13 employee performance and integrity program which deal
14 with open communication with the NRC, full and
15 complete provision of information to us. And again, I
16 regard these as very positive approaches.
17 It's my intent that we will have today's
18 enforcement conference and continue this spirit of
19 full and open communication. And to that end, I would
20 encourage as we ask questions to interpret our
21 questions broadly, to look for the spirit as well as
22 the letter of the question. And if you are aware of
23 additional information that may bear on the question
24 or the concern that you think would be of interest to

2

1 us, I would encourage you to provide it. I think it
2 will help us reach a decision and I think it will
3 stand you in good stead.
4 Apropos to that, I'd like to make it
5 clear that I don't know or I'm not sure is a perfectly
6 acceptable response for you to provide for us. We
7 would far rather you caveat your answers if you're not
8 certain than to make a firm answer that you have to
9 change again. That would make life easier for both of
10 us.
11 With that in mind, I'm looking forward to
12 good communication in the next couple of hours and to
13 hear your views on these matters. John, I'd be happy
14 to hear what you have to say.
15 MR. SCANDALIOS: As you all know, I'm
16 John Scandalios, President and CEO of RTI, Inc. Here
17 with me today representing Process Technology are Paul
18 Shapiro, Vice President and Corporate RSO; John
19 Schlecht, Facilities RSO and Plant Manager; Michael
20 Slobodien, of General Public Utilities; and James
21 Nicolosi, Manager of Special Projects at Scientific
22 Technology Group, a Division of Westinghouse. Both
23 Mr. Nicolosi and Slobodien have provided independent
24 audits. In addition, at this table is our counsel,

1 Brad Jones, of Akin, Gump.

2 Our presentation will take approximately

3 one hour. I've put a considerable amount of thought

4 in this presentation. We feel it will answer the

5 questions raised in your letters of May 31st and July

6 20th. I would like to ask that questions be held

7 until the presentation is completed because your

8 questions may be answered during the presentation.

9 As directed in your letter of July 20,

10 1990 setting up today's enforcement conference, it is

11 not our intent to criticize the O.I. reports; however,

12 we do not agree with all the facts and sections in the

13 reports. The purpose of this presentation is to

14 directly address the questions raised as a result of

15 the investigation regarding the ability and

16 willingness at Process Technology to comply with the

17 NRC requirements, including the requirements to

18 provide complete and accurate information to the NRC.

19 It is my personal philosophy that a

20 company must operate in strict compliance with

21 regulations and procedures, recognizing that in the

22 long run both safety and economy are served by this

23 philosophy. While I intend to address the issue of

24 NRC confidence in Process Technology's performance, I

1 first want to address the specific aspects of the O.I.
2 investigations that involve current Process Technology
3 management.

4 First I wish to address the reports'
5 comments on myself and then Mr. Shapiro will address
6 the reports' comments on himself. I had assumed my
7 responsibilities as President and CEO on February 17,
8 1989 and had no prior technical knowledge of this
9 facility's design and safety features. I did not know
10 anything about the climbing incidents prior to the
11 enforcement conference of 1989. I did not read the
12 April 24th memo until sometime after the April 26,
13 1989 enforcement conference. At this point, I had not
14 completed my evaluation of management nor had I begun
15 the attitudinal and management changes that would have
16 assured such information was in my hands.

17 I am concerned over any questions of my
18 integrity raised by the April 17, 1989 memorandum that
19 references the door failing on one occasion prior to
20 the February 13, 1989 audit report by Mr. Shapiro. I
21 had requested the prior RSO for this report to help me
22 to analyze the occurrence more fully.

23 In my briefing with the prior RSO, no
24 particular significance was placed on any earlier

1 failure of the door by him. Neither the prior RSO nor
2 the prior corporate RSO pointed out the very important
3 significance of this happening. There remains some
4 confusion in my mind over whether this was an
5 additional incident to that already known by the NRC.
6 The O.I. report may be in error when it states that
7 there was no indication that the NRC already had this
8 information, because the inspection report actually
9 mentions that the loose doorknob caused the mechanism
10 to fail once prior to the February 13, 1989 audit.
11 The March NRC inspection report states,
12 and I quote, "In late January, 1989, an operator
13 experienced trouble with the personnel access door
14 lock mechanism, a component of the main access control
15 system. The mechanism was loose which caused the
16 interlock malfunction."
17 Today, after the attitudinal and
18 management changes that have taken place, I would
19 promptly know about this and the appreciation -- the
20 significance of any issue of the type raised by the
21 climbing incident and the doorknob incident. Had I
22 known about the incidents and appreciated their
23 significance, I would have discussed them at the
24 enforcement conference.

1 Under the above circumstances, I do not
2 believe it is reasonable to conclude that my actions
3 were in careless disregard of NRC regulations. The
4 other question relating to current members of the
5 Process Technology management concerns the Vice
6 President of Quality, Mr. Paul Shapiro. I will now
7 ask Mr. Shapiro to address the issue of O.I.'s
8 findings relating to him. Paul?
9 DR. KNAPP: Excuse me, let me take
10 advantage of the pause just to note that Jim Lieberman
11 and Susan Chidakel from headquarters have now joined
12 us. Thank you.
13 MR. SHAPIRO: I would like to address the
14 two concerns in the O.I. report that pertain to me.
15 At the time of my audit and the enforcement conference
16 in April of 1989, I was responsible for RTI,
17 Incorporated's corporate quality assurance auditing
18 and regulatory affairs. I was not involved with the
19 daily operations of Process Technology, but performed
20 the function of auditor for all of the RTI facilities.
21 My duties required me to be away from my office about
22 one week each month auditing the other places.
23 Now I will address both of the O.I.
24 concerns separately, but the reasoning behind both is

1 similar in nature. When I do an audit, it is normal
2 practice to attempt to open the irradiator cell door
3 without the key. On February 13, 1989, while
4 performing the audit, I was the one who raised the
5 issue with the operator that I was going to try to
6 open the door without using the key. I asked when the
7 source would next be coming down and I was told that
8 the source would be coming down shortly. And then
9 something to the effect that I could most likely open
10 it. I do not recall the operator saying at that time
11 or at any other time prior to the enforcement
12 conference that he had previously opened the door
13 without the key. That particular operator frequently
14 raises issues that cannot be verified. Since I was to
15 test the door in a matter of minutes, I made no
16 further inquiries.
17 After testing the door and finding that
18 it could be opened, operations were immediately
19 stopped until the problem was corrected. I then asked
20 the operator why he had made the statement that I
21 could most likely open the door. He then told me
22 about the damaged doorknob. He said that somebody on
23 the night shift must have done it, but he was not sure
24 who. I do not recall him saying that he actually

1 opened the door himself or that it was ever opened.

2 Prior to the enforcement conference, the

3 former RSO and former corporate RSO V.P. of operations

4 presented me with a detailed explanation of the

5 doorknob problem that led up to my being able to open

6 the door on February 13, 1989. They assured me that

7 the problem was simply a loosening of the decorative

8 plate, that at no time was there any danger of

9 radiation exposure. And I was told by them that there

10 had been no prior opening of the cell door without the

11 key.

12 My job at that time prior to John

13 Scandalios was to perform audits at all RTI facilities

14 and to document the results to the former RSO, the

15 former corporate RSO and the former president, which I

16 did. I had no reason to question the information

17 given to me by the former RSO and plant manager and

18 former corporate RSO V.P. of operations who should

19 have been the most knowledgeable people with regard to

20 operational activities at the plant. I also knew that

21 the audit finding had been addressed by them.

22 Therefore, I do not believe it is

23 reasonable to conclude that my actions were in

24 careless disregard of NRC regulations. Had I such

1 information, I would have discussed it at the
2 enforcement conference.
3 The second concern involving the door
4 climbing incident is of a similar nature. An operator
5 had told me that he heard from somebody that somebody
6 had climbed over the door. When I pressed him, he
7 said that he thought it was another operator, but he
8 was not sure and did not know when it had happened,
9 nor could he remember who he heard it from. Being
10 aware of that operator's ability to raise issues that
11 are not always verified, I asked the former RSO about
12 that situation. He told me that it had occurred. He
13 also told me that he had taken care of it, but he gave
14 no facts. I asked for a written detailed report.
15 Now, I did not mention the incident at
16 the enforcement conference for three reasons. One, I
17 was concentrating on the door plate incident, as I was
18 the person who had documented and identified that
19 problem and also concentrating on other areas of
20 concern documented by the NRC in their inspection
21 report that were within my responsibility. And two,
22 since the quality of the information that I had on the
23 climbing over the gate incident was mainly s[illegible]d or
24 third hand and without facts, I did not want to

1 communicate incomplete or inaccurate information. And
2 three, the former RSO and former corporate RSO who
3 should have been the most knowledgeable people
4 regarding this incident were at the enforcement
5 conference.

6 I believe that complete and accurate
7 communications are essential for efficient and safe
8 operations. At the enforcement conference, I did not
9 have complete nor accurate information to relate. For
10 these reasons, I do not believe it is reasonable to
11 conclude that my actions were in careless disregard of
12 NRC regulations. In my mind, the issue of climbing
13 over the gate was never identified. However, if it
14 had been identified and had I such information, I
15 would have discussed it at the enforcement conference.

16 In summation, my response to these
17 concerns are one, I was never advised prior to my
18 opening the irradiator cell door during my audit on
19 February 13, 1989 that it had previously been opened
20 without the key. And two, I did not have factual
21 information regarding the climbing over the door
22 incident.

23 One major item has taken place since the
24 last enforcement conference that should prevent

1 concerns like these. Since July of 1989, under the
2 new Scandalios organization, I have the responsibility
3 and authority to follow through and take immediate
4 corrective action wherever and whenever they are
5 required. John?
6 MR. SCANDALIOS: The O.I. report mentions
7 a serious concern about one of our operators'
8 truthfulness. Late last week, under the Freedom of
9 Information Act, we received the O.I. detailed
10 information obtained during the investigation. We are
11 in the process of evaluating these documents
12 concerning the operator and the corrective action that
13 may be appropriate. I will personally be in contact
14 with your office to inform you of actions taken or
15 planned.
16 I would now like to talk about changes in
17 personnel and attitudes that should help reduce any
18 continuing concerns the NRC has as to the ability of
19 the company to comply with procedures and provide
20 complete and accurate information to the NRC. The
21 presentation will have two parts. The first will be
22 an overview of the Process Technology quality status
23 and improvement plan. The second part will be a
24 presentation by the independent consultants on how

1 they perceive Process Technology has changed over
2 approximately the last 18 months.
3 On February 27, 1989, I assumed the
4 office of President and Chief Executive Officer. My
5 first priority was to develop an effective management
6 team that would run the company safely and in
7 accordance with government regulations and company
8 policies. Although I had only been with the company a
9 few weeks, the NRC Region I inspection in March, 1989
10 and the enforcement conference that followed amplified
11 my belief that tough, hands-on management would be
12 necessary to bring about the type of operation I
13 wanted and which wa needed. It became increasingly
14 obvious to me that a significant attitudinal change
15 was necessary to bring operations at Process
16 Technology to the level of excellence that was
17 required.
18 After I reviewed matters brought up by
19 the enforcement conference, management personnel were
20 given clear and concise instructions and orders
21 regarding the appropriate -- the operation of the
22 company and the changes that were needed. I made it
23 clear that the company was to operate in strict
24 compliance with regulations and according to approved

1 procedures. Managers who did not demonstrate the
2 ability to operate under this policy resigned, or in
3 one case, was asked to resign. Other technically
4 competent people who believed in and were committed to
5 the new safety attitude and policies were assigned the
6 responsibilities of those who had left.
7 On March, 1989, I issued a policy
8 statement which became the precursor to the Process
9 Technology quality improvement plan and which embodies
10 these principles mentioned. Following the resumption
11 of operations in 1986, there was a series of temporary
12 presidents of Process Technology. When I arrived in
13 late February, I began a process of evaluating
14 operations at the facility and other facilities owned
15 by Process Technology's parent corporation. My first
16 priority was to develop an effective management team.
17 A new management team was needed to assure compliance
18 with company procedures, to run our facility safely
19 and in accordance with government requirements.
20 The lessons learned from the Nuclear
21 Regulatory Commission Region I inspection in March,
22 1989 and the enforcement conference in April, 1989
23 helped to confirm my belief that hands-on management
24 would be necessary to bring about the type of

