

I'm not robot!





**A Texas farmer found this astronaut helmet in his field after the Columbia disaster that killed 7 space shuttle crew members in 2003. Along with pieces of the shuttle and equipment, searchers in the debris field also found human body parts, including arms, feet, a torso, and a heart.**



Columbia space shuttle disaster investigation report. Did the columbia crew die instantly. What caused the columbia shuttle disaster in 2003. Why did the columbia shuttle disaster happen. How did the columbia shuttle crew die. Were the bodies of space shuttle columbia recovered.

[House Hearing, 108 Congress] [From the U.S. Government Printing Office] THE COLUMBIA ACCIDENT INVESTIGATION BOARD REPORT ===== HEARING BEFORE THE COMMITTEE ON SCIENCE HOUSE OF REPRESENTATIVES ONE HUNDRED EIGHTH CONGRESS FIRST SESSION SEPTEMBER 4, 2003 Serial No. 108-27 Printed for the use of the Committee on Science Available via the World Wide Web: 89-216 U.S. GOVERNMENT PRINTING OFFICE WASHINGTON : 2003

For Sale by the Superintendent of Documents, U.S. Government Printing Office Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; (202) 512-091800 Fax: (202) 512-092250 Mail: Stop S50F, Washington, DC 20402-090001 COMMITTEE ON SCIENCE HON. SHERWOOD L. BOEHLERT, New York, Chairman LAMAR S. SMITH, Texas RALPH M. HALL, Texas CURT WELDON, Pennsylvania BART GORDON, Tennessee DANA ROHRBACHER, California JERRY F. COSTELLO, Illinois JOE BARTON, Texas EDDIE BERNICE JOHNSON, Texas KEN CALVERT, California LYNN C. WOOLSEY, California NICK SMITH, Michigan NICK LAMPSON, Texas ROSCOE G. BARTLETT, Maryland JOHN B. LARSON, Connecticut VERNON J. EHLERS, Michigan MARK UDALL, Colorado GIL GUTKNECHT, Minnesota DAVID WU, Oregon GEORGE R. NETHERCUTT, JR., MICHAEL M. HONDA, California WASHINGTON CHRIS BELL, Texas FRANK D. LUCAS, Oklahoma BRAD MILLER, North Carolina JUDY BIGGERT, Illinois LINCOLN DAVIS, Tennessee WAYNE T. GILCHREST, Maryland SHEILA JACKSON LEE, Texas W. TODD AKIN, Missouri ZOE LOFGREEN, California TIMOTHY V. JOHNSON, Illinois BRAD SHERMAN, California MELISSA A. HART, Pennsylvania BRIAN BAIRD, Washington JOHN SULLIVAN, Oklahoma DENNIS MOORE, Kansas J. RANDY FORBES, Virginia ANTHONY D. WEINER, New York PHIL GINGREY, Georgia JIM MATHESON, Utah ROB BISHOP, Utah DENNIS A. CARDOZA, California MICHAEL C. BURGESS, Texas VACANCY JO BONNER, Alabama TOM FEENEY, Florida RANDY NEUGEBAUER, Texas C O N T E N T S September 4, 2003 Page Witness List..... 2 Hearing Charter..... 3 Opening Statements by Representative Sherwood L. Boehlert, Chairman, Committee on Science, U.S. House of Representatives..... 23 Written Statement..... 24 Statement by Representative Ralph M. 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Gehman, Jr., U.S. Navy retired, Chairman of the Columbia Accident Investigation Board..... 86 THE COLUMBIA ACCIDENT INVESTIGATION BOARD REPORT ----- THURSDAY, SEPTEMBER 4, 2003 House of Representatives, Committee on Science, Washington, DC. The Committee met, pursuant to call, at 10 a.m., in Room 2318 of the Rayburn House Office Building, Hon. Sherwood L. Boehlert [Chairman of the Committee] presiding, hearing charter COMMITTEE ON SCIENCE U.S. HOUSE OF REPRESENTATIVES The Columbia Accident Investigation Board Report Thursday, September 4, 2003 10:00 a.m.-12:00 p.m. 2318 rayburn house office building 1. Purpose On Thursday, September 4th at 10:00 a.m., the Science Committee will hold a Full Committee hearing on the findings and recommendations of the Columbia Accident Investigation Board (CAIB). The Committee will receive testimony from retired Navy Admiral Harold Gehman, Chairman of the 13-member Board, along with three members of the Board. 2. Background This is the first in a series of hearings the Science Committee will hold this fall on the Space Shuttle accident and related problems highlighted in the CAIB report. This hearing provides an opportunity for Admiral Gehman to present the report to the Committee and will set the stage for the follow-up hearings. The overall goal of this fall is to fully understand the risks, costs, and benefits of the human space flight program, including the Space Shuttle, and to determine what actions need to be taken to reform NASA. While the CAIB has said it intends the report to help NASA in safely getting back to human space flight, the report is hard hitting. It describes in detail the specific physical causes of the Shuttle Columbia's demise and documents the failures of NASA's organization in recognizing and dealing with the dangers the Shuttle faced. The CAIB makes a number of recommendations to remedy both problems, some that NASA must meet before the Shuttle returns to flight, and others that the report suggests will take longer to implement. It is likely that Congress will ultimately be responsible for ensuring those recommendations are met. The CAIB report also cites as contributions to the Shuttle