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

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

MR. PEDDE: (Nods).

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

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

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

-- we welcome you here, Keith.

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

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

As part of that I have two what I call

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

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

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

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

MS. OLINGER: Since May of last year.

VICE CHAIRMAN EGGENBERGER: Oh, okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

activities and things going on as planned and scheduled.

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

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

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

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

evaluation plan.

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

Moving then to some lessons learned from the Columbia Accident, you know, one of the lessons in there is lack of independence, checks, and balances in the organizational structure. The budget and schedule pressures in their observation reduced the technical capability of oversight organizations. As I've said before, I've taken deliberate steps to achieve independence in the safety oversight through having the Fac Reps being able to report up through a different chain.

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

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

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

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

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

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

Noting that some comments in previous testimonies given to you, you observed or didn't know what managing the contract meant to different people. This is specifically what it means to me at Richland. First, having good contracts, knowing the

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

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

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

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

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

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

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

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

CHAIRMAN CONWAY: It's one of complacency.

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

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

CHAIRMAN CONWAY: Okay. Dr. Eggenberger?

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

CHAIRMAN CONWAY: The staff brought it to my attention.

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

CHAIRMAN CONWAY: John?

DR. MANSFIELD: What's your -- I'm going to ask a question, and I'm going to answer it. What's your analog of the massive foam strike issue? Here's one. The -- you had a number, a few, a number of unpredictable and so far, I believe, un-analyzed equipment evolutions. The one I'm particularly concerned about was the cold vacuum drying incident about a year ago, where the system put itself in a state that no one ever expected it would. Nothing bad happened, just like the foam strikes, so my question to you is, do you look on

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

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

DR. MANSFIELD: Because nothing bad happened.

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

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

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

where we want to pull the string on it.

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

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

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

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

MR. KLEIN: Yes.

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

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

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

MR. KLEIN: Amen.

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

CHAIRMAN CONWAY: Dr. Matthews?

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

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

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

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

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

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

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

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

DR. MATTHEWS: Okay. Thank you.

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

MR. KLEIN: Correct.

CHAIRMAN CONWAY: Your counterpart at

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

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

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

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

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

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

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

MR. KLEIN: No, sir.

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

MR. GALLAGHER: That's correct.

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

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

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

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

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