1 operations appropriate for Process Technology's
2 activities. As will be explained later, a number of
3 efforts were commenced to change the attitude of
4 Process Technology personnel. In fact, these efforts
5 included not only that facility but also the other
6 facilities run by Process Technology's parent
7 corporation.
8 In addition to the above, a Radiation
9 Safety Committee was created to make sure all levels
10 of management were informed and made responsible for
11 correcting deficiencies identified through internal
12 and/or external audits and inspections. The vice
13 president for quality who had been identifying
14 problems in the past but who had lacked the authority
15 to assure corrective actions were taken assumed an
16 enhanced vice presidential position which included a
17 role as corporate RSO. In this new position, he has
18 the authority and the responsibility to follow-up on
19 problems he identifies to be certain that adequate
20 corrective actions are taken. Further --
21 MR. HOLODY: Excuse me for a second.
22 Does he have the authority to shut down the facility
23 in the event of a safety issue?
24 MR. SCANDALIOS: Yes. Further, an

1 experienced and degreed RSO with a background in
2 administering a government radiological safety program
3 and in operating the irradiator at Process Technology
4 assumed the RSO position at the facility during 1989.
5 Our RSO's resume is attached to the submittal made
6 earlier.
7 We believe the above changes as well as
8 the actions described later have served to create a
9 management team that has brought about a substantial
10 improvement in safety and effectiveness to Process
11 Technology operations. We will continue to monitor
12 the effectiveness of our organization and our managers
13 to insure that the new team will achieve our safety
14 goals.
15 An issue that was of special interest to
16 me when I first joined Process Technology, as
17 exemplified in some of the undisputed findings of the
18 March, 1989 inspection, was the question of assuring
19 corrective actions were taken when issues were clearly
20 identified during either internal or external audits
21 and inspections. To assure that expedient corrective
22 action was taken regarding radiological concerns,
23 procedure 10.0, Radiation Protection Program was
24 implemented in the second quarter of 1989. This

1 procedure set up the Radiation Safety Committee. The
2 committee is composed of corporate officers, the RSO
3 and plant manager. The committee has met monthly
4 since 1989.
5 This process assures that top management
6 is aware of and involved with radiological safety
7 matters. We believe this program has had a positive
8 effect in preventing problems being identified but not
9 corrected. Copies of the minutes of the committee
10 meetings are available. As part of this program, the
11 plant manager is required to report to the committee
12 on a weekly basis concerning corrective actions for
13 the items cited on internal and external audit reports
14 until the corrective action is completed. This
15 committee will continue to operate to improve the
16 safety of operations.
17 Mr. Shapiro in his presentation will
18 expand on corrective actions taken since the inception
19 of this committee. Following the April '89
20 enforcement conference, it was made clear to employees
21 that they are expected to follow strict guidelines
22 established by the company. As described above,
23 several significant management changes were necessary
24 and were made in the process of creating a team that

1 had nuclear excellence as their goal. As I said
2 previously, these changes were made -- included
3 management changes at all our facilities.
4 After the new management team was in
5 place and after efforts to communicate the philosophy
6 of strict compliance to all personnel which were
7 commenced in the second and third quarters of 1989,
8 Process Technology's internal audit showed an overall
9 improvement in attitudes and performance. We believe
10 the improvements shown in these audits is evidence
11 that the corporate philosophy was beginning to reach
12 all levels of our operations. Copies of the audit
13 reports are available. I have noted this personally
14 with plant personnel during my visits to all shifts.
15 Mr. Slobodien and Mr. Nicolosi will be telling you of
16 similar observations.
17 One example of what we believe is an
18 improvement in both attitudes and performance was the
19 handling of an exposed film badge. This matter will
20 be discussed by John Schlecht. Low level radioactive
21 contamination is another example of an issue being
22 handled well by the new team. Again, Mr. Schlecht
23 will address this issue.
24 Continuing management attention and

1 resources will be placed on assuring -- that things
2 have been and will continue to be placed on assuring
3 that things are done correctly. Process Technology
4 understands its duty and is committed to providing
5 accurate and complete information to the NRC in all
6 communications.

7 We will continue to be sensitive in our
8 communications and responsibilities and will promptly
9 take action to assure ourselves that the NRC has
10 received or is receiving accurate information. We
11 believe the handling of the film badge incident
12 displays the type of prompt and effective
13 communications that Process Technology wants to have
14 with the NRC.

15 There is an obvious and important need to
16 further improve communications and trust between the
17 NRC and Process Technology. Accordingly, the
18 management of Process Technology has launched an
19 effort to improve communications at all levels of the
20 NRC. I began our efforts by visiting with each of the
21 Commissioners in accordance with their busy schedules.
22 While at NRC headquarters, I also met with senior
23 management of the headquarters staff to improve
24 communications with those individuals. In addition, a

1 meeting was held between me and the Regional
2 Administrator and his staff. I hope that the visit
3 with you, Mr. Martin, or the Deputy Regional
4 Administrator becomes an annual event to provide
5 additional assurance of good communications.
6 We believe it would be advantageous to
7 have an NRC representative familiar with operations at
8 a variety of material licensees come to our facility
9 and talk to Process Technology management and
10 operators once a year to discuss current regulatory
11 issues and lessons learned from other material
12 licensees. We have already implemented action to keep
13 abreast of the latest developments in radiological
14 safety. Managers attend and participate in seminars
15 and meetings such as those held by nuclear
16 organizations. Both the RSO and corporate RSO are
17 members of ASDM Committee E-10 Nuclear Technology and
18 Applications and have participated in related seminars
19 and meetings.
20 Process Technology plans to continue the
21 practice of holding meetings with operators to discuss
22 audit and inspection results to assure that concerns
23 related to proper operations are reaching appropriate
24 individuals. In addition, I and or a vice president

1 will hold a meeting with employees on at least a
2 semiannual basis to review the status of audit
3 findings, corrective actions, the results of any
4 actions proposed as a result of the lessons learned,
5 information received from the NRC and to reinforce
6 corporate safety policy. We will continue to
7 emphasize to all employees that they have the
8 responsibility to question an action that they believe
9 to be wrong and or questionable with respect to either
10 NRC regulations or company procedures. We will
11 continue to emphasize to all employees that if they do
12 not get a satisfactory answer to their questions, they
13 are to escalate the question through the management
14 chain and to the NRC if they are not satisfied with
15 the answer they are receiving. The need to assure
16 completeness and accuracy of all communications with
17 the NRC will be reconveyed to all employees.
18 I would now like to call on Mr. Shapiro
19 to expand on the improvement plan.
20 MR. SHAPIRO: From February 26, 1986 to
21 March 21, 1989, the NRC Region I inspectors visited
22 Process Technology facilities 38 times. On only three
23 of those occasions were non-compliances noted. Two of
24 the non-compliances were a severity level 4 and one

1 was a severity level 5. Only the one inspection
2 conducted in March of 1989 has resulted in special NRC
3 attention.

4 From August 16, 1989 to Ju'y 3 1990,
5 five NRC visits noted two severity level 4
6 non-compliances. At the end of the last visit in July
7 of 1990, the inspector stated that she had observed a
8 vast improvement and that there were no items of
9 non-compliance.

10 Between February 1988 and March 1990, as
11 required by our license, nine quarterly independent
12 audits were conducted by Mr. Michael Slobodien, our
13 health physicist consultant, who is known to you.
14 These audits documented continued improvements.
15 Eleven internal audits were conducted by me between
16 January of 1988 and June of 1990. Internal audit
17 results show a trend that has resulted in a high level
18 of compliance. These audits and the NRC inspections
19 provided valuable information that was used to improve
20 operations. Now an effective method of assuring
21 complete compliance with the requirements is audited,
22 but identifying the problems is only the first step.
23 Effective corrective action must be taken.

24 To assure that expedient corrective

1 action is taken regarding radiological concerns, the
2 Radiation Protection Program set up a Radiation Safety
3 Committee. As was mentioned by John Scandalios
4 earlier, the committee is composed of the corporate
5 officers, the RSO and the plant manager. The
6 committee has met monthly since May of 1989. Top
7 management has expanded their scope of review and
8 attention to radiological safety matters and
9 participates in solving the problems.
10 Some examples of this involvement are a
11 review of all NRC inspection reports and corrective
12 actions, a review of all internal and outside auditor
13 reports and corrective actions, a review of the film
14 badge overdose incident, a review of the activities
15 regarding low level radiation contamination, a review
16 and input into the problem of degradation of the
17 90-second time delay switch. This committee will
18 continue to operate, evaluate and follow-up to improve
19 the safety of operations.
20 After the April, 1989 enforcement
21 conference, procedures relating to radiation safety
22 were reviewed by me, by operations and an outside
23 radiation health physicist consultant. Procedures
24 were first prioritized. Those relating to safety were

1 addressed first. We discussed and reviewed the
2 procedures from the standpoint of appropriateness,
3 safety and completeness. A number of procedures were
4 rewritten and improved. The configuration control
5 procedure system has been given new emphasis.
6 Procedures are numbered, dated and approved by
7 management. Distribution is controlled and
8 documented. Operational and radiation safety
9 procedures have been submitted to the the NRC for
10 review.

11 Both Mr. Scandalios and I have emphasized
12 the new corporate message that procedures must be
13 correct and must be followed. This approach to safety
14 has been emphasized by written warnings to some people
15 who have not complied with our policy. In addition to
16 the incident mentioned by Mr. Scandalios, one operator
17 was dismissed who did not heed formal warnings.

18 Managers' appraisals are based in part on
19 the level of compliance achieved by them and their
20 staffs to procedure. Procedure review is an ongoing
21 task. Plant managers have programs for reviewing
22 procedures, and procedures will be reviewed at
23 intervals of approximately two years or as necessary.
24 The emphasis by management on procedures will

1 continue. We have increased our emphasis on equipment
2 performance and preventive maintenance. I am in
3 contact with the plant RSO, John Schlecht, and the
4 operators to locate possible problem areas and to
5 assure that appropriate corrective or preventive
6 action is taken.
7 One example of this is the procurement
8 and installation of a back-up computer terminal for
9 the irradiator in the spring of 1990. A major effort
10 was made to review irradiator operations. In the
11 review, safety features and operations were
12 reevaluated. Preventive maintenance was expanded and
13 improved. Preventive maintenance is done on a
14 documented scheduled basis. Replacement parts are
15 being documented. Tracking is done by the plant
16 manager/RSO and reviewed by me. The RSO frequently
17 reviews the P.M. records to determine items of concern
18 appropriate for preventive action.
19 For example, documentation showed that
20 the 90-second time delay start up switch in the cell
21 was requiring frequent replacement or repair due to
22 its presence in a high radiation area. Upon
23 evaluation by the RSO, myself as corporate RSO and the
24 Radiation Safety Committee, additional shielding was

1 installed to reduce the rate of deterioration. In
2 addition to the shielding, we are actively seeking a
3 switch that is better suited for the radiation
4 environment. These important areas are receiving and
5 will continue to receive the necessary attention to
6 assure proper performance of nuclear and personnel
7 safety functions.
8 Historically, training was not
9 consistent, regular or well documented in that lesson
10 plans and attendance sheets were not utilized. With
11 an emphasis on improving training, I have been
12 preparing lesson plans, continue to add, to update and
13 utilize them. Training schedules are prepared in
14 advance. Copies are submitted to me. And all
15 operators receive formal, regular and documented
16 training. Some type of training is given on
17 approximately a monthly basis.
18 During training, we stress if there is
19 any doubt about how to proceed or doubt about whether
20 a specific action is permitted, clarification from
21 management is to be received, which may include
22 stopping operations until an answer is obtained.
23 These actions reflect the new corporate philosophy
24 that the most important asset of our company is a well

1 trained staff.

