

1 listen to them, but our direction from a contract
2 perspective comes from those selected individuals.

3 CHAIRMAN CONWAY: Okay. I might say we
4 have a list here that runs more than, I forget, three
5 or four pages over the years where contractors were
6 going down the road that would have been a major
7 problem from a safety point of view, and it was the
8 Facility Reps that caught it. We just had one this
9 past week, not at your location, elsewhere, but it's
10 a serious problem, and if it hadn't been for the
11 Facility Rep, it would have been really -- it could
12 have been a bad accident.

13 MR. PEDDE: (Nods).

14 CHAIRMAN CONWAY: Thank you, gentlemen.
15 Incidentally, Bob, I agree with the Vice Chairman
16 that on the basis what you fellows have had on the
17 self-assessment has been the best that we have
18 observed. I would agree with him on that, and I hope
19 you'll keep it, and you don't let it weaken.

20 MR. PEDDE: I have no intention of
21 changing it.

22 CHAIRMAN CONWAY: Okay. Keith? Keith,
23 I'm going to encourage you and Mr. Gallagher to
24 whatever extent you can, to summarize some of it, and
25 we'll take your whole statements if given, but please

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1 -- we welcome you here, Keith.

2 MR. KLEIN: Thank you. I wanted to use
3 this first view graph to just illustrate a few
4 points, if we can get it up there. Thank you. Let
5 me just start with the work itself, and just a couple
6 of observations here that I know that you're all
7 familiar with, but we do a wide range of work at the
8 site, spent fuel stabilization, D&D of an old
9 building, soil remediation on shipping, and it covers
10 a wide geographic area. The Site itself is 500
11 square miles, 100 square miles of that which these
12 particular activities are going on.

13 So with that then, let me just briefly
14 describe the organizational philosophy with respect
15 to oversight. First, of course, line management is
16 responsible. That authority flows directly from the
17 Assistant Secretary Roberson through Chief Operating
18 Officer Paul Golan to me, as the head of contracting
19 activity, through the contract to Ron Gallagher, and
20 from Ron Gallagher down to the facilities at the
21 working level. I hold the contractor accountable for
22 its safety performance, and my organization supports
23 me in the execution of my line management
24 responsibilities.

25 As part of that I have two what I call

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1 mission elements, one responsible for restoring the
2 river corridor, the other responsible for
3 transitioning the central plateau. Separate from
4 that, I have an Assistant Manager for System
5 Engineering, Shirley Olinger, who is here today, and
6 I think you know Shirley, that she's smart,
7 competent, tough, and certainly not averse to making
8 her feelings or views or concerns known to anybody at
9 any time. Part of her responsibility includes
10 programmatic, safety programmatic oversight. The
11 Facility Reps report to Shirley, they work very
12 closely with the folks in the mission element --

13 VICE CHAIRMAN EGGENBERGER: That's new
14 then, is it not?

15 MR. KLEIN: No. It's been that way for
16 several years. It --

17 VICE CHAIRMAN EGGENBERGER: That the
18 Facility Reps that report to Shirley?

19 MS. OLINGER: Since May of last year.

20 VICE CHAIRMAN EGGENBERGER: Oh, okay.

21 MR. KLEIN: Well, since Shirley was in
22 that function, but when I got there four or five
23 years ago I changed the organization to have the
24 break-up what I considered stove-pipes, where the so-
25 called line element -- I mean, this is part of

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1 changing, going from managing the contractor
2 personnel to managing the contract was part of
3 breaking that all up. There was just too much
4 authority vested in what was then called the line
5 organization that I felt I wasn't getting a good
6 stereoscopic view of what was actually going on at
7 the Site.

8 Then another feature I would point out is
9 what's set up as the Office of Independent Oversight,
10 which is kind of my internal watchdog organization
11 that's helping me assess whether these different
12 elements are doing what they're supposed to be doing
13 as laid out in our program description and
14 procedures. Part of one of our lessons learned from
15 this last year in following up on the sludge incident
16 was that I needed to further clarify responsibilities
17 for oversight of certain programmatic things like
18 conduct of engineering within the contractor's
19 organization, and so we've done a number of things to
20 strengthen and clarify the role of the mission
21 elements versus Assistant Manager for Safety and
22 Engineering in that respect.

