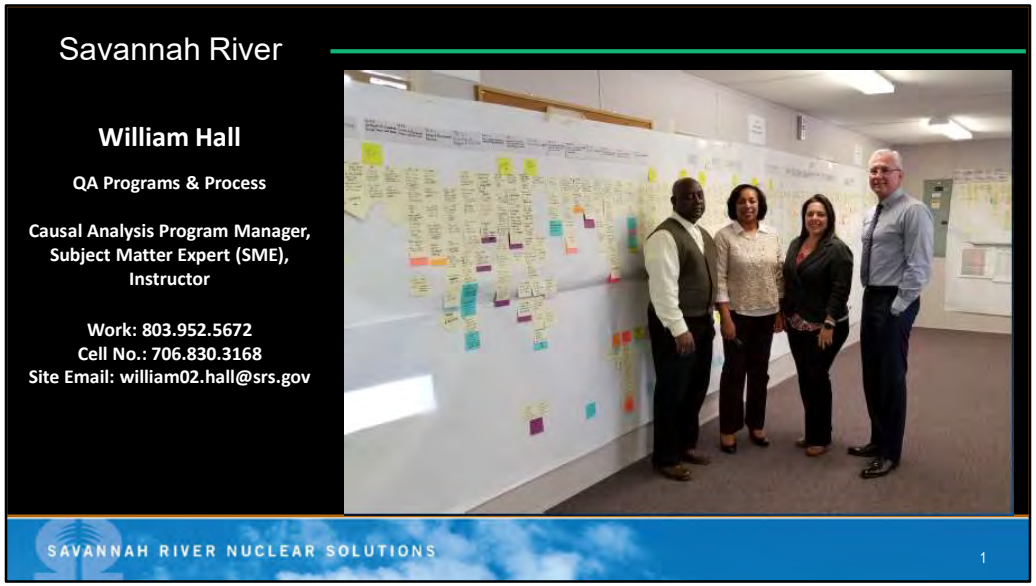
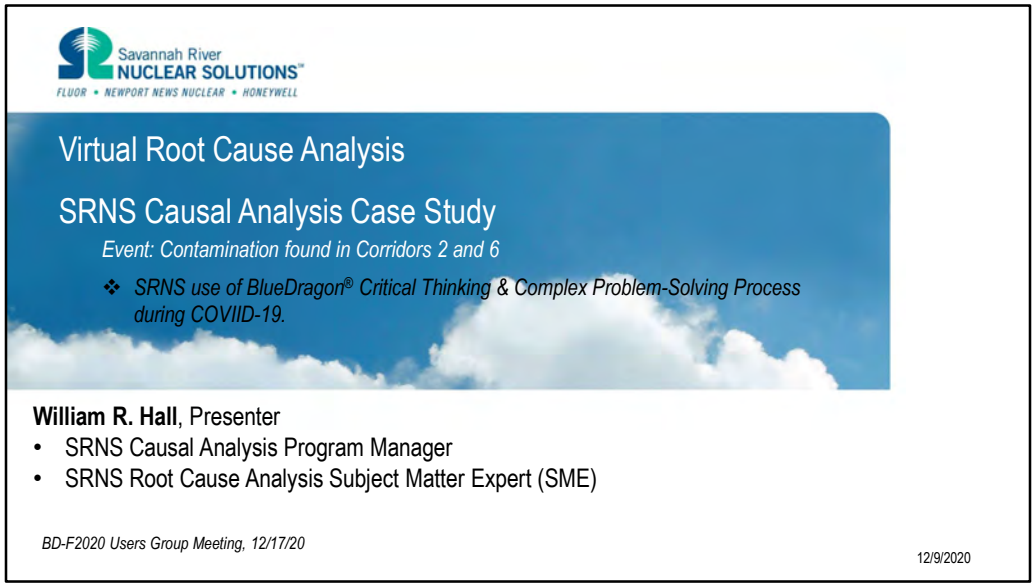


Talking Points

Introduction:

- Employed with Contractor SRNS at Savannah River Site
- QA Programs & Process Group – Operational Excellence
- Causal Analysis related title:
  - Causal Analysis Program Manager
- Causal Analysis related Roles & Responsibilities:
  - Subject Matter Expert
  - Instructor
  - Site Lead Apparent/Root Cause Analyst
  - Causal Analyst Qualifying Program Manager
  - Quality Grading Lead