2 Managers' appraisals are based in part on

3 the training that they have given their staffs. These

4 efforts with full management participation will

5 continue. A key element of this training program is

6 the standards of business conduct or ethics training.

7 Ethics training emphasizes honest and trustworthy

8 practices and law abiding business activities. We are

9 continually building upon this training core.

10 At this point, I'd like to call on John

11 Schlecht, the plant manager/RSO to add some additional

12 items. John?

13 MR. SCHLECHT: Thank you. As Paul said,

14 I am John Schlecht, RSO and plant manager at Process

15 Technology of North Jersey. I was first employed by

16 RTI in January, 1988 as a radiation physicist. I

17 became plant manager in July, 1989 and was given the

18 duties of radiation safety officer in October, 1989.

19 I can personally attest to a tremendous

20 improvement in attitudes and performance over the past

21 18 months. I would like to address some of the areas

22 where I believe a vast improvement has occurred during

23 this time. The NRC has expressed concerns in the past

24 regarding staffing and supervision of the shifts. It

1 appeared to the NRC that back shifts were staffed by
2 the newest, least trained personnel.
3 Operators assigned to the back shifts
4 must first qualify with a seasoned operator and are
5 assigned only after I am satisfied through examination
6 and observation that they should be placed on that
7 shift. Additionally, radiation safety audits are
8 conducted quarterly by RTI corporate staff to review
9 all shifts and operators. I initiate corrective
10 action and submit weekly reports until all corrective
11 action is complete.
12 Radiation safety audits are also
13 conducted quarterly by outside auditors. Management,
14 including myself, the vice president of quality and
15 the president make unannounced visits to the
16 operational areas on all shifts. The responsibility
17 to determine the adequacy of operations is fully
18 recognized by all levels of management at Process
19 Technology. Actions of this type will continue to be
20 conducted.
21 As Mr. Scandalios indicated, I believe
22 the handling of the overexposed film badge in
23 February, 1990 displays the type of prompt and
24 effective communications that Process Technology wants

1 to have with the NRC. I notified the NRC of the
2 overexposed film badge within a few minutes after
3 receiving the exposure report. Meetings regarding the
4 incident were held with the corporate RSO, the
5 president and myself. A real team effort was made to
6 resolve this issue.
7 Low level contamination is another
8 example of an issue being handled well by the new
9 team. Studies were undertaken to determine the extent
10 of the contamination that apparently occurred years
11 ago at the North Jersey facility. We identified four
12 specific areas. Progress reports and a clean-up plan
13 were submitted to Region I. After receiving feedback
14 from Region I, a re-evaluation was performed and I
15 submitted a final clean-up plan to the NRC. Under the
16 final plan, the grounds contamination will be
17 appropriately handled by February, 1991.
18 The May 14th, 1990 proposed new
19 regulation 10 CFR 30.50 regarding notification
20 requirements has been reviewed by both the corporate
21 RSO and myself. We will continue to keep abreast of
22 changing regulations and will make every effort to
23 maintain strict compliance. All personnel have been
24 made aware that the irradiator must be operated in

1 accordance with the regulations and safe practices. I
2 have made it clear to all operations personnel that
3 they are to immediately discontinue operations and
4 contact me if they believe that there is a potential
5 radiation safety problem. Preventive maintenance logs
6 are reviewed weekly by myself or the radiation safety
7 supervisor to spot any problem areas ahead of time. I
8 inspect all parts replacements which are recorded in
9 the preventive maintenance log. I will continue to
10 review these areas and any problem areas that may
11 arise. As RSO, I review any unusual irradiator
12 problems with the Corporate RSO or President prior to
13 restart.
14 Thank you for your attention and I'd like
15 to turn things back to John Scandalios.
16 MR. HOLODY: One question. After you
17 have provided this instruction to the operators, have
18 there been any incidents where they had discontinued
19 operations because of some concern?
20 MR. SCHLECHT: Yes, there have.
21 MR. HOLODY: How frequently has that
22 been?
23 MR. SCHLECHT: I couldn't put a frequency
24 on it. I wouldn't want to put a frequency on it.

1 MR. HOLODY: Has it happened more than a
2 few times?
3 MR. SCHLECHT: Yes.
4 MR. LIEBERMAN What message have you
5 given to the operators as to what will happen if they
6 don't follow your rules and operate your irradiators
7 without the procedures being followed?
8 MR. SCHLECHT: They will potentially be
9 terminated.
10 DR. KNAPP: I'd like to allow, if we can,
11 RTI to finish with their presentation. We'll be
12 reviewing all these things and questions afterwards.
13 Thanks.
14 MR. SCANDALIOS: Thank you. To begin
15 part two of our presentation, I call on Mike
16 Slobodien.
17 MR. SLOBODIEN: I'm Michael Slobodien.
18 I'm certified in health physics practice by the
19 American Board of Health Physicists. I'm a member of
20 the American Academy of Health Physicists. I've been
21 conducting independent safety audits for Radiation
22 Technology for a number of years. My experience with
23 the company dates back to 1977. While I was an
24 employee with NRC from 1977 through 1981, I had

1 experience at the facility as an NRC employee.
2 Periodically since 1984, I've conducted the health and
3 safety audits. I've conducted over 20 audits of
4 activities primarily directed at radiological health
5 and safety and compliance with NRC rules and
6 regulations.
7 I'd like to concentrate on my
8 observations over the past year and a half.
9 DR. KNAPP: I'd like the record to show
10 that we're having a view graph presentation now and
11 you will make copies available?
12 MR. SLOBODIEN: I do have a copy for the
13 record. Can everyone see that clearly? Okay. Among
14 the features that have taken place in particular in
15 the past 18 months are the following with regard to
16 organization and management first: There's a clear
17 structure of organization, clear management structure
18 within the company. It's promulgated in writing and
19 the employees understand it.
20 When I perform my health and safety
21 audits, I talk to a variety of persons, including
22 operators, material handlers, staff and management,
23 including the president. It's clear to me that
24 people, in particular at the operator and supervisory

1 level, have an understanding of management and
2 management's expectations. This was not the case in
3 years past, in particular in the '70s and early '80s.
4 Responsibilities are defined. My understanding from
5 talking to the staff is that they know what their jobs
6 are. They know what's expected of them. They
7 understand they're accountable for carrying out their
8 activities and they have the authority which has been
9 delegated to them to conduct their jobs. This is also
10 different from what was present, in particular in the
11 1970s and again in the early '80s.
12 The attitude that has been espoused by
13 the president and has been inculcated through the
14 organization, and in my view, working its way down to
15 all levels of the staff, is one of safety first. The
16 production at all cost attitude that was prevalent 15
17 years ago is not the case today.
18 An area of considerable attention that
19 Radiation Technology has given is training and
20 qualification. First, the management understands the
21 systems. This was not always the case. They have a
22 general understanding appropriate to their level of
23 experience and position in the company. And people
24 who are actively involved with operating the system do

1 understand in great detail. There has been formal
2 training conducted on site for a variety persons and
3 it's appropriate to their level, from people who are
4 materials handlers, primarily warehouse personnel to
5 operators, supervisors and the managers.
6 I have examined the lesson plans, but
7 more importantly, I've talked to the people who
8 receive the training and have determined that they do
9 have a reasonably good understanding of the facility
10 and they have an appropriate level of understanding in
11 particular of radiation safety for their job and for
12 their association with radiation at the facility.
13 One thing that is positive also is that
14 training has been documented. You can go back into
15 the records, and I do this, and verify that training
16 has been accomplished. Generally the records were
17 easy to find, although occasionally I found errors
18 there, but that is an area that has also been
19 improving. I note that periodic refresher training
20 does take place. Training exists at a couple of
21 levels in this regard. There's a program which
22 Radiation Technology identifies as general employee
23 type training, which is a general familiarization of
24 persons who generally work in the facility almost

1 anywhere. But there's a higher level of radiation
2 safety training which is directed at persons who have
3 access to the areas that would be controlled for
4 radiation protection purposes.
5 Again, the training is appropriate to the
6 level of the personnel and the hazards that they're
7 going to encounter. It certainly is not the kind of
8 training that makes them health physicists, but
9 appropriate to the level of the hazard that they're
10 exposed. Operators also going through a training
11 program, I note that they're observed. I've observed
12 them. I can attest to the fact that when I speak to
13 them, especially recently, operators do understand
14 that if they have a safety concern that they believe
15 threatens the ability to comply with either the
16 company procedures or regulations, they have the
17 authority to discontinue operations. They can do that
18 without calling management, and I'm aware that they
19 have done that upon occasion.
20 Surveillance programs. One thing we can
21 say first of all, they exist. This was not the case a
22 number of years ago, but they do exist now. They are
23 formalized. They are written procedures. The
24 programs have been improving. There are still

1 problems in getting surveillance activities done in a
2 timely fashion. They occasionally bump up against the
3 end of a surveillance period, whether it be monthly or
4 quarterly. This is an area that we've addressed.
5 There have been some improvement in that regard,
6 particularly with the safety supervisor conducting
7 them.
8 There is good adherence in particular
9 with the interlock testing. I've observed the
10 testing. I've observed the records of the testing and
11 it is done with the requirements of license condition.
12 I find that the audits that are performed by the
13 quality department are good in the sense that they're
14 independent. I think that they've been improving as
15 well. They show an improving, questioning attitude.
16 Early audits were straightforward and simplistic, but
17 they have been improving recently.
18 With regard to audits, again they're
19 improving. They're documented, and I mentioned there
20 is a questioning attitude generally present. And they
21 do in fact get high level attention by senior
22 management, something that is distinctly different
23 from what I would have observed for example four years
24 ago.

1 In that regard, I note that written
2 responses are required. John Scandalios takes a very
3 active interest. I've seen notes going back and forth
4 on audit reports directing people to respond to
5 actions. I think there's an example that can be cited
6 for improved performance. I haven't heard it
7 mentioned yet today, but I think that some credit
8 ought to be taken for it. In April, 1990, a shipment
9 of cobalt-60 was received. This is probably one of
10 the more difficult things for a facility of this kind.
11 It requires opening up the systems, in particular
12 opening up the roof of the irradiator cell to the
13 environment. It requires working under water with
14 long handled tools, handling very highly radioactive
15 materials. It's probably one of the times when people
16 have potential for exposure or damaging equipment
17 which could be very serious to the facility.
18 Although I never observed it in the
19 period of the '70s and early '80s, I'm aware from
20 talking to people how it was done and it was done on
21 an ad hoc basis. In April, 1990, I noted that there
22 was extensive planning prior to the job. Procedures
23 were written and they were tested. Scheduling was
24 done so that all relevant portions of the organization

1 that had an impact were participating. There was a
2 documented work plan. Documentation is an area that
3 has been particularly weak in the periods say five
4 years ago and past. They did mockup training;
5 something very unusual for this facility, but it has
6 been done and I'm sure it will be done in the future.
7 In this case, they used an available pool
8 under water to move simulated cobalt-60 with the long
9 handled tools so people who were going to do it would
10 have actual hands-on experience. There was an
11 independent audit that was done of this. It was done
12 by the quality department and there was a report that
13 was developed. I think that this activity in
14 particular in my mind has demonstrated kind of a
15 holistic way, an approach that has been taken for
16 improving structure and improving a thorough approach
17 to activities that incorporates senior management
18 attention and also examines detail at rather close
19 level. Furthermore, it sends a message to employees
20 that this is what the management wants to do. In
21 particular because of training that was done, that
22 sends a message to employees that there is a
23 seriousness in preparing for the job. That wasn't
24 always the case.

