MR. RUDDY: Sure. Thanks again.

CHAIRMAN CONWAY: Now, it's our practice to always have at our hearings to throw it open to the public. I have one individual who has indicated he would like to speak, and that Mr. William L. Hicks, who from the public would like to come before us.

Mr. Hicks. Mr. Hicks, it might be a little helpful if you give a little of your background for the record.

MR. HICKS: Thank you, Mr. Chairman, for this opportunity to provide some thoughts to the Board.

My background consists of some 30 years in the Rickover program on the operational and inspection side, so I have seen that at some detail.

And for the last 12 years, I have been associated within DOE primarily in Defense Programs, but also with significant amount of time in some of the other nuclear activities in the area of operations, oversight, assessments; some of these areas that you're talking about.

If you like, I can provide some additional information for the record after we're complete.

I thank you for the opportunity to provide my thoughts, and these are my thoughts for the Board,

as you review the status of DOE including the NNSA oversight management of contracts and contractors.

As you noted in the notice of this hearings, this will focus on what impacts, if any, DOE's new initiatives may have or might have had upon assuring adequate protection of the health and safety of the public and workers at the DOE defense nuclear facilities.

As I noted, my experience includes 30 years in the Navy Nuclear program, 12 years within DOE and NNSA complex associated with operation, oversight, and management of nuclear activities. The observations and conclusions in this presentation are based on that experience coupled with my evaluation of the ongoing efforts to reorganize the NNSA and to change the DOE/NNSA oversight model.

The discussion in the presentation is going to focus primarily on the nuclear activities and the risks from those activities. I believe it's an important focus for several reasons. First, you are the Defense Nuclear Facilities Safety Board. You have a primary focus on the safety of nuclear facilities and activities.

Secondly, I believe the nuclear activities present the potential for the most severe consequence

to the public and the worker as well as the environment should a significant accident occur.

Thirdly, I believe that if we lose focus on the severe consequences of a nuclear accident, we become complacent and look to historical statistics concerning industrial construction type accidents as a basis for reduced regulation and vigilance. I believe this phenomenon is one of the critical lessons and conclusions from the Columbia accident. The ongoing and proposed NNSA/DOE oversight model seemed to justify a past record of performance without consideration of the processes that defined that performance or the minimum controls to ensure continuation of the record of zero significant nuclear accidents. I believe it is reckless in the extreme to depend on OSHA [Occupational Safety and Health Administration] statistics to justify reduction of the defense-in-depth safety management systems and programs that provide the appropriate assurance that a nuclear accident with unaccepted consequences will not occur.

As I consider the question of adequate oversight, I realize I can't evaluate the adequacy of oversight without a better understanding of the purpose of the oversight and the credit in the overall

management and regulatory strategy ascribed to oversight. Prior to the evaluation of oversight, the entire regulatory model of which it is a part must be understood.

During the initial public meeting of this series, Jim McConnell, the Deputy Technical Director, describes three separate and possibly conflicting responsibilities assigned to DOE/NNSA. The responsibilities are as a customer for the products, including research and remediation, developed by the contractors; responsibility as the landlord of the facility in which the contractors create product; and as the sole regulator of nuclear activities. As Mr. McConnell discussed, the goals of the customers or program side of DOE may be in conflict with the regulatory responsibilities. DOE and NNSA is unique in that the Atomic Energy Act assigns to it the responsibility to manage the development of the products and infrastructure as well as to regulate the activities. As you know, from the civilian sector, the NRC [Nuclear Regulatory Commission] was established to avoid the conflict that exists within DOE/NNSA today.

Much of the effort of the Board in the last 12 years I have been associated with DOE/NNSA has

focused on various aspects of these regulatory responsibilities. Some elements of the regulatory model have been developed, various initiatives have evolved, been criticized, modified and disappeared in the name of streamlining, graded approach, necessary and sufficient, etcetera. However, despite the emphasis of the Board and many within DOE and NNSA, I do not believe that a clear, holistic model to accomplish the regulation of nuclear facilities and activities within DOE and NNSA has been defined and sustained. Without such a model, it's not possible to judge the adequacy of any individual part or initiative.

