



Department of Energy
National Nuclear Security Administration
Washington DC 20585

April 10, 2012

OFFICE OF THE ADMINISTRATOR

Dr. Paul J. Himmert
President and Laboratories Director
Sandia Corporation
P.O. Box 5800
Albuquerque, New Mexico 87185

Dear Dr. Himmert:

As the Fee Determination Official for Sandia Corporation's contract number DE-AC04-94AL85000 with the U.S. Department of Energy, National Nuclear Security Administration, I have determined that the Motor Vehicle Accident that occurred at Kodiak Island, Alaska on February 23, 2006, constitutes a "catastrophic event" under Clause L75, "DEAR 970.5215-3, Conditional Payment of Fee, Profit, or Incentives (DEC 2000)" and that a reduction of fee is warranted.

Before determining the amount of fee reduction, I am seeking your views on any mitigating circumstances related to this catastrophic event that I should consider. Please provide me this information no later than 10 days of your receipt of this letter.

Sincerely,

Neile L. Miller
Principal Deputy Administrator



Printed with soy ink on recycled paper.

Attachment 1



Sandia National Laboratories

Operated for the U.S. Department of Energy's
National Nuclear Security Administration
by Sandia Corporation

P.O. Box 5800
Albuquerque, NM 87185-0101

P.O. Box 969
Livermore, CA 94551-0669

Phone: (505) 844-7261
Fax: (505) 844-1120
Internet: psb@nnsa.sandia.gov

Dr. Paul J. Hornbert
President and Laboratories Director

May 10, 2012

Ms. Neile L. Miller
Principal Deputy Administrator
National Nuclear Security Administration
Department of Energy
Washington, D.C. 20585

Dear Principal Deputy Administrator Miller:

Subject: *Contract No. DE-AC04-94AL85000
April 10, 2012, Principal Deputy Administrator's Request for Information
Under DEAR 970.5215-3, Conditional Payment of Fee, Profit or Incentives (Dec 2000)
Motor Vehicle Accident in Kodiak, Alaska*

This letter responds to your April 10, 2012, request for input from Sandia Corporation (Sandia) under the above referenced Contract as you consider whether a reduction of Sandia's fee is warranted under DEAR 970.5215-3, the Conditional Payment of Fee, Profit or Incentives (Dec 2000) clause. Your April 10, 2012, letter was hand-delivered to me on April 30, 2012, by Geoff Beausoleil, NNSA's Sandia Site Office Manager. The basis identified in your letter for a potential reduction in Sandia's fee arises from a February 23, 2006, motor vehicle accident which occurred near Narrow Cape Lodge involving Sandia employees who had been performing NNSA approved national security work for the Missile Defense Agency (MDA) at the Kodiak Launch Complex earlier that day. Four Sandia employees were injured as a result of the vehicle accident, two severely.

For the reasons stated in this letter, while Sandia acknowledges that this was a tragic accident, we do not believe it is either justified or consistent with the relevant contractual and regulatory framework for any reduction of fee to be taken here. The basis for our position is premised on several points.

1. In 2003, based on an amendment to the Atomic Energy Act, DOE revised its ES&H regulations and the Conditional Payment of Fee clause to remove catastrophic events as a basis for the discretionary reduction of fee. Instead, DOE, in response to Congressional direction, instituted a new clause focused more objectively on ES&H performance. It is this current, statutorily mandated standard that should be applied here.



Exceptional Service in the National Interest



2. As I believe you are aware, the Sandia Site Office Contracting Officer, after a thorough review of the facts concerning the accident, made a final determination that the costs associated with the accident are allowable costs under Sandia's Contract. A fee reduction would be inconsistent with that allowability determination.
3. Sandia is concerned, based on the wording of your request for information, that you already have determined that a fee reduction is in order, even though the Conditional Payment of Fee clause requires consideration of whether willful misconduct or negligence was involved in the triggering event and whether mitigating factors would eliminate or reduce *any* fee adjustment under the clause. The current version of the clause requires the contracting officer, and not the Fee Determination Official (FDO), to assess these mitigating factors and to make the determination on any fee adjustment. While the clause in Sandia's Contract is silent on the mitigating factors to be considered, the current version of the Conditional Payment of Fee clause sets forth a helpful listing of mitigating factors that must be taken into account on any fee reduction.
4. Your proposed action has long term negative implications for Sandia National Laboratories and our ability to support national security. This conclusion applies in this instance to the Work for Others (WFO) at issue, which constituted national security work squarely within the purposes stated in the NNSA Act. The Act specifically establishes that the NNSA Administrator shall provide for the use of national security laboratories' capabilities by agencies and entities outside of the NNSA.

When all of these factors are considered, it is clear that no reduction of Sandia's fee is warranted. I would welcome the opportunity to discuss these points with you and to address any further questions you may have.

DISCUSSION

The motor vehicle accident at issue and its consequences have been the subject of extensive exchanges of information between Sandia and NNSA's Sandia Site Office. I do not believe it would be productive to recount here all the details of those exchanges. However, as background to the following discussion, there are a few essential facts that help place the issues in context. The accident occurred in connection with a WFO agreement under which Sandia personnel were supporting MDA's launch activities at a remote location in Alaska. This was a unique, off site engagement in which mission requirements were set by MDA under the WFO agreement. Such customer requirements led to launch delays and a switch to nighttime operations with Sandia employees working extended hours - factors contributing to the eventual accident.

Very generally, a government-owned vehicle had become stranded, and it was believed that it would be swept away by the rising tide. Accordingly, a Sandia senior manager directed that it be retrieved. The senior manager's direction to take action to preserve government property (i.e., the vehicle) was reasonable, appropriate, and consistent with the Contract's Property Clause. There are no facts known to Sandia, or presumably to the Sandia Site Office, which support in any fashion a conclusion that the senior manager disregarded the safety of the personnel involved or other hazards in directing that the vehicle be retrieved.

As the accident occurred following the celebration of a successful launch at which alcohol was consumed, it had been suggested initially by NNSA that alcohol was a significant factor in the accident. The facts strongly support a conclusion that this suggestion is not correct. _____ had a blood alcohol level well below that at which the State of Alaska presumes a person is under the

influence of alcohol. Instead, the facts strongly support a conclusion that fatigue was the leading, if not sole, factor in the accident.