1 Corrective maintenance was also performed
2 during the time. I think that also sends the message
3 saying that we're willing to be smart about how we do
4 our operations. I'd like to summarize this by saying
5 that in my view, having performed audits for quite a
6 period of time and having had the experience of seeing
7 this licensee on and off for a period of about 13
8 years, that there's been quite a transformation, in
9 particular in the last year and a half. There's a
10 safety awareness that is present on the part of
11 management it has extended down to the employees. It
12 has been expressed in writing. Management is
13 responsive to the concerns that have been raised by
14 employees. They do this through the Radiation Safety
15 Committee. There's an encouraging attitude toward
16 raising concerns on the part employees.
17 I think that the company also, from the
18 experience in talking directly with me, has shown a
19 sincere willingness to demonstrate compliance,
20 cooperation with regulatory authorities. I think that
21 they've been responsive to suggestions that I have
22 made directed at improving both operations and safety.
23 I don't detect an attitude of get the job done at all
24 costs. That was present when I first saw the facility

1 in 1977. This management does not have that attitude.
2 It says it in writing and it says it by its actions.
3 I think that in particular that recent experience
4 shows th.t this willingness will continue as well.
5 John?
6 MR. SCANDALIOS: Jim would be next.
7 MR. NICOLOSI: My name is Jim Nicolosi.
8 I'm currently manager of special projects with the
9 Scientific Technology Group. It's a subsidiary of
10 Westinghouse in Oak Ridge, Tennessee.
11 From '80 to '85, I did not have any
12 personal knowledge of Radiation Technology during that
13 time, however, I have been involved with Process
14 Technology and its predecessor since 1986 in the term
15 of I was an approved third party auditor for both the
16 Rockaway and Salem facilities through 1988. You have
17 on file approximately a year and a half, two years'
18 worth of audits that I have performed on which I have
19 commented on the management and growth of the Process
20 Technology organization through those periods of time.
21 With respect to Mr. Scandalios, shortly
22 after he took office in late winter, early spring of
23 1989, he requested my services for an independent
24 consultation concerning his operational safety with

1 respect to radiological management and other controls.
2 This was during the time when NRC was conducting its
3 activities. Mr. Scandalios had just come on board and
4 was wanting to know more about this matter of
5 radiation safety and I was therefore invited to
6 participate and provide my opinion concerning his
7 operations.
8 Also during early 1989, Mr. Scandalios
9 used my company's resources and expertise to update
10 Process Technology's radiation control procedures and
11 also provided support for the license renewal
12 application. During 1989 also, Mr. Scandalios
13 requested that I provide a radiological safety
14 evaluation of the West Memphis, Arkansas facility in
15 preparation for sale of that facility to another
16 company. These taken together have been my
17 involvement, and it is my opinion that these are not
18 the actions of somebody who is operating with careless
19 disregard to the Commission's rules and regulations.
20 With respect to Mr. Shapiro, my
21 involvement with him goes back I think to 1987-1988
22 when Mr. Shapiro came on board at RTI. I have
23 observed Mr. Shapiro perform objective and thorough
24 audits. It has been my experience that he always

11

1 addresses the radiological and other issues related to
2 quality in a he.ds-on manner. Again, this is not the
3 action of someone operating with careless disregard,
4 in my opinion.

5 In my association with Mr. Scandalios and
6 Mr. Shapiro, I have always observed that they have
7 exhibited an attitude of willingness to comply with
8 the Commission's rules and regulations. There has
9 been management responsiveness to key issues of
10 radiation safety and operations. The current
11 management cannot, in my opinion, be compared to the
12 Martin Welt era. Rather, it is my opinion that it is
13 a model for the industsry, not only for irradiator but
14 other types of by-product materi-l operations. John?

15 MR. SCANDALIOS: Thank you. I have made
16 it clear to management and other employees that any
17 employee not adhering to the rules may be dismissed.
18 Those who did not believe or could not accept this
19 message are no longer with the company. Our company
20 will continue to commit the management attention and
21 resources necessary to satisfy the NRC concerns and to
22 continue to improve operations. If concerns remain
23 with the NRC about our operations, we be ieve that the
24 actions discussed today will lead quickly to a

1 resolution of those concerns.

2 I want to acknowledge that many of the

3 elements of our improvement plan were either suggested

4 or made more effective because of suggestions and

5 information provided through NRC inspections or

6 independent audits mandated by the NRC. These efforts

7 have amply demonstrated that more can be accomplished

8 when the NRC and Process Technology cooperate to

9 improve operations.

10 We are committed to achieving excellence

11 in our operations. At this time, I would like to

12 point out that Process Technology is a company

13 committed to strict adherence to procedures and good

14 accurate information -- good accurate communications

15 with the NRC. I believe for all the reasons discussed

16 today that the NRC should exercise its discretion and

17 take no enforcement action that would hinder or

18 jeopardize the continuing improvements outlined here

19 today.

20 The improvements evidenced in the last 18

21 months are not over, but are a continuing effort that

22 I expect will result in the NRC having increased

23 confidence in Process Technology. Mr. Jones has an

24 additional comment.

1 MR. JONES: I wanted to bring to your
2 attention a few points that we believe should be
3 considered as you make your decision on the issues
4 related to this enforcement conference. The
5 Commission, in the Statement of Considerations that
6 supported the regulations governing accuracy and
7 completeness of communications with the NRC, addressed
8 at some length the issue of whether or not to have the
9 regulations cover oral communications. They stated
10 that a rule of reason would govern whether oral
11 communications would be cited. The licensee has
12 attempted today to give you information that goes to
13 the factors the Commission said should be considered
14 in making a decision on oral communications.
15 Specifically addressed today has been the
16 information processed by current Process Technology
17 management at the April, 1989 enforcement conference,
18 including addressing Mr. Scandalios' limited nuclear
19 experience and the previous organizational structure
20 that resulted in Mr. Shapiro not being in a position
21 where reliable information was in his possession on
22 some of the issues discussed or which may have been
23 discussed at the 1989 enforcement conference.
24 There are other factors in this case that

1 indicate that escalated enforcement action now may not
2 be needed or appropriate. First, this is not the same
3 company in attitude or personnel that appeared before
4 you in April, 1989. Changes in responsibilities and
5 personnel have resulted in many beneficial changes, as
6 have been described today. Mr. Martin, in your
7 presentation to the Commission on June 27, 1990, you
8 recognized that the people of primary concern to you
9 were no longer with the company. In addition, it has
10 been almost a year and a half since the inspection
11 which gave rise to these issues.
12 Because of the nature of the issues
13 alleged, false statements by omission, specifically
14 what was said at that enforcement conference and how
15 questions were phrased are of crucial importance.
16 Interviews taking place from several months to a year
17 after the original conference depend heavily on
18 individual's memories which easily could have been
19 infirmed by the passage of time and factual matters
20 coming to the individual's attention after rather than
21 before the enforcement conference. Frankly, we can
22 never be certain what was specifically asked and what
23 was specifically answered at that enforcement
24 conference.

12

1 Under all the circumstances, we believe
2 the NRC should ask what the purpose would be in taking
3 significant enforcement action against this company.
4 Now, it is clear that the company has devoted
5 significant resources as well as time and attention to
6 improving its performance and is committed to
7 continuing these efforts. That is the appropriate
8 place for the company to be devoting its resources.
9 Charges of careless disregard involve
10 questions involving people's integrity which have long
11 term personal and business implications. It goes
12 beyond the corporation's responsibilities for its
13 employees who fail to follow technical requirements
14 and extends specifically to what people thought and
15 what they actually knew and believed when certain
16 actions were taken. We do not believe it would be
17 appropriate to label a company or an individual as
18 lacking integrity based on the standard of strict
19 liability. That is, even if ideally someone should
20 have been informed, you should not label the person or
21 the company as lacking integrity when the individuals
22 that make up the company today were not in a position
23 or did not yet have enough nuclear experience to
24 really be responsible for lacking knowledge of or an

1 appreciation of a specific piece of information.

2 We suggest that given the totality of the

3 circumstances you should not label the Process

4 Technology of today or the current management of the

5 company as individuals or a company whose integrity is

6 still in question. This would be consistent with the

7 rule of reason approach described in the Statements of

8 Consideration which accompanied the issuance of the

9 1987 regulation which addresses communications with

10 the NRC. Thank you.

11 MR. SCANDALIOS: Thank you. Thank you

12 very much for your attention. We will take any

13 questions.

14 DR. KNAPP: All right. I suspect we will

15 have a number. I know that some have come to my mind

16 during the presentation. I think my interest now is

17 in raising our questions in the most effective way,

18 the most efficient way to get the job done. What I

19 would suggest, if NRC feels that this is reasonable,

20 that I would like to proceed by following the

21 organizational framework in my letter to you -- either

22 of the letters to you -- but the letter of July 20th

23 or May 31st. You have spoken specifically to a number

24 of issues that were raised in that letter. My notes

1 so far suggest that you have not spoken to two or
2 three of the issues and I would like to just briefly
3 go through those, ask whether you do have a statement
4 to make on a particular issue and ask if staff have
5 any questions. After we've done that, then I'd like
6 to provide for an opportunity for staff to ask general
7 questions.

8 With that in mind, the first bullet of
9 interest to me -- I'm looking at my letter of July
10 20th, I'm looking at the second paragraph, and it was
11 the concerns expressed in the O.I. report that RTI
12 acted with careless disregard of NRC regulations when
13 operators gained keyless access to the irradiator by
14 either climbing over the irradiator cell access door
15 or forcing the locked door open.

16 Now, I appreciate what Brad Jones has
17 just said in terms of the concepts of careless
18 disregard and rule of reason. I think my personal
19 question here is have you anything to add to or change
20 the conclusion drawn in the report that in fact two
21 operators apparently did gain access by climbing over
22 the door? Is that an appropriate construction of what
23 occurred?

24 MR. SCANDALIOS: Paul?

1 MR. SHAPIRO: Yes, that did occur, that's
2 right.
3 MR. LIEBERMAN: Now, if I could ask a
4 question, if that happened today, what would your
5 response be to those employees?
6 MR. SHAPIRO: They would be dismissed.
7 MR. SCHLECHT: I couldn't happen.
8 MR. SHAPIRO: It can't happen today in
9 any case, it can't possibly happen.
10 DR. KNAPP: Recognizing that when these
11 employees did climb over the door, I think there's a
12 question -- there certainly could be a question as to
13 whether in fact that was a violation of an NRC
14 requirement as such in that they did not force the
15 door or they did not break the door, but they went
16 over it. My question would be were they to climb over
17 today and were they -- or were one of them to climb
18 over and be dismissed currently, would you think this
19 is something you'd bring to the NRC's attention as a
20 situation you had to deal with? How would you deal
21 with it that today?
22 MR. SHAPIRO: Absolutely.
23 MR. SCANDALIOS: Absolutely, absolutely.
24 DR. KNAPP: Fine.

1 MR. SCANDALIOS: Instantly, within
2 minutes.
3 MR. SHAPIRO: I think we have already
4 demonstrated that anything that may have a possible
5 concern to the NRC will be communicated with them, as
6 I did with John White about a week ago.
7 MR. HOLODY: So that's understood
8 throughout the entire organization, so if something
9 like this were to occur on a midnight shift and
10 another operator were to observe something like that
11 they would know immediately to get on a phone and
12 contact the NRC; is that what you're saying?
13 MR. SHAPIRO: No, I'm not saying that.
14 The operators have been instructed by both John
15 Schlecht and myself directly that those incidents are
16 to be brought to our attention. The operator, if he
17 does not get what is a satisfactory response and what
18 appears to be a resolution would then call the NRC,
19 but their first approach would be to contact us for
20 corrective action.
21 MR. HOLODY: But they would contact you
22 immediately; is what you're saying?
23 MR. SHAPIRO: That's correct.
24 MR. GLENN: I was wondering maybe you

1 could comment just a little bit on any insight you
2 might have into the motivation of individuals to
3 something like this and whether in fact you have
4 looked at possible other aspects of your safety
5 systems where maybe there is some reward for going
6 around a system and maybe some punishment from doing
7 it right. Have you looked at things from that point
8 of view?

9 MR. SCANDALIOS: Yes. Early on, right
10 after the initial enforcement conference, I issued
11 directives to Paul and shortly thereafter to John to
12 survey all the safety features in our system and to
13 take any corrective action necessary. And also at the
14 time that John became plant manager, to initiate
15 safety programs and training with the operators,
16 indicating to them that under no circumstances does
17 production come first.