I believe a regulatory model must have three elements: requirements, implementation, and enforcement.

Requirements for the control of the hazards of nuclear activities are now adequately defined, I believe. In general, they are included in the contracts or are laws that all DOE/NNSA contractors must meet. The foundations for the requirements are within the Nuclear Safety Rule, 10 CFR 830, and the Radiation Protection Rule, 10 CFR 835.

The Nuclear Safety Rule specifies

requirements for Quality Assurance programs, Documented Safety Analysis and safety management programs. Other DOE/NNSA orders and contract requirements specify the attributes for the safety management program. The Board has been actively involved in assuring the adequacy of the requirements starting, at least to my knowledge, back with Recommendation 90-2 [DOE High Priority Defense Nuclear Facilities: Design, Construction, Operation and Decommissioning Standards].

Implementation. As I look at it, implementation is the action to develop programs and processes through which requirements will be met, followed by the deliberate execution of the programs and processes to achieve the results specified in the requirement.

The record across DOE and NNSA complex of implementation is not as clear, consistent, or persuasive as the record in the definition of requirements. A number of initiatives have supported implementation. Operational readiness reviews [ORR] verify the satisfactory implementation of the DSA [Document Safety Analysis] and safety management programs when an activity has been started or restarted.

The Integrated Safety Management System [ISMS] initiative, including verification of the implementation of the system, provided a baseline of implementation of the safety management programs as well as many work safety initiatives.

The ISMS initiative provided a comprehensive regulatory framework. It might even be argued that the ISM initiative does define a regulatory model. However, the effectiveness of the ISM system is not being consistently monitored nor have consistent expectations been enforced. In the current draft oversight policy, expectations associated with a robust ISMS are barely mentioned.

The implementation of subpart B of the Nuclear Safety Rule provides another opportunity to achieve and verify implementation. The development, review, and approval and implementation of the required DSAs has occurred with significant variations across the complex. In some cases the review of the submitted, rule-compliant, DSA prior to approval is thorough and adequate. In other cases, less effort with less competence is applied to the review. In some cases there's a formal process to verify the adequacy of the implementation of the approved DSA. At some sites, the contractor accomplishes the

verification. At other sites, DOE or NNSA verifies adequacy of implementation. However, in some cases, neither DOE and NNSA nor the contractor has formal processes to ensure accurate and complete implementation of the DSA. This lack of consistency indicates that there is not a clear regulatory model being followed by DOE and NNSA.

More importantly, my observation is that in some cases the implementation does not achieve the expectation of the requirements, and there is no systematic process to detect the inadequate implementation. In these cases the level of risk exceeds that which DOE and NNSA as the regulatory as accepted.

Enforcement is the critical third leg of an adequate regulatory model. DOE/NNSA documents does not define a comprehensive enforcement model into which oversight is one part. Glenn Podonsky testified on October 21 that his office performed some, but not all, of the functions normally associated with a regulator. He explained what he did not do. He explained what his office did, but not how that fit into a holistic regulatory model. He acknowledged being a source of information for decision-makers, not a regulator and not empowered to enforce. His

presentation also noted the Price-Anderson Amendments Act enforcement office performs some enforcement functions, although how these functions fit into the overall regulatory model was not discussed.

NNSA testimony defended deregulation of oversight and regulatory responsibilities to the field without benefit of a basis of why that action was consistent with a comprehensive regulatory model. It was also acknowledged that the processes in the field have not yet been fully defined or implemented. It was further indicated that NNSA Headquarters did not intend to oversee or inspect the adequacy of the field oversight program or the effectiveness of the implementation of those programs. No compensatory measures were identified to be in place during the transition.