23 Then let me turn to the program for
24 oversight of the contractors. Submitting for the
25 record a program description document that formally

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1 describes the -- how oversight authorities are
2 derived, starting from the Atomic Energy Act, so this
3 is for all of the staff to be able to read and
4 understand the reasons we're doing what it is that
5 we're doing. It describes different types of
6 oversight, establishes, including operational
7 awareness, what the Facility Reps do on a day-to-day
8 basis, what we do through management walk-throughs,
9 and so forth, surveillances and assessments, how and
10 when you use those different tools, the frequencies
11 which they'll be done, and establishes oversight
12 responsibilities. The program description is
13 certainly not perfect, we're continuing to improve
14 it, but at least it's there and it's moving towards a
15 -- away from an expert-based system on how we do
16 oversight to a more systems-based where it is
17 articulated, and expectations are very clear to
18 everybody. What I described was basically one of
19 the, you know, program in that overall program
20 description, RL [Richland] oversight of contractors.
21 We have other program description documents that are
22 summarized here that are part of our Richland
23 Integrated Management System and part of this effort
24 to make more rigorous how we conduct our business at
25 Richland. It includes a description for the

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1 Facility Rep program, how we -- training
2 qualification of personnel performance surveillances
3 and assessments, and specifically a system safety
4 oversight. Also you'll notice that as part of this
5 Integrated Management System we have written
6 procedures, cross-cutting procedures, then
7 organization-specific procedures. Specifically in
8 your lines of inquiry you want to know how we do
9 oversight, how we do the planning for that and how it
10 gets integrated with the contractors.

11 I call attention to one of the procedures
12 called Integrated Evaluation Planning, which is a
13 document that is updated quarterly, and we have a
14 very specific procedure for how we put that together,
15 that lists all the contractor assessments, it lists
16 all the Richland formal oversight assessments,
17 surveillances, and so forth, that are planned by
18 quarter. We've done that to remove some of the
19 redundancy so that I, or Mr. Gallagher, anyone on the
20 Site at any given time knows who is assessing what,
21 in what facility, and where, so that helps in case we
22 want to piggy-back or if Headquarters wants to come
23 in and be part of oversight of something, they can
24 see when it's scheduled, and the purpose of updating
25 it quarterly, of course, is to take advantage of

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1 anything that we're observing, any new plans for
2 work.

3 The process for updating that involves
4 Shirley convening first, on the Richland side, the
5 applicable mission element, going over all the
6 performance indicators, accidents, investigations,
7 concerns that are happening, mission element gone
8 over, similarly their observations, concerns, what
9 work is coming up, more concerns, then we make
10 adjustments as far as planned oversights, and then,
11 of course, at any given time, we can do for cause
12 investigations or assessments.

13 I'd also call attention to the training
14 qualification program for assessors. So far, 76 of
15 my staff have attended that program, and that's
16 shaping up well.

17 Lastly, I'll call attention to the
18 corrective action management process. It defines our
19 process for corrective action management, depending
20 on significance of deficiencies, will require
21 corrective action program or may require for us to do
22 a verification of the effectiveness before they
23 start, but just to summarize some of the key
24 assessments, we did the planned and for cause
25 assessments last year. I think you're familiar with

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1 a number of those. You know, lockout/tagout
2 obviously was an area of major concern, as was sludge
3 water system design and start-up and what happened
4 there, how did we get so far along without, you know,
5 to the point of the contractor declaring readiness
6 prematurely? Once again, in the K-Basin safety
7 culture systems engineer program reported a number of
8 deficiencies there and what we needed to do to
9 correct that. I also used -- part of my oversight
10 last year focused on 14 key performance indicators to
11 routinely monitor safety performance. You can see a
12 dashboard-type of format where we can see for any
13 particular quarter how we rated the contractors based
14 on our observations and data, will look at what the
15 contractor says, but this is focusing on 14 things
16 that are of particular concern to us.

