In the Matter of:	Curtis Hall II	)		
		)		
Filing Date:	November 21, 2023	)	Case No.:	WBH-24-0003
		)		
		)		

Issued: May 23, 2025

Initial Agency Decision

James P. Thompson III, Administrative Judge:

This is an Initial Agency Decision on the revised complaint (Complaint) filed by Curtis Hall II against Central Plateau Cleanup Company (CPCCo) under the Department of Energy's (DOE) Contractor Employee Protection Program and its governing regulations set forth at Part 708 of Title 10 of the Code of Federal Regulations (Part 708). Mr. Hall alleges that CPCCo terminated his employment in retaliation for making protected disclosures under Part 708. For the reasons set forth below, I conclude that Mr. Hall is not entitled to relief.

I. Background

A. The DOE Contractor Employee Protection Program

DOE's Contractor Employee Protection Program was established to safeguard "public and employee health and safety; ensur[e] compliance with applicable laws, rules, and regulations; and prevent[] fraud, mismanagement, waste and abuse" at DOE's government-owned, contractor-operated facilities. 57 Fed. Reg. 7533 (Mar. 3, 1992). Its primary purpose is to encourage contractor employees to disclose information which they believe exhibits unsafe, illegal, fraudulent, or wasteful practices and to protect those "whistleblowers" from consequential reprisals by their employers. *Id.*

The Part 708 regulations provide, in pertinent part, that a DOE contractor may not discharge or otherwise retaliate against any employee because that employee has disclosed, to a DOE official, a DOE contractor, or other specified official, information that the employee reasonably believes reveals a substantial violation of a law, rule, or regulation; a substantial and specific danger to employees or to public health or safety; or fraud, gross mismanagement, gross waste of funds, or abuse of authority. 10 C.F.R. § 708.5(a). Employees are also protected from retaliation for refusing to participate in an activity, policy, or practice if the employee believes that doing so would violate

a Federal health or safety law or cause the employee to have a reasonable fear of serious injury to themselves or others, provided that the employee first asks the contractor to correct the violation or remove the danger. *Id.* at §§ 708.5(c), 708.7(a).

Employees of DOE contractors who believe they have been retaliated against in violation of the Part 708 regulations may file a complaint with DOE, and that complaint may be forwarded to the Office of Hearings and Appeals (OHA) for an investigation, followed by a hearing before an OHA Administrative Judge, and an opportunity for review of the Administrative Judge's Initial Agency Decision by the OHA Director. *Id.* §§ 708.22, 708.25, 708.32.

An employee who files a timely complaint has the burden of establishing by a preponderance of the evidence that he or she made a protected disclosure, as described under 10 C.F.R. § 708.5, and that the disclosure was a contributing factor in one or more alleged acts of retaliation against the employee by the contractor. *Id.* § 708.29. If the employee meets that burden, the burden shifts to the contractor to prove by clear and convincing evidence that it would have taken the same action without the employee's disclosure. *Id.* If the complainant prevails, available relief includes reinstatement, transfer preference, back pay, reimbursement of the complainant's reasonable costs and expenses, and such other relief as may be appropriate. *Id.* § 708.36(a).

B. Procedural History

CPCCo has the current contract with DOE for the cleanup of the Hanford Central Plateau area, including the Waste Encapsulation Storage Facility (WESF). Mr. Hall filed his original Part 708 complaint on June 8, 2023, with the DOE Hanford Site (Hanford) Employee Concerns Program (ECP) against CPCCo alleging that he had made several protected disclosures while an employee at CPCCo and that CPCCo retaliated against him on several occasions during and after his employment with the company. The original complaint was subsequently forwarded to OHA on November 16, 2023, and OHA conducted an investigation that was completed on May 8, 2024. After the investigation, the OHA Director appointed me as the Administrative Judge.

On June 7, 2024, CPCCo filed a Motion to Dismiss the Complaint. Mr. Hall filed an opposition brief on June 18, 2024, and CPCCo then requested permission to file a reply to the opposition, which was granted. CPCCo filed its reply on June 26, 2024. Mr. Hall, in turn, filed a Motion to File Restated Complaint Under 10 C.F.R Part 708 on June 27, 2024, and CPCCo filed an opposition on July 8, 2024. Both motions were granted in part and denied in part on September 11, 2024. In partially granting CPCCo's motion, several alleged instances of protected conduct and the alleged instances of pre- and post-termination retaliation were dismissed from the original complaint and Mr. Hall was granted leave to file a revised complaint. Two days later, Mr. Hall filed the Complaint. Then, on October 4, 2024, after the completion of discovery, CPCCo filed a Motion for Summary Judgment and Mr. Hall filed an opposition on October 21, 2024. The Motion for Summary

Judgment was denied on November 1, 2024.[1] Beginning on November 4, 2024, a six-day hearing was held on the Complaint. The parties submitted over 150 exhibits[2] and fourteen witnesses testified at the hearing.

C. Factual Background

On August 22, 2022,[3] Mr. Hall started his employment with CPCCo at WESF as an instrument specialist journeyman technician. Hearing Transcript, OHA Case No. WBH-24-0003 (Tr.)[4] at 112; RX 3 (Offer Letter). WESF is a Hazard Category 2 nuclear facility that stores highly radioactive capsules that contain cesium and strontium submerged under water. Tr. at 45, 113, 693. Cesium and strontium are radioactive waste products left over from extracting plutonium from nuclear fuel. *Id.* at 114.

Mr. Hall joined CPCCo as a probationary employee.[5] *Id.* at 1445–46, 1474 (testimony of Cynthia West, CPCCo labor relations specialist, that all applicants external to CPCCo that are hired into "a bargaining unit role" begin as probationary employees and Mr. Hall applied to the position as an external applicant). He had a four-year degree in Electrical Engineering from Washington State University and was certified as a Bechtel Certified Control Systems Engineer and an Instrumentation, Systems, and Automation Certified Control Systems Technician Level 3. *Id.* at 40; CX 121 at 9 (resume). He also had fourteen years of experience in nuclear facilities, including at Hanford, and the "commercial nuclear industry at power plants for temporary outage work." Tr. at 40; CX 121 at 9. For example, Mr. Hall had worked for Bechtel in 2005 at Hanford as a control system engineer. Tr. at 43, 75. Mr. Hall testified that he sought employment at Hanford because his sister had thyroid cancer which was "closely related to operations at Hanford where they released radioactive material into the atmosphere" and she later died of "a certain rare form of leukemia . . . associated with radiation." *Id.* at 46. He explained that he wanted to make sure the "facilities operate in a safe, reliable manner so there's not a nuclear accident and that people, . . . workers, . . . [and the] public . . . are not exposed to radiation . . . ." *Id.* at 45.

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[1] On this same date, CPCCo's Letter Requesting Clarification filed on October 15, 2024, was granted, striking two newly alleged protected activities from the Complaint.

[2] CPCCo objected to several exhibits offered by Mr. Hall, and several were accordingly excluded from the record as identified in the hearing transcript. Mr. Hall's exhibits are identified by CX and the appropriate page number of the document while CPCCo's exhibits are identified by RX followed by the bates number at the top of the page (excluding the zeros that precede the bates number.) *See, e.g.*, RX 1 at 1 (instead of RX 1 at 000001).

[3] All dates referenced hereafter are to 2022 unless otherwise noted.

[4] The transcript is composed of six different volumes with continuing page numbers.

[5] During the hearing, the parties presented significant evidence regarding whether Mr. Hall should have been hired as a former bargaining member instead of a new employee on probation. However, the record is clear that CPCCo determined that he was not a prior bargaining member entitled to seniority and, from day one, they considered him a probationary employee and took action consistent with that view. *See, e.g.,* RX 52 at 897 (termination letter with the subject line "Probationary Termination" indicating Mr. Hall was considered a probationary employee).

Mr. Hall described himself as somebody who has raised safety concerns throughout his career and suffered punishment as a result. *Id.* at 45–58. Mr. Hall testified that he had utilized Part 708 procedures twice at Hanford before his employment at WESF.[6] *Id.* at 409–10. He explained that it "was an obligation" to make sure the control systems at Hanford operated "safely and reliably." *Id.* at 58–59. He stated that he had filed a successful Part 708 complaint in 2005 after Bechtel terminated him for raising a concern regarding a "substantial and specific danger to the workers or the public health and safety." *Id.* at 59. As a result, he was reinstated at Bechtel in 2008. *Id.* He filed another Part 708 complaint against Bechtel in 2017 after he was terminated subsequent to alleging additional concerns. *Id.* at 62. That second case resulted in a settlement. *Id.* Mr. Hall testified that, based on his experience, ECP and management "circle the wagons" to protect the organization instead of the employees. *Id.* at 63.

Prior to arriving at WESF, Mr. Hall did research into the facility. *Id.* at 115–16, 126. During his research, he viewed a presentation entitled Hanford Challenge which described the dangerous materials stored at the WESF facility. *Id.* at 128. One Hanford Challenge presentation describes the WESF encapsulation basin as "severely damaged" and "failing," which could result in a lack of sufficient water in the basin and the encapsulated cesium being released into the environment. CX 134 at 6, 19–20. Mr. Hall testified that if the pool cells that stored the capsules "were to lose water level and [the capsules] got exposed to air, anybody in that area . . . would die within days from radiation . . . ." Tr. at 114. He believed that WESF was "past its design life" and the "pool cell . . . doesn't have a high enough rating for seismic activity in the area . . . . [s]o . . . a major earthquake . . . could [cause] a nuclear accident." *Id.* at 115. Mr. Hall testified that he also learned about WESF being beyond its design life by reading a DOE announcement but not from any CPCCo materials. *Id.* at 128. He testified that he believed after reviewing the Hanford Challenge materials that WESF is more dangerous than a nuclear reactor because of WESF's vulnerability to severe earthquakes. *Id.* at 130.