The Under Secretary of Energy focused on worker accident statistics as a measure of the adequacy of the oversight using much the same logic as NASA leading up to the Columbia accident. He also focused on the importance of speed in the clean-up and risk reduction and the detrimental affect of non-value added requirements. In many cases, the non-value added requirements are the defense-in-depth safety management programs that are mandated to ensure the

accident with unacceptable consequences does not occur. When regulating high consequence nuclear activities, the only acceptable statistic is zero. His discussion approaches an analog to an argument for speeding on the highway since less time will be spent in the dangerous highway environment.

During the testimony from Naval Reactors, it was clear that a complete regulatory model is in place and is effective. I had many years of personal experience in many aspects of that holistic model and can attest to its effectiveness and completeness. The role, process, and expectations for enforcement and oversight are clear. The Chairman's September 2nd letter to Admiral Bowman further attests to the continuing effectiveness of Naval Reactors.

Oversight is clearly an element of the enforcement leg of a regulatory model. However, since DOE and NNSA has never had a defined regulatory model, there has never been a clear oversight model. Little effort beyond the vague terms of "graded approach" or "risk based" has been given to the definition of oversight expectations, criteria, or measurable results. As a result, oversight success is judged through OSHA statistics vice the adequacy of the implementation of the safety management programs that

define defense-in-depth for nuclear activities. Little distinction is made between nuclear and non-nuclear activities. The high level expectations of the ISMS feedback and improvement function permit a definition of oversight expectations. However, as can be seen from a review of ISMS verification reports as well as the OA reports, feedback and improvement expectations or requirement frequently were and are not adequately defined and not effectively implemented. DOE Policy 450.5 concerning line ES&H oversight also provides a reasonable set of expectations at a high level but they, too, were never effectively implemented.

NNSA and DOE have recently promulgated draft policies associated with oversight. The NNSA policy document concerned line oversight and Contractor Assurance System is seriously flawed, although it still is a work in progress.

DOE Draft Policy 226.1 [DOE Oversight Policy] and the implementing guidance in the DOE Draft Notice 226 provide little improvement on the existing requirements specified in ISMS Policy 450.4 and the line ES&H Oversight Policy 450.5. It does, however, have one significant reduction in that it fails to require any DOE/NNSA Headquarters line oversight or

verification of field performance. What it will accomplish is to further delay maturity of the oversight and assurance systems already in place as well as to codify the current lack of structured Headquarters line oversight of field programs and performance. Since DOE Policy 226.1 is applicable to NNSA, it is not clear that the NNSA LO/CAS [Line Oversight/Contractor Assurance System] effort is necessary or serves any useful purpose towards the definition of the oversight element of an overall regulatory model.

The specific elements or attributes defined in the draft oversight policy are in general appropriate and if effectively implemented could provide a significant element of the enforcement leg of a holistic regulatory model. The fatal flaw is in the lack of commitment to a process for assurance that the elements and attributes will be met and maintained. The underlying assumption seems to be that DOE and NNSA need only define expectations and that they will be met. Contractors will apply the necessary resources and take the necessary actions to achieve the desired elements without intrusive oversight. DOE and NNSA field elements will do the same. Does this approach it within an adequate

regulatory model for the regulation of nuclear activities? I think that it does not.

My experience in 12 years across the DOE and NNSA complexes is that the implied assumptions are far from reality. Assessment and oversight activities required resources that take from profits or award fees. Therefore, in general, contractors voluntarily applied minimal resources to assessment and less resources to issues management to improve performance. DOE/NNSA personnel hear the message that oversight detracts from the contractor's ability to do more work and is intrusive. Therefore, the pressure on the Site Office is to reduce oversight and allow the contractor to perform. The mantra is to tell the contractor what, not how, and let him do it. If the risks were minimal and the worker safety were regulated by others, that attitude might be appropriate for DOE and NNSA in their role as a customer. However, as the regulator for the high consequence nuclear activity, the assumptions are not appropriate, and the strategy fails to meet the intent of the Atomic Energy Act.