18 MR. WHITE: Let me just maybe go on
19 John's question here and be specific as to this one
20 point. The reason these two operators climbed over
21 the fence is that they forgot their instrument in the
22 room which had the operation key attached to it, so
23 they effectively locked themselves out of the cage.
24 That could happen again, there's nothing to prevent

1 that type of forgetfulness or just error where an
2 operator -- that might occur on the back shift. If
3 that occurred, what operations --
4 MR. SCHLECHT: It has occurred two or
5 three times. They called the RSO and the RSO comes in
6 and unlocks the door.
7 MR. WHITE: How do you view that, John,
8 if you have to come in in the middle of the night?
9 MR. SCHLECHT: Part of my job.
10 MR. WHITE: Relative to the operators
11 themselves, do they become somewhat criticized for
12 that forgetfulness?
13 MR. SCHLECHT: No, I don't criticize
14 them. If they did it once a week, I guess I probably
15 would criticize them.
16 MR. WHITE: But for normal circumstances,
17 the operators who forget and have to call their boss
18 to come in in the middle of the night are not under
19 any cloud?
20 MR. SCHLECHT: No. I encourage them to
21 call me when they have any questions.
22 MR. SHAPIRO: You have to also understand
23 that it was very easy before when those incidents took
24 place to walk out of the cell to just flip the door

1 shut. To make it easier so that that would not
2 happen, we have a latch on the door now so when the
3 door is open, it is latched open. So it's not just a
4 question of inadvertently having the door swing
5 closed, it's got to be deliberately closed, which just
6 helps to remind them.
7 DR. KNAPP: Any other concerns at this
8 point? The second concern mentioned in my letter is
9 the concern about allowing irradiator operations to
10 continue with a less than [illegible]nctional door lock
11 mechanism. And my concern [illegible]re, I think is that the
12 mechanism the screws became loose. It maybe less [illegible]
13 functional, the screws were tightened, that apparently
14 cured the problem. After two or three tries at this,
15 I think it would become evident that the tightening
16 mechanism is simply not the way to go about it. And I
17 recognize that I think it was the 13th of February
18 when you did your inspection, at that point things
19 were changed. My concern is, I've heard about this
20 peripherally I think in some of your preventive
21 maintenance, could you talk about actions that you are
22 taking that if you see something go defective and you
23 see it go defective another time that you begin to
24 highlight this, and rather than make repeated repairs,

1 that you take actions to insure that you're not in a
2 marginal area?
3 MR. HOLODY: Before you go into those
4 actions, the corrective actions for this particular
5 issue, do you acknowledge this particular finding or
6 do you contest that finding?
7 MR. SHAPIRO: Would you please -- the
8 finding -- what is the finding specifically?
9 MR. HOLODY: The finding in the July 20th
10 letter from Dr. Knapp.
11 MR. SHAPIRO: That we allowed operations
12 to continue?
13 MR. HOLODY: It says the former radiation
14 safety officer and safety supervisor acted in careless
15 disregard in allowing irradiator activities to
16 continue with a less than fully functional door lock
17 mechanism.
18 MR. SHAPIRO: I do not agree with that.
19 DR. KNAPP: Make sure that we understand.
20 We understand that you would disagree from Mr. Jones'
21 perspective that the question of careless disregard is
22 one that you would take issue with. Do you disagree
23 with the apparent observations that in fact the door
24 was faulty? It was repaired. It was faulty. It was

1 repaired. This happened a number of times.

2 MR. SHAPIRO: I agree there was a

3 problem. It was repaired. There was a problem. It

4 was repaired. To the best of my understanding each

5 time the problem occurred, it was repaired and the

6 door was fully functional. And the interlock on the

7 door, which is the micro switch was always fully

8 operational.

9 DR. KNAPP: So that -- fine, so that you

10 would essentially agree with the observations. Your

11 disagreement would be in the conclusion that this

12 series of repeated repairs is an example of careless

13 disregard. Am I characterizing your position

14 accurately?

15 MR. SCANDALIOS: Yes.

16 MR. SHAPIRO: I do agree that there was

17 repeated problems with the doorknob.

18 MR. SCANDALIOS: I think it's important

19 to answer Dr. Knapp's question. I would refer to our

20 preventive maintenance program and how this would work

21 in corrective action being taken a lot sooner than

22 four or five or whatever number of times. Is that the

23 question?

24 DR. KNAPP: Well, that's mine, but since

14

1 Dan Holody -- Dan, has your question been answered in
2 terms of --
3 MR. HOLODY: Do you feel that the
4 individual took a proper course of action in fixing
5 the door back in the February time frame, prior to
6 your identification of the problem in February, on
7 February 13th, that you have a problem, he fixes it by
8 tightening the screws I believe was the corrective
9 action, a short time later, same fix. Now I believe
10 there was a third occasion where it was the same fix.
11 Is that a proper -- was that a proper course of
12 action?
13 MR. SCANDALIOS: I believe our preventive
14 maintenance program instituted since that will answer
15 that question, if you would allow us to get into it,
16 sir.
17 MR. HOLODY: Okay.
18 DR. KNAPP: Go ahead.
19 MR. SHAPIRO: The current preventive
20 maintenance program includes tracking of replacement
21 parts. This was something which was very much
22 highlighted by John White and which we took to heart,
23 and we are currently tracking all repairs and
24 replacements so that anything that is repetitious will

1 be highlighted, reviewed, brought up to the Radiation
2 Safety Committee, if necessary, and corrected before
3 it becomes a problem.
4 MR. HOLODY: So if this happened on two
5 occasions, like it did in February of '89, this would
6 make it to the Radiation Safety Committee and the
7 committee would do what then?
8 MR. SHAPIRO: Well, I think that we can
9 use the example of the 90-second key switch which is
10 in the cell which we do have continuing problems with.
11 There was a continuing problem due to degradation.
12 This was discussed, it was decided to put up
13 shielding. Lead bricks and cinder blocks were put up.
14 This increased the uses but --
15 MR. SCANDALIOS: The life.
16 MR. SHAPIRO: It increased the life of
17 the unit, however it still has -- it still degrades.
18 Therefore, the decision was made to go out and search
19 for a switch that did not have a plastic part in it,
20 or at least that would not be subject to the
21 degradation, and that would be the type of action that
22 we would take, we are taking.
23 DR. KNAPP: Just an aside, make sure I
24 understand this. You just said that you tracked

1 replacement parts to keep an eye on repeated
2 difficulties. It just occurred to me that actually
3 this situation with the doorknob would not necessarily
4 result in replacement parts since what you really did
5 was a maintenance job, I presume with a screwdriver.
6 Would your system catch if you, like labor, if you had
7 a series of repairs, or is your system right now
8 limited to tracking ordering of new parts?
9 MR. SHAPIRO: I'd like John to answer
10 that since he is the one that controls that.
11 DR. KNAPP: Fine.
12 MR. SCHLECHT: The particular preventive
13 maintenance procedure only calls for documenting on
14 this form which is kept in the preventive maintenance
15 log parts replacements. So all parts replacements are
16 tracked. In addition, I track all -- I read the
17 operators' log on a daily basis and they are to log in
18 there any type of labor, you know, any type of work
19 they had to do on the system. So I track it in that
20 way.
21 MR. LIEBERMAN: So a screwdriver
22 adjustment you would expect to have in a log?
23 MR. SCHLECHT: Yes, I would, especially
24 if it had something to do with the interlock.

1 Anything involving the interlocks would be documented.

2 MR. LIEBERMAN: Even a one-minute change

3 like that

4 MR. SCHLECHT: If it involves the

5 interlocks, it's documented. That's been made clear

6 to the operators.

7 MR. SCANDALIOS: Jim would like to --

8 MR. NICOLOSI: This door, it has a knob

9 or handle, the door also has a micro switch that when

10 it's activated, and it's my understanding that

11 whenever that door was open and the source was up, it

12 was activated to drop the source back in the pool.

13 That would be the primary safety system. The doorknob

14 is as simple as the doorknob on that door.

15 DR. KNAPP: We are aware of that, but

16 thanks for that.

17 MR. HOLODY: But I understand it's

18 two-fold though. You want to drop the source if you

19 open the door, but you also want to preclude that door

20 from ever being opened if the source is up, so that if

21 you have a failure, a single failure of that micro

22 switch, you're not going to be in trouble.

23 MR. MARTIN: The regulations require a

24 locked high radiation area, so an inoperable lock is a

1 violation.

2 MR. SHAPIRO: We don't disagree with

3 that.

4 MR. MARTIN: Let me get back, Paul, to

5 your formal presentation. You indicated when you

6 talked to the operator and explained to him what you

7 were about to do that he told you that you're probably

8 going to be able to. I'm paraphrasing what you said.

9 Why did he believe that? Did you inquire? Did he

10 know that the nuts were loose?

11 MR. SHAPIRO: I did not inquire until

12 after I had opened the door, as I say, which was a

13 couple of minutes later. At that time, he told me

14 that he thought I would be able to open it because the

15 back doorknob had been banged against the wall and had

16 been damaged.

17 MR. MARTIN: So he was aware that it had

18 been damaged?

19 MR. SHAPIRO: That's correct.

20 MR. MARTIN: So your operator allowed

21 continued operation with what he thought was a damaged

22 locking mechanism?

23 MR. SHAPIRO: That may be. The damage --

24 he did not tell me that the door could be opened, and

15

1 this was the inside doorknob.

2 MS. CHIDAKEL: I'd like to raise the

3 issue of that particular operator. Was any action

4 taken with regard to him? Was he given any kind of

5 reprimand or disciplined in any way, or what is his

6 position with the company now? Is he still with your

7 company?

8 MR. SCANDALIOS: Yes, he's still with the

9 company. He is the subject of my statement. We are

10 evaluating -- we've just received, under the Freedom

11 of Information Act, the O.I.'s detailed reports and we

12 are evaluating, reviewing and evaluating. And we

13 received notice that he was the individual who was

14 identified a couple weeks ago and then we requested

15 additional information. We received it late last

16 week. I don't believe you were here when I stated

17 that we are evaluating and deciding what corrective

18 action we will take with the individual. And I did

19 state that I would notify Region I of any actions

20 planned.

21 MS. CHIDAKEL: Thank you.

22 MR. WHITE: John, to go further on this

23 tracking of repairs, as you discussed it, it's totally

24 up to you then to recall on any one event whether this

1 is a recurrence or not. That is, in this particular
2 instance, if it occurred once and then maybe a week
3 later it occurred again, for your system to work, it
4 would be incumbent upon you to recollect that it had
5 occurred previously or more than once previously and
6 then to take action accordingly; is that correct?
7 MR. SCHLECHT: Not wholly in that if I
8 saw a problem with the interlocks in the log, I would
9 bring it up in the Radiation Protection Committee.
10 Then it would not be completely upon me to remember
11 it. It would be in the minutes of that meeting if I
12 had a problem with it later, though it would be easy
13 to make a change to add repairs to the preventive
14 maintenance tracking system.
15 MR. SCANDALIOS: Let's do it.
16 DR. KNAPP: Any additional comments? I'd
17 like to turn now to the second paragraph of my letter
18 dealing with acknowledgment of keyless entries to the
19 irradiator cell. We have already heard John
20 Scandalios' position in terms of his involvement and
21 Paul Shapiro's position in terms of his involvement.
22 I think that addresses any concerns that I have with
23 respect to you gentlemen.
24 We have not heard anything from RTI with

1 regard to the two former employees. Have you any
2 comments that you would care to make or does the
3 report as received appear to appropriately describe
4 what occurred? Again, I'm talking to the description
5 contained in the report, and I again recognize your
6 position with whether or not this in fact constitutes
7 careless disregard.
8 MR. SHAPIRO: The first thing that I have
9 to request is your definition of keyless entry.
10 Numerous keyless entries are made every single day,
11 which are clearly permitted, into the cell. And in my
12 mind, this may have caused some confusion because the
13 term keyless entry is a question. Once the source is
14 lowered, the door is opened and the cell is cleared,
15 the area in the cell is no longer a high radiation
16 area and may be entered and is entered without the
17 key.
18 MR. SCANDALIOS: I believe the question,
19 Paul, was whether the former RSO or the corporate RSO
20 had acted in careless disregard. Am I understanding?
21 DR. KNAPP: Well, again, I understand
22 your view on whether careless disregard occurred, I
23 think, whether this occurred in any of the
24 circumstances. More, it's simply have you any new or

1 different information about their involvement than
2 what is in the report?
3 MR. SHAPIRO: Than what is in the O.I.
4 report?
5 DR. KNAPP: Yes.
6 MR. SHAPIRO: No. As I stated, I was
7 clearly told that there has been no other entries.
8 MR. LIEBERMAN: Now, could I ask a
9 question going back to Mr. Shapiro's opening
10 statement? I wasn't at the last enforcement
11 conference so I only know what occurred from reading
12 the O.I. report and speaking to various people. You
13 indicated that -- I think you indicated that the
14 reason why you didn't bring up the issue of climbing
15 over the fence to the interlocks, basically three
16 reasons: One, you were focusing on the doorknob
17 issue; second, the information was second or third
18 hand, you weren't sure how accurate it was; and third,
19 there were other people present who had better
20 information. Is that correct?
21 MR. SHAPIRO: Yes.
22 MR. LIEBERMAN: Does that mean that you
23 interpreted the question as being raised during the
24 meeting was focusing in part on whether climbing over

1 the fence occurred?