accident NASA's reluctance to realistically assess its ability to conduct human space flight missions on a constrained budget and the lack of a national commitment to an ambitious and probably expensive vision for human space flight. The report sets the stage for a thorough public policy debate regarding the future of human space flight, the prospects for a Shuttle replacement, the appropriate balance of human and robotic missions, future priorities in space exploration, and the level of resources that should be allocated for such activities. The Committee's findings will, among other things, form the basis of a NASA reauthorization bill next year. 3. Witnesses Admiral Harold Gehman (retired), Chairman, Columbia Accident Investigation Board. Formerly Co-Chairman of the Department of Defense review of the attack on the U.S.S. Cole. Before retiring, Gehman served as the NATO Supreme Allied Commander, Atlantic, Commander in Chief of the U.S. Joint Forces Command, and Vice Chief of Naval Operations for the U.S. Navy. Gehman earned a B.S. in Industrial Engineering from Penn State University and is a retired four star Admiral, James Hallock, Ph.D., Manager, Aviation Safety Division, Volpe National Transportation Systems Center, Massachusetts. Dr. Hallock contributed to Group III of the CAIB, which focused on engineering and technical analysis of the accident and resulting debris. He has worked in the Apollo Optics Group of the MIT Instrumentation Lab and was a physicist at the NASA Electronics Research Center, where he developed a spacecraft attitude determining system. He joined the DOT Transportation Systems Center (now the Volpe Center) in 1970. Hallock received B.S., M.S., and Ph.D. degrees in Physics from the Massachusetts Institute of Technology (MIT). He is an expert in aircraft wake vortex behavior and has conducted safety analyses on air traffic control procedures, aircraft certification, and separation standards, as well as developed aviation-information and decision-support. Major General Kenneth W. Hess, Commander, Air Force Safety Center, Kirtland Air Force Base, New Mexico, and Chief of Safety, United States Air Force, Headquarters U.S. Air Force, Washington, D.C. Major General Hess contributed to Group II of the CAIB, which scrutinized NASA training, operations, and the in-flight performance of ground crews and the Shuttle crew. Hess entered the Air Force in 1969 and has flown operationally in seven aircraft types. He has commanded three Air Force wings—the 47th Flying Training Wing, 374th Airlift Wing, and 319th Air Refueling Wing—and commanded the U.S. 3rd Air Force, RAF Mildenhall, England. Hess also has extensive staff experience at the Joint Staff and U.S. Pacific Command. He holds a B.B.A. from Texas A&M University and a M.S. in Human Relations and Management from Webster College. Sheila E. Widnall, Ph.D., Institute Professor and Professor of Aeronautics and Astronautics and Engineering Systems, Massachusetts Institute of Technology (MIT), Massachusetts. Dr. Widnall also contributed to Group III of the CAIB, which focused on engineering and technical analysis of the accident and resulting debris. Widnall has served as Associate Provost, MIT, and as Secretary of the Air Force. She is currently Co-Chairman of the Lean Aero-space Initiative. A leading expert in fluid dynamics, Widnall received her B.S., M.S., and Ph.D. in Aeronautics and Astronautics from MIT. 4. Attachments: Executive Summary, Columbia Accident Investigation Report. Chapter 11, Recommendations, Columbia Accident Investigation Report. CRS Report, NASA's Space Shuttle Columbia, Synopsis of the CAIB Report (RS21606). CRS Report, NASA's Space Shuttle Columbia: Quick Facts and Issues for Congress (RS21408). Attachment 1 COLUMBIA ACCIDENT INVESTIGATION BOARD REPORT Volume 1 August 2003 EXECUTIVE SUMMARY The Columbia Accident Investigation Board's independent investigation into the February 1, 2003, loss of the Space Shuttle Columbia and its seven-member crew lasted nearly seven months. A staff of more than 120, along with some 400 NASA engineers, supported the Board's 13 members. Investigators examined more than 30,000 documents, conducted more than 200 formal interviews, heard testimony from dozens of expert witnesses, and reviewed more than 3,000 inputs from the general public. In addition, more than 25,000 searchers combed vast stretches of the Western United States to retrieve the spacecraft's debris. In the process, Columbia's tragedy was compounded when two debris searchers with the U.S. Forest Service perished in a helicopter accident. The Board recognized early on that the accident was probably not an anomalous, random event, but rather likely rooted to some degree in NASA's history and the human space flight program's culture. Accordingly, the Board broadened its mandate at the outset to include an investigation of a wide range of historical