17 We trend -- see the arrows on this one,
18 improving or not, and again, we used that, and we go
19 over these things quarterly with the contractor, in-
20 house monthly, our staff goes over it, updates it, we
21 -- I'll be adding a number of things this next year
22 and doing some further modifications, particularly
23 tracking delinquent corrective actions, looking at
24 the USQ [Unreviewed Safety Question] process,
25 particularly monitoring differing readiness

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1 activities and things going on as planned and
2 scheduled.

3 It is part of our planning for oversight,
4 as I said before, we take into account any number of
5 things. A certain amount of surveillance is required
6 by different orders, you know, to be done annually,
7 but then we also have the for cause and just areas of
8 concern. This is just summarizing, shows where our
9 areas of concern are next year. I know the new DOE
10 policy talks about scaling back oversight as we get
11 more confidence. We're actually going on a number of
12 planned assessments, oversights for next year is
13 going up, and that's for a number of reasons, but
14 including a number of new starts, concerns from the
15 past year of performance, a number of reasons like
16 that.

17 As far as questions regarding technical
18 staffing, this just basically shows how our technical
19 staff are distributed within the organization. You
20 can see by degrees and also by people who are in the
21 Tech Qual Program, or professional engineers, STSMs
22 [Senior Technical Safety Manager], Fac Reps. One
23 thing I didn't point out before was we have a group
24 set up called the Program Management Support Division
25 under System Manager for Administration that provides

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1 matrix support for the other different elements. So
2 if we need to do additional assessments, we call on
3 that group to help, and we set up certain projects
4 through the mission elements; people are coming and
5 going from that one. They're not on-call and
6 assigned to one of those, they're available for
7 training so they can sharpen up their skills in other
8 areas as we're looking ahead at our human capital
9 strategy and whether it's going to be the skill mix
10 in the future. So part of it is dynamic environment
11 where things are changing daily on the Site and it's
12 not just a continuous operation. We want to keep our
13 skills matched with the work, and so trying to
14 forecast ahead of time what skills are going to be
15 needed a couple of years down the road.

16 You asked, describe the site's corrective
17 action program with particular emphasis on how it's
18 integrated with the contractor's oversight program.
19 I'd say corrective action program in the context you
20 described falls in two categories we do to identify
21 problems, and then what we do to fix problems through
22 quality improvement. I already talked about on the
23 problem identification side -- things we do to
24 integrate our plans with oversight plans, the formal
25 planned ones with the contractor, this integrated

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1 evaluation plan.

2 As I talked about before, the RL internal
3 program for developing that -- they do the same thing
4 on their side -- the two sides come together, and we
5 adjust schedules accordingly to remove any redundancy
6 in that. As far as the quality improvement, it
7 covers efficiency evaluation, causal analysis, the
8 usual things, but I'm here to tell you today that
9 we're certainly not at a point where we're
10 sufficiently confident in the contractor's program to
11 back off on our oversight. To the contrary.

12 Moving then to some lessons learned from
13 the Columbia Accident, you know, one of the lessons
14 in there is lack of independence, checks, and
15 balances in the organizational structure. The budget
16 and schedule pressures in their observation reduced
17 the technical capability of oversight organizations.

18 As I've said before, I've taken deliberate steps to
19 achieve independence in the safety oversight through
20 having the Fac Reps being able to report up through a
21 different chain.

22 Identifying -- problem identification,
23 I've done things to improve how the mission element,
24 what all is encompassed in their oversight of the --
25 on the production side, the getting the work done.

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1 We're doing things to improve the corrective action
2 system, and certainly we're using metrics for making
3 cost schedule and safety.

4 With respect to attitude and safety
5 culture, that is covered as part of the Columbia
6 Accident, lack of intellectual curiosity and
7 skepticism, certainly we're very mindful of that.
8 I'm making very deliberate efforts to query, whether
9 it's in my weekly meetings with the senior manager of
10 the contractor site or our mission elements and their
11 interaction with counterparts in the organization and
12 with Fac Reps, and it's just a matter of drilling
13 down and you know, asking the what-if questions.
14 Certainly I'd also try to encourage, you know,
15 differing professional opinions and not shooting the
16 messenger, just being mindful of that environment.