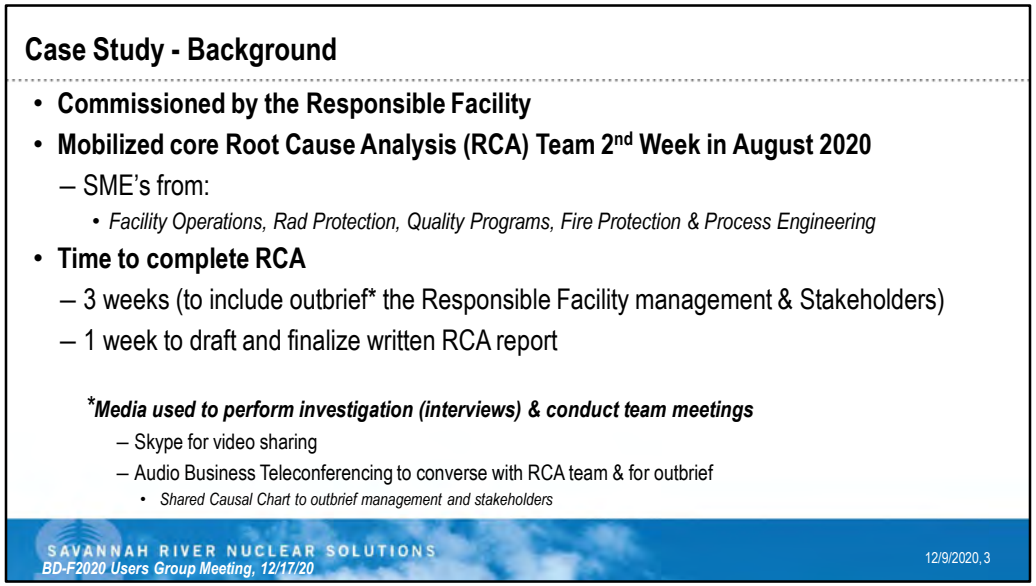


Talking Points:

- SRNS started using BlueDragon in 2018

- Program Implementation:
  - Qualification Program
    - Lead Root Cause Analyst (LRCA) – 5 qualified
    - Lead Apparent Cause Analyst (LACA) – 19 qualified
  - Causal Analysts Community Meetings
  - Quality Grading Process of completed RCAs & ACAs
    - Grading results feedback to Analyst(s) and Responsible Manager

- 40+ individuals have been trained (most face-to-face / 5-6 participated virtually)
  - BlueDragon overview was provided to Managers



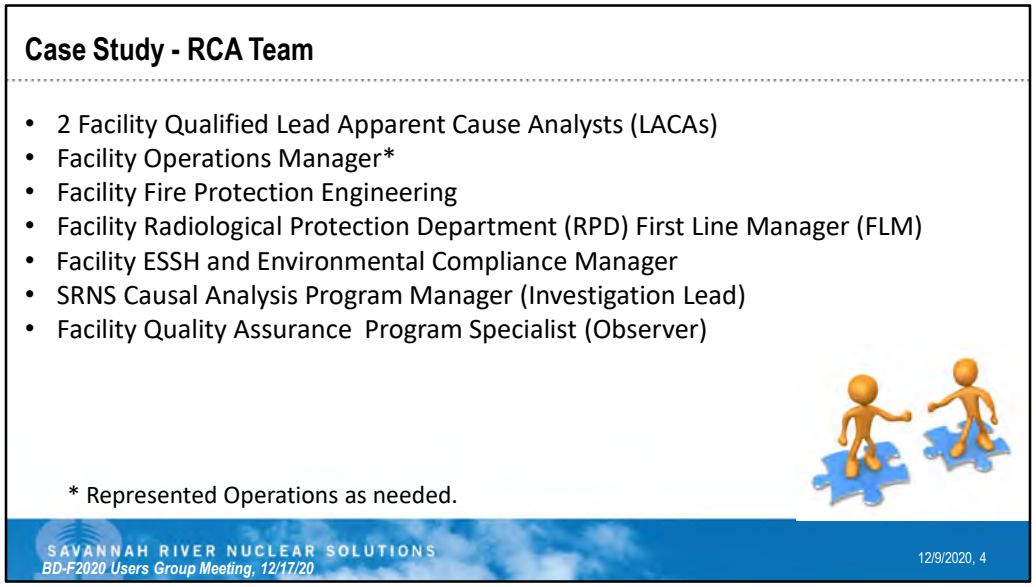
Talking Points:

Commissioned by the Responsible Facility following the completion of Fact Finding

Using the facilitated BD approach allowed the team to uncover several weaknesses

Problems found:

1. Corridors 2 and 6 impeded access to other processing areas
2. Affected part of system could not be used until issue was resolved.
3. Had been a "Lack" of effective contamination control
4. Documentation of previously identified weaknesses were not being tracked appropriately
5. Material used in facility to control the spread of water hadn't always received appropriate approval



Talking Points:

RCA Team
Program Manager, SRNS Causal Analysis Program
- Root Cause Team Lead
- Qualified Lead Root Cause Analyst/Practitioner

2 Qualified Lead Apparent Cause Analysts
- Root Cause Lead Analyst In-Training Candidate; Team Member
- Trained and Qualified Lead Apparent Cause Analyst for SRNS

Radiological Protection Department (RPD) First Line Manager (FLM)
- Root Cause Team Member

RCA Team (cont'd)
Fire Protection Engineer
- Root Cause Team Member

ESSH and Environmental Compliance Manager
- Root Cause Team Member

Facility Operations Manager
- Root Cause Team Member

Quality Assurance Program Specialist
- Root Cause Observer

Case Study - Scope, Methodology and Process*

- Identified the Scope
- Held "kick-off" meeting w/Management Sponsor
- Developed Problem Statement
- Performed research and Data Analysis
- ID Barriers, determined effectiveness of Barriers
- Developed Lines of Inquiry (LOI)
- Determined most suitable Analysis Model (Method)
- Identified individuals to interview
- Scheduled and conducted interviews
- Used "Why-Why" and Socratic Questioning during interviews

* All interaction done virtually using Skype and audio business conferencing.