and organizational issues, including political and budgetary considerations, compromises, and changing priorities over the life of the Space Shuttle Program. The Board's conviction regarding the importance of these factors strengthened as the investigation progressed, with the result that this report, in its findings, conclusions, and recommendations, places as much weight on these causal factors as on the more easily understood and corrected physical cause of the accident. The physical cause of the loss of Columbia and its crew was a breach in the Thermal Protection System on the leading edge of the left wing, caused by a piece of insulating foam which separated from the left bipod ramp section of the External Tank at 81.7 seconds after launch, and struck the wing in the vicinity of the lower half of Reinforced Carbon-Carbon panel number 8. During re-entry this breach in the Thermal Protection System allowed superheated air to penetrate through the leading edge insulation and progressively melt the aluminum structure of the left wing, resulting in a weakening of the structure until increasing aerodynamic forces caused loss of control, failure of the wing, and break-up of the Orbiter. This breakup occurred in a flight regime in which, given the current design of the Orbiter, there was no possibility for the crew to survive. The organizational causes of this accident are rooted in the Space Shuttle Program's history and culture, including the original compromises that were required to gain approval for the Shuttle, subsequent years of resource constraints, fluctuating priorities, schedule pressures, mischaracterization of the Shuttle as operational rather than developmental, and lack of an agreed national vision for human space flight. Cultural traits and organizational practices detrimental to safety were allowed to develop, including: reliance on past success as a substitute for sound engineering practices (such as testing to understand why systems were not performing in accordance with requirements); organizational barriers that prevented effective communication of critical safety information and stifled professional differences of opinion; lack of integrated management across program elements; and the evolution of an informal chain of command and decision-making processes that operated outside the organization's rules. This report discusses the attributes of an organization that could more safely and reliably operate the inherently risky Space Shuttle, but does not provide a detailed organizational prescription. Among those attributes are: a robust and independent program technical authority that has complete control over specifications and requirements, and waivers to them; an independent safety assurance organization with line authority over all levels of safety oversight; and an organizational culture that reflects the best characteristics of a learning organization. This report concludes with recommendations, some of which are specifically identified and prefaced as "before return-to-flight." These recommendations are largely related to the physical cause of the accident, and include preventing the loss of foam, improved imaging of the Space Shuttle stack from liftoff through separation of the External Tank, and on-orbit inspection and repair of the Thermal Protection System. The remaining recommendations, for the most part, stem from the Board's findings on organizational cause factors. While they are not "before return-to-flight" recommendations, they can be viewed as "continuing to fly" recommendations, as they capture the Board's thinking on what changes are necessary to operate the Shuttle and future spacecraft safely in the mid- to long-term. These recommendations reflect both the Board's strong support for return-to-flight at the earliest date consistent with the overriding objective of safety, and the Board's conviction that operation of the Space Shuttle, and all human space flight, is a developmental activity with high inherent. Chairman Boehlert. The hearing will come to order. I want to welcome everyone here for the first of what will be an extensive series of hearings on the future of the Shuttle program, and of the manned space flight programs, in general. This is a pivotal moment in NASA's history, and this committee intends to lead the way in examining the issues that will enable Congress and the White House to chart NASA's future. Perhaps I should say in "confronting the issues" because moving forward will require asking tough questions and facing up to tough choices. We will be better able to do that because of the extraordinary work that has been done by Admiral Gehman and the entire membership and staff of the Columbia Accident Investigation Board. The Board members have been inspiring models: independent, focused, inquiring, tough, candid, and accessible. The Board report has to be the starting