17 With respect to lessons learned in the
18 Columbia Accident Investigation by decision-makers
19 not hearing the facts on technical issues, the issues
20 getting rolled up or dummed down, we have regular
21 plan of the day meetings that is a roll-up of
22 information that's coming in daily from the Fac Reps,
23 goes into the line -- the mission element
24 organization as well as Assistant Manager for Safety
25 Engineering. There is a, you know, four o'clock into

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1 the plan of the day meeting where that meeting is
2 rolled up for, that information rolled up for myself
3 or the Deputy Manager.

4 You asked about our self-assessment
5 activities. Again, I go back to our Quality
6 Assurance program description document requires each
7 organization, as a minimum, to annually self-assess
8 how it's doing its job. I supplemented that with a
9 memo saying I don't want people to wait until the
10 last quarter to do this. Everyone has a self-
11 assessment due on this first quarter, and also as
12 part of our self-assess, we in RL are operating, I
13 set up this Office of Independent Oversight. They
14 conducted eight organizational assessments this last
15 year, came up with 24 findings, 43 observations, five
16 deficiencies, and a number of criteria. Next there
17 will -- be that Office of Independent Oversight will
18 continue to perform the same, do some of the same
19 work, probing deeper, going into some different
20 organizations.

21 Noting that some comments in previous
22 testimonies given to you, you observed or didn't know
23 what managing the contract meant to different people.

24 This is specifically what it means to me at
25 Richland. First, having good contracts, knowing the

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1 contract, enforcing the contract, monitoring
2 incidents, monitoring progress, monitoring
3 compliance, taking contract action when indicated,
4 controlling who gives direction to the contractor,
5 and what directions. In the case of the Fluor
6 contract, I'm the head of contracting activity. I
7 have two contracting officer representatives, one on
8 the legal side, and one with limited responsibilities
9 in the management and administration. The technical
10 guidance and direction all comes up to me, so I can
11 make sure that it is integrated. Managing the
12 contract means that we, you know, if we need to fix
13 the contract, we fix the contract. We don't have
14 individuals expressing preferences of what they want
15 done on a daily basis to the contractor personnel.
16 I'd say our relationship is cordial, but arm's
17 length, and we work very hard at knowing what's going
18 on on the ground floor.

19 I guess, to summarize, it's one of my key
20 learnings this last year in translating that, or even
21 relating that to the Columbia Accident Investigation,
22 you know, they had 86 successful launches between
23 Challenger and the Columbia. They had also eight
24 different foam strikes during that process.
25 Certainly the symptoms and signs were all there.

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1 I think where we lost the bubble this
2 last year was -- I'll call it quality of engineering,
3 and I wouldn't call it production over safety, but I
4 would say we're guilty of schedule over quality when
5 it came to elements of engineering. You know,
6 certainly it was caught at the ORR stage, but it
7 never should have gotten to that stage.

8 I'm very proud of our Fac Reps, I'm proud
9 of our -- how we walk the spaces. I'm very confident
10 things will not get to a point of being unsafe, but
11 for me, getting to the next plateau gets to a level
12 of quality and goodness, such that safety and
13 productivity are one, and it's because we've done a
14 good job in planning and executing the work. Jobs go
15 off as planned, but they can only do that if the
16 quality of engineering, training, and so forth,
17 analysis of hazards, is all done in a quality way,
18 and that would be manifest in the different
19 indicators coming from our oversight system, whether
20 it's daily operational incidents or just how we are
21 executing according to plan and you see it in costs
22 and schedule variances, relative to the contract. We
23 certainly have a long way to go there.

24 I think in the past we were measuring
25 ourselves [to] a wrong standard. We were getting so

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1 much more work done than was done in the past. You
2 know, we're moving spent fuel. We're stabilizing
3 plutonium. We shipped off uranium, and so forth.
4 Like the shuttle had 88 successes, but for us to get
5 to this next plateau, we have to really jack up our
6 overall management productivity, efficiency, and
7 quality, and that's where we'll be focusing next
8 year.