Talking Points:

1. Scope – the team was to determined the root cause(s) and identify any contributing factors
2. Problem statement - The team drafted Problem Statement:
   "On July 23, 2020, during normal operation of an absorption system, at approximately 0730, an operator notice standing water in Corridors 2 and 6 coming from under the West door of one of the process rooms. The operator notified the proper shift management and Radiological Protection Department (RPD) immediately. Additional absorbent material were placed on the water in the corridors to control (keep) the water from spreading farther. As a precaution pending survey results, RPD expanded the existing Radiological Buffer Area. Although no detectable elevated air activity was present in the corridors, the wet smears taken of the water indicated a very high level of contamination was present in the water. Due to the level of detectable contamination found the area was deemed a High Contamination Area (ACA) and was posted appropriately."
3. Kick-Off Mtg – the team met with and briefed the Management Sponsor
4. Barrier Analysis – reviewed and evaluated effectiveness of barriers

Case Study - Casual Analysis Sessions*

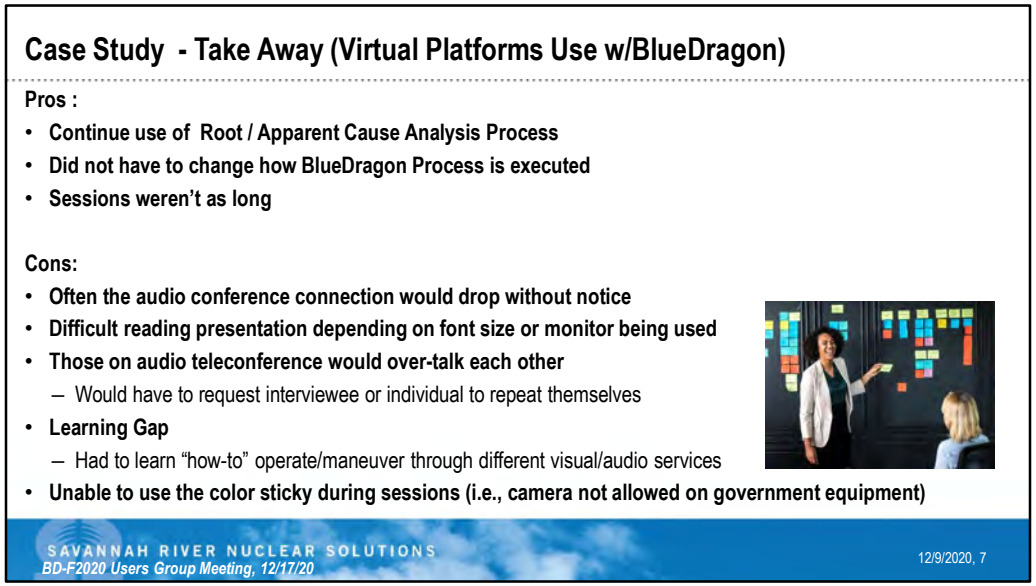
- **Conducted question and answer sessions**
  - Had conversations during interviews
  - Were able to expand on LOIs during interviews
- **Engaged individuals (across functional disciplines) - non-exempt to management**

- ✓ Radiological Protection Depart (RPD) Inspector
- ✓ Shift Technical Engineer (STE)
- ✓ Fire Protection Engineers (FPEs)
- ✓ Fire Protection Engineering Mgrs.
- ✓ Radiological Protection Department FLM
- ✓ Facility Operations Manager
- ✓ Facility System/Process Engineers
- ✓ Reps for Management Team & Stakeholders
- ✓ Reps from Facility Management Team
- ✓ Facility Training Supervisor
- ✓ Facility Operations Training Trainer

* All interaction done virtually using Skype and audio business conferencing.

Talking Points:

- Using the layout of the “Chart” made it easier to organize and process the information.
- Using the BD approach to Causal Analysis provides a quicker and more efficient way for performing Causal Analysis.



Talking Points:

- Speak to a few Pros/Cons:
  - Pros – allowed continued use of BD for Causal Analysis
  - Cons – Calls would be dropped
  - Cons – Unable to use the color sticky

- Since implementing the use of BD, the results have greatly improved
  - Causes are determined faster
  - Quality of results (i.e., Results to Prevent the Recurrence and Occurrence of issues) have proven to be more effective.

Questions and Wrap Up