point for setting NASA's future course. If the Shuttle is to return to flight, then, at a minimum, every single one of the CAIB's return-to-flight recommendations must be implemented. That includes the recommendation that NASA have a detailed plan for addressing the organizational and cultural deficiencies the CAIB has so convincingly described. Indeed, Mr. Hall and I wrote to Admiral Gehman back in the early summer suggesting just that sort of recommendation to help ensure that NASA would act on the central recommendations concerning organization and culture. I think all of us need to face up to the rather disheartening picture of NASA that has been so painstakingly drawn by the CAIB. If we fail to do so, it is readily apparent that we will just have to go through this same and sad exercise again. NASA's experience may be the ultimate proof of Santayana's famous observation about those who fail to learn from the past being doomed to repeat it. The sad fact is that the loss of the Columbia and her crew was preventable. This is not even close to being a case in which the problems could only be seen in hindsight. We need to clearly identify and root out each of the systemic and individual failures that led to this accident. The CAIB report is a blueprint for doing so. The memory of the Columbia crew compels us to do no less. I have to say that I am concerned about some of the ways NASA has been approaching the return-to-flight thus far. I admire Administrator O'Keefe and I am pleased he has embraced the CAIB report with his words. But deeds are what count. And I am concerned that NASA may already be rushing to meet unrealistic launch dates instead of examining this report closely and moving deliberately. I am also concerned that NASA has been trumpeting changes in its safety organization that do not appear to address any of the problems that have been persuasively identified in the Board's report. Delay is not the goal, but if safety is to improve, NASA must not be judging itself by how quickly it can send the Shuttle back into orbit. And undue haste is ill advised for another reason, too. We, as a Committee, and as a nation, need some time to consider our overall space policy. We need to make fundamental decisions about the future of the Shuttle program and of the manned space flight program. We need to get, perhaps for the first time, accurate cost estimates of what it will cost to run the Space Shuttle and other manned programs safely and accurate descriptions of what they will be able to accomplish. I, for one, am not willing to write NASA a blank check for the Shuttle program. We also need to have a better appraisal of what the risks are of operating the Space Shuttle, because even after implementing the CAIB recommendations, the Shuttle will continue to be a risky vehicle, and I am not willing to see the Shuttle fly without regard to the level of risk. Finally, we need to better define NASA's overarching human space flight vision: something that has been lacking for more than a generation. That won't be easy, and it can only be done after hearings that will enable us to make a clear-eyed appraisal of







programs to the NASA Headquarters budget office, from NASA to OMB, and pass-overs from OMB to NASA? A11a. We received no documents from OMB, and no documents containing pre-decisional budget data from NASA. Q11b. The Board is a NASA panel, so why couldn't the Board at a minimum have gotten all the material in the possession of the agency? A11b. Executive privilege protects pre-decisional, NASA-executive office communications. We could have requested such information from NASA, but we were advised by NASA general counsel's office that the request would have been denied on the basis of executive privilege. Q11c. Did anyone advise you not to pursue the budget document requests? If so, who? A11c. Executive privilege protects pre-decisional NASA-Executive office communications. We could have requested such information from NASA, but we were advised by NASA general counsel's office that the request would have been denied on the basis of executive privilege. Q11d. Do you have any strong opinion about the current mix of Shuttle upgrades and the appropriateness/robustness of the Shuttle upgrades program? On what is that opinion based? A11d. The Board does not have a strong opinion regarding this question. Q12. The report notes on page 78 that the tests conducted to validate the hypothesis that the foam had damaged the thermal protection system did not meet with wholehearted approval from NASA. Please describe the circumstances surrounding the conduct of the test program? Is this episode related to the Board's comment that, "The changes we recommend will be difficult to accomplish--and will be internally resisted?" A12. The foam impact testing became so important to the investigation that the Board felt we must have control