9 CHAIRMAN CONWAY: Keith, you mentioned,
10 that's a good an analogy you made of all the
11 incidences that nobody paid attention to, in your
12 safety indicators, you have the green, all green is
13 OSHA [Occupational Safety and Health Administration]
14 recordable case rate, and many -- we've been hearing
15 in the past statistics showing how the OSHA records
16 show it's been going down and down. But that is not
17 necessarily a good indicator because, as you say,
18 all the various other problems you've had in the
19 safety basis and what have you, so the OSHA
20 recordable incidents per se is not that dependable.

21 MR. KLEIN: No, and I certainly don't --
22 we don't rely on that for --

23 CHAIRMAN CONWAY: It's one of
24 complacency.

25 MR. KLEIN: -- if it's going up, you

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1 certainly know you have a problem. You like to see
2 it constantly going down, that things are better, so
3 the absolute numbers are not nearly as significant as
4 the trends in my mind on that particular indicator.

5 CHAIRMAN CONWAY: Okay. Dr. Eggenberger?

6 VICE CHAIRMAN EGGENBERGER: I have no
7 questions other than a comment on Chairman Conway's
8 OSHA --

9 CHAIRMAN CONWAY: The staff brought it to
10 my attention.

11 VICE CHAIRMAN EGGENBERGER: Yes. I
12 suggest that you also read Captain Hicks' discourse
13 on OSHA statistics.

14 CHAIRMAN CONWAY: John?

15 DR. MANSFIELD: What's your -- I'm going
16 to ask a question, and I'm going to answer it.
17 What's your analog of the massive foam strike issue?

18 Here's one. The -- you had a number, a few, a
19 number of unpredictable and so far, I believe, un-
20 analyzed equipment evolutions. The one I'm
21 particularly concerned about was the cold vacuum
22 drying incident about a year ago, where the system
23 put itself in a state that no one ever expected it
24 would. Nothing bad happened, just like the foam
25 strikes, so my question to you is, do you look on

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1 that as your foam strike problem? I'll give you
2 another example if you want.

3 MR. KLEIN: That may be one of them.
4 There's -- we have lots -- you know, the interesting
5 thing about the foam strike is you go back and look
6 at their technical specifications and requirements,
7 and it's very clearly the requirement that thou shalt
8 not have, you know, dings greater than a certain
9 size, yet they just seemed to blow by that.

10 DR. MANSFIELD: Because nothing bad
11 happened.

12 MR. KLEIN: Because nothing bad happened,
13 precisely. We have lots of incidents where things
14 are happening and aren't talked about. We're
15 sharpening up our responsibility for oversight in the
16 conduct of engineering. You know, clearly there are
17 violations of quality requirements in there, but we
18 somehow missed them, and this may very well, the
19 example you brought up, be another case where, you
20 know, there's, you know, something's wrong and we
21 haven't figured it out yet.

22 DR. MANSFIELD: Okay. So you do see that
23 as a foam strike incident. That's what I meant.

24 MR. KLEIN: Well, I think wherever there
25 some anomalies, you have a potential, and that's

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1 where we want to pull the string on it.

2 DR. MANSFIELD: Just because nothing bad
3 happened, doesn't mean you shouldn't solve the
4 problem. Another foam strike type question. I know
5 you were under pressure to get the K-Basin DSA
6 [Documented Safety Analysis] finished, but the ORR
7 was, the DSA that you put in place at about the time
8 of the ORR, was based on a 60 percent design. The --
9 I believe that's highly risky, and that's, you know,
10 permitting that to happen is kind of like permitting
11 foam strikes to happen, because you have no idea of
12 what the outcome might be. Do you look on basing
13 DSA's on a 60 percent design as a high-risk activity
14 like a foam strike?