Your request for input states that you have determined that the motor vehicle accident constitutes a "catastrophic event" under the Conditional Payment of Fee clause and that a reduction of fee is warranted. Your letter requests Sandia to provide its views on any mitigating circumstances related to this "catastrophic event" that you should consider in making your final determination. Sandia believes that no reduction of fee is warranted based on the circumstances of the accident at issue. While the version of the Conditional Payment of Fee clause in Sandia's Contract provides for unilateral discretion in the FDO to reduce fee based on the occurrence of a "catastrophic event," DOE's policies and regulations for the conditional payment of fee had changed substantially by the time of the accident at issue. This change was mandated by Congress in a Fiscal Year 2003 amendment to the Atomic Energy Act. That amendment imposed specific requirements to be implemented by DOE for any reductions of fee due to ES&H performance failures. In response to that statutory mandate at 42 U.S.C. 2282c, DOE revised the Conditional Payment of Fee regulations and relevant contract clauses. Although NNSA has never inserted the statutorily mandated clause into the Sandia Contract, the terms of that clause and the regulatory history behind the clause's promulgation provide solid guidance for any fee reduction that NNSA may consider in this instance.

First, and perhaps most important, DOE's and NNSA's current fee reduction regulations have eliminated the concept that any fee reduction should occur based solely on the occurrence of a "catastrophic event." While this concept existed in the December 2000 version of the relevant clause, it was eliminated in the rewrite of the clause in December 2003. In making this change to the regulations, DOE stated, "[T]he interim final rule includes language making it clear that performance failures only occur if the contractor does not comply with the related terms and conditions of the contract. *The mere occurrence of an event does not necessarily create the potential for a fee reduction.*" (68 Fed. Reg. 68773, Dec. 10, 2003). The regulatory history for the 2003 revision to the Conditional Payment of Fee clause and regulations underscores that, based on the then recent amendment to the Atomic Energy Act, a purely discretionary reduction in fee based on an "event" would no longer be consistent with DOE's requirements for such reductions.

Second, and consistent with DOE's current focus under the Conditional Fee Reduction clause, the matters underlying the accident in Kodiak have been the subject of an extensive, in-depth review by both Sandia and the Sandia Site Office. The focus of that review was Sandia's compliance with the terms of its Contract and the allowability of the related costs. On October 11, 2011, after all of these detailed exchanges, the Sandia Site Manager and Contracting Officer, Patty Wagner, made a final determination that the costs related to the Kodiak accident were allowable costs under the Sandia Contract. That determination necessarily was based, in part, on Ms. Wagner's consideration of whether any of Sandia's actions were noncompliant with the terms and conditions of Sandia's Contract. That is an essential element of any cost allowability determination. That finding, based on detailed analysis and fact-finding by the contracting officer, is consistent with the proper focus under the Conditional Payment of Fee clause: "Was there a noncompliance with the ES&H terms and conditions of the contract constituting a performance failure that warrants a reduction in fee?" The contracting officer's final determination allowing the costs of the accident strongly supports the conclusion that no such non-compliances for performance failures occurred with respect to the Kodiak accident.

Third, I am troubled by the process that appears to have been followed in your issuance of the April 10, 2012, letter. The regulatory framework for fee reductions, which DOE implemented in 2003 and has been in effect for now almost a decade, contemplates that it will be the contracting officer who will

make the determination of a reduction of fee and not the FDO. See 970.5215-3(a)(4) (providing that, if the contractor does not satisfy the contract's ES&H performance requirements, the fee may be unilaterally reduced by the *contracting officer*). The transfer in responsibility from the FDO to the contracting officer to decide on a fee reduction is consistent with the new system for fee reductions introduced in 2003 and continuing to today which requires a more particularized examination of the contractor's overall ES&H compliance.

Fourth, regardless of whether the contracting officer or you, in your capacity as FDO, are responsible for making the fee reduction determination, I am concerned based on the wording of your letter that the determination has already been made to reduce fee, and the only remaining question is to determine the amount. The December 2000 version of the relevant clause provides that "[i]n determining *any* diminution of fee . . . resulting from a catastrophic event, the FDO will consider whether willful misconduct and/or negligence contributed to the occurrence and will take into consideration any mitigating circumstances presented by the contractor or other sources." 970.5215-3(b) (Dec 2000 version)(emphasis added). This quoted text supports the conclusion that *before* making any determination that a fee reduction is warranted, the FDO should consider whether *both* willful misconduct or negligence contributed to the catastrophic event and the relevant mitigating circumstances. In other words, these considerations are not limited to determining the amount of any fee adjustment after a threshold determination to reduce the fee has been made. They need to be considered in the first instance, and it does not appear to have occurred here based on the wording of your April 10, 2012, letter.

Fifth, as noted above, the Conditional Payment of Fee clause in the Contract contemplates consideration of mitigating circumstances as well as other factors in determining whether and to what extent a fee reduction is appropriate. This older version of the clause does not identify any mitigating circumstances to be considered. DOE's current clause and regulations for the Conditional Payment of Fee identify a nonexclusive list of mitigating factors that the contracting officer must take into account in considering any reduction of fee. A number of the listed factors bear directly on the fee reduction issue raised by your letter:

- Degree of control the Contractor had over the event or incident. As noted in my brief summary of the motor vehicle accident in Kodiak, this was an incident that occurred off of Sandia's laboratory facilities, in a remote location. The Sandia team's schedules were dictated by the changing operations from day to nighttime hours to meet Federal Aviation Administration specified launch hours, as well as technical delays. Employees worked significant overtime hours leading up to the launch. This increased their fatigue which appears to have been the leading, if not the sole, factor in the accident. The accident also occurred, in effect, "after hours," following a celebration with other MDA employees and contractors for a successful launch. Notably, DOE's guidance in effect at the time of the accident expressly recognized the unique nature of accidents involving employees' use of government-owned vehicles at offsite locations as being outside the framework for the type of ES&H accidents subject to the accident review process. See DOE Order 225.1A (Rescinded), Attachment 2 ("Offsite accidents meeting the Type A or Type B criteria involving Federal or contractor employees driving government-owned or rented vehicles shall not be investigated unless the Head of the Field Element determines an investigation is appropriate based on circumstances surrounding the accident or the potential for significant lessons learned.")
- Efforts the Contractor had made to anticipate and mitigate the possibility of the event in advance. The motor vehicle accident at the Kodiak site was an unforeseen event resulting from a number of factors (including the remote location, long hours of support to meet customer needs, outside the

typical Sandia environment, fatigue, adverse conditions including darkness, off-duty conduct and possibly alcohol consumption). Sandia provided housing at the Narrow Cape Lodge to be close to the Kodiak Launch Complex, to avoid unnecessary additional travel after long hours, thereby trying to prevent vehicle accidents.