over the entire process. There initially was resistance from some NASA personnel as to the type of testing that was required and the importance of testing to the final outcome of the investigation. The Board concluded that the most effective method for conducting the test was for the Board to have final authority over the entire foam-testing program. This issue was not specifically related to the Board's concern that changes would be internally resisted, but did contribute to the overall sense that NASA is resistant to outside criticisms. Q13. One thread running through the Board's review of NASA's budget history is the continuing quest to find efficiencies in the Shuttle program, to reduce the annual request for appropriations. Congress has heard testimony on many occasions that budget cuts have safety impacts, but there is no metric by which a particular reduction in budget can be tied directly to a specific reduction in safety. Group IV John Logsdon has been contacted and is responding. Q13a. Is it fair to say that your report concludes that because of budget pressures the Shuttle program was operating at thin margins, but that you couldn't tie this accident directly to budget cuts? If so, why couldn't you make a stronger statement about the effect on safety of the declining Shuttle budget? A13a. Precisely because there was no way of establishing a direct causal link, we felt that what is said in the report was as strong as we could substantiate. Q13b. Does the Board have any advice for us on how to recognize in the future when a lack of resources has pushed the program into an unsafe condition? How will we know? Who will be competent to make this assessment? A13b. Both the independent technical authority and the independent safety authority we recommend in the report will be able to make these judges, as would a reconstituted and effective ASAP. Questions submitted by Representative Bart Gordon Q1. Please provide some specific "benchmarks" that will allow Congress to assess the extent to which NASA is complying with the recommendations of the Columbia Accident Investigation Board (CAIB) over the next several years. A1. The HSC has asked that the CAIB be reconvened in one year to track the progress of the recommendations. The CAIB is prepared to do this. Q2. Many of the findings and recommendations in your report were in fact clearly stated in the 2000 report of the Space Shuttle Independent Assessment Team (SIAT), chaired by Dr. Henry McDonald. One could conclude that if SIAT report had been embraced by the agency, the Columbia accident might never have happened. Q2a. Can you explain why NASA failed to heed Dr. McDonald's report in the three years after its release? A2a. It is unfair to say that NASA failed to heed the SIAT report since there was follow-up on some of the report's recommendations by NASA; however, NASA did not agree with all the recommendations of the SIAT report. The reasons NASA resists implementing recommendations from outside reviews are complex. Among the chief reasons are: NASA thinks it knows better; budget constraints have caused shrinkage of R&D activities and independent, in-house engineering work; schedule pressure; and, leadership shifts toward managers and away from engineers. Q2b. What will have to occur for your report to receive a more favorable reception, and how likely do you think that is? A2b. The Stafford-Covey RTF group will be one means to track the short-term recommendations. A newly chartered ASAP, periodic reconvening of the CAIB and Congressional oversight may be a means to ensure mid-term and long-term recommendations are followed. The Board Report predicts resistance to change, which are the primary reasons we recommended an independent technical/engineering authority with the authority to safeguard and/or grant all waivers to basic system requirements and specifications. Questions submitted by Representative Sheila Jackson Lee Q1. What actions would you recommend be taken by NASA and the Congress to ensure that the International Space Station program is not facing safety concerns similar to those uncovered by the CAIB investigation? A1. The investigation of the ISS was not part of the Charter of the CAIB so we do not feel qualified to answer this question. However, the lessons learned from the Columbia Accident should be studied by the ISS program management for benchmarking purposes. The NASA IG is capable of using the Columbia Accident Investigation Board's report as a roadmap to use in the case of the ISS. Q2. Your report seems to be quite critical of the amount of downsizing of the government employees and the amount of contracting out that has occurred at the agency. Q2a. Is that true? If so, what is the basis of your concern? Q2b. How many government employees do you think will need to be added to address the concerns raised in your report? A2a,b. Since NASA was established