In summary, I believe firm conclusions concerning oversight must be made in the context of an overall holistic regulatory model. DOE/NNSA should be expected to have defined that model within which the

oversight component can be judged. Until such time as that regulatory model is defined, adequate oversight must be judged in comparison to other government organizations and industries with similar risks and consequences such as NASA, NRC, or Naval Reactors. When judged against the standards of those examples, the DOE and NNSA oversight is not adequate. While the attributes defined in the draft policy may be adequate, the lack of a defined process or expectation to ensure implementation and continued adequacy is a fatal flaw in the nuclear regulatory environment.

Further, I conclude that in this period of transition, expectations from existing programs and policies as ISMS and line oversight are not being met and that no compensatory measures are in place. Most NNSA Site Offices lack procedures, staff, and competence to meet all of these newly assigned responsibilities. Contractors are allowed to believe that there will be no verification of the adequacy of the assurance program they implement. EM [Environment Management] is encouraging reduction of requirements and "non-value added" processes which defeat the defense-in-depth safety management programs that are important to prevent the high consequence nuclear accident.

The importance of the Defense Board has never been more apparent. Your forceful and timely intervention must reverse this trend. In the near term, the Defense Board becomes a critical compensatory measure in the field. The longer-term action should be to force the description of the regulatory model within which DOE/NNSA oversight and contractor assurance may be judged. The final step is to ensure that the programs to implement the regulatory model are sound and that they achieve the desired outcome.

I thank you for this opportunity to present my personal observations and conclusions concerning this important subject. Subject to your questions, that concludes my testimony.

CHAIRMAN CONWAY: Thank you, Mr. Hicks.

Dr. Eggenberger?

VICE CHAIRMAN EGGENBERGER: I don't have any questions, but I'll make a comment.

I think this provides an excellent summary of what we've heard to date. And I understand what you said very clearly.

Thank you.

CHAIRMAN CONWAY: Dr. Mansfield?

DR. MANSFIELD: Thank you, Mr. Chairman.

I second that. This is a valuable contribution. A clear definition of what I believe DOE's expectations should be for a regulatory framework.

I am encouraged that Integrated Safety Management in your view, could provide a comprehensive framework. To the extent that it doesn't yet, is it possible in your view for Headquarters to have metrics for the implementation of ISMS at the sites that would give them the degree of knowledge of ISMS execution that they would need to be effective regulators? Are there metrics that could be established that would allow Headquarters to effectively do that?

MR. HICKS: In thinking about this, it's not clear to me what we would use if we put under the term of metrics. But I think back to a letter that EM, that Jessie Roberson wrote about a year and a half or two years ago in which she required that each of her sites accomplish the annual verification of effectiveness of ISM that's called for in the DEAR [Department of Energy Acquisition Regulations] and that they report on that. Were that to be done diligently with some degree of independence as was intended in the ISMS guidance and then reported appropriately with the kind of metrics that come out

of a review of the effectiveness of the ISMS system, I think that the answer to that is absolutely yes, it could. The problem, again, as I tried to say is that only at one or two sites in the complex is there a diligent effort to actually do an annual review and, to my knowledge -- I'm not knowledgeable of how the reports are being evaluated and looked at within EM -- there is no similar requirement within NNSA that I'm aware of. But that system defines the requirements, talks about the rolldown in requirements. I mean, I listened to Ruddy talk about his requirements model, and that's clearly the ISMS model of understand the requirements, have the flowdown document, and so if any change occurs, you can go right into the system and see how that changes effect.

Diligent implementation and review, verification of effectiveness as the DEAR requires, I believe would have the desired effect. However, that, too, has passed, and we're approaching a new paradigm, whatever that new paradigm may be is what it would appear to me.