- Contractor self-identification and response to the event to mitigate impacts and recurrence. Following the event, Sandia management created OP-21, Requirements for Off-Nominal Work Conditions, for Sandia's Integrated Military Systems Center, to further emphasize the applicability of Sandia's policies and procedures to remote work. Sandia's Integrated Military Systems Center, responsible for most remote fielding operations and activities of this character, also conducts regular management safety reviews and work planning and controls meetings. An investigation of the accident was conducted and shared with management. The senior manager received counseling on his management accountabilities and responsibilities for employee safety. The vice president received performance feedback about expectations regarding employee safety, risk, and operational excellence in regards to remote operations.
- General status (trend and absolute performance) of ES&H and compliance in related areas. Sandia has made continuous improvement in ES&H areas, with development and improvement of the integration of ES&H into Work Planning & Controls and Human Performance Improvement. SSO rated Sandia as Excellent in the FY2011 Performance Evaluation Report. As noted above, OP-21 applies to remote operations and is regularly reviewed. ES&H support personnel have been engaging with the vice presidents through the Executive Safety Committee to bring about awareness of safety. The ES&H Dashboard has been utilized since 2007 to display performance measures related to the Performance Evaluation Plan, and the Sandia Site Office has regularly been briefed on the status of the performance measures through the Joint Performance Assurance Team. Quarterly analysis is performed regularly in accordance with DOE O 232.2, Occurrence Reporting and Processing of Operations Information, as well as DOE O 231.1B, Environmental, Safety, and Health Reporting. The results of the Quarterly Performance Analysis are presented to the ES&H Management Review Board and identified issues are then rolled up to be presented to the Executive Management Review. In addition, ES&H has recently implemented a Severity Analysis which scores events on various attributes including impact to worker, impact to mission, and impact to the environment.
- Contractor demonstration to the Contracting Officer's satisfaction that the principles of industrial ES&H standards are routinely practiced (e.g., Voluntary Protection Program, ISO 14000). This was not an instance in which Sandia's failure to follow overall systems led to a tragic accident. Notably, the motor vehicle accident at issue was a single, unique event, which occurred outside of laboratory facilities. The nature of that accident stands in contrast to the other instances that have triggered modest fee reductions at other DOE sites where there were repeated and systematic failures resulting in operational and safety issues. The fee reduction process is intended to deal with those latter instances and not the former. Sandia maintains an environmental management system (EMS) as part of its Integrated Safety Management System (ISMS) that is third-party ISO 14001:2004 certified at both Sandia/CA and Sandia/NM. The EMS is a continuing cycle of planning, implementing, evaluating, and improving processes to achieve environmental goals. In addition, enhancing the ISMS requirements for effective integration of safety into all facets of work planning and execution, Sandia has conducted engineered safety pilot projects for a systems engineering approach to design, plan, and conduct of hazardous operations. Engineered safety is the process of systematically and critically analyzing the operational system to identify failure modes. The failure modes then require a redesign or controls to mitigate the consequences in the event of a failure. The operational system

includes the test or experiment article, tools, equipment, and operational layout, including features and characteristics, personnel, procedures, technical basis, and positive verification. Finally, quality assurance criteria are integrated into ISMS and are applied to all work. Numerous Sandia operations, including the Integrated Laboratory Management System, the framework by which Sandia manages all work done at Sandia, are third-party ISO 9001:2008 certified for a system consistent to technical standards, administrative controls, and hazard controls for both industry and government.

- Event caused by "Good Samaritan" act by the Contractor (e.g., offsite emergency response). A Sandia senior manager, who is not key personnel under the Contract, directed the stranded vehicle be retrieved, consistent with the Contract's Property Clause. The employees willingly complied, and one even volunteered to go along to assist. Employees had driven these vehicles in this location previously. The eagerness to quickly assist and employee dedication led to an accident that even the strongest controls likely would not have prevented.
- Contractor demonstration that a performance measurement system is routinely used to improve and maintain ES&H performance. On an annual basis, Sandia reviews its ISMS by performing the ISMS Effectiveness Review. The results of the ISMS Effectiveness Review are documented in the ISMS Description which is transmitted to the Sandia Site Office. Sandia also conducts a thorough review of its Worker Safety and Health Program Plan (WSHPP) on an annual basis and transmits the results of that review to the Sandia Site Office. The WSHPP details the flow-down and integration of ISMS requirements for Sandia projects, including those projects at non-Sandia-controlled premises. Line self-assessments have been performed in FY10 and FY11 to evaluate implementation of Work Planning and Control. Each organization in Sandia/NM maintains an ES&H Coordinator to assist compliance with ES&H requirements. ES&H support personnel offer corporate-level assistance for all ES&H disciplines at all Sandia locations, including Environmental Compliance Coordinators to assist line operations in meeting environmental requirements. The Interdisciplinary Team approach exists in Sandia/CA and consists of subject matter experts in all ES&H disciplines who meet with researchers, facility engineers, and functional program managers to evaluate ES&H hazards and define methods to control those hazards for proposed projects and programs or any major modifications to proposed projects and programs. Finally, safety committees are in place for implementation support and improvement of ES&H programs.
- Contractor demonstration that an Operating Experience and Feedback Program is functioning that demonstrably affects continuous improvements in ES&H by use of lessons learned and best practices inter- and intra-DOE sites. Sandia maintains a Corporate Lessons Learned Program that develops and evaluates site-specific lessons learned across all aspects of operations with a focus on preventing recurrence of problems. During the NNSA Line Oversight Contractor Assurance System Affirmation in November 2011, NNSA noted that the Sandia ES&H Lessons Learned is mature and should be used to help other organizations achieve Lessons Learned maturity. Sandia also has deployed a LiveSafe website with training materials designed to support management of employee safety.

This letter outlines our legal concerns with the potential actions you propose, as well as the continuous safety improvement efforts we have had underway for many years. These elements alone constitute compelling reasons why the fee reduction action you are considering is not justified. However, I have an additional concern with your proposed actions that has the potential to have negative implications far

Ms. Neile L. Miller

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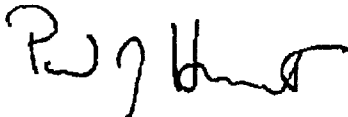
May 10, 2012

beyond allowability and challenges to fee. These implications are significant to the nature of the Laboratories and our ability to support national security. Let me explain.