Mr. Hall's new position was in WESF's Fuels Facilities Instrument Maintenance group, which was managed by Dave Denson. *Id.* at 608–09. As manager, Mr. Denson supervised two other instrument specialists, Jeff Gibson and James Gjersing. *Id.*; *see also* RX 14 (Organizational Chart). At the time, Mr. Denson had worked at Hanford for fourteen years, and he had twenty-four years of experience including working as an instrument technician, electrician technician, and a field supervisor. Tr. at 607. Mr. Gibson was the lead instrument specialist over Mr. Hall and Mr. Gjersing. *Id.* at 284. Mr. Gjersing was an instrument technician who had eight years of experience working at Hanford. *Id.* at 1071. Mr. Denson's immediate supervisor was the maintenance manager, Scott Garrison. *Id.* at 610, 839–40; RX 14.

The Fuels Facilities Instrument Maintenance group is responsible for maintenance at WESF, and maintenance is accomplished through tasks referred to as maintenance packages (packages). Tr. at

[6] This fact became known to other employees at WESF. For example, Mr. Gjersing testified that he searched Mr. Hall's name about four weeks into Mr. Hall's employment. Tr. at 1112. Mr. Denson testified that he searched Mr. Hall's name online after he learned from Mr. Gjersing that Mr. Hall had previously filed lawsuits against his employer. *Id.* at 766.

286, 616–17, 692, 843. Mr. Garrison testified that the maintenance program framework is described in the Nuclear Maintenance Management Program[7] (NMMP), which outlines the operation standards for Category 2 nuclear facilities such as WESF; the NMMP is derived from DOE Order 433.1B, "which is the guideline to maintaining nuclear facilities;" and the NMMP incorporates the requirements of applicable laws, rules, and regulations. *Id.* at 844–45 (also testifying that the copy in the record at RX 57 was in effect at the time of Mr. Hall's employment); *see* RX 57 at 936, 1079 (referencing DOE Order 433.1B).

Mr. Denson described the process of creating packages by using, as an example, the repair of a pool cell flow switch, which is the subject of one of Mr. Hall's alleged protected disclosures. The creation and performance of packages are driven by DOE work standards and requirements. Tr. at 698–99. The package for repair of a malfunctioning flow switch is created through working with a "planner," the "craft," "radiological techs," and "safety" to create the work steps required to complete the task. *Id.* at 693. Once the steps are determined, the package is generated, and it goes under review for radiation control, safety, and engineering. *Id.* In the case of changing parts that are not like-for-like, the package includes an engineering chance notice (ECN). *Id.* at 693–94; *see also id.* at 844 (Mr. Garrison's testimony that the process for procuring replacement parts is outlined in the NMMP). The package then goes to "operations," who receives the package up to a week before the work is performed. *Id.* at 695. Operations reviews the package and then releases it by handing it to the field work supervisor, like Mr. Denson. *Id.* The package is then reviewed by the supervisor and the supervisor places it on the work schedule. *Id.* Mr. Denson said that he brings the physical package to a "prejob" where the package is discussed at different levels with the employees involved in the work, and their participation in the prejob is recorded by name. *Id.* at 695–96. The package is then held by a responsible individual who watches the package throughout the day and fills out any necessary information, including data sheets. *Id.* at 697.

Michael Gerst, who is a mechanical engineer, Design Authority,[8] and system engineer[9] for the ventilation systems at WESF, and who has worked at the Hanford site for over twenty years and WESF for over ten, also testified that work at WESF is "procedure-driven," and those procedures ensure operations comply with DOE requirements. *Id.* at 802–03. He testified that

> The procedures are written in such a way that the folks that have to perform the procedures don't have to worry about what the upper level requirements are. If they follow the procedures, the procedures will ensure that they do the work compliantly.

Id. at 804.

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[7] Mr. Garrison erroneously referred to the document as "nuclear facility maintenance program" before recalling the actual title when reviewing the NMMP at Exhibit RX 57. Tr. at 844.

[8] An explanation of Design Authority is provided, *infra.* Generally, they ensure work is completed according to national code standards and they are involved in creating packages and approving changes to procedures. Tr. at 976, 978–79.

[9] Mr. Gerst explained that a system engineer deals with "vital safety systems." Tr. at 802–03.

All newly hired employees at Hanford must complete all of Hanford's training courses, which are craft-specific. *Id.* at 688–89. They have to complete various trainings before being permitted to do certain work, like radiological training before being permitted to enter radiological zones or fall protection training before being permitted to work from a height that required fall protection. *Id.* at 1076–77. On Mr. Hall's first day, he was required to first complete training off-site entitled Hanford General Education Training (HGET). *Id.* at 626. Mr. Denson explained that HGET goes over "basically everything that you generally at a hundred-foot level need to know before you even go out on the site[,]" including "all of the agreements, the safeties, [and] the rights." *Id.* at 626–27.

An employee does not receive their badge until they have completed HGET. *Id.* at 627; *id.* at 1270 (testimony of Shawn Olivarez, CPCCo human resources specialist). After HGET, the new employee completes CPCCo General Employee Training (CGET), which is a training module specific to CPCCo. *Id.* at 77, 627. Mr. Denson testified that typically all employees finish CGET on their first day and give him a call afterward. *Id.* at 628. He then directs them to come to the facility so he can give them a tour and show them their workspace. *Id.* Mr. Hall started his HGET training his first day, but he did not contact Mr. Denson on his first day. *Id.*; *see also id.* at 853–55. On the second day, August 23, Mr. Hall had completed HGET but was still working through CGET. *Id.* at 628. Ms. West instructed Mr. Hall to come to WESF and that he could finish CGET later. *Id.* at 629. Mr. Denson said that Mr. Hall later confirmed he had completed his CGET the afternoon of his second day. *Id.* at 639.

Mr. Hall testified that the CGET training encouraged him to report concerns to a supervisor verbally and not in writing or by email, which he considered "kind of odd." *Id.* at 75–77, 510 (stating he "thought that was . . . a way for them to make sure you don't document your concern"). However, he also confirmed that a preemployment document that he reviewed, entitled Code of Ethics and Business Conduct Policy (Conduct Policy), stated that employees could raise concerns to their immediate supervisor or use other avenues to address concerns. *Id.* at 406–09; *see also* RX 5B at 405 (a copy of the Conduct Policy) *and* RX 6 (Mr. Hall's signed acknowledgement of the Conduct Policy and agreement to follow it). Those other avenues included Human Resources (HR) or Labor Relations and CPCCo's ECP. RX 5B at 405. Mr. Hall also testified that the CGET training required him to click through slides that required confirming that he had reviewed the information and sometimes tested the information before continuing. Tr. at 510–12. The CGET training slides included in the record from that training explicitly state that employees are expected to "promptly notify . . . their supervisor of changes in facility status, abnormalities, or difficulties encountered in performing assigned tasks." RX 77 at 1644. The slides further state that employees may raise employee concerns to their supervisors or other individuals using different methods, including in writing. *Id.* at 1657 (suggesting ECP forms, letters, or emails). Mr. Hall testified that, contrary to Mr. Denson's testimony, he completed CGET on August 29. Tr. at 518.

Mr. Hall testified that his approach to raising safety concerns changed over the years given his experience at Bechtel. *Id.* at 101. He used to "first speak up at meeting[s]" and follow up with management "further up the chain of command" by email. *Id.* at 101–02. He said he followed this

strategy twice at Bechtel and he was terminated twice. *Id.* at 102. He said that when he came to CPCCo, he was going to "try not to raise concerns" because he "needed[ed] this job." *Id.* He testified he therefore did not want to pursue his concerns as "so vigorously" as in the past. *Id.* at 416. He also testified that he changed his approach on August 25 after he experienced "retaliatory actions" from Mr. Garrison and Mr. Denson after raising his first alleged safety concern on his second day at WESF. *Id.*

1. Concerns Regarding the Swamp Cooler

On August 23, two days into Mr. Hall's employment, and his first day on-site at WESF, Mr. Hall observed a swamp cooler that he testified was "malfunctioning" and had "a lawn sprinkler on top." *Id.* at 138. The swamp cooler was located at the building known as 225BE. RX 15. Mr. Hall observed the condition at approximately 11:00 a.m. when he arrived at the facility. Tr. at 419. He said that he saw a "super-slick surface" of "algae spread from the swamp cooler downhill on asphalt" that went into a parking lot and people "couldn't avoid it." *Id.* at 139–40. He said that the perimeter was not, and could not, be "cordoned off" because the substance had spread into the parking lot next to the building, and he noted that there were "two orange cones next to the swamp cooler." *Id.* Mr. Hall said the area covered by the algae was approximately twelve feet wide and thirty feet long. *Id.* at 144; *see* CX 34 at 7–18 (photographs of the swamp cooler, orange cones, and water runoff showing a large wet area with one or two visible stripes of green-brown color in the wet surface; there is no sprinkler pictured on the swamp cooler).

Mr. Hall mentioned the swamp cooler runoff to Mr. Denson moments after they first met that morning. Tr. at 139–40. Mr. Denson testified that Mr. Hall said, "there is a lot of water from that swamp cooler." *Id.* at 629. Mr. Denson replied, "yeah, just walk around. Don't walk through the water." *Id.*; *see also id.* at 140. Mr. Denson said they walked around the water, he showed Mr. Hall the location of the orange cones, and they then entered the building where Mr. Denson introduced Mr. Hall to his officemates.[10] *Id.* at 629–30.