DR. MANSFIELD: DEAR has obviously chosen the mechanism that the Site Office, relevant Site Offices, would review the ISM programs and provide a summary report as well to Headquarters. Is there a

role for intrusive Headquarters' involvement and verification of ISM?

MR. HICKS: I believe absolutely there is.

DR. MANSFIELD: Okay.

MR. HICKS: I mean, I harken to some of the things that we've done within DOE, the verification process, the ISMS verification process caused a significant amount of improvement, I believe, in the way that the complex was managed. The Operational Readiness Review process has caused -- when it has been applied -- it has caused some improvement. But these things have not been systematic, they have been kind of ad hoc.

If I go back to my Naval Reactors experience, I had experience as the customer. I was the regulator. I was the senior member of the Nuclear Power Examining Board. I was a squadron staff. I was a squadron. And in all of those cases there was a systematic expectation of verification of your implementation of the requirements. And it's that systematic expectation that you have asked Mr. Glenn and Mr. Brumley do they believe that external -- that a Headquarters' validation of the effectiveness of their work is appropriate? I think they have agreed that it probably is. I know there is some other

communications going on about that. But clearly both the incentive of somebody coming in that your boss works for to look at you and the incentive of a fresh set of eyes, you just can't lose the value of that. And when you're in something as critical as nuclear oversight. Trip, slips and falls; ladder safety; we have lots of regulations of those things, lots of people understand them. Any individual being hurt is bad. But we're talking about the public being damaged. We're talking about significant risk to the complex and to the nuclear weapons mission, and in those areas, a different set of rules ought to apply, and we don't do that. We don't see that.

DR. MANSFIELD: Thank you.

CHAIRMAN CONWAY: Dr. Matthews?

DR. MATTHEWS: Thank you.

These are strong words, Mr. Hicks. And the strongest part that I see in here is implied -- kind of implied -- that you feel that we're as a result of the re-engineering and a result of the new oversight policies, that we could be moving closer to a high consequence nuclear accident. My question is: is that the message, the take away message from this, and what evidence do you have? That's a real scary statement.

MR. HICKS: Let me define it this way: As I watch the evolution of improvement of the management of the complex from 1992, which was when I became associated with the complex, through the completion of the implementation of the Integrated Safety Management initiative I think that there was always a improving status of the defense-in-depth, the safety management programs that are important to maintaining the zero risk of the unacceptable consequence accident.

Since the last verification of the Integrated Safety Management System at each of the sites, it's my view that improvement is no longer occurring and that a degradation of the formality, degradation of the holistic oversight is occurring.

Now, has that decreased to the point where an accident is imminent? I doubt it. Has it decreased to less than it was at the height of ISM? I believe it absolutely has. Do the processes that I see being put forth cause me to think that there's going to be a turnaround and it's going to be improved? I don't think it will.

So I think that what we're doing is we're seeing a slide back into the good old days before the Defense Board, before some of the other openness initiatives that have occurred in the last ten years.

And that turning the complex over, pushing the responsibility to the field, getting rid of that defense-in-depth. Defense-in-depth is important not only in safety management programs, but it's important in the oversight of the implementation of those programs, and it's that that I see slowly going into the -- deteriorating.

And so is an accident imminent?

DR. MATTHEWS: I didn't ask imminent. Greater than zero?

MR. HICKS: No, no. I don't believe that it is. But if you listen today, and you have listened to the other testimony, and I know that you have, Bill Brumley talks about programs in being and he is, in fact, doing the oversight. And Glenn talks about training programs being developed, processes being put into place, but in my judgment, a large proportion of what you heard today was "plans to do what we said" as opposed to "processes in place doing what we said with little or no compensatory action in place that says while I am putting these new processes in place, I have these old processes that are still effective."

450.5 line oversight remains, at least the last time I checked, is a requirement of the Department. There is, for all intents and purposes,

no Headquarters line oversight of the field.