As discussed earlier, I am puzzled by this action taken by the NNSA with no discussion or rationale provided to me or my leadership, especially after the prior documented position on this accident. We are also struck by the first ever invocation at Sandia of the "catastrophic clause." I, and undoubtedly my Board, cannot help but wonder why such an unusual and extraordinary step is being proposed on this issue at this time. Furthermore, we naturally juxtapose this proposed action with your recent decision to effectively prohibit us from conducting BSL-3 work at other facilities which will undermine the long term viability of our bio-security work. Taken in aggregate all these actions are interpreted by me and my leadership as intended (whether rightly or wrongly) to send us a message that our broader national security work is not supported by the NNSA. As I'm sure you recognize, especially as you enter a competition for the Sandia M&O Contract, the implications of such a message will impact our ability to support the nation's national security challenges. First and foremost among the challenges that will be impacted are the needs of our nation's nuclear deterrent, which we cannot meet without our broader work.

Thank you for this opportunity to help inform your process for considering a fee reduction based on the motor vehicle accident in Kodiak, Alaska. I strongly believe that no such reduction is justified or warranted either under the December 2000 version of the Conditional Payment of Fee clause or under DOE's statutorily mandated, current version of the clause and its implementing regulations. I would welcome the opportunity to discuss these issues further with you and your staff at your convenience.

Sincerely,



Dr. Paul J. Hommert
President and Laboratories Director

Copy to:
Thomas D'Agostino, DOE/NNSA
Geoff Beausoteil, DOE/NNSA/SSO
Marilyn Hewson, Lockheed-Martin Corp.



Department of Energy
National Nuclear Security Administration
Washington, DC 20585
November 21, 2012



Dr. Paul J. Hommert
President and Laboratories Director
Sandia Corporation
P.O. Box 5800, Org. 00001, MS-0101
Albuquerque, New Mexico 87185

SUBJECT: Final Determination on Reduction of Fee for Kodiak Island, Alaska Motor Vehicle Accident

Dear Dr. Hommert:

On April 10, 2012, I notified you that as the Fee Determination Official (FDO) for Sandia Corporation's contract with the U.S. Department of Energy, Contract No. DE-AC04-94AL8500, I have determined that the Motor Vehicle Accident that occurred at Kodiak Island, Alaska on February 23, 2006, constituted a "catastrophic event" under Clause L75, Conditional Payment of Fee, Profit, or Incentives (DEC 2000) of Sandia Corporation's contract and that a reduction of fee was warranted.

Before deciding on the actual amount of fee reduction, I asked for your views on any mitigating circumstances related to this catastrophic event that I should consider. You responded on May 10, 2012, and I have considered all of the information that you provided to me regarding this incident in making my decision on the amount of fee reduction. My final fee reduction decision is attached and incorporated into this letter.

Sincerely,

Neile L. Miller
Principal Deputy Administrator
and Fee Determination Official

cc: Macillyn Hewson, Chair, Sandia Corporation Board of Directors
Michael Lempke, Associate Principal Deputy Administrator
Geoffrey Beausoleil, Manager, Sandia Site Office Manager
JoAnn Wright, Contracting Officer, Sandia Site Office



**FEE DETERMINATION OFFICIAL'S FINAL DECISION
OF SANDIA CORPORATION'S FY2006 FEE REDUCTION
FOR KODIAK ISLAND INCIDENT**

I have decided to reduce Sandia Corporation's FY 2006 earned fee of \$24,306,799 by 25 percent, for a fee reduction in the amount of \$6,076,699.75 for the tragic accident that occurred at Kodiak Island, Alaska, on February 23, 2006. On April 10, 2012, I wrote to Dr. Paul Hommert, Sandia Corporation President and Laboratories Director, to inform him that I had determined that the vehicle accident at Kodiak Island constituted a "catastrophic event" under Clause L75, DEAR 970.5215-3 "Conditional Payment of Fee, Profit, or Incentives (DEC 2000)," and that a reduction of fee is warranted (Attachment 1). I asked Dr. Hommert for his views on any mitigating circumstances related to this catastrophic event before deciding on the amount of fee reduction. In a letter dated May 10, 2012, Dr. Hommert provided me with his views on this issue (Attachment 2). I have considered all of the information that Dr. Hommert provided to me in making my decision on the amount of Sandia's FY 2006 earned fee that should be reduced.

THE ACCIDENT

The facts of the Kodiak Island accident are described in an internal investigation, dated July 27, 2007, entitled "Motor Vehicle Accident, Narrow Cape, Kodiak Island, Alaska" that was conducted by Sandia Corporation's Legal Division. This investigation was made to determine what, if any, legal liability Sandia Corporation and its employees may incur in connection with the accident. In addition, several separate investigations were conducted on behalf of those injured in the accident, and the Alaska State Troopers conducted an investigation resulting in its August 2006 report.

In January and February 2006, Sandia employees supporting the Missile Defense Agency (MDA) were assigned to work at the Kodiak Launch Complex located at Kodiak Island, Alaska to assemble and prepare a Strategic Target System (STARS) rocket and its payload for launch. Beginning on about February 17, 2006, the efforts shifted to night operations to accommodate mission needs. During the week between February 17 and the launch of the rocket on February 23, Sandia employees worked long hours with work typically beginning at 2115 and ending early to mid-morning the following day. The STARS rocket was successfully launched at 0709 on February 23, 2006. Beginning mid to late morning that day a launch celebration was held at Narrow Cape Lodge, located approximately three miles from the Kodiak Launch Complex, where the Sandia employees stayed during their assignment at Kodiak Island. The launch celebration appeared to be an informal event, with no specific sponsor, although the internal investigation revealed that such celebrations were apparently a tradition after a successful launch. There were "launch beers" purchased specifically for the launch celebration, and other

beer and liquor was available. There was evidence that all of the individuals who were involved in the accident, ~~were~~ drinking alcoholic beverages during the launch celebration.