15 MR. KLEIN: I think the -- in hindsight
16 we saw that it was based on 60 percent design, and
17 that's why I talked about there's something wrong
18 with our system that we didn't pick that up until the
19 ORR stopped it, and we pulled the string on what's
20 going on here. Certainly the symptoms were there
21 earlier that the conduct of engineering, that's
22 precisely what I was referring to, that when I talked
23 about, you know, schedule over quality, I think
24 people were lulled again that things were viewed as
25 higher risk activity, spent fuel and so forth, were

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1 getting so much attention, that quality slipped on
2 this, and there is just no good reason for it to have
3 gotten as far as it did, you know, up to an ORR stage
4 --

5 DR. MANSFIELD: I blame that on
6 incomplete oversight on your part, of the
7 engineering activities. Is that going to improve?

8 MR. KLEIN: Yes.

9 DR. MANSFIELD: Okay. Another good
10 example is apparently, to satisfy the agreement, the
11 acceptance for beneficial use was signed for this.
12 You need to have a lot of confidence to do that, it
13 seems to me, based on your oversight of the process
14 of the engineering -- progress of engineering. Do
15 you believe now that that was warranted?

16 MR. KLEIN: In hindsight it certainly
17 wasn't warranted, and there are clearly management
18 failings on both sides of the fence on this one, that
19 they thought -- their management believed that they
20 were ready. I know we certainly had some skepticism,
21 but we didn't think it was as bad as it turned out to
22 be once we got in and pulled the string on them.

23 DR. MANSFIELD: So I would learn from
24 this that heightened skepticism is an important part
25 of your job.

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1 MR. KLEIN: Amen.

2 DR. MANSFIELD: That's all the questions
3 I have.

4 CHAIRMAN CONWAY: Dr. Matthews?

5 DR. MATTHEWS: The assessment that you
6 did on the Columbia accident was pretty good, and
7 everybody's done that, and I appreciate that. I
8 think it's a good job, and the lessons learned in
9 particular. Your performance indicator chart sort of
10 reminded me of another lesson learned out there that
11 I haven't heard anybody talk about, and that's the
12 Davis-Besse near miss, and what I have seen is, they
13 had a performance indicator chart that looked all
14 green before this happened [the problem was
15 discovered]. You really don't need to answer this; I
16 want everybody to think about this a little bit, you
17 know. How are you developing your performance
18 indicators, and have you looked at the Davis-Besse as
19 a lesson learned for doing those properly? Because I
20 think there's some important lessons for all of us in
21 that today.

22 MR. KLEIN: Roy Schepens will talk more
23 specifically even about, you know, some analysis of
24 that. We haven't put in the same degree of rigor in
25 analyzing that as we have the Columbia accident, but

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1 it's certainly risen on my screen and I'll be looking
2 much closer at that.

3 DR. MATTHEWS: Good. The other chart I
4 want to comment on and ask about is your planned
5 oversight for FY04 [Fiscal Year 2004], and the
6 question I had is your, you know, frequency or
7 number. What is that based on. Is that based on a
8 risk approach? Is that based on a mission essential
9 approach? How did you get to those numbers?

10 MR. KLEIN: They're a variety of things
11 that factor into that. One is certainly, you know,
12 every year you try to assess a certain amount, number
13 of cross-cutting systems and programs, but more
14 importantly we gauge it on the hazard, the perceived
15 hazard of the activity, we base it on, you know, new
16 starts, what's new? Some are specifically for cause
17 based on, you know, problems we had in the last year.
18 So it's based on judgments and compliance.

19 DR. MATTHEWS: So there isn't a formal
20 risk-based approach to it. It's sort of an
21 integrated synthesis of what you feel, is that what
22 you're saying?

23 MR. KLEIN: No. We don't have a rigorous
24 risk base where we assign some kind of risk number to
25 each of our activities, but I'd say it's -- but

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1 certainly it's, you know, in our minds, we do, you
2 know, bin things into different categories based on,
3 you know, is it a category of the facility, the
4 nature of the activity, worst case accident, you
5 know. As we're getting off of the D&D, the nature of
6 the hazards, the questions you talked about before,
7 shifting from, you know, large scale, at least to the
8 public, to more worker safety, where if you can
9 protect the workers, you certainly can protect the
10 public, but it's as the major source terms are
11 getting reduced, and it's, you know, it's hard to --
12 I certainly don't need to tell you this, Dr.
13 Matthews, but you know, comparing risk to the workers
14 versus risk to the public and to put in a real
15 rigorous form like that.