Now, there are some metrics that are being monitored, there's some you tell me the information, and I will look at what you tell me, and I will evaluate that. But as far as going out to the field and verifying that what we think is there is what's really there, which is what 450.5 intends, I don't think that's happening anywhere.

DR. MATTHEWS: Let me just follow up a little bit if I can. In my experience, the technical -- real true technical expertise for understanding the safety of these systems and avoiding the high consequence accidents -- really resides at the sites. And so I wondered if you've seen a degradation in that capability and this trend toward putting more responsibility and authority at the sites where the expertise mostly lies? I could come to a different conclusion than you have. I'm curious what you think about that.

MR. HICKS: Well, you and I would look at this slightly differently, I'm sure. You would say, I believe, that the technical expertise is there, we have adequate technical expertise. Then, therefore, we have adequate assurance of safety.

I would look at it differently. I would

look at it more in the Naval Reactors model, which was that the most conscientious perfect person makes mistakes. And that if you can accept those mistakes, then you can accept the consequences of whatever those mistakes bring.

Challenger leads you, or Columbia leads you to that: that some people made some judgments about the safety of the conditions that existed. And so it was a knowledge-based environment.

I believe, and my whole thesis is that in order to ensure the safety, you need the defense-in-depth that is provided by the process-based environment. We have processes for DSAs. Those processed take into account the significant technical evaluations that you talk about, and they result in a number of controls. The controls are only as good as the implementation of those controls. Those technical experts in the field don't look at the implementation of the controls so much as they look at the adequacy of the control that's defined. The process. The process of the formality of operations. The process of configuration management. The process of training and qualification. Those processes are what make sure that those controls maintain the high probability of the zero accident.

If we get rid of those processes, either through thinking they're not important because they're slowing us down or because they're too expensive and if we get rid of them, we haven't caused an inability to do the work, then we increase the risk because we reduce the defense-in-depth that those processes have given us.

And all of our argument is about how much of that defense-in-depth is necessary, and how much can we depend on the strong individual capability of that individual on the floor? And if that individual on the floor is doing ladder safety or is doing some OSHA something that's going to hurt himself and maybe a coworker beside him, we have one level of concern. But if what he's doing is working in a hazard nuclear facility, whether it's one for which we don't quite understand the criticality safety concerns, or whether it's one in which we're doing nuclear explosives, or whether it's one where we're packaging and handling highly enriched uranium, then my thesis and the thesis of the safety rule is you need to have those defense-in-depth processes in place because we can't depend on the perfect performance of each individual every day to make sure that we don't have the accident. We've got to have the processes, and those processes are

what are being allowed to deteriorate as we don't anymore enforce or we don't enforce it and evaluate how we're doing on CONOPS, how we're doing on training. The Board has pointed out some issues with training and qualifications associated with nuclear operations, the fact that it's not being overseen, on and on.

We found at Bechtel Jacobs in Oak Ridge that the training qualification program didn't even exist. It had been done away with.

DR. MATTHEWS: It's a good answer. I wouldn't go any further.

CHAIRMAN CONWAY: Okay. Mr. Hicks, over the years there's been a number of outside studies of DOE. And two of them I can think of, was it the Galvin Report and 120 Day Report, both of which complained of too much oversight by DOE on contractors. I don't know if you're familiar with those two reports. There have been others. But would you have any comment on those reports? Are you familiar?

MR. HICKS: No, I'm familiar, at least in general with both of those reports.

CHAIRMAN CONWAY: Right.

MR. HICKS: And in both cases my cynical

view is that the folks who did those reports went out and talked to the workers and talked to the managers in the field, were told some things, wrote them down and issued the report. And that there was not necessarily an understanding of the nuclear safety requirements.