in 1958, its civil service workforce has fluctuated widely. In 1967, at the height of the Apollo program, the workforce reached approximately 35,900 personnel. In the mid-70s an involuntary separation program decreased the workforce by several thousand employees. By 1980, the workforce had stabilized near 21,000. It remained close to that level until 1986, when the Space Shuttle Challenger accident forced a re-examination of NASA, adding significant man-hours to Safety and Quality Assurance processes. NASA began some ambitious new programs in the late '80s and its workforce began to grow again peaking in 1992 at more than 25,000. When the Clinton Administration took office in 1993, it initiated steps to reduce the size of the overall federal workforce. Total NASA headcount went from approximately 25,000 civil servants in FY 1993 to slightly more than 18,000 (full-time permanents) by the end of 2002. As the NASA workforce declined, the continuing strategy was to lose junior personnel first, resulting in an experienced but aging workforce. In November 1995, NASA selected United Space Alliance--a Rockwell International and Lockheed Martin partnership--as the prime contractor for space flight operations. Thus, fewer civil servants were required to manage the program. NASA estimated that it would be able to make personnel reductions in the range of 700 to 1,100 full-time equivalent personnel (FTEs) at the Kennedy Space Center alone. The challenge to Space Shuttle contractors, including United Space Alliance, was to address the aging workforce concerns through a continual influx of inexperienced personnel who could stay with the industry for many years. Contractors have much more flexibility in their personnel decisions than does the Federal Government. Compensation packages, including both wages and benefits, are tailor made to address the shortages that face the industry while correcting oversupply in some skills. All SSP contractors, including United Space Alliance, have been given financial incentives to reduce the cost of performing the contract. Personnel costs can be reduced by eliminating personnel in overhead support or management functions, or by encouraging efficiencies in the direct labor elements. United Space Alliance, through the Space Flight Operations Contract, is accountable for professional, managerial and technical workforce support to the Space Shuttle Program. Jobs range from maintenance personnel at Kennedy Space Center to subsystem managers within the Mission Control structure. USA recognized its obligation to maintain a balanced workforce in the professional skills, and that there must be a flow of personnel through the "pipeline" to guard against future shortfalls in critical skills. United Space Alliance stated that while they accepted the challenge to reduce the headcount on the Space Shuttle program, they intended to do so without reducing the direct headcount. They would do this primarily through efficiencies achieved by consolidations. USA did not place the same emphasis on the retention of the nonprofessional, technician workforce. USA has stated that they do not suffer from the same concerns as with engineers and has never faced a shortage of applicants for these jobs. United Space Alliance closely tracks personnel trends, especially with respect to engineering manpower. USA has a nearly bi-modal distribution with respect to age or experience. There are a significant number of personnel over 40 years of age as well as a significant number in the under 30 age group. This illustrates a pipeline from which the workforce of the future will be drawn. Other Space Shuttle contractors may not have had the flexibility to make these kinds of "overhead only" process gains, as elimination of direct as well as indirect personnel was necessary. While reducing the cost of labor through lay-offs, the contractor must continually guard against creating an impression of the company as an unattractive workplace. Contrast the United Space Alliance distribution with ATK Thiokol Propulsion in Utah, the supplier of the Reusable Solid Rocket Motor (RSRM) since the 1970's. During the peak production of the RSRM in the 1980's, Thiokol employed over 4,000 personnel. Today, with production of the RSRM at less than 30 units annually, their personnel count is stable at 1350. Demographics at the Utah plant show a spike in the 45-49 age group, with the majority of the workforce being over 45 years old. This trend is true for engineering as well as plant personnel. ATK Thiokol has identified their aging workforce as a significant issue in relation to the Shuttle program Service Life Extension Program (SLEP). ATK Thiokol recognizes that they must "pump significant new energy into recruiting new talent and retaining/training the younger ones currently in our workforce now." The contracting community at Marshall Space Flight