While still daylight in the late afternoon, at approximately 1730 to 1800, a number of Sandia employees decided to start a bonfire. ~~(b)(6)~~ used his assigned GSA Jeep Cherokee to collect driftwood from the Narrow Cape beach, a short distance from the lodge. ~~(b)(6)~~ reportedly had Sandia management approval to use his GSA Jeep to retrieve firewood. Two others, ~~(b)(6)~~ decided to accompany ~~(b)(6)~~. While on the beach, the Jeep became stuck and ~~(b)(6)~~ had to walk back to the lodge. On their return trip, they reportedly saw a large gully or sinkhole, later described to be approximately six feet deep and twelve feet wide.

Upon their return to the lodge, ~~(b)(6)~~ the driver, apologized for getting the GSA Jeep stuck and stated that ~~(b)(6)~~ would retrieve the vehicle in the morning. ~~(b)(6)~~ Senior Manager, directed ~~(b)(6)~~ to retrieve the GSA Jeep that night, apparently concerned that it may be washed out to sea with the tide. After ~~(b)(6)~~ reportedly attempted to object, ~~(b)(6)~~ told "[y]ou get that car back here or there'll be hell to pay." ~~(b)(6)~~ refused to go back, but another Sandia employee, ~~(b)(6)~~ volunteered to help. At approximately 1900, when it was reportedly "pitch black dark," ~~(b)(6)~~ drove a second GSA Jeep to retrieve the stuck vehicle. ~~(b)(6)~~ accompanied ~~(b)(6)~~ in the front passenger seat, and ~~(b)(6)~~ was in the rear seat. ~~(b)(6)~~ drove into the sinkhole that he had seen earlier, but could not see in the darkness.

Alcohol clearly was a contributing factor in the cause of the accident. ~~(b)(6)~~ blood alcohol count several hours after the accident was .059, below the .080 level where alcohol is presumed to be a factor, but still above .040, the point below which a presumption of non-impairment would have applied. Nevertheless, the Alaska Motor Vehicle Collision Report dated 8/18/06 stated that "[a]lcohol was a factor," and charges of Assault in the first degree and DUI were referred to the Kodiak District Attorney's office for review. Several months later, the DA decided to not pursue charges due to "the uniform desire of both victims" and "[g]iven the relative degree of potential criminal liability." There are also reports that ~~(b)(6)~~ was intoxicated when ~~(b)(6)~~ volunteered to help, and that ~~(b)(6)~~ had been drinking before ~~(b)(6)~~ "ordered ~~(b)(6)~~ to retrieve the stuck vehicle.

~~(b)(6)~~ was restrained by a seat belt and suffered a broken arm in the accident. ~~(b)(6)~~ not wearing ~~(b)(6)~~ seat belt, hit the windshield and suffered a closed head brain injury and broken bones. ~~(b)(6)~~ also did not wear ~~(b)(6)~~ seat belt (which apparently was stuck behind the seat) and suffered multiple injuries that left ~~(b)(6)~~ permanently disabled and requiring constant care.

Lump sum settlements were paid to (b)(6) and (b)(6) in addition to (b)(6) under the New Mexico Workers Compensation Act. (b)(6) The Sandia Site Office approved (b)(6) settlement on August 15, 2007 and (b)(6) settlement on September 8, 2008. Total costs incurred by Sandia for the Kodiak Island accident to October 28, 2011 are \$4,293,328.85. In addition, (b)(6) are expected to be incurred.

LEGAL AND PROCEDURAL ISSUES RAISED BY SANDIA CORPORATION

In his May 10, 2012 response to my letter requesting his view on mitigating circumstances involved in the Kodiak Island accident, Dr. Hommert first raises a number of legal and procedural issues regarding my authority to make a fee reduction determination. I have addressed each of the issues raised by Dr. Hommert below.

Applying the Correct Clause

Dr. Hommert first challenges the legitimacy of the Conditional Payment of Fee clause in Sandia Corporation's contract. Dr. Hommert asserts that the clause is outdated and should have been replaced with the current version of the clause DEAR 970.5215-3 "Conditional Payment of Fee, Profit and Other Incentives – Facility Management Contracts (AUG 2009)." While Dr. Hommert is correct in his assertion that the Department of Energy was required by statute to develop a new version of the clause, he is incorrect that the August 2009 version should apply in this case.

The Department of Energy promulgated a new rule on December 10, 2003 for the inclusion of a new clause – DEAR 970.5215-3 "Conditional Payment of Fee, Profit, and Other Incentives – Facility Management Contracts (JAN 2004)" (later amended with minor clerical changes with a new date of August 2009). However, Sandia Corporation's contract in place at the time of the accident was made effective as of October 1, 2003, and Contracting Officers were directed in the rulemaking to only include the new 2004 clause into contracts that were awarded or extended after the effective date of January 1, 2004. Further, it had been Sandia Corporation's position during annual fee and scope negotiations that the newer version of this clause not be incorporated into its contract, including in the FY 2011 negotiations.

On September 29, 2012, the Sandia contract was extended for an additional year, and DEAR 970.5215-3 "Conditional Payment of Fee, Profit, or Other Incentives – Facility Management Contracts (AUG 2009)" was incorporated into Sandia Corporation's contract. Since the Kodiak Island accident occurred during FY 2006, and my determination affects the amount of earned fee

that Sandia Corporation earned during that fiscal year, the December 2000 version of the Conditional Payment of Fee clause is used as the basis in making my fee reduction determination. Nevertheless, I have decided to also consider the Department's policy relating to the amount of fee reduction as articulated in the August 2009 version of the clause.

Cost Allowability Determination

Dr. Hommert points out that Patty Wagner, former Sandia Site Office Manager and Contracting Officer, made a determination on October 11, 2011 that the costs associated with the Kodiak Island accident were determined to be allowable. However, Dr. Hommert goes on to assert that a fee reduction for this incident would be inconsistent with that allowability determination. The fact that Ms. Wagner found these costs to be allowable under her authority as Contracting Officer is irrelevant to my determination the Kodiak Island accident is a catastrophic event that warrants a reduction of fee. A determination of cost allowability is governed by the regulations included in FAR Part 31; a determination of whether a fee reduction is appropriate is governed by the Conditional Payment of Fee clause that was included in Sandia Corporation's contract.

Dr. Hommert's argument on this point appears to be based on a belief that both a negative cost allowability determination and a determination of a fee reduction require either a finding of noncompliance with general terms and conditions of the contract, or the Environment Safety & Health (ES&H) terms and conditions of the contract, respectively. Neither determination requires such a finding.