2 MR. SHAPIRO: No.

3 MR. LIEBERMAN: Then why would you have

4 considered these other two issues, if you only had

5 second or third hand knowledge and there were more

6 knowledgeable people present, if those are two

7 reasons, why you didn't raise that issue?

8 MR. SHAPIRO: Well, those are reasons why

9 I didn't really give it any consideration because I

10 was concentrating on the areas where I had been

11 involved with. And if it was involving other areas,

12 the other people there had the knowledge, I did not.

13 MR. LIEBERMAN: But are you really saying

16

14 that during this conference, you didn't give any

15 thought to whether the questions that were being

16 raised had to do with anything other than the doorknob

17 issue?

18 MR. SHAPIRO: That was my prime

19 consideration.

20 MR. LIEBERMAN: I don't want to go over

21 and over this, but what I thought I heard the first

22 time was during the meeting, there were three reasons

23 why you didn't bring up the issue of climbing over the

24 fence. And what I'm trying to find out is whether you

1 even considered the questions to be pertaining to
2 climbing over the fence at the time.
3 MR. SHAPIRO: Not really.
4 MR. LIEBERMAN: So then these other two
5 reasons that you've given today were really irrelevant
6 to your thought process at the time?
7 MR. SHAPIRO: They may have been very
8 minor to my thought process at the time.
9 MR. LIEBERMAN: Well --
10 MR. MARTIN: Did they even come up? Did
11 you even think of them when the questions were being
12 asked?
13 MR. SHAPIRO: I really can't say that at
14 this time. I read a lot and have gone over a lot
15 since that time and exactly what my -- I was
16 concentrating on the areas that I was involved with.
17 Whether I had thought of them momentarily and just
18 dismissed them, those would have been the reasons why
19 I would have dismissed them.
20 MR. LIEBERMAN: So with hindsight and
21 examining why it didn't come up in your mind, these
22 were the three reasons that you did not at the time it
23 occurred, these were the three reasons.
24 MR. SHAPIRO: Item number 2 and item

1 number 3 are probably due to hindsight.

2 MR. LIEBERMAN: Okay. That's all.

3 DR. KNAPP: All right. The next item has

4 to do with the statement by the RSO that the system

5 computer records all entries to the cell, and in fact

6 it turned out that that was an incorrect statement as

7 you reported to us in a letter I think of May 4th or

8 5th which we received about May 8th. I feel I have a

9 clear understanding of those facts? Is there any

10 disagreement or is there any misunderstanding?

11 MR. SCANDALIOS: No.

12 DR. KNAPP: Are there any questions on

13 that particular issue with the NRC? The next item is

14 is whether the former RSO willfully misrepresented his

15 prior knowledge of damage to the cell door lock

16 mechanism. Again, we have the results of the O.I.

17 report in which that's essentially an admission on his

18 part, I think. Is there again any disagreement? Have

19 you any additional information apropos to what the

20 former RSO might have said?

21 MR. SCANDALIOS: No. Do you?

22 MR. SHAPIRO: I only know what I read in

23 the O.I. report.

24 DR. KNAPP: Fine. Are there any

1 questions within the NRC on that topic? The last item
2 I think you have already spoken to, and that is the
3 circumstances under which the operator apparently
4 intentionally misinformed the NRC with respect to the
5 entries to the cell, whether they were over the door
6 or through the lock. And you've already spoken to
7 that. I don't believe I have any questions on that
8 item. Again, anyone from the NRC?
9 With that in mind, I have some other
10 additional questions I'd like to ask, but let me ask
11 other people are there additional questions within the
12 NRC that don't really address these particular issues?
13 DR. BETTENHAUSEN: Let me ask a couple
14 here. You've stated that some operators have
15 essentially been terminated since last March and
16 April. The operator we're talking about with respect
17 to this item here and the false reports, he's still on
18 the payroll and he's still functioning? Have you
19 taken any actions against him in the last 18 months?
20 MR. SCANDALIOS: I'd have to defer to the
21 plant manager as to whether he's been disciplined or
22 reprimanded.
23 MR. SCHLECHT: Regarding this incident?
24 DR. BETTENHAUSEN: No, any incidents.

1 MR. SCHLECHT: I haven't -- no, nothing
2 regarding Nuclear Regulatory requirements.
3 MR. SCANDALIOS: The question is any
4 incidents has he been reprimanded at all.
5 MR. SCHLECHT: At all, regarding
6 anything, yes, not anything regarding the Commission.
7 DR. BETTENHAUSEN: So he has functioned
8 as an operator in the facility in accordance with the
9 license, insofar as you know, and has not been
10 reprimanded for that?
11 MR. SCHLECHT: Right, correct.
12 DR. BETTENHAUSEN: But there are other
13 non-regulatory things that he's run afoul of the
14 management with?
15 MR. SCHLECHT: Right.
16 DR. KNAPP: I have a few additional
17 questions. I guess the first is for I think John
18 Schlecht, but let me -- whoever would be the most
19 knowledgeable. You speak in your plan about -- I'm
20 not sure exactly whether it's a document or a
21 program -- it's called the "Standards of Business
22 Conduct." Could I have a little more description on
23 exactly what that is? Whoever is most knowledgeable
24 about it, I'd just like to learn a little more about

1 what this entails. Is it a concept, a training
2 program, a philosophical statement by management?
3 MR. SHAPIRO: That is a training session
4 that was developed by the corporation, the corporate
5 legal department to -- that all employees of the
6 corporation must go through or do go through which
7 emphasizes proper and honest -- honesty, dealing with
8 integrity and doing things that are right and not
9 lying or hiding things.
10 MR. WHITE: Why was that developed?
11 MR. SCANDALIOS: This, if I may, this was
12 in conjunction with a DLA action against the company
13 back -- I can't give you a time period, but it is
14 under the Welt era.
15 MR. WHITE: DLA being Defense Logistics
16 Agency?
17 MR. SCANDALIOS: Yes. And as part of the
18 agreement, negotiated agreement with the DLA -- this
19 happened prior to my coming on board -- we had to give
20 training to every employee upon hiring in what we call
21 the integrity program, business ethics and integrity
22 program. Every employee, upon hiring, is trained in
23 this document. It's a one-time training that takes
24 place. They read it or it is read to them, and

1 correct me if I missed the procedure here, and we do
2 it -- we review it once a year -- once a year.
3 MR. SHAPIRO: Not with the employees,
4 just management has to -- it's reinforced with
5 management. Part of that training also includes the
6 section of 10 CFR which states that people who inform
7 the NRC cannot be subject to disciplinary acts.
8 MR. WHITE: Let me just characterize it
9 the way I understand it, and correct me if I'm wrong,
10 Defensive Logistics Agency, probably in 1987, 1988 --
11 MR. SCANDALIOS: Somewhere in there.
12 MR. WHITE: -- took RTI off the
13 government bidders list.
14 MR. SCANDALIOS: It did not -- it took
15 them off, yeah, okay, yes.
16 MR. WHITE: So it effectively banned you
17 from participation in government contract work, which
18 was not a big part of your business at that time
19 anyway. In order to reestablish yourself into that
20 contractual regimen with the government, you entered
21 into a negotiation with DLA in which they required the
22 formation of this Conducts of Ethics?
23 MR. SCANDALIOS: Right, and which was
24 developed in conjunction with counsel and was in place

1 something that John just said. In passing you may
2 have missed what he said. The timing of this was --
3 this is training that was actually instituted and
4 completed after the March, April time frame of last
5 year, so it is a change in the company which is what
6 the presentation was focusing on is how the company
7 has changed, for whatever reason.
8 MR. SHAPIRO: The training program was
9 developed by us of what it would contain, and it
10 contains, in addition to the things that the DLA
11 wants, it also, as we told it to them, this would
12 contain the honest and truthfulness in dealing with
13 government agencies such as the FDA and the NRC. And
14 as I just said, it incorpora es those sections of 10
15 CFR which states that the employees have the
16 responsibility to report certain items to the NRC.
17 And it highlights and emphasizes the fact that
18 employees who do that can't be -- will not be subject
19 to punishment because they notified the NRC, as stated
20 in the CFR.
21 DR. KNAPP: Let me pursue this one
22 second, make sure I have my understanding clear. I
23 know that under your management that training has been
24 strengthened. I'm not clear from what you've just

1 said, this particular aspect of training, how long has
2 this been going on? In other words, has this been
3 something that's been around for several years and is
4 strongly incorporated in the new program or was this
5 essentially dropped into place in April last year?
6 MR. JONES: My understanding it was late
7 '88 or early '89 when the agreement was reached with
8 DLA and the program was implemented shortly after the
9 enforcement time period.
10 DR. KNAPP: I can verify that, but that's
11 my recollection right now.
12 MR. SCANDALIOS: It was after the
13 conference.
14 MR. LIEBERMAN: The way it works in
15 practice, the new employee reads that and then he
16 signs it or somehow gives an indication that he's read
17 it and understood it?
18 MR. SCHLECHT: It's basically presented
19 to him.
20 MR. SHAPIRO: He does sign a statement.
21 MR. SCHLECHT: The only exception to that
22 was a few Hispanic employees who had it interpreted
23 for them by family members and signed it.
24 MR. WHITE: But an official statement

1 that the employee takes --

2 MS. SMITH: Certification or something?

3 MR. SCHLECHT: Yes, he signs a

4 certification.

5 MR. LIEBERMAN: But my point was the

6 company management presents it as a company

7 philosophy; it's not just a document someone has to

8 read and sign, theoretically.

9 MR. JONES: The certification, as I

10 understand it, is the certification they've taken the

11 training. It's not just a statement that they signed

12 that says they'll be honest.

13 MR. WHITE: That's in fact right. It's

14 something more than just signing a piece of paper.

15 MR. SHAPIRO: Oh, yes, there's a training

16 class that's given and the certification says I was

17 given this training and I had certified or whatever

18 the wording is.

19 MS. JOHANSEN: I have one question. This

20 training, that has also been given to current

21 employees; is that correct?

22 MR. SCHLECHT: That's correct.

23 DR. KNAPP: Two or three different times

24 I've heard things that I think folks could speak to.

1 shortly after I arrived.

2 MR. WHITE: So the question is how does

3 that -- that was done for a purpose other than any

4 integrity problem that the NRC had with RTI as a

5 corporation. How does that, in the way that you

6 expressed it in the document that you sent to Mr.