It was if you focus your attention in this subject as a customer. Why do weapons cost so much? Why does it take so long to start up enriched uranium? You come to the conclusion that there are too many hoops to jump through. You say, well okay. Let's get rid of some of the hoops rather than say, gee, those hoops are important so let's figure out how to get through them more efficiently. And so we're in this dichotomy or dilemma of the customers. And I believe that these reports were from a customer and from a production focus as opposed to come in and tell me how I'm doing regulating my activities.

So, you know, I think there is clearly is some issue with the fact that DOE does have an oversight model. Does not have a regulatory model. And so in the early days we had NS [Nuclear Safety] and EH [Environmental Health] sparring with who could say no last, or first, or whichever. We've had a lot of turmoil which has been talked about at these

hearings before of non-value added oversight. And I wouldn't disagree that there has been non-value added oversight that has occurred. One of the places that we talk about that we hear non-value oversight, the ORR process. The ORR process in some places has evolved to four separate reviews.

CHAIRMAN CONWAY: Yes.

MR. HICKS: And yet the fourth review --

CHAIRMAN CONWAY: Still doesn't do it.

MR. HICKS: -- frequently finds problems that the other three didn't. And so until we can get our performance to the point where the fourth review really is a no brainer and finds nothing, I'm not sure how for starting nuclear activities you can justify saying one is okay because whatever the one doesn't find probably wasn't important anyway. Are you prepared to accept that risk as the regulator? And to date, fortunately, DOE has not been willing to accept that, and so we continue to do two ORRs and because of other problems, that has evolved into a contractor review and then a DOE line management assessment. And so, as they say, in some places it's two and in some places it's four.

CHAIRMAN CONWAY: Yes.

MR. HICKS: But we haven't gotten a track

record yet to say it's okay. And that's one of the disconcerting things about LO/CAS is that we're going to get rid of the second and third reviews before we've demonstrated that the first review is adequately robust and effective.

CHAIRMAN CONWAY: Well, it seems to me to follow your approach and with a process, a proper process, you need technically competent people to work the process.

MR. HICKS: Absolutely.

CHAIRMAN CONWAY: So my question then is how does DOE obtain and retain good technical people? And that's one of the big things we've been pushing for a long time, and it seems it's very difficult to get the technically trained people that obtain them first and then keep them and retain them to do the kind of process, undertake the kind of process that you suggest.

MR. HICKS: And I don't have a good answer to that, other than the obvious. I mean, I have watched over the last 12 years the downsizing of DOE and NNSA.

CHAIRMAN CONWAY: That's right.

MR. HICKS: And I have seen the outflow of the talent, and I have seen -- Mr. Brumley talks about

hiring freezes, and in fact the freeze was just released or there has been a hiring freeze. And I think that goes back to you have to feel an urgency to have the technical confidence before you're going to do what it takes to get the technical competence. And I don't sense an urgency to retain it, because I don't sense an understanding of the importance.

You believe it's important. I believe it's important. But I don't think that that belief is necessarily unanimous in terms that would allow the Department to go to the Congress and to get the understanding.

I mean, these decisions are not all being made up the road in the Forrestal. They're being made in response to some budgetary requirements. I mean, I'm not so naive as to say as to say that there aren't drivers external to the Department. And to the degree that the Department has or has not made the case for why they need more or less people, that's way outside of my pay grade and experience.

CHAIRMAN CONWAY: Anything else?

Well, I thank you. Thank for the time you have put into this to bring this to the Board.

Now, is there anybody else in the audience that wishes to speak?

If not, the Board will recess at that time. And we will meet again. We'll recess until 9:00 a.m. tomorrow morning. Thank you.

(Whereupon, the Board recessed at 12:29 p.m., to reconvene at 9:00 a.m. on December 4, 2003.)

CERTIFICATE

This is to certify that the foregoing transcript in the matter of: Meeting

Before: Defense Nuclear Facilities Safety Board

Date: December 3, 2003

Place: Washington, DC

represents the full and complete proceedings of the aforementioned matter, as reported and reduced to typewriting.