The next morning, on August 24, Mr. Hall raised the condition of the swamp cooler in a 6:30 a.m. morning meeting[11] attended by Mr. Denson, Mr. Garrison, and twenty coworkers. *Id.* at 140, 146–47, 77, 421. During that meeting, Mr. Garrison asked if anybody had anything to add. *Id.* at 183. Mr. Hall said that he stated he had "a DOE 10 C.F.R. Part 851 regulation safety and health concern" about the algae by the swamp cooler, "it's really slick," and "somebody can get seriously injured

[10] Mr. Gjersing said that shortly after meeting Mr. Hall on Mr. Hall's first day at the facility Mr. Hall mentioned the swamp cooler water and asked "wouldn't you be concerned . . . you can slip or fall on that?" Tr. at 1080. In response, Mr. Gjersing said he told Mr. Hall that he could write it up in a safety logbook and report it anonymously. *Id.* Mr. Gjersing said Mr. Hall responded by stating, without further explanation, that he could not do it anonymously. *Id.*

[11] Each morning of work, at six o'clock in 225BE, a meeting is held to go over the work assignments for the day and other topics, including safety concerns. Tr. at 636; *see also id.* at 856–57 (Mr. Garrison stating that these meetings are "an opportunity to bring [safety issues] to light"). The morning meetings are attended by all the maintenance fieldwork supervisors and workers. *Id.* at 636.

or die, what can be done to fix this?" *Id.* However, other attendees recall Mr. Hall's statements differently. Mr. Denson recalled that Mr. Hall merely stated he had a safety concern about the water runoff from the swamp cooler. *Id.* at 637–38. Mr. Garrison recalled that Mr. Hall said he had a "safety issue, safety concern . . . . about the water and what appears to be green slime outside." *Id.* at 857.

Mr. Garrison said that he responded to Mr. Hall by stating that they knew about the issue and that they sweep it at least weekly. *Id.* at 858; *id.* at 147, 183 (Mr. Hall confirmed he heard the same). The meeting then continued on. *Id.* at 184. Mr. Hall testified that at the end of the morning meeting on the following day, August 25, Mr. Garrison stated, "[Mr. Hall] raised a safety concern yesterday about the swamp cooler, you know algae. . . . I think I'll have the fitters show [Mr. Hall] the broom so he can sweep the slime from the asphalt." *Id.* at 422; *see also id.* at 868 (Mr. Garrison confirming that he told everybody at the meeting the area needed to be cleaned around the swamp cooler and that they should "grab [Mr. Hall] and . . . get a broom and go out there [] so he can see how we . . . mitigate this swamp cooler area."). Mr. Hall testified that he interpreted the statement as a threat. *Id.* at 99, 147. Mr. Denson recalled things a bit differently in that Mr. Garrison responded by stating that the water is a known issue, it is a team effort to mitigate it, and "I'll make sure that you're [Mr. Hall] involved so that you can see what we do to mitigate that the next time we do it." *Id.* at 638. Mr. Hall did not say anything in response to Mr. Garrison's statement.[12] *Id.* at 423.

Mr. Hall said that he met separately with Mr. Denson and Mr. Garrison on August 25 after the morning meeting. *Id.* at 148. He said that Mr. Denson came to speak to him regarding a new hire checklist and told him that the safety concern he raised during the August 24 morning meeting "didn't go too well" with Mr. Garrison. *Id.* at 185; *but see id.* at 675 (Mr. Denson testifying that Mr. Hall stated, "I brought up a safety concern yesterday, and it did not go over well with Mr. Garrison," which Mr. Denson denied in response). Mr. Hall said that he again told Mr. Denson that the swamp cooler runoff needed to be cleaned because somebody could get injured or killed. *Id.* at 152.

2. Concerns Regarding the Repair of a Pool Cell Flow Switch

On August 30, Mr. Gjersing and Mr. Gibson were tasked with repairing a beta monitor flow switch that had stopped functioning in the WESF Building 225B pool cell area.[13] Tr. at 540–41; RX 21 at 499. The pool cell area contains several pool cells that store encapsulated radioactive material under water. Tr. at 240, 615, 702–03; RX 21 (Pool Cell Engineering Package describing the pool cell beta monitor flow switch task) at 507. Mr. Hall attended the prejob and participated as a "shadow" to observe the work. Tr. at 541, 543, 712.

[12] Mr. Hall testified that Mr. Garrison's statement was intimidating and humiliated him. Tr. at 523.

[13] The malfunctioning flow switch was discovered in April 2022 during a monthly function test—four months before the August 30 repair. Tr. at 701 (testimony of Mr. Denson); *see also* RX 21 at 499 (the Flow Switch Work Package).

The online beta monitor is one of two systems that protects workers located in the pool cell area at WESF in the event that a capsule has a failure and slowly leaks radioactive material into the pool cell water.[14] *Id.* at 980. If the material from such a leak continues to collect, the concentration could reach a level high enough to provide a radiation dose to workers. *Id.* The beta monitor system includes a pump that moves water through a line to a heat exchanger that cools the water heated by the capsules in the pool. *Id.* Attached to the line coming from that pump is a smaller line that contained the flow switch. *Id.* The flow switch is essentially a flat paddle installed in a pipe. *Id.* at 172, 999; *see also* RX 23 (photographs of flow switches). The flow switch monitors the presence of flow in the pipe because there is a chamber down the line from the flow switch that contains a radiation detector that is calibrated to set off an alarm if it detects the slow collection of leaking material in the water. Tr. at 980–81.

The manufacturer of the original flow switch went out of business in the 1970s. *Id.* at 694. Therefore, a like-for-like part was not available. When a part is going to be replaced with a not like-for-like part, an ECN must be created. *Id.* at 694. An engineer named William Zeithaml completed the ECN for the flow switch. *Id.* at 984; *see also id.* at 717 (Mr. Denson testifying that Mr. Zeithaml was the primary engineer on the flow switch ECN, which required two engineers because it was Defense In Depth[15]). Mr. Zeithaml was the Design Authority for miscellaneous instrumentation and control and power systems at WESF. *Id.* at 976, 978–79 (explaining that the Design Authority's "primary objective is to make sure we stay within the . . . safety basis design[,]" which includes observing national code standards; the Design Authority also helps initiate or provides input on preventative maintenance and surveillance; and they are responsible for supervising or approving changes to procedures to make sure work is performed within the safety profile). Several layers of review approved the ECN before replacing the flow switch. *Id.* at 987–91; *see also id.* at 716–17 (Mr. Denson identifying the various parties involved in the flow switch ECN process, including himself; the engineers; instrument specialists; and representation from "waste planning," "oversight," and "RadCon.") *and* RX 21 at 552 (listing the work planning roster). Mr. Zeithaml did the research to identify the electrical and mechanical specifications of the original switch to find a suitable replacement. Tr. at 984; *see* Tr. at 709, 716 (Mr. Denson testifying that Mr. Zeithaml identified two different vendors that produced acceptable replacements for the original flow switch).[16] Mr. Zeithaml identified an adjustable replacement flow switch, and the manufacturer provided technical specifications for cutting or modifying the

[14] The other system is the Area Radiation Monitoring System, which protects against radiation released quickly. Tr. at 979.

[15] The record includes a DOE Office of Environment, Health, Safety and Security presentation on Defense In Depth which states that Defense In Depth is a "fundamental approach to hazard control of nuclear facilities that is based on several layers of protection to prevent the release of radioactive materials." CX 109 at 4. The protective layers are "generally redundant and independent of each other to compensate for human and mechanical failures." *Id.*

[16] As a result, they created two ECNs, one for each replacement flow switch. Tr. at 709.

switch in the field.[17] *Id.* at 715; *see also* 996–97 *and* RX 21 at 517 (identifying that flow switch model V10SS is acceptable replacement), 520 (indicating V10SS is "[f]ield adjustable . . . .").

During the flow switch repair, Mr. Hall accompanied Mr. Denson and Mr. Gjersing to meet with Mr. Zeithaml to retrieve a replacement flow switch. Tr. at 170. Mr. Hall observed Mr. Zeithaml hand Mr. Denson the replacement flow switch for the repair. *Id.* at 170–71. According to Mr. Hall, Mr. Denson told Mr. Hall that as part of the flow switch task, Mr. Gibson and Mr. Gjersing were going to cut the "vane paddle on the [replacement] switch to some unspecified length" using "metal tinsnips or a hacksaw" because it "wouldn't fit in the pipe." *Id.* at 171, 202. Mr. Hall asserted that he asked Mr. Denson at what length the switch was to be cut and Mr. Denson "shrugged his shoulders like he didn't know." *Id.* Mr. Hall testified that Mr. Denson told him that the modified length "should work." *Id.* at 202.

Mr. Hall also accompanied Mr. Gjersing to retrieve a gland or electrical fitting from the "tool crib"[18] as part of the flow switch repair. *Id.* at 228. The gland fitting's purpose is to prevent excess wiring from interfering with the operation of the flow switch. *Id.* at 718. Mr. Hall said that Mr. Gjersing did not know what size or type of gland fitting to use and "just grabbed a bunch out of the drawer [that] had no paperwork with it[] and brought them back to Mr. Gibson . . ." and Mr. Gibson and Mr. Gjersing "tried to figure out which one to install." *Id.* at 228. While present, Mr. Hall did not observe Mr. Gibson actually performing the installation.[19] *Id.* at 545.

At the hearing, Mr. Gjersing explained that the gland fitting he retrieved during the repair was based on the work package instructions, which instructed that he retrieve the fitting from the General Service store stock items, and he obtained several different sizes from the tool crib because he was not sure which size would be a perfect fit.[20] *Id.* at 1087, 1090. Mr. Gjersing also referred to the gland fitting as a "cord grip." *Id.* at 1087. So too did Mr. Zeithaml, who testified that the cord grip for the flow switch was "commercial grade." *Id.* at 985. The package indicates that the flow switch replacement would require "an appropriate sized cord grip," and the cord grip is identified in the items list as "COM'L." RX 21 at 517. Thus, Mr. Gjersing followed the package instructions in retrieving the gland fittings.

Mr. Gjersing said that Mr. Hall questioned why he was grabbing "any old conduit fitting." Tr. at 1090. Mr. Hall testified that he told Mr. Gjersing that "this would never be done at a nuclear facility,

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[17] They determined the proper size for the replacement flow switch after removing and examining the original flow switch during a first attempt at the repair on August 23. Tr. at 710, 715. The final repair was scheduled for August 30 to modify and install the adjustable replacement flow switch. *Id.*

[18] The tool crib is in building 272BB, where General Service rated parts are stored. Tr. at 613.