7 Martin and took credit for that program, in terms of

8 an integrity program --

9 MR. SCANDALIOS: As far as authorship?

10 MR. WHITE: Well, no, in terms of

11 identifying changes in the agency today that were not

12 prevalent then, you did mention that program was being

13 one of the attributes that should be seen as affecting

14 integrity, but how is that in fact connected with the

15 issues that we're talking about today?

16 MR. SCANDALIOS: Well, basically it

17 addresses the issues, good honest business sense. It

18 addresses integri[illegible] And I felt that it certainly

19 does an excellent job and it should be part of what we

20 hope to give to all our employees concerning not only

21 the business but the NRC and all of our regulatory

22 agencies. I think it's excellent and that's why what

23 we're talking about --

24 MR. JONES: I don't want you to miss

1 Mike Slobodien, for example, mentioned that, based on
2 your audits, you find that staff is now well aware of
3 the management philosophy about safety and about
4 openness and those things, and I've heard about
5 training just now, training with respect to standards
6 of conduct. Can you speak to whether or not these
7 actually have had an impact? I mean it's one thing to
8 apprise employees of management philosophy. It's one
9 thing to get them to attend a session. It can be
10 another thing entirely to get them to endorse it, to
11 get an understanding that they in fact buy into it.
12 And my question is in general, I just heard with
13 respect to standards of conduct that yes, they sign
14 the form, but are there any other methods that have
15 been employed to learn whether the employees do in
16 fact endorse what management is now putting forward?
17 MR. SLOBODIEN: During my audits, I
18 discuss with employees, and particularly the people
19 who operate with irradiator, various scenarios that I
20 construct, set up a scenario say, for example, where I
21 fail a piece of equipment and ask them how they
22 respond to it, and set up a thing where a circumstance
23 occurs and ask them how they respond and their
24 responses generally give me favorable impression.

1 when it would be appropriate for them to discontinue
2 operations, for example, they will do that.
3 Now, I have not observed firsthand a
4 scenario that I've set up, but it's through
5 questioning, and I try to do it in a way that it's not
6 so obvious, that the answer is, you know, an expected
7 answer. For example, the key breaks in the lock, what
8 do you do, and the answer I get is we're supposed to
9 call the RSO. Okay. That's an appropriate answer.
10 So that's how I assess that kind of thing. Something
11 untoward, for example, you notice th t the water level
12 is decreasing in the storage pool, what do you do.
13 And again, I would expect the answer to be shutdown
14 the irradiator if it's operating and call my boss.
15 That's the kind of answer I get.
16 MR. LIEBERMAN: Mike, you noted that
17 you've seen lots of changes since back in 1977 when
18 you first became involved with Radiation Technology.
19 What changes have you seen since 1988 and today?
20 MR. SLOBODIEN: First of all, management
21 is heavily involved with operations, in particular the
22 presid nt, the V.P. for quality, the plant manager,
23 they communicate with one another. Previously they
24 were compartmentalized, their activi.ies were

1 compartmentalized, there was not good communication
2 between the V.P. for operations, that was Varaklis and
3 Shapiro. The structure had been set up where they
4 didn't talk to one another very effectively. And that
5 does not occur today.
6 It's quite clear that there's a close
7 relationship between Shapiro and Schlecht and
8 Scandalios and they talk to one another. They have
9 common information. They share information. So that
10 the company philosophy is understood by all and in
11 fact, you don't have a situation set up where one
12 party is fighting with another, and that was apparent
13 in the days when Varaklis was pr[illegible] in particular.
14 MR. LIEBERMAN: How [illegible] the attitude of
15 the individual operators, have you seen a significant
16 difference there?
17 MR. SLOBODIEN: They're more open and
18 less fearful of management. They were very
19 suspicious, in particular when Mar[illegible] Velt was present
20 there.
21 MR. LIEBERMAN: I realize, but during
22 1988 --
23 MR. SLOBODIEN: Well, there was some par-
24 ticular concern on the part of operators in the period

1 of say '87, and I notice they have a more openness
2 toward management. They're more willing to discuss
3 things, less fearful, perhaps not fearful at all.
4 MR. LIEBERMAN: How about their thoughts
5 on following procedures?
6 MR. SLOBODIEN: They're cognizant of
7 procedures. They refer to procedures when I'm there.
8 And in fact, I've seen them take procedures out to do
9 things that they don't do repeatedly. So I think
10 there's an awareness that they're supposed to follow
11 procedures. It's an expectation that they understood.
12 I've seen them do it.
13 MR. LIEBERMAN: That's today?
14 MR. SLOBODIEN: Today.
15 MR. LIEBERMAN: How about in '88, did
16 they do those things then?
17 MR. SLOBODIEN: When procedures were
18 being developed, first of all, there was a period of
19 time when procedures were being presented and there
20 was information when Mike Burren was present, and that
21 was in '89, and at that time, procedures became
22 developed and structured. Prior to that time, there
23 was much more ad hoc activity.
24 MR. HOLODY: What's the duration of your

19

1 audits, Mike?

2 MR. SLOBODIEN: How long do I --

3 MR. HOLODY: Yes.

4 MR. SLOBODIEN: I'm there for a full day.

5 MR. HOLODY: Is that always during the

6 day?

7 MR. SLOBODIEN: No, I come on different

8 shifts. I've been there on every shift and weekends.

9 MR. HOLODY: How much of the audit is

10 actual observation of activities, talking to personnel

11 versus records review?

12 MR. SLOBODIEN: It depends on the

13 activities that are taking place, but generally it's a

14 matter of perhaps an hour to two hours looking at

15 actual operations. Most of the tim operations are

16 very straightforward. If I happen to arrive when the

17 irradiations are in a long-term situation, there's not

18 much to look at from an operations standpoint, it's a

19 very static situation. In that situation, I talk to

20 operators, review records, make plant tours, make my

21 own independent radiation measurements, talk to the

22 radiation safety supervisor who does the surveillance

23 program.

24 If I happen to be there on a weekend or a

1 night period I spend more time with the operators
2 because there's no one else to talk to. If they are
3 doing a lot of work with short irradiations or if I
4 happen to see material handlers doing a lot of work,
5 I'll speak to them.
6 MR. WHITE: John, I might ask,
7 notwithstanding the fact that Paul is the corporate
8 radiation safety officer, can you explain in your view
9 why there is or is not a conflict of interest between
10 your duties as plant manager and plant radiation
11 safety officer?
12 MR. SCHLECHT: I think that the plant
13 manager, the person -- there's not a conflict. The
14 thing that's good about it is there's not a conflict
15 between two people, one who wants the source up and
16 one who wants to shut it down because of a safety
17 issue. I understand, you know, I understand that
18 things must be operated in strict compliance, and
19 that's the only way to operate, and who better than
20 the plant manager to be the radiation safety officer
21 in that regard. I see no conflict there, none at all.
22 MR. WHITE: So internally, I mean
23 you're -- there's only just you making the decision?
24 MR. SCHLECHT: Well, no, as I stated, any

1 unusual irradiator problem, one that wouldn't be
2 common or was not fully understood by myself would be
3 discussed with upper management prior to restarting
4 the irradiator.

5 MR. WHITE: The position that you have
6 now of being a combination of plant manager and
7 radiation safety officer, is that in fact new to
8 Radiation Technology or was Russen in the same
9 position?

10 MR. SCANDALIOS: When I came into the
11 position, Russen had the same position, and basically
12 I can tell you this, John, in our New Jersey facility,
13 we have the combination. And in our North Carolina
14 facility, we have it separated out. I'm in the
15 possess of evaluating which system works better, and
16 after 18 months, it's a flip of the coin issue. I
17 think they're both operating well, so it doesn't mean
18 that we'll go either way. We're just going to leave
19 it the way it is.

20 MR. SHAPIRO: Prior to your arrival, the
21 plant manager in all the plants was also the radiation
22 safety officer in all of the facilities, prior to your
23 arrival.

24 MR. SCANDALIOS: So I tried it in North

1 Carolina one way. I have personally, in my experience
2 throughout my career, has been both ways, and it works
3 both ways.
4 MR. WHITE: What is your view when John
5 Russen was in fact -- he was in fact the plant manager
6 and the radiation safety officer; is that right?
7 MR. SHAPIRO: Yes.
8 MR. WHITE: What is your view of his
9 performance in fulfilling both those functions at that
10 time? Do you have a --
11 MR. SCANDALIOS: You're addressing me or
12 him? My view?
13 MR. WHITE: Since you weren't there, you
14 might not have a --
15 MR. SCANDALIOS: Well, I mean for the
16 limited time that I was exposed to John, without
17 seeming to attack the individual, I thought he lacked
18 management skills in any area, and I think that's
19 about what I want to answer.
20 MR. WHITE: Do you think there's a
21 difference between Mr. Russen's ability and capability
22 as opposed to Mr. Schlecht's ability?
23 MR. SCANDALIOS: Absolutely.
24 MR. SHAPIRO: Considerably.

1 MR. SCANDALIOS: Absolutely, no doubt
2 about it. But again, I don't know what, you know,
3 this is an open forum and I don't know how much is
4 stated, but John's -- John lacked considerable skills
5 in both management -- and I'm no judge, I think he
6 lacked depth in character also. That's my call.
7 MR. WHITE: So you're telling us that
8 whatever deficits that he might have had are probably
9 not going to be repeated by Mr. Schlecht?
10 MR. SCANDALIOS: Absolutely not.
11 MR. SLOBODIEN: I can add to that from
12 the sense that I've had dealings with John Schlecht
13 either via questions or comments that I provide to
14 him, and I find him to be quite competent in the
15 ability to conduct his role as radiation safety
16 officer. I can't speak to the plant manager role, but
17 I find him quite competent in the role of radiation
18 safety officer.
19 MR. GLENN: I was wondering if maybe I
20 could explore an area a little bit about the
21 mechanisms of how decisions are made, if I can, in
22 terms of decisions as to what should be reported to
23 the NRC. Obviously there's always going to have to be
24 a decision made. We don't want to hear every day from

1 you about trivial matters, and so I think we'd be
2 interested in the mechanism. We had an example cited
3 where John did see a high film badge reading and
4 reported it immediately, but are those decisions made
5 unilaterally by the RSO? Is there a review process
6 where you get input from different systems? I guess
7 one would be your preventive maintenance log. Is
8 there something there that the NRC needs to know about
9 from your Radiation Safety Committee when you review
10 things; is there anything that you view should be
11 reported?
12 MR. SCHLECHT: If it's something that
13 should be immediately reportable, if I couldn't get a
14 hold of the corporate RSO or president, I would make
15 the decision to notify the NRC myself, but I would
16 want to review everything with them ahead of time, but
17 if it wasn't possible --
18 MR. SHAPIRO: I think I should repeat,
19 any unusual items must be discussed with either myself
20 or John Scandalios, and anything that is discussed
21 with us, there is always the question should this be
22 reported to the NRC. And we have taken the approach
23 at this time, if there is the slightest possibility,
24 we will call right now John White and say John, this

1 is what happened, should we go any further in

2 reporting to you.

3 MR. GLENN: Do you depend upon John to be

4 the manager who's aware of our regulations and knows

5 the ins and outs of what is to be reported? Is there

6 a general awareness among the management?

7 MR. SHAPIRO: John Schlecht and myself

8 have the bulk of the knowledge and the information.

9 We review the CFR; we review all the regular guides

10 that come out, and we are the basis of the knowledge

11 of what NRC requirements are. We attempt to relate

12 this to the operators and to other management

13 personnel through training classes.

14 I would say, as an example of that,

15 recently the NRC has started publishing incidents that

16 occur at licensees, and those documents -- there have

17 been two of them so far -- those documents are the

18 subject of training programs with our employees and

19 training programs and discussions with all of our

20 employees in all of our facilities.

21 MR. GLENN: Are you talking about the

22 irradiator incidents?

23 MR. SHAPIRO: That's correct. That's an

24 example of how we attempt to see to it that all

1 employees are up to -- have some knowledge.

2 MR. WHITE: Let me ask a question of

3 John. As CEO and president of the corporation, the

4 corporation is about 40 people, in that vicinity?