According to Dr. Hommert's argument, since the Kodiak Island accident costs were determined to be allowable, Patty Wagner must have found that Sandia Corporation complied with all of the contract's terms and conditions, including its ES&H terms and conditions. However, no such finding was made in the cost allowability determination, nor was it required to be made to find the costs allowable. Sandia Corporation's contract contains the older version of FAR 31.201-2(a)(4) (from 1996), which does not establish "compliance with the terms and conditions of the contract" as a *prerequisite* to allowability but rather as *one of several factors to be considered*. Accordingly, the determination of allowability does not necessarily mean that a determination of compliance with the contract terms and conditions was made.

Likewise, Dr. Hommert's reading into either version of the Conditional Payment of Fee clause that there must first be a threshold finding of "a noncompliance with the ES&H terms and conditions of the contract constituting a performance failure that warrants a reduction in fee" is without merit. The only threshold finding for application of the December 2000 version of the Conditional Payment of Fee clause is whether there is a catastrophic event such as a serious workplace-related injury to a contractor employee. Under the August 2009 version of the Conditional Payment of Fee clause, the threshold finding is an ES&H performance failure as the

result of either noncompliance with the contract's ES&H terms and conditions, including Sandia's Integrated Safety Management System, or a breakdown of Sandia's Safety Management System. While there is no need for me to make such a finding, the Kodiak Island accident clearly represents at the very least a breakdown of Sandia's Safety Management System.

Authority to Make Fee Reduction Determination and Consideration of Mitigating Factors

Dr. Hommert challenges my authority to make a fee reduction determination based on his erroneous assertion that the December 2000 version of the Conditional Payment of Fee clause should be replaced with the August 2009 version of that clause. Under the August 2009 Conditional Payment of Fee clause, the Contracting Officer, and not the Fee Determination Official, makes any determination on the reduction of fee.

As discussed previously, the December 2000 version of the Conditional Payment of Fee clause is the clause that was included in Sandia Corporation's contract at the time of the Kodiak Island accident. At the time of the 2003 contract extension negotiations, the December 2000 clause was deviated from the standard clause by replacing the DOE Operations/Field Office Manager with the Fee Determination Official. That change was made because of the reorganization of NNSA in 2002 that eliminated the position of Albuquerque Operations Office Manager, and because it was more appropriate that the same official making the decision as to the amount of fee earned also make any decisions regarding the withdrawal of fee. The December 2000 clause never gave the authority to reduce fee to the Contracting Officer.

Dr. Hommert also expresses concern that the wording of my April 10, 2012 letter reflected my determination that a fee reduction was in order. He is correct in his reading of my letter. Based on my review of Sandia Corporation's July 27, 2007 internal investigation report and settlement authority requests, I had determined that the negligence of Sandia employees contributed to the Kodiak Island accident. My April 10, 2012 letter to Dr. Hommert asked him to provide me with any mitigating factors that he wished me to consider in making my decision on the amount of fee reduction. This decision incorporates my consideration of the mitigating factors that Dr. Hommert provided me in his May 10, 2012 response.

Support of National Security Work for Others Activities

Dr. Hommert claims that a fee reduction for the Kodiak Island accident would have long term negative implications for Sandia National Laboratories and its ability to support national security. Dr. Hommert appears to be implying that a fee reduction for a Work for Others program performed for the MDA would have a chilling effect on Sandia Corporation's desire to do other Work for Others projects. As the NNSA Deputy Administrator, I fully support Sandia

Corporation's work for other federal agencies that are in support of national security. My decision to reduce Sandia Corporation's fee for the Kodiak Island accident is in no way designed to discourage Sandia Corporation in doing Work for Others. Rather, it is designed to ensure that all such work is done with the utmost consideration for the safety and health of its employees, as is the Government's expectation for all of the work that Sandia Corporation performs.

MITIGATING FACTORS PRESENTED BY SANDIA CORPORATION

In presenting mitigating factors for my consideration, Dr. Hommert relied on those mitigating factors that are required to be considered by the Contracting Officer under the August 2009 version of the Conditional Payment of Fee clause. Since this clause was not applicable to Sandia Corporation's contract at the time of the Kodiak Island accident, I am not required to consider these specific mitigating circumstances. However, since these are the mitigating circumstances that were offered by Dr. Hommert, I will consider each of them in turn.

Degree of Control the Contractor had Over the Event or Incident

Dr. Hommert notes (1) the Kodiak Island accident occurred off of Sandia's laboratory facilities in a remote location; (2) the Sandia team's schedule to support the MDA mission resulted in significant overtime hours and fatigue appears to be the leading factor in the accident; (3) the accident occurred "after hours" following a launch celebration; and (4) DOE's guidance in DOE Order 225.1A, in place at the time of the accident, stated that "[o]ffsite accidents meeting the Type A or Type B criteria involving Federal or contractor employees driving government-owned or rented vehicles shall not be investigated unless the Head of the Field Element determines an investigation is appropriate based on circumstances surrounding the accident or the potential for significant lessons learned."

I do not find Dr. Hommert's arguments here persuasive. The launch celebration, while perhaps not a sanctioned Sandia event, and occurring "after hours" apparently had the active participation of Sandia senior managers. Fatigue of the Sandia employees was a factor in the accident. However, since the accident occurred more than eight hours after their work had ended, the employees involved in the accident certainly had the opportunity to rest. Further, the employees fatigue was no doubt exacerbated by their consumption of alcohol, and as noted earlier, alcohol was clearly a factor in the accident.

The DOE guidance in DOE Order 225.1A cited by Dr. Hommert refers to whether a formal DOE investigation is required for offsite accidents. There was no formal DOE investigation into this accident. Nevertheless, Sandia Corporation correctly determined that this accident did warrant a thorough internal investigation.

I find that the unique facts and circumstances of this case are relevant to the issue of Sandia's control, particularly the specific direction given by Senior Sandia Manager, (b)(6) to retrieve the stuck vehicle that night, in the "pitch black darkness," despite the fact that (b)(6) knew that (b)(6) was fatigued, had been drinking and the terrain was rugged. (b)(6) appeared to be more concerned about getting blamed for the possible loss of a government vehicle and having to explain why a government vehicle was being used to gather firewood for a launch celebration, than (b)(6) was about the safety of employees. (b)(6) statement to (b)(6) that "[y]ou get that car back here or there, I'll be hell to pay" under the conditions described is especially telling. The decision by (b)(6) to refuse to accompany (b)(6) demonstrates that (b)(6) thought retrieval of the vehicle that night was simply too dangerous. It was (b)(6) actions on the evening of February 23, 2006 that created a significant potential liability for Sandia Corporation under the New Mexico "Delgado doctrine" and was the primary reason Sandia settled the (b)(6) cases for more than what was statutorily required under workers compensation. Sandia also apparently believed it had control over its employees in this case because it accepted all employees' workers compensation claims, and retained counsel to defend the driver. For these reasons, I find that Sandia Corporation had a great deal of control over the circumstances that led to the Kodiak Island accident.