[19] Mr. Gibson was in a "lower area" that he entered after grating had been removed to provide access. Tr. at 547.

[20] Mr. Gibson ultimately determined which fitting was appropriate to use. Tr. at 1090.

getting parts on the fly." *Id.* at 549. Mr. Gjersing said he responded by explaining that he was following the package instructions. *Id.* at 1090.

Mr. Hall said that, after the task was completed, he said he had a "10 C.F.R. Part 830 concern" because the flow switch was not a like-for-like replacement and "what they did could cause an accident." *Id.* at 549. He said that he told Mr. Denson that "when you make a cut like that, it's not going to meet the quality level it had from the manufacturer." *Id.* at 206. Mr. Hall also said he raised a 10 C.F.R. Part 830 concern regarding the gland fitting. *Id.* at 548. Mr. Hall said that Mr. Denson responded that "they had the correct quality level for the flow switch." *Id.* at 549. Mr. Hall also testified that Mr. Denson never identified the quality level or provided any paperwork or the work package to substantiate the assertion that the flow switch met the correct quality level. *Id.* 206, 209, 545.

Mr. Denson testified to a different interaction with Mr. Hall regarding the flow switch work package. Mr. Denson recalled that after the flow switch replacement was completed according to the package, including completing a successful function check, Mr. Hall asked him if the flow switch was "QL rated"[21] to which Mr. Denson responded affirmatively that "it was Q3, a green tag[[22]], and the green tag is in the package." *Id.* at 713, 719; *see* RX 21 at 550. According to Mr. Denson, Mr. Hall then asked about the gland fitting and whether it was okay to use one that is not QL rated. Tr. at 713. Mr. Denson said that he responded in the affirmative again and stated that "the gland fitting is strictly for wire routing, and it does not need a QL package," to which Mr. Hall responded "Okay." *Id.* Mr. Denson said that he only learned that Mr. Hall had remaining concerns regarding the work package to repair the flow switch on October 4. *Id.* at 719. He also testified that Mr. Hall never asked to see the package. *Id.*

3. Concerns regarding the K1 and K2 Supply Fans

On September 1, 2022, Mr. Hall was assigned to assist Mr. Gjersing on a package that involved two fans at WESF known as the K1 and K2 air supply fans. *Id.* at 160, 264; *id.* at 729 (Mr. Denson described the task as a "switch calibration on an averaging sensor" that is responsible for triggering heaters). The supply fans were located in building 225B. *Id.* at 615. Mr. Hall attended the prejob for this task. RX 42 at 819. According to Mr. Hall, as part of completing the package, two of the three available supply fans were locked out and inoperable. Tr. at 160, 164. Mr. Hall testified that he told Mr. Denson that "you got three supply fans that supply air to the WESF facility, and you've got two out of three locked out." *Id.* at 160. Mr. Hall testified that he then told Mr. Denson "this is a DOE 10 C.F.R. Part 830 nuclear safety concern of mine" and "if this third fan failed . . . then there would be no supply air fan for the WESF facility . . . . ." *Id.* He testified he told Mr. Denson

[21] Mr. Denson explained that when replacing any Defense In Depth equipment, "it has to be a QL rating of a QL3," and the way he verifies that is by checking the "green tag" to make sure the numbers on the tag match the numbers on the item. Tr. at 714.

[22] The green tag is a green label attached to the envelope that contained the replacement flow switch. Tr. at 714. The green tag provides information, including the item description, model number, quality level, inspector, and inspection date. RX 21 at 550.

that "if there was a loss of supply air [then] people could breathe in radiation, radioactive particles." *Id.* at 557. Mr. Hall said that Mr. Denson responded by stating "well, next time I won't do that." *Id.* at 167. At the hearing, Mr. Denson denied that Mr. Hall raised the issue and denied providing a response. *Id.* at 731. Mr. Denson stated that he only learned about Mr. Hall's alleged concerns regarding the supply fans after Mr. Hall's termination. *Id.* at 736.

4. Concerns Regarding the K3N Unit Flow Switch

On September 6, Mr. Hall participated in a task to check the calibration of a flow switch in the K3N unit heater, which itself is part of the K3 ventilation system in Building 225B—the same building that houses the K1 and K2 ventilation systems described above. Tr. at 234, 739; RX 29 at 569 (diagram of K3 ventilation system), 601, (work package) 708 (diagram of K3N heater). Within the K3 system, there is a heater that removes moisture from air coming out of contaminated areas in the building before the air reaches the air filters in the system. Tr. at 740. The moisture is removed to prevent its buildup in the filters. *Id.* Mr. Denson said that the K3N heater has a sensor that will shut the heater off if the air flow in the system drops below 4,000 cubic feet per minute (CFM). *Id.* at 743. Mr. Denson led a prejob for the package that was attended by Mr. Hall, Mr. Gjersing, Mr. Gibson, a facility operating engineer, and a member of RadCon support.[23] *Id.* at 741; RX 29 at 707. The flow switch calibration test required maintaining the balance of the ventilation systems in the building because the K3 system creates suction from the "most contaminated area" in the building.[24] Tr. at 743. Accordingly, during the test, the facility operating engineer shut off the K1 and K2 exhaust fans and manually lowered the K3 exhaust fan flow, reaching 3,911 CFM before the heater tripped. *Id.* at 741, 744. Mr. Denson testified that the heater tripped within the lower level of the tolerable range, plus/minus 100 CFM, which meant the test was successful. *Id.* at 744–45 (referencing RX 29 at 698).

Mr. Hall testified that, while shadowing, he learned that the K3N flow switch had a trip flow tolerance of 4,000 CFM. *Id.* at 246. He said that he also learned from Mr. Denson that it "was tripped at 3,911, which was only 11 cubic feet in tolerance." *Id.* at 247. Mr. Hall testified that he told Mr. Denson at that time that "it's going to drift out of tolerance by the time it's checked again" and "it should be readjusted to 4,000 CFM." *Id.* He also said he specifically told Mr. Denson that his concern was a DOE 10 C.F.R. Part 830 nuclear safety concern and violation. *Id.* at 250. Mr. Hall testified that Mr. Denson responded by stating that he was not going to spend the time doing the recalibration. *Id.* at 247.

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[23] Mr. Hall testified that the calibration task occurred on August 8, however, this is contradicted by the date included in the work package and Mr. Denson's testimony that the calibration work that Mr. Hall described is only consistent with the September 6 work package. Tr. at 741–42. I conclude, after reviewing the evidence, including the work package's instruction to check whether the calibration is 4,000 CFM plus/minus 100 CM, which aligns with Mr. Hall's description of the work, that the September 6 package is related to the work that formed the basis of Mr. Hall's alleged K3N unit concern. *See, e.g.*, RX 29 at 698.

[24] The most contaminated area is known as the Canyon, where the now-submerged capsules were filled with radioactive cesium and strontium. Tr. at 819. Mr. Gerst testified that the Canyon had been decontaminated and is a radiological boundary area without large areas of high levels of contamination. *Id.* at 817.

Mr. Denson testified that after the test concluded he asked for the fans to be turned back on, and Mr. Hall then asked if they were going to adjust the trip value to 4,000 CFM. *Id.* at 745. Mr. Denson recalled that Mr. Hall then stated that it was poor operating or maintenance practice to leave it as-is and that it should be set to 4,000. *Id.* at 746. Mr. Denson testified that there was no requirement to adjust the tolerance. *Id.* at 747.

5. Mr. Hall's Termination from WESF

On October 17, approximately two months after Mr. Hall's first day at WESF, members of CPCCo held a disciplinary review board (DRB) to determine whether to release Mr. Hall as a probationary employee based on concerns raised by other employees and management. RX 48. Mr. Hall was terminated later that day at a meeting attended by himself, an HR representative named Audra Goldie, and Mr. Denson, among others. Tr. at 341. Mr. Hall testified that he was shocked, despite allegedly experiencing several instances of retaliation, because he had done "a good job." *Id.* at 358–59. The record includes the DRB summary of Mr. Hall's documented performance issues, such as failing to report to his work location after completing HGET, and several procedural compliance issues, including that he repeatedly questioned the work performed by coworkers, that his questioning attitude led management to conclude that he did not have sufficient experience to comprehend procedures, and that he lacked "Teaming and Respect."[25] RX 51 at 884–85.

II. Analysis

A. Mr. Hall's Protected Disclosures.

The Complaint alleges that Mr. Hall's above reporting of concerns regarding the swamp cooler condition, the beta flow switch repair, the supply fan maintenance, and the K3N flow switch calibration constituted protected disclosures under Part 708 because he raised substantial violations of DOE regulations and substantial and specific dangers to employees or public health or safety.[26] Complaint at 2–5. In order to carry the initial burden to demonstrate a protected disclosure for reporting an alleged violation of a DOE law, rule, or regulation, a complainant must show that they disclosed information that they reasonably believed would reveal a substantial violation of that law, rule, or regulation. 10 C.F.R. § 708.5(a)(1). Minor or insubstantial issues are not covered. *See Edward G. Gallrein*, III, OHA Case No. WBA-13-0017 at 7–8 (2014). The reasonableness of a

[25] The record is replete with various instances of Mr. Hall's behavior that CPCCo asserts its employees found challenging and unacceptable and various instances of behavior that Mr. Hall believed constituted threatening, humiliating, and retaliatory conduct on behalf of CPCCo. However, that information is not relevant to determine whether Mr. Hall failed to carry his burden to establish that he made a protected disclosure.