5 MR. SCANDALICS: Yes.

6 MR. WHITE: How do you see your

7 involvement in the day-to-day running or knowledge of

8 the day-to-day activities of the program, particularly

9 at the North Jersey Process Technology?

10 MR. SCANDALIOS: How do I see my

11 knowledge of daily activities of --

12 MR. WHITE: You say you're a hands-on

13 manager, what does that mean in terms of what --

14 MR. SCANDALIOS: Well, I talk to John

15 almost every day, almost every day I ask him questions

16 specifically that might have to do -- well, how's the

17 irradiator running, are there any problems with the

18 irradiator. If there are, what are you doing about

19 them. Has it been reported. Every day.

20 MR. WHITE: So your expectation is that

21 almost on a daily basis that you would be fairly

22 knowledgeable of the status and the operation of the

23 facility?

24 MR. SCANDALIOS: When I'm there. Now I

1 do travel a little, so I'm not there every day, but
2 when I'm there, John and I and Paul and I are in
3 constant communication with each other. That's
4 basically my management style.
5 MS. CHIDAKEL. Would you say that that
6 has changed since your previous RSO or were -- did you
7 have similar contact with him when he was there?
8 MR. SCANDALIOS: I think I can, if I may
9 take a moment to explain my predecessor's corporate
10 structure, only as I look back at it and not being --
11 not having firsthand experience, the organization
12 structure was such that not only was it
13 compartmentalized, but each compartment was restricted
14 to its own area and shall have nothing to do with the
15 other areas. And communications were limited to each
16 compartment reporting to the president and he in turn,
17 if he saw fit or whatever, passing it down to the
18 other department.
19 The quality department, it's hard to say
20 did not talk, but did not communicate with the
21 operations department on any audit findings, on any
22 matters of significance. The finance department,
23 to cite a totally neutral area, was strictly the
24 keeper of the records. They did not communicate with

1 the others. I'm trying to paint a picture that I was
2 not there, however, as I see it looking back --
3 MS. CHIDAKEL: But I'm talking about
4 since you came on board.
5 MR. SCANDALIOS: Since I came on board,
6 I've reported -- what I've done is I've broken down
7 the barriers and everybody talks to everyone and
8 everyone is involved in the problems, in the reports.
9 MS. CHIDAKEL: I guess my question was
10 would you say that your relationship -- you said now
11 your relationship with your present RSO, Mr. Schlecht,
12 is you see him on a daily basis, you talk to him on a
13 daily basis to find out what the problems are and so
14 forth. Is that different from when Russen was in that
15 position?
16 MR. SCANDALIOS: Well, again, you weren't
17 here. I took over the company late February of '89,
18 Russen was the RSO. I tried to communicate with him
19 on a daily basis. He reported to the corporate RSO
20 who limited the information I received from the
21 facility RSO, and he in turn limited the information
22 that he would give me only because of the former
23 structure of the corporation. And it was after they
24 both left that we were able to start functioning on a

1 much better basis. Does that answer your question?

2 MS. CHIDAKEL: Yes, thank you.

3 MR. GLENN: I wonder if I may be

4 permitted one quick follow-up. One reason I'm here is

5 to see whether as a program we're doing the right kind

6 of licensing inspection and regulations and so forth,

7 and you did mention the regulation notices have been

8 useful to you. Something we started in the last

9 couple of years is a newsletter which gives a much

10 larger cut in the kinds of activity. Have you found

11 that useful?

12 MR. SCANDALIOS: I have, it's very

13 educational and very informative to me and I use it.

14 MR. GLENN: Is that shared down to the

15 operator level?

16 MR. SCHLECHT: That particular newsletter

17 I have not yet been given, but I do give monthly

18 training sessions and I do review procedures and

19 notification of, like Paul mentioned, irradiator

20 incidents and such. I have reviewed those with the

21 operators.

22 MR. SCANDALIOS: There is one that Mr.

23 Bernaro mentioned to me when I was there, the one

24 in Nicaragua who was the licensee and that's going

1 to be forthcoming in the next newsletter.

2 MR. GLENN: I think we will have an

3 update. That incident is a couple years old.

4 MR. SCANDALIOS: But that would be

5 applicable to our operation and it would be useful,

6 using it in training.

7 MR. SHAPIRO: I think we should reiterate

8 the fact that the better and more training the people

9 have, not only are they more knowledgeable, they

10 operate under safer conditions and quite frankly, it

11 serves the fact that they're usually better employees.

12 They're more productive. It goes hand in hand and

13 it's definitely to our advantage to have them as well

14 trained as possible, to be able to think for

15 themselves. We are doing everything we can now to

16 give them as wide and broad a training as possible.

17 DR. KNAPP: I have one or two questions

18 that I would like to address, and although we seem to

19 not have a great many left, I think these last two are

20 very important to me.

21 Turning to some of the observations in

22 the supplemental investigation report, there were some

23 perceptions that the former RSO had that I'd like you

24 to speak to, and the two perceptions that I'm

1 concerned about are that apparently he was of the
2 understanding at the last enforcement conference that
3 there was an intent to, almost as a matter of policy,
4 deny the apparent violations which the NRC had
5 observed and that when in fact he was -- he recognized
6 some of the violations, apparent violations might
7 have merit, that subsequent to the enforcement
8 conference that in fact he was somewhat chastised for
9 this position. I'd like to know, if you know, I'd
10 like you to comment on that, on how he may have
11 arrived at these perceptions and what your views are
12 on them.
13 MR. SCANDALIOS: Well, the first one was
14 I believe he was given instructions to be honest and
15 forthright, and the second one was at a luncheon
16 where -- and I believe several of the people in this
17 room were there, where I made -- I was upset. I was
18 upset and I think I told all of them that from now on
19 we're going to follow the letter of the law and God
20 help the guy that doesn't. Yes, I did say words to
21 that effect and probably a little more than that
22 because I was upset. Not at their performance, not at
23 denying anything, but that I was shocked and amazed
24 that this company had operated the way it did. And

1 that was going to cease and they were going to desist,
2 and if they didn't like it, they could leave right
3 then and there. I believe words to that effect. I
4 think Mr. Lessy was there. I think Paul was there.
5 MR. SHAPIRO: Yes, I was there.
6 MR. SCANDALIOS: That's what I did.
7 DR. KNAPP: So that the former RSO really
8 misunderstood the intent of that post conference
9 communication?
10 MR. SCANDALIOS: Well, I don't know what
11 he understood really.
12 DR. KNAPP: Well, as reported to us,
13 apparently he misunderstood.
2
14 MR. SCANDALIOS: Yes.
15 DR. KNAPP: I think that completes my
16 questions. Are there any others from the NRC? I
17 would like, if I may, to ask you to indulge us for a
18 few minutes. This is obviously a very significant
19 action for both you and for us, and what I'd like to
20 do would be to ask that you just wait here for a few
21 minutes while we excuse ourselves. We'd like to chat
22 internally. I want to be sure that there are no
23 additional questions, that we take advantage of you
24 being here. So if you excuse us a second.

(Brief recess.)

DR. KNAPP: After speaking among ourselves, I don't believe at this point that we really do have any significant additional questions to ask. We appreciate the time that you've taken to come in. I do have one or two closing remarks. Have you anything that you would like to say?

MR. SCANDALIOS: I've said it all, I think.

DR. KNAPP: Well, one or two things, I guess maybe first I'd like just to, although I imagine most of you are familiar with our enforcement policy and what the next actions are that we will be taking, I'd like to have Dan Holody take just a moment and go over those.

MR. HOLODY: I think I summarized it at the last conference in April, 1989. The policy is Part 2, Appendix C. We have three enforcement options available to us. We can issue a notice of violation. We can issue a civil penalty. We can issue some type of order to modify, revoke or suspend the license. What we will do is review the findings of the April, 1989 enforcement conference, which were the violations set forth in the March '89 inspection report. We'll

1 also evaluate the findings in the investigation
2 reports and we'll evaluate what you've told us during
3 both the conferences as far as the reasons for those
4 particular issues and what you've done to fix them,
5 and we'll make the final decision on that.
6 Normally, you'd hear from us in about a
7 month after the conference. I think I may have said
8 that at the last conference and you still haven't
9 heard from us, but this may be a little bit longer.
10 We'll take into consideration all the escalating and
11 mitigating factors which are described in the policy,
12 how these issues were identified, what types of
13 actions were taken back then and what types of actions
14 have been taken to this date, what the history has
15 been like at this facility, and we'll make a final
16 decision. And whatever decision we do make, we'll
17 transmit it to you in writing.
18 Let me point out that if there is any
19 type of the latter two actions, that is a civil
20 penalty or an order, we will issue a press release.
21 That's not negotiable. You'd receive a copy of our
22 enforcement action prior to the press release being
23 issued. You'd also receive the press release on the
24 same day that it was issued prior to hitting the wire.

1 That would not be for concurrence or anything like
2 that, but just so you had it before anybody else did.
3 If we were to issue simply a notice of violation or if
4 we were to exercise enforcement discretion and do
5 nothing, there would be no press release issued in
6 that case.
7 And finally, I would just point out that
8 issues of integrity are issues that the agency takes
9 very seriously, and when they're -- the higher up in
10 the organization we see concerns in that area, the
11 greater the concern becomes within the agency. You
12 know, the license we give you is a privilege, it's not
13 a right, and we expect you to adhere to all the
14 conditions that we associate with that privilege.
15 That's all I have.
16 DR. KNAPP: I would echo what Dan has
17 said about the extreme importance that we place on
18 integrity and full disclosure. I'd also note that, as
19 I said at the beginning of the conference, we
20 appreciate the actions that John Scandalios has taken
21 with respect to increased communication both by his
22 meetings with various NRC officials and the receipt of
23 the quality document which we received last week. I'm
24 encouraged by that and I'm also encouraged by the

1 positive results that we have heard about today.

2 Dan has told you what our next actions

3 will be, and I think the only other thing I would like

4 to do is to thank you for coming, thank you for the

5 obvious attention that you have p.'. to this problem

6 since you've learned about it and for your preparation

7 for today's meeting.

8 MR. NICOLOSI: May I raise one question?

9 If in your subsequent action RTI disagrees with your

10 final decision, what opportunities do they have for

11 recourse to dispute that?

12 MR. HOLODY: Okay, whatever action we

13 issue is a proposed action. You'll be given the

14 opportunity to respond in writing to that proposed

15 action. Unless there were an immediately effective

16 order, for example, then you'd -- that would be

17 effective upon issuance, there would be hearing rights

18 associated with that, as there would be with any other

19 type of an order, modification order or a non-

20 immediately affected order. If it's simply a notice

21 of violation or civil penalty, you can respond in

22 wri:ing and provide your reasons why you don't think

23 the violations occurred; why, if you think they

24 occurred but the severity level was too high, it

1 should be of a lower severity level; why you think we
2 didn't apply the mitigating factors properly and the
3 type of action that was issued was not warranted.
4 You'd have the opportunity to -- RTI would have the
5 opportunity to provide all those reasons in writing.
6 We would then evaluate those reasons and
7 if they were valid, we would reduce the action or
8 mitigate the action in part. If we found they were
9 not valid, the action would stay and we would impose
10 it by some type of an order, at which time you then
11 have an opportunity to put your arguments -- take your
12 arguments before an administrative law judge by
13 requesting a hearing.
14 MR. JONES: I have one question. Will
15 they get a copy of the transcript to review for
16 accuracy and resubmittal?
17 MR. WHITE: Yes, sir.
18 DR. KNAPP: We'll provide you with a copy
19 of the transcript. Is it our plan to --
20 DR. BETTENHAUSEN: We have in the past
21 not had any problems with the transcript, so your
22 question is new, Mr. Jones.
23 MR. JONES: My experience has been
24 there's usually routinely correction sheets just

1 because of names and misunderstandings.

2 DR. KNAPP: If you find anything

3 substantive, we certainly would like to hear about it.

4 We would not like there to be an error on the record.

5 I think that concludes our business, and

6 again, thank you for coming.

7 MR. SCANDALIOS: Thank you

8 (Proceedings closed.)

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