Efforts the Contractor had Made to Anticipate and Mitigate the Possibility of the Event in Advance

For Sandia Corporation's efforts to anticipate and mitigate the possibility of a vehicle accident at Kodiak Island, Dr. Hommert cites the fact that Sandia provided housing at the Narrow Cape Lodge to be close to the Kodiak Launch Complex to avoid unnecessary additional travel after long hours and thereby try to prevent vehicle accidents. Whether or not the selection of the Narrow Cape Lodge was made with the thought of preventing vehicle accidents, the fact that the Narrow Cape Lodge was the focal point of the launch celebration makes this mitigating factor largely irrelevant. Further, if Dr. Hommert's stated reason was the primary consideration, Sandia Corporation's line management was apparently unaware of this desire to avoid unnecessary travel when they reportedly gave permission to use a government vehicle to gather firewood on the beach.

Contractor Self-Identification and Response to the Event in an Attempt to Mitigate Impacts and Recurrence

Dr. Hommert cites the following response actions taken by Sandia Corporation to the Kodiak Island accident to prevent a recurrence of such an incident: (1) Creation of OP-21 "Requirements for Off-Nominal Work Conditions;" (2) regular management safety reviews and work planning and controls meetings; (3) an internal investigation of the accident that was shared with management; (4) counseling of the Senior Manager on his management

accountabilities and responsibilities for employee safety; and (5) performance feedback to a vice president about expectations regarding employee safety, risk, and operational excellence in regards to remote operations.

While not specifically described by Dr. Hommert, my understanding is that OP-21 incorporated new policies specific to the Kodiak Launch Complex that include rules for work and rest hours, the availability of portable radios, and explicit language regarding the use of alcohol while on assignment. While commendable, I find this to be a minimal response to inexcusable lax safety standards that were in place for Sandia employees at the Kodiak Launch Complex and Narrow Cape Lodge at the time of the accident. More disturbing to me is the fact that it appears that ^{(b)(5), (b)(7)} no disciplinary action was taken against any of the employees involved in this accident. Sandia's Senior Manager who directed the stuck vehicle be retrieved, received "counseling" as an "opportunity for improvement." The relevant Vice President - who was not on-site - received negative "interim feedback," but for the performance year received an overall rating of Outstanding Contributor. I find that Sandia Corporation's minimal response to this very serious accident, and particularly its failure to discipline any of its employees, was not reasonably calculated to prevent a recurrence of this type of incident.

General Status (Trend and Absolute Performance) of ES&H and Compliance in Related Areas

Dr. Hommert cites a number of efforts to make continuous improvement in ES&H areas. These include (1) the engagement of ES&H support personnel with the vice presidents through the Executive Safety Committee; (2) utilization of the ES&H Dashboard to display performance measures related to the Performance Evaluation Plan; (3) regular briefings to the Sandia Site Office on the status of performance measures through the Joint Performance Assurance Team; (4) quarterly analysis performed in accordance with DOE Order 232.2 and DOE Order 231.1B; (5) presentation of the Quarterly Performance Analysis to the ES&H Management Review Board and to the Executive Management Review; and (6) implementation of a Severity Analysis which scores events on various attributes including impact to worker, impact to mission, and impact to the environment.

While these administrative efforts to make improvement in ES&H are commendable, I am nevertheless concerned that an ES&H culture that properly values worker safety was not ingrained in Sandia Corporation at the time of this accident, particularly among line management. Further, Sandia Corporation has not taken sufficient actions since this accident to significantly change its safety culture.

NNSA noted its concern for Sandia Corporation's safety culture in its FY 2005 Performance Evaluation Report, the year before the Kodiak Island accident, where NNSA noted "Work

Hazard Identification and Analysis, at the activity level, needs improvement in order to integrate ES&H requirements into line organization activities.”

In November 2008 Sandia Corporation convened an Executive Safety Review Board “to assess how and why SNL failed to prevent a recent series of incidents and accidents that could have resulted in serious injury or death.” In its report, dated December 23, 2008, the Board made a number of significant conclusions with respect to Sandia Corporation’s safety culture, particularly with respect to the role of line management:

Executive management has not demonstrated by their behaviors that safety is a value at SNL. Executive management has not taken the steps necessary to establish the performance expectations and clear accountability structure to make safety a value. The large number of initiatives and absence of prioritization result in line management being unable to devote the time required to assure safe operations. These factors combine to create a continuing risk that employees will be injured or killed.

SNL does not exhibit the behaviors and strengths of a learning organization, which compromises its ability to learn from past safety incidents and studies (including this report) and prevent their reoccurrence.

SNL’s management system and work environment prevent the workforce from moving beyond awareness to the deep understanding, personal commitment, and action required for safety to be a value at SNL.

Unclear roles, poor teaming, and a lack of mutual understanding and respect between personnel in the ES&H and Emergency Management Center and many line organizations create barriers to safe operations at SNL.

Poor requirements management, an over-reliance on process, and poorly designed or inadequate processes and tools create barriers to assured safety at SNL and contribute significantly to the complexity that line management encounters when planning and executing work.

The Board also urged Sandia Corporation to address these issues immediately:

The Board believes that SNL faces a continuing risk that employees will be injured or killed. SNL must take steps now to assure that work is being performed safely, and it is essential that the issues discussed in this report are addressed with urgency.

Although Sandia Corporation has made improvements in ES&H, NNSA has continued to express concerns on its safety performance, including in its FY11 Performance Evaluation Report in which NNSA notes that safety performance needs to improve across all mission areas, and all line organizations need to be held accountable for safe, secure, and environmentally sound operations across the laboratory.