[26] The Complaint also asserts that each instance also constituted a disclosure of "gross mismanagement, gross waste of funds, or abuse of authority." Complaint at 5. However, the Complaint does not set out facts to support such a finding. Furthermore, Mr. Hall did not provide any substantive argument on this point or reference any evidence in the record to support such a conclusion in his closing argument briefs.

complainant's beliefs under Part 708 is assessed from the perspective of a disinterested person with knowledge of the essential facts known to and readily ascertainable by the complainant. *Dr. Shou-Yuan Zhang*, OHA Case No. WBA-16-0006 at 5 (2017). Furthermore, the inquiry into whether a danger is sufficiently "substantial and specific" to warrant protection under Part 708 is guided by several factors, including the likelihood of harm resulting from the danger, when the alleged harm may occur, and the nature of the harm, *i.e.*, the potential consequences. *Brien Williams*, OHA Case No. WBH-22-0003 at 11 (2022) (citing *Dennis Rehmeier*, OHA Case No. TBU-114 at 4 (2011)). Assertions of remote dangers, which may or may not occur, do not meet the requirements of Part 708. *See Vincent E. Daniel*, OHA Case No. WBH-13-0006 at 22 (2013) (citing *Chambers v. Dep't of the Interior*, 602 F.3d 1370, 1376 n.3 (Fed. Cir. 2010)).

In the below analysis, evidence not previously referenced will be noted by citation to its location in the record.

1. The Swamp Cooler

The Complaint alleges that Mr. Hall disclosed the presence of a "super slick dangerous . . . algae on sloping asphalt that couldn't be avoided by all employees and was not being properly abated, a substantial violation of . . . 10 C.F.R. Part 851 . . . ." Complaint at 2. The record demonstrates that Mr. Hall could not have reasonably believed the condition of the swamp cooler runoff constituted a substantial violation of a law, rule, or regulation or a substantial and specific danger for the following reasons.

I first conclude that Mr. Hall's evidence regarding the condition of the swamp cooler runoff is not as persuasive as the evidence submitted by CPCCo. Mr. Hall testified that he "knew from years of experience," including mandatory safety training[27] on the dangers of slip-and-falls, that the combination of water and slick algae was "obvious," "unsafe[,]" and a "substantial danger." Tr. at 143. He also testified that he had never seen a Hanford swamp cooler being operated in such a "reckless manner" with a "lawn sprinkler on it." *Id.* Furthermore, he testified that he "slipped on" the algae a few days or weeks into his employment, but he "didn't hit the ground."[28] *Id.* at 140, 145. Further still, Mr. Hall testified that sweeping the runoff just spread the problem and did not solve it. *Id.* at 147. And he testified that the instruction to "walk around it" did not resolve his concern because he believed that somebody could "slide on it" and get injured, hit their head, or die. *Id.* at 140.

The photographs of the swamp cooler runoff display an area near a building covered with water that included strips of a brown-green substance. Mr. Hall took the photographs immediately after the August 25 meeting. *Id.* at 145. However, the images do not include the presence of a sprinkler on the swamp cooler nor demonstrate whether the swamp cooler was malfunctioning. And while

[27] Mr. Hall testified that he had received the training at the National Safety Council. Tr. at 143.

[28] Mr. Hall testified that he did not report the slip because he did not get injured. *Id.* at 519.

CPCCo's witnesses readily described the presence of the swamp cooler and runoff, they did not mention the presence of a sprinkler. Accordingly, I conclude that the swamp cooler did not have a lawn sprinkler that contributed to the runoff. I furthermore conclude that the presence of the water does not establish that the swamp cooler was malfunctioning or being operated in a reckless manner. There is no dispute that the swamp cooler was the primary cooling for the buildings. *Id.* at 682. Mr. Denson explained that as part of the swamp cooler's operation, water drips and there is overflow over the sides that drains below. *Id.* at 683. Mr. Denson's testimony is consistent with the testimony of a CPCCo WESF pipe fitter named Justin Evans who testified that he works on the swamp coolers monthly and that the swamp cooler operates by spraying water over a mat that a fan passes air over to cool the building, and the water runoff is "the nature of the beast."[29] *Id.* at 955, 970. Therefore, the record demonstrates that the runoff was the result of the swamp cooler's normal operation as opposed to reckless operation.

Mr. Hall allegedly referred to 10 C.F.R. Part 851 when he raised his concern regarding the swamp cooler runoff during the morning meeting. Part 10 C.F.R. 851 establishes requirements for a worker safety and health program that reduces or prevents occupational injuries, illnesses, and accidental losses by providing DOE contractors and their workers with safe and healthful workplaces at DOE sites. 10 C.F.R. § 851.1(b)(1). 10 C.F.R. § 851.10(a)(1) states in relevant part that "a Contractor must: Provide a place of employment that is free from recognized hazards that are causing or have the potential to cause death or serious physical harm to workers." However, it does not require DOE contractors to completely eliminate all conceivable risks; instead, it establishes a complex regulatory enforcement regime under which contractors are required to assess risk hazards and then "prioritize and implement abatement actions according to the risk to workers." *Id.* § 851.22(a)(2)(i). For example, to prevent or abate known hazards, contractors are able to select "hazard controls" that are "[w]ork practices and administrative controls that limit work exposures[.]" *Id.* § 851.22(b)(3).

The evidence demonstrates that CPCCo took action to abate or mitigate the known hazard presented by the swamp cooler runoff. CPCCo provided the testimony of Denise Pitts, a board certified industrial hygienist (IH) and safety professional who provided IH and safety services to the WESF facility. Tr. at 1148. She was responsible for ensuring WESF follows 10 C.F.R. Part 851 for worker safety and health, and she described how CPCCo's organizational matrix provides the procedures that have been implemented to cover the topical areas listed in Part 851. *Id.* at 1150–51. She explained that the swamp cooler runoff did not violate any rules or regulations, including

[29] Mr. Evans also provided testimony stating that the orange cones were not placed by the swamp cooler because the runoff presented a hazard. Tr. at 970–71. Instead, he maintained that the cones were merely there for the accumulated water. *Id.* at 971. Mr. Evans's response therefore puts his credibility into question. However, given that his experience is maintaining the swamp cooler, and his testimony regarding the operation of the swamp cooler is corroborated by Mr. Denson's testimony, I have relied upon Mr. Evans's testimony in reaching my conclusion regarding the operation of the swamp cooler and not whether the condition produced by the swamp cooler constituted a hazard.

10 C.F.R. 1910.22, which governs fall hazards associated with walking-working surfaces.[30] *Id.* at 1152; *see* 10 C.F.R. § 851.23(a)(3) (providing that "[c]ontractors must comply with the following safety and health standards that are applicable to the hazards at their covered workplace: . . . . Title 29 C.F.R., [P]art 1910, 'Occupational Safety and Health Standards,' . . . ."). Ms. Pitts also testified that the runoff created by the operation of the swamp cooler constituted a mitigated hazard. Tr. at 1158 (clarifying, under questioning, her earlier testimony that the condition did not present a hazard). Additionally, Mr. Garrison testified that he inspected the area daily as he walked past it into the building, and he directed its sweeping if he determined it was needed. *Id.* at 859. And there is no dispute that workers were directed to sweep the runoff. Mr. Garrison testified that the runoff issue had been occurring for the past two years. *Id.* at 862. And Ms. Pitts testified that nobody had slipped on the water runoff. *Id.* at 1148, 1153. Finally, there is no dispute the area was marked by cones.

Thus, a reasonable person who observed the condition on their first day, and easily avoided it as Mr. Hall did, would have understood that the condition was obvious and efforts were being taken to mitigate the runoff created by the operation of the swamp cooler. Furthermore, as Mr. Hall relies on 10 C.F.R. Part 851 to support his position, those same regulations provide that contractors may take actions to mitigate hazards. Thus, without any indication of what additional expertise he has in 10 C.F.R. Part 851 or 29 C.F.R. Part 1910, I do not find it reasonable for Mr. Hall to conclude that the condition of the swamp cooler runoff, including the efforts CPCCo had taken to address the issue, violated the dictates of 10 C.F.R. Part 851. Furthermore, as he learned more about the condition—that it was swept regularly—it would be even more unreasonable for him to conclude that the condition violated a law, rule, or regulation because it provided evidence that management was taking regular actions to mitigate the avoidable hazard.

Turning to whether the issue presented a substantial and specific danger, I find that the evidence weighs in favor of finding that no reasonable person could have concluded that the swamp cooler runoff presented a substantial and specific danger.

First, Mr. Hall did not present persuasive evidence to establish that there was a significant likelihood of harm from the swamp cooler runoff. Mr. Hall testified that the swamp cooler runoff presented a risk to workers and visitors that sometimes visit the building to attend safety meetings. Tr. at 146. However, as I concluded above, the condition was easily identified and readily avoided. There were cones present to draw attention to the issue and, by Mr. Hall's testimony, he and Mr.

[30] 29 C.F.R. § 1910.22(a)(3) states that an employer must ensure "[w]alking-working surfaces are maintained free of hazards such as . . . leaks, spills, snow, and ice." It defines walking-working surfaces as "any horizontal . . . vertical surface on or through which an employee walks, works, or gains access to a work area or workplace location." *Id.* § 1910.21(b). 29 C.F.R. § 1910.22(d), entitled "Inspection, maintenance, and repair," subparts (1)–(2) state, in pertinent part, that employers must ensure [w]alking-working surfaces are inspected, regularly and as necessary, and maintained in a safe condition" and "[h]azardous conditions on walking-working surfaces are corrected or repaired before an employee uses the walking-working surface again. If the correction or repair cannot be made immediately, the hazard must be guarded to prevent employees from using the walking-working surface until the hazard is corrected or repaired." Thus, these regulations provide that employers may take action to mitigate hazards in accordance with the regulation.

Denson uneventfully navigated the runoff when walking to 225BE on Mr. Hall's first day at WESF. I also concluded that management had been taking efforts to mitigate the condition by sweeping the area to remove the slick substance and thus reduced the likelihood of harm that may result. Lastly, based on my above findings, I find persuasive the conclusion of Ms. Pitts, the IH responsible for ensuring the safety of WESF operations, that the hazard presented by the runoff had been mitigated consistent with DOE regulations and there had been no reports of anybody slipping on the runoff. Accordingly, there was a very low likelihood that harm would result from the swamp cooler runoff.