16 DR. MATTHEWS: Okay. Thank you.

17 CHAIRMAN CONWAY: Thank you. Keith, you
18 say that the new oversight, as you understand, the
19 new oversight policy calls for scaling back on
20 oversight as more confidence is gained, and you don't
21 have that confidence now, obviously, and if I hear
22 you correctly, you're going to put in more oversight
23 right now.

24 MR. KLEIN: Correct.

25 CHAIRMAN CONWAY: Your counterpart at

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1 Savannah River, his testimony, as I understood it,
2 was he doesn't see any change in the oversight
3 expected with the new oversight policy. I have a
4 hard time getting my hands around what is going to
5 result form the new policy. I look over managing the
6 contract. As I come down there on the right hand
7 side, is that different from what we were doing in
8 the past?

9 MR. KLEIN: I think the new policy
10 certainly allows for a scaling or grading of how we
11 do oversight depending on the situation, but I think
12 the overall philosophy is, we all yearn for the day
13 where the contractors' programs are so good. I mean,
14 certainly you can't oversee safety in, so you want it
15 to be built-in, and their self-correcting programs
16 and processes to be so good that it's very hard for
17 us to find anything wrong, and when we start seeing
18 that, then I'd say we can start backing off. Jeff
19 may very well be at that point, we're just not.

20 CHAIRMAN CONWAY: But now you see, you
21 have the ability to know what's going on daily at the
22 floor level, and the only way you're going to know
23 that, it seems to me, is with your Facility Rep on
24 the floor, unless you've got one of your other
25 officials down on the floor level.

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1 MR. KLEIN: And I don't see that
2 changing, nor do I necessarily read the new policy as
3 pushing us in that direction. Certainly as a goal,
4 you would like to think that we didn't have to have
5 people constantly walking the spaces, and certainly
6 we can't be everywhere all the time and doing that,
7 but in general, as we get more comfortable with how
8 they're doing things, you feel less compelled that
9 you have to walk, be as many places, as frequently,
10 as often, and I think that's the principle at play.

11 CHAIRMAN CONWAY: Are you giving any
12 different directions to your Facility Reps as they
13 are doing apparently down at Savannah River under the
14 new policy?

15 MR. KLEIN: Not under the new policy.
16 The new policy in my mind allows us the same
17 flexibility we did before to do things the way we
18 think it needs to be done, and scale it to the
19 hazard, to our degree of concern, whether it's a new
20 start or not, and you know, we have been and continue
21 to adjust how many surveillances, where, when, and
22 what they're focused on based on our perception of
23 what's going on.

24 CHAIRMAN CONWAY: Are you cutting back on
25 your -- numbers of your Facility Reps?

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1 MR. KLEIN: No, sir.

2 CHAIRMAN CONWAY: Okay. Thank you.
3 Anyone else have anything? We turn to Mr. Gallagher,
4 Mr. Ronald Gallagher. We welcome you here. This is
5 your first meeting, I think, with the Board --

6 MR. GALLAGHER: That's correct.

7 CHAIRMAN CONWAY: -- interface with the
8 Board in any way. We welcome you.

9 MR. GALLAGHER: I appreciate it, Mr.
10 Chairman, members of the Board, I appreciate the
11 opportunity to present. I am President and Chief
12 Executive Officer of Fluor Hanford. I assumed those
13 duties the first week of December of this year, so
14 I'm relatively new at the job. I did bring along
15 with me my Chief Operating Officer, someone I
16 appointed only this last week into that position,
17 George Jackson.

18 CHAIRMAN CONWAY: Please, you're welcome
19 to come up to the table.

20 MR. GALLAGHER: George is a 25-year
21 veteran of the Hanford Facility, and will certainly
22 be able to comment on past issues as it relates to
23 areas that I might not be able to address.

24 CHAIRMAN CONWAY: -- so that the reporter
25 has your full name and -- if you would give him your

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