Contractor demonstration to the Contracting Officer's satisfaction that the principles of industrial ES&H standards are routinely practiced (e.g., Voluntary Protection Program, ISO 14000)

Dr. Hommert posits that this was not a failure of a system, but rather a single, unique event, which occurred outside of laboratory facilities. I disagree. My assessment is that this accident resulted from the failure of Sandia Corporation to instill a safety culture throughout its organization, regardless of whether the work is being done onsite or at remote sites such as Kodiak Island. The Sandia employees at Kodiak Island, particularly its on-site line managers, should have been able to recognize that it was not safe to have a launch celebration with alcohol following the completion of a mission in which many employees worked very long hours that resulted in extreme fatigue. Nor was it safe to use, or to approve the use, of a Government supplied vehicle by employees who were fatigued and had been consuming alcohol. Sandia Corporation's line manager, _____ arguably exercised reckless disregard for the safety of _____ subordinates by ordering them to retrieve the stuck vehicle under these conditions and in pitch black darkness. I find that this accident reflected a serious breakdown of Sandia Corporation's Integrated Safety Management System, and that this breakdown was the result of many of the problems cited in the Executive Safety Review Board report. The fact that Sandia's Integrated Safety Management System is ISO certified is impressive, but that fact apparently did not have much of an impact in preventing the tragic accident that occurred on Kodiak Island on February 23, 2006.

Event caused by "Good Samaritan" act of the Contractor (e.g., offsite emergency response)

Dr. Hommert's attempt to justify any of the actions by his employees on the evening of February 23, 2006 at Kodiak Island as a "Good Samaritan" act is particularly troubling to me. Dr. Hommert cannot use the contract requirement to protect government property as a shield in this matter when Sandia employees caused the circumstances jeopardizing the government property and necessitating such protection in the first place. But even more troubling is Dr. Hommert's assertion that "[t]he employees willingly complied, and one even volunteered to go along to assist." This statement is contrary to the facts described in Sandia Corporation's own internal investigation. _____ initially proposed to retrieve the stuck vehicle in the morning, when it was light, but was pressured by _____ order to retrieve the vehicle that night. Dr. Hommert's claim that his employees "willingly complied" also ignores the fact that one of the

three employees who was directed to go back, (b)(6) refused to follow (b)(6) order and went back to Narrows, Cape Lodge. And based on the investigations of the accident, there is evidence that, (b)(6) the unfortunate volunteer who did agree to go along to assist, was intoxicated at the time (b)(6) made that decision.

The assertion by Dr. Hommert that "employees had driven these vehicles in this location previously" is also not consistent with Sandia Corporation's internal report, where one of the victims is quoted as saying (b)(6) had not done so and was unaware of other employees doing so. If line managers were aware that this was the case, then they should have recognized the risk and halted the practice, particularly if employees had previously driven the beach at night after working night shifts and drinking alcohol.

Finally, Dr. Hommert's claim that "[t]he eagerness to quickly assist and employee dedication led to an accident that even the strongest controls likely would not have prevented" is disingenuous. Sandia employees did exhibit strength of character that night, but it was not in complying with an ill-advised order, it was in response to their co-workers' tragic accident that resulted from compliance with that ill-advised order.

Contractor demonstration that a performance measurement system is routinely used to improve and maintain ES&H performance

Dr. Hommert's further description of Sandia Corporation's efforts to improve and maintain ES&H performance is once again to be commended and I agree that these efforts are steps in the right direction. Nevertheless, NNSA continues to have concerns that Sandia Corporation's safety performance needs further improvement, particularly among line management, as described in the 2008 Executive Safety Review Board Report.

Contractor demonstration that an Operating Experience and Feedback Program is functioning that demonstrably affects continuous improvements in ES&H by use of lessons learned and best practices inter- and intra-DOE sites

Dr. Hommert points to Sandia Corporation's Corporate Lessons Learned program as another mitigating factor. Once again, this is a commendable effort and I expect that the series of events that led up to the Kodiak Island accident has been incorporated into its Lessons Learned program.

DETERMINATION

After a thorough review of all of the facts of the tragic accident that took place on Kodiak Island on February 23, 2006, the legal and procedural issues raised by Dr. Hommert, and the mitigating

circumstances that he has provided me in his letter of May 10, 2012, I find that the accident constitutes a "catastrophic event" as that term is defined in clause I.75 of Sandia Corporation's FY 2006 contract, and that a reduction of FY 2006 earned fee is warranted.

My determination is based on my finding that this accident resulted from the failure of Sandia Corporation to instill a safety culture throughout its organization, regardless of whether the work is being done onsite or at remote sites such as Kodiak Island. The Sandia employees at Kodiak Island, particularly its on-site line manager, should have been able to recognize that it was not safe to have a launch celebration with alcohol following the completion of a mission in which many employees worked very long hours that resulted in extreme fatigue. Nor was it safe to use, or to approve the use, of a Government supplied vehicle by employees who were fatigued and had been consuming alcohol. Sandia Corporation's line manager, ^{(b)(6)} arguably exercised reckless disregard for the safety of subordinates by ordering them to retrieve the stuck vehicle under these conditions and in pitch black darkness. I find that this accident reflected a serious breakdown of Sandia Corporation's Integrated Safety Management System.

DECISION ON THE AMOUNT OF EARNED FEE REDUCTION

In deciding on the amount of fee reduction that is appropriate I have chosen to use as guidance the current version of this clause that has recently been incorporated into Sandia Corporation's contract to provide a set of objective criteria for an appropriate amount of fee reduction. DEAR 970.5213-3 "Conditional Payment of Fee, Profit, and Other Incentives - Facility Management Contracts (AUG 2009)" lists three degrees of safety performance failures. I find the Kodiak Island accident to fall within the definition of a Second Degree performance failure that resulted from a breakdown of Sandia Corporation's Safety Management System and that resulted in a Type B accident as defined in DOE Order 225.1A. A Type B accident was defined as "[a]ny accident that results in the hospitalization of one or more DOE, contractor, subcontractor employees or members of the public for five continuous calendar days or longer due to serious injury (as defined in 49 CFR 830.2), occupational illness (except members of the public), chemical exposure, or biological exposure." For a Second Degree performance failure, a reduction of fee shall be not less than 11 percent nor greater than 25 percent.

I am, therefore, reducing Sandia Corporation's earned fee for FY 2006 of \$24,306,799 by an amount of \$6,076,699.73, representing a reduction of 25 percent.



Neile Miller
National Nuclear Security Administration
Principal Deputy Administrator and Fee Determination Official


Date