Regarding when the alleged harm may occur, common sense dictates that when water is present on a walking surface, exacerbated by the presence of slick algae, there is a potential for somebody to walk over it and slip. Lastly, regarding the nature of the harm, Mr. Hall made clear that he was concerned that somebody could fall on the asphalt and be injured or die, which is a potential consequence from the hazard.

After weighing the above evidence, I find that the likelihood of harm was very low, and I therefore conclude Mr. Hall could not have reasonably believed the swamp cooler runoff constituted a substantial and specific danger. Thus, I conclude that his report of the condition does not constitute a protected disclosure.

2. The Flow Switch Repair

The Complaint alleges the following:

> Mr. Hall disclosed to Mr. Denson that the installation of a replacement flow switch and gland connector in the WESF Pool Cell 5 Beta Monitor control system violated U.S. DOE 10 C.F.R. Part 830 nuclear safety management regulation [sic] nuclear safety and quality requirements. Specifically, Mr. Hall reported that:
>
> a. The new flow switch was not an identical replacement for the old defective flow switch.
>
> b. The new flow switch lacked proper documentation to prove it met nuclear safety quality level Q requirements for this application and nuclear safety function.
>
> c. The metal paddle on the new flow switch had been cut to an unspecified length to make it fit, in which it no longer met manufacturer specifications and potentially compromising its functionality.
>
> d. The electrical gland fitting installed with the flow switch also lacked documentation proving it met quality level Q requirements.
>
> Mr. Hall warned that these issues could lead to the flow switch failing to generate an alarm or properly control the water level in the pool cell storing dangerous high-

> radiation cesium and strontium capsules, potentially causing a nuclear accident, a direct threat to the health and safety of WESF workers and the public.

Complaint at 3–4.

The evidence demonstrates that Mr. Hall could not have reasonably believed he was reporting a violation of a law, rule, or regulation or a substantial and specific danger when he raised his concern regarding the beta monitor flow switch repair. I reach my conclusion after considering the below evidence in the record that demonstrates Mr. Hall based his opinion on a misunderstanding of the purpose of the flow switch and therefore the related risk, and his misunderstanding was not reasonable given his experience and the information available to him at the time via the work package and from more experienced WESF workers such as Mr. Denson, Mr. Zeithaml, and Mr. Gibson.

Although the Complaint only references 10 C.F.R. Part 830, Mr. Hall testified that his concerns regarding the flow switch were also based on 10 C.F.R. Part 851 Worker Safety and Health Regulation and the "NQA1 standard." Tr. at 222–23. He explained that 10 C.F.R. Part 851 "broadly states the requirement that the [DOE contractor] . . . is supposed to provide a place that is free of hazards or potential hazards to their workers[,]" and cutting the flow switch to an "unspecified length" presents a substantial and specific danger to people and workers because it "creates . . . a potential hazard that can cause functional failure of that switch, which would cause a nuclear accident at WESF in the pool cell area." *Id.* at 223–24. Mr. Hall testified that he did not observe whether they conducted a function check to test the replacement flow switch. *Id.* at 228 (stating he may have been "directed to leave the pool cell area when they did that"). However, he testified that he still believed, on the hearing date, that "any quality level it may have had . . . was destroyed." *Id.* at 225.

The record demonstrates that Mr. Hall completely misunderstood the function of, and therefore the hazard that could result from, the flow switch. Mr. Hall testified that on August 30, he believed that the flow switch was in a pipe that supplied water to the pool cell, and if there was inadequate flow through that pipe, the water level would drop and expose the stored capsules, and if there was a spark while the capsules were thus exposed, it could cause "an explosion." *Id.* at 174. Mr. Hall stated that he developed this opinion after viewing a Hanford Challenge "video" that described what would happen if the water level sank as a result of "instrumentation failure . . . ." *Id.* Mr. Hall testified that he concluded, based on the information available to him and his experience, that "the most important systems in that facility were in the pool cell area . . . that had to do with maintaining the water level in the pool cell[,]" which he believed included the flow switch. *Id.* at 205. Mr. Hall explained that the flow switch was not a like-for-like replacement and that cutting it to an unspecified length, not by the manufacturer, would destroy the quality level, which Mr. Hall believed was NQA1. *Id.* 174–75. Mr. Hall stated he believed the decision to cut the flow switch was "a compromise hurry up decision, devoid of any proper quality requirements." *Id.* at 228. He further testified that he had never observed a switch at a nuclear facility being cut to an unspecified length and offered the following basis for his concern:

> At a nuclear facility, you just don't hand somebody a switch and say, well, we're going to cut it to some unspecified length. Nobody told me that there was any procedure or design change for that. I just knew it wasn't a like-for-like replacement of the old switch . . . .

Id. at 171; *see also id.* at 227–30. Furthermore, Mr. Hall stated that Mr. Denson stating the modified length "should work" concerned him because in a nuclear environment you cannot just "hope" things work. *Id.* at 202. Mr. Hall's above opinion of the purpose of the flow switch, when compared with its actual function described by the Design Authority, outlined *supra* at Section I.C.2, clearly establishes that Mr. Hall did not understand its purpose.

The record also demonstrates that Mr. Hall did not observe the flow switch being cut to "some unspecified length." Mr. Zeithaml determined where the replacement vane should be cut and confirmed the location with Mr. Gibson before Mr. Gibson performed the field cut.[31] *Id.* at 998–99. Mr. Gibson said that the work package gave "direction to cut the switch to the proper height, we cut the switch, installed the switch, and then we performed . . . a function check . . . more than once." *Id.* at 1046–47; *see also id.* at 995 (Mr. Zeithaml confirming that a successful function test was performed as part of the August 30 repair) *and* RX 21 at 506, 512 (the Engineering Package describing the design requirements of the replacement flow switch and documenting the physical modification of the replacement by field cut). Mr. Gibson also described consulting the manufacturer's manual and with Mr. Zeithaml before making the cut with a hacksaw and filing it off. *Id.* at 1049. Mr. Gibson testified that he chose a hacksaw because he could use a clamp with it before filing. *Id.* at 1049–50. Mr. Gibson testified that he had done similar work of cutting components to manufacturers' specifications. *Id.* at 1054.

Furthermore, I find that Mr. Denson discussed the quality level of the replacement flow switch with Mr. Hall in terms that indicated that Mr. Denson was confident the replacement flow switch was of the appropriate quality level instead of merely shrugging his shoulders in response to Mr. Hall's questions. The flow switch in the pool cell is part of Defense In Depth in the pool cell. *Id.* at 702; *see also* RX 21 (work package stating the same). Mr. Denson testified that as part of the job he had to make sure that the replacement flow switch was therefore rated at QL3, and he verified that it was QL3 by matching the numbers and reviewing the green tag on the flow switch envelope. Tr. at 702. Mr. Denson testified it was reasonable for Mr. Hall to ask whether the items were QL rated, but it was not reasonable for Mr. Hall to have any continuing concern given that he did not ask to see the green tag, the package, or ask Mr. Zeithaml about it. *Id.* at 721. I agree. I further conclude that even if Mr. Denson had shrugged in response to Mr. Hall's question, it would

[31] According to Mr. Zeithaml, Mr. Hall was present when Mr. Zeithaml gave the instructions to Mr. Gibson. Tr. at 999. However, there is no testimony to corroborate this statement and it is contradicted by the testimony of Mr. Hall, Mr. Gjersing, and Mr. Gibson which indicates that Mr. Gibson remained at the installation site and therefore did not speak with Mr. Zeithaml at the time of installation. Mr. Zeithaml may have been mistakenly referring to Mr. Gjersing or Mr. Denson instead of Mr. Gibson, or he may have been mistakenly referring to a discussion that occurred before August 30 given that they planned and attempted an earlier repair on August 23. Tr. at 722–23.

not be reasonable for Mr. Hall to conclude therefrom that the replacement was not appropriately conducted by following the procedures contained in the package or that Mr. Gibson, the person who actually made the cut, did so without following those procedures. Given that Mr. Denson's testimony matches the package in this case, I conclude that it is more credible than Mr. Hall's recollection of their discussion.

Further still, the record is clear that Mr. Hall attended the prejob and therefore had the opportunity to ask any questions he may have had regarding the procedures or the flow switch. *Id.* at 543, 712. Mr. Denson testified that he did not specifically state that the replacement flow switch was Q3 during the prejob but that he did reference the ECN, which necessarily meant that the task involved a not like-for-like replacement. *Id.* at 723–25. And Mr. Hall testified that he had observed the like-for-like standard "extensively" during his prior work, including at Hanford. *Id.* at 201.

Lastly, Mr. Hall testified that he understood that a work package typically contains a procedure and a data sheet to perform the work. *Id.* at 546. The record demonstrates that Mr. Hall never asked to see the work package and confirmed he did not know whether Mr. Gibson had reviewed the work package at the time he raised his concerns. *Id.* at 545. Mr. Hall did observe that Mr. Denson had "paperwork in his possession." *Id.* However, Mr. Hall testified that Mr. Denson should have provided the paperwork to confirm the statement regarding safety quality after Mr. Hall "raised the concern." *Id.* at 551. Mr. Hall said that it was typical to get a copy of the work package.[32] *Id.* at 602.

I conclude it would not have been reasonable for a person of Mr. Hall's experience working at the Hanford site and knowledge of the work package process to conclude the flow switch replacement represented a violation of 10 C.F.R. 830 or any other regulations. Mr. Hall attended the prejob where the ECN was outlined and therefore Mr. Hall should have known that the procedure to be followed would include modifying the flow switch. If he had any concerns about the modification, he could have addressed them at the prejob or at the time he accompanied Mr. Denson to meet with Mr. Zeithaml. The fact that the flow switch would be modified, standing alone, does not provide a reasonable basis to conclude that the quality of the equipment would be destroyed because the purpose of the ECN process is to ensure the not like-for-like replacement meets the same quality level as the original. Mr. Hall knew the ENC process existed, and he did not provide any evidence from which he could reasonably conclude that the ECN process was not followed in creating the package for the flow switch. In reaching my conclusion, I reject the argument that his failure to see the package or any paperwork for the flow switch or gland fitting supports a reasonable belief that the items did not meet the appropriate quality standard. Mr. Hall bears the burden to demonstrate he had a reasonable basis to conclude that he had observed a violation of

[32] Mr. Hall also testified that he did not have access to the diagrams and procedures regarding the installation of the flow switch, which would typically be provided based on his experience previously working for Bechtel at Hanford. Tr. at 230, 234. But he testified he only requested access to this information a week after the installation occurred. *Id.* at 231. Thus, his asserted lack of access occurred after he raised his alleged concern according to the Complaint and therefore does not impact my analysis. Furthermore, my analysis demonstrates that he did have access to the information contained in the package and certainly the information discussed during the prejob.

DOE regulations or a substantial and specific danger; he cannot carry that burden by pointing to a lack of information and misunderstanding when he attended the prejob and did not ask to see the package.

Furthermore, to the extent he did question Mr. Denson and Mr. Gjersing, the responses he received do not support his conclusion that the modification would destroy the quality of the flow switch. When Mr. Hall questioned the quality of the flow switch, Mr. Denson responded using appropriate technical language that the replacement and gland fitting met the quality standard and offered him the ability to review the package. Even Mr. Gjersing's response, that he followed the procedure, is consistent with how instrument technicians complete the work. As Mr. Gerst explained, the package provide the procedures, and the instrument technicians follow the procedures without having to understand the upper level requirements. Thus, Mr. Gjersing's and Mr. Denson's responses do not support Mr. Hall's conclusion that the gland fitting did not meet the quality level requirements. Furthermore, had Mr. Hall examined the package, he would have reviewed the information described above that establishes his opinion was incorrect. I therefore conclude that Mr. Hall could not have reasonably believed he reported a substantial violation of a law, rule, or regulation when he raised issues concerning the flow switch and gland fitting.

I also conclude that Mr. Hall could not have reasonably believed that he was reporting a substantial and specific danger. Based on the above evidence, no reasonable person would conclude that there was any likelihood of harm that would result from the repair of the flow switch. Mr. Hall alleged that his concern was based on his understanding that a malfunction in the flow switch might result in the emptying of the pool cell, which would result in hazardous material being exposed to air and a nuclear explosion. However, his understanding of the purpose of the flow switch was incorrect given its actual function, as described by Mr. Zeithaml. Furthermore, even if his professed understanding of the function of the flow switch had been correct, Mr. Hall attended the prejob where the need to modify the flow switch was discussed; he spoke with and received information regarding his alleged concerns from two, more experienced WESF employees, including his supervisor who offered him the opportunity to review the package; and he had experience working at nuclear facilities and allegedly understood the ECN framework. It would therefore be unreasonable for him to dismiss all of that information and instead interpret Mr. Denson's alleged shrug, Mr. Gjersing's reference to just following procedure, and a failure to see paperwork as support for a concern that the quality of the flow switch was destroyed and a nuclear accident was therefore potentially imminent. Mr. Hall cannot both rely upon his purported experience working with packages and ECNs at nuclear sites, including Hanford, to support his claim he was concerned about the actions of the WESF workers to successfully replace the flow switch while simultaneously refusing to interpret his observations of that work through that same lens. Furthermore, the package demonstrates that Mr. Gibson and Mr. Gjersing followed the outlined procedures when accomplishing the tasks that Mr. Hall raised concerns over. A reasonable person in the position of Mr. Hall could have readily ascertained the above facts, in addition to what was directly told to Mr. Hall by Mr. Denson and Mr. Gjersing, and those facts demonstrate that Mr. Hall's belief regarding the work and the risk it presented was incorrect. Since Mr. Hall held an incorrect understanding of the function of the flow switch and the hazard that could result

from its malfunction, he was wrong that the replacement did not meet the appropriate quality level, and he could have easily obtained information to dispel his incorrect understanding by reviewing the package, Mr. Hall could not reasonably believe that the repair of the flow switch presented a substantial and specific hazard. *Zhang* at 5; *see also Dongwook Lee v. Dep't of the Army*, 2021 MSPB LEXIS 3140, *13 (2021) (finding that a complainant's belief was not reasonable because the facts known to or reasonably ascertainable at the time indicated the complainant's belief was incorrect). Accordingly, I conclude that Mr. Hall failed to demonstrate that a reasonable person could have concluded there was any risk or likelihood of harm resulting from radiation exposure or an explosion as a result of the flow switch repair.

3. The K1 and K2 Supply Fan Maintenance

The Complaint alleges the following:

> Mr. Hall disclosed to Mr. Denson that taking two of the three air supply fan trains out of service simultaneously for maintenance is a substantial violation of 10 C.F.R. 830[33]. . . and it puts at risk the health and safety of WESF workers from exposure from breathing in radioactive contamination if no supply fan was in operation . . . . [because] if the third supply fan were to fail . . . there would be no supply fans ready to supply outside air to WESF, potentially exposing workers to radioactive contamination and risking public safety if the facility could not maintain negative pressure to properly filter air before discharge to the atmosphere."

Complaint at 3. The evidence demonstrates that Mr. Hall did not actually state a concern to Mr. Denson regarding the K1 and K2 supply fans as alleged in the Complaint, and, even if he had, he could not have reasonably believed he was reporting a violation of a law, rule, or regulation or a substantial and specific danger.

First, the record demonstrates that Mr. Hall did not understand the operation of the supply fan systems at Building 225B. There are four ventilation systems connected at WESF, identified as K1, K2, K3, and K4. RX 27. Mr. Denson testified that the building is designed so that the exhaust fans create and maintain a vacuum that brings air inward into the building. Tr. at 728. However, the supply fans, such as the K1 and K2 supply fans, are used for "convenience heating and air." *Id.* at 729. Mr. Gerst, the technical authority for the supply and exhaust systems confirmed the same. *Id.* at 804. Mr. Gerst testified that the exhaust fans drive the confinement and containment of hazardous material, not the supply fans. *Id.* at 809. Mr. Gerst testified that the K1 exhaust system is Defense In Depth. *Id.* at 805–06. The K1 supply system and the K2 supply and exhaust systems are General Service along with the K3 exhaust and supply systems and the K4 supply system, which means they are built and maintained to general industry standards and therefore are not part of the nuclear safety management system at WESF. *Id.* Mr. Gerst testified that if the K1 and K2

[33] The Complaint also asserts the supply fan maintenance work violated 10 C.F.R. §§ 851.10(a)(1), 830.122, 830.201, and 830.202. Complaint at 3.

supply fans were shut down for any reason, there would be no nuclear safety implications because they do not provide "containment or confinement for any nuclear areas." *Id.* at 806.

By contrast, Mr. Hall testified that he raised his concern regarding the K1 and K2 supply fans because the third fan failing would mean that the facility could not remain at a "progressively negative pressure as you went into progressively more contaminated areas before that contaminated air was filtered . . . and then the cleaner air discharged to the atmosphere." *Id.* at 164–65. He said that if the air was thus discharged, then people who lived downwind could get cancer from the radiation. *Id.* Therefore, he believed that the supply fan being out of service put the employees at risk of breathing in air contaminated with radioactive particles. *Id.* at 167. Mr. Hall testified he never examined a diagram of the area or the fans prior to assisting Mr. Gjersing on this maintenance task. *Id.* at 555. He based his opinion that the issue could result in a catastrophic incident on his experience in the nuclear industry, his two-year degree in instrumentation controls and his degree in electrical engineering, coupled with the fact he had worked on supply fans at other nuclear facilities as a technician and "helped design supply fan trains at Hanford" as an engineer. *Id.* at 555–56. Given Mr. Hall's claimed experience designing supply fan systems, I conclude that the evidence in the record, including the testimony of Mr. Gerst and Mr. Denson regarding the operation of the supply fans in Building 225B, establishes that it would have been unreasonable for Mr. Hall to hold the above belief.

The record also demonstrates that Mr. Hall should have understood that the K1 and K2 supply fans were not going to be turned off during the maintenance work because he attended the prejob briefing led by Mr. Denson. *See id.* at 732. Mr. Hall is identified on the September 1 package prejob roster along with Mr. Denson, Mr. Gjersing, and Ms. Pitts. RX 42 at 819. During the prejob, Mr. Denson stated that the workers could shut the K1 and K2 supply fans off to reduce noise while performing the task, and the workers, including Mr. Gjersing, decided not to shut them down. Tr. at 732–33. Mr. Denson testified that the K1 and K2 supply fans kept running along with the K3 fan during the maintenance work. *Id.* at 735. I therefore conclude that no reasonable person would conclude that the K1 and K2 supply fans were shut down.

I further conclude that Mr. Hall did not raise a concern to Mr. Denson regarding the supply fans. I have already concluded that portions of Mr. Hall's testimony lack credibility, including his testimony that the swamp cooler had a sprinkler, that the swamp cooler runoff was unavoidable, or that he slipped on the swamp cooler runoff. *See also supra* at I.C. (Mr. Hall stating that the HGET training encouraged only verbal raising of concerns while confirming the training indicates employees can raise concerns in writing). Here, his alleged specific reference to 10 C.F.R. Part 830 when raising a concern to Mr. Denson is directly contradicted by Mr. Denson's denial that Mr. Hall made any such statements. I find credible Mr. Denson's denial that he told Mr. Hall he would not turn off two out of the three fans again because Mr. Denson did not turn off the fans and, even if he had, it would have been an acceptable procedure to complete the maintenance work—Mr. Denson would therefore have no reason to respond in the manner described by Mr. Hall. Furthermore, Mr. Denson has acknowledged in his testimony other instances of Mr. Hall raising

alleged safety issues, so I find it unlikely that here he would falsely deny that Mr. Hall expressed concerns regarding this incident.

However, even if Mr. Hall had stated the alleged concern regarding the violation of DOE regulations, I would find that he did not make a protected disclosure. The K1 and K2 supply fans were not shut down or "locked out" during the maintenance. Considering that Mr. Hall's alleged protected disclosure is based on his concern for what could happen if the two fans were shut down, I conclude that he could not have held a reasonable belief that the work constituted a substantial violation of a law, rule, or regulation or presented a substantial and specific danger. Even if they had been shut down, the testimony of the relevant authority, Mr. Gerst, persuasively establishes that there would be no risk of a hazardous nuclear event, as alleged by Mr. Hall, because of the role the K1 and K2 supply fans play in in the facility's heating and cooling systems. Mr. Hall's reference to his general background and expertise working on nuclear sites does not establish how a reasonable person in Mr. Hall's position would conclude that the K1 and K2 supply fans being shut down risked workers or the public being exposed to contaminated air.

4. K3N Unit Flow Switch Calibration

The Complaint alleges the following:

> Mr. Hall disclosed to Mr. Denson the DOE 10 C.F.R. Part 830[34] nuclear safety and quality substantial violations concern of his that the nearly out of tolerance level of a K3N unit low flow switch trip point associated with the WESF K3N control system ventilation duct system must be adjusted closer to the required trip point . . . and warned that:
>
> a. The flow switch was only in tolerance by 11 cubic feet per minute and would likely drift out of tolerance within 12 months, such that the switch should be adjusted close to required trip close of 4000 CFM so this system reliably and safely operates to protect the health and safety of people.
>
> b. An out-of-tolerance flow switch could shut off the K3N stack system, leading to a lack of filtration of radiation particles in the K3N stack flow stream.
>
> c. This issue could result in improper filtration of contaminated air before discharge to the atmosphere, posing risks to workers and the public.

Complaint at 4. The evidence demonstrates that Mr. Hall could not have reasonably believed that he was reporting a violation of a law, rule, or regulation or a substantial and specific danger when he allegedly raised concerns regarding the K3N flow switch. My reasoning here follows my above reasoning regarding the K1 and K2 supply fans in that Mr. Hall, again, did not understand the

[34] Mr. Hall again referenced the following additional DOE regulations: 10 C.F.R. §§ 851.10(a)(1), 830.122, 830.201, and 830.202. Complaint at 4.

purpose of the K3N flow switch or the consequences that might result from a failure to recalibrate it.

Mr. Hall said he believed that the K3N unit had a fan and filters that filtered radiation out of the air coming from the WESF facility before it went up the stack and downwind from the facility. Tr. at 243–44. He believed that the flow switch at issue checked the flow of "dirty radioactive air." *Id.* at 244–45. Mr. Hall testified that if the flow switch drifted out of tolerance "it would . . . shut the flow stream off and there would be no filtration of radioactive particles." *Id.* at 248. Mr. Hall said that if there was no flow and a "leak in the ventilation duct," then contaminated air could escape and expose facility workers throughout the facility. *Id.* at 246–47.

As for why he believed it was concerning that the flow switch was not calibrated to 4,000 CFM despite being in tolerance, Mr. Hall said that it was "nearly out of tolerance" and that "regulations have certain quality requirements that they require." *Id.* at 564. He testified that 10 C.F.R. Part 830 provides a general description of the safety baseline that has to be maintained at nuclear facilities like WESF, and the quality of devices in the WESF systems must be maintained in accordance with 10 C.F.R. Part 830. *Id.* at 250–51. He explained that the flow switch would not be checked for another six or twelve months, the flow switch was "almost 100 out of tolerance[,]" it would not take that long to drop eleven more CFM and out of tolerance, and "then it would cause a nuclear accident." *Id.* at 247–48. He also testified that it is just "standard practice" to recalibrate instruments if they are not going to be checked for another year. *Id.* at 248. He also testified that at "[m]any facilities . . . the reasonable thing to do is . . . adjust it so it's close to the specified value of 4,000 CFM." *Id.* at 249. Mr. Hall stated that he based his concern on his experience at Hanford as an Instrument Specialist Technician, as a Control Systems Engineer, and his experience as an Instrument Mechanic Journeyman Technician. *Id.* at 248.

Mr. Hall was correct that the flow switch is calibrated annually. *Id.* at 814. However, Michael Gerst, who is a mechanical engineer and the Design Authority and system engineer for the ventilation systems at WESF provided a different explanation for the function of the K3N flow switch. *Id.* at 802–03. The K3N flow switch is a protective measure for the heater that is part of a system that prevents the heater elements from damage by shutting down the heater if there is low or no air flow in the system. *Id.* at 812–13. The package for the K3N maintenance, in the section entitled Scope, states that the "work instruction provides the needed steps to function check [the flow switch] . . . which ensures shut down of the K3 Heater upon low flow indication." RX 29 at 700. Mr. Gerst further explained that "the system is built with redundancy" and has "multiple items, such as the alarms and . . . interlocks . . ." to prevent the heater from being damaged, which would result in a higher moisture content reaching the separators or filters. Tr. at 836. He also testified that if too much moisture got through, the system would shut down if the filters "got out of compliance." *Id.* Stated differently, if the heater flow switch failed to identify the absence of sufficient flow, and the temperature interlock failed to shut down the heater element, then the resultant buildup of heat could damage the heating element to the point that it would stop removing moisture, which would place more work on the K3N moisture filters and result in more moisture reaching the moisture collection system. *Id.* at 833–35. Mr. Gerst said that the flow switch

calibration protects the heater elements and that it is impossible for the flow switch to result in a release of radiation.[35] *Id.* at 815.

Mr. Gerst also testified that the 4,000 CFM tolerance in the work package and the allowable plus/minus CFM is set to ensure safe operation. *Id.* at 818. Contrary to what Mr. Hall proposed, Mr. Gerst said that it could not be independently changed by a person in the field. *Id.* Mr. Gerst testified that while he had the authority to change the range, the current range "is a fairly tight tolerance" and "it was set with study and prudence." *Id.* at 819. He also testified that the September 6 K3N task was conducted appropriately because the flow switch was "within tolerance." *Id.*

I first find that Mr. Hall could not have reasonably believed that the failure to adjust the calibration, once it was determined to be within the tolerance identified in the package, constituted a violation of 10 C.F.R. Part 830 or any other law, rule, or regulation. 10 C.F.R. Part 830 provides quality assurance requirements for contractors conducting activities that may affect nuclear safety at DOE nuclear facilities. 10 C.F.R. § 830.120. For example, 10 C.F.R. § 830.122(e)(4) states that contractors must conduct work in accordance with the quality assurance criteria, which includes "[c]alibrat[ing] and maintain[ing] equipment used for process monitoring . . . ." Similar to the other maintenance tasks, Mr. Hall attended the prejob for the K3N. He therefore was privy to the information regarding the maintenance task and could have asked questions or asked to view the package if he had concerns about the parameters of the work task. Had he reviewed that information, he would have seen the package instructions which set out the acceptable tolerance level for the flow switch determined by the Design Authority for the ventilation systems at WESF. Given the package lays out the procedure to follow to complete the calibration, the current range is appropriate to ensure safe operation, and the work was successfully completed according to the instructions, it would be unreasonable to conclude that the maintenance work violated a law, rule, or regulation.

Furthermore, regarding Mr. Hall's asserted concern for what may result if the flow switch dropped out of tolerance, I am again persuaded primarily by the testimony of Mr. Gerst and the package instructions and conclude that the purpose of the flow switch was not to detect the presence of contaminated air or ensure filtration of radioactive particles. The flow switch instead ensured that the K3N heater turned off if at risk of damage due to the lack of airflow, and the worst case scenario that would result from the flow switch not operating properly is damage to the K3N heater's heating element. Since Mr. Hall held an incorrect understanding of the function of the K3N flow switch and the hazard that could result from its malfunction, and he could have easily obtained information to dispel his incorrect understanding by reviewing the package, Mr. Hall could not have reasonably believed that the flow switch dipping out of tolerance presented a risk of unfiltered contaminated air being released into the atmosphere. Accordingly, I conclude that the concerns he raised regarding the K3N calibration task did not report a substantial violation of a law, rule or regulation or a substantial and specific danger.

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[35] Mr. Denson testified that a failure of the heater flow switch to trip could possibly result in a fire inside the system. Tr. at 742–43. However, there is no evidence in the record regarding what would result from a fire in the system nor was that potential result raised in the Complaint or Mr. Hall's testimony.

Since Mr. Hall failed to establish that he made a protected disclosure under Part 708, he has not met his burden to demonstrate that such a disclosure was a contributing factor in one or more acts of alleged retaliation by CPCCo. 10 C.F.R. § 708.29. Therefore, the burden of proof does not shift to CPCCo, and I will not consider whether CPCCo would have terminated Mr. Hall's employment regardless of his alleged disclosures.

III. Conclusion

For the aforementioned reasons, I determined that Mr. Hall has not established that his alleged disclosures were protected conduct under Part 708. Thus, he cannot demonstrate that one or more protected acts contributed to any alleged acts of retaliation by CPCCo.

It Is Therefore Ordered That:

(1) The Complaint filed by Mr. Curtis Hall II on September 12, 2024, OHA Case No. WBH-24-0003, is hereby DENIED.

(2) This is an Initial Agency Decision, which shall become the Final Decision of the Department of Energy unless a party files a notice of appeal by the fifteenth day after the party's receipt of the Initial Agency Decision, in accordance with 10 C.F.R. § 708.32.

James P. Thompson III
Administrative Judge
Office of Hearings and Appeals