Center recognized the risk associated with downsizing and has eliminated incentives associated with cost cutting in the latest RSRM contract. The Michoud Assembly Facility workforce has been declining over the past five years. In 1998, there was some increase in hiring as a result of the RLV and X-33 programs. However, after that, hiring was limited to budget driven replacements only. Budget challenges have led to the involuntary separations which approached ten percent in 2002. One of the risks of multiple periods of downsizing is that it may lead to a perception among the workforce of limited potential for both growth and reliable employment. This has been highlighted as one of the most significant reasons for the voluntary attrition over the past three years. The average age of the employee at Michoud is now 47.8 years, but the skilled labor (represented) employees average 48.2 years. In conclusion, the issues associated with aging workforce present formidable challenges to the future of the Shuttle Program, especially if the vehicle is expected to serve until 2020 and beyond. Of the major contractors only USA has a recruiting effort with significant numbers. Additionally, while USA's benefit packages have been considered by some to be below the industry standard, we have reviewed DCAA documentation that reflects that the packages are among the better in the industry and may actually be considered excessive. It is essential that NASA take actions to ensure a stable experienced base of support for the Shuttle programs. This may require modifications to way contract incentives are used or other contractual changes. It may benefit NASA to continue the bundling of Space Shuttle element contracts, ETR, SSME, and RSRM under the SFOC and USA in order to maximize the return on leverage of personnel recruitment efforts.

Il disastro dello Space Shuttle Columbia è l'incidente che causò la perdita dello Space Shuttle Columbia la mattina (ore 09:00:58) del 1º febbraio 2003, nel corso della missione STS-107 partita il 16 gennaio dello stesso anno.La navicella si disintegrò nei cieli del Texas durante la fase di rientro nell'atmosfera terrestre. Tutti e sette gli astronauti a bordo morirono. 01/02/2003 - The space shuttle Columbia broke apart on February 1, 2003, while re-entering the Earth's atmosphere, killing all seven crew members. The disaster occurred Breve historia do acidente. No dia 1 de fevereiro de 2003, os sete astronautas a bordo do ônibus espacial Columbia iniciam os preparativos para regressarem a casa: terminam a última verificação dos sistemas da nave e comunicam ao controle da missão no Centro Espacial Lyndon B. Johnson, localizado em Houston, no Texas, que se encontravam alinhados para o início da ... 10/02/2022 - The Columbia disaster In 2000, Chawla was selected for her second voyage into space, to serve as a mission specialist on STS-107 . The mission was delayed several times before finally launching on ... The Space Shuttle Challenger disaster is probably the most significant event in the history of spaceflight in terms of its impact on the general public and on the US space program.The death of a crew of seven, which for the first time included civilian astronaut Christa McAuliffe, in a fiery explosion broadcasted in national television for days after the accident left a mark in the public ... The Columbia Accident Investigation Board (CAIB) was an internal commission convened by NASA to investigate the destruction of the Space Shuttle Columbia during STS-107 upon atmospheric re-entry on February 1, 2003. The panel determined that the accident was caused by foam insulation breaking off from the external fuel tank, forming debris which damaged the ... STS-107 (english Space Transportation System) ist die Missionsbezeichnung für einen Flug des US-amerikanischen Space Shuttle Columbia (OV-102) der NASA.Der Start erfolgte am 16. Januar 2003. Die Föhre brach nach zweiwöchigem Flug am 1. Februar 2003 beim Wiedereintritt in die Erdatmosphäre auseinander. Alle sieben Besatzungsmitglieder kamen dabei ums Leben. 10/02/2022 - The Columbia disaster In 2000, Chawla was selected for her second voyage into space, to serve as a mission specialist on STS-107 . The mission was delayed several times before finally launching on ... 05/11/2021 - The explosion killed all seven crew members aboard. An investigative commission found that a piece of insulating foam had broken off a tank and struck one of the wings, leading to the disaster. The space shuttle program continued until July 2011 when the Space Shuttle Atlantis successfully made its way to the International Space Station. The Space Shuttle Challenger disaster is probably the most significant event in the history of spaceflight in terms of its impact on the general public and on the US space program.The death of a crew of seven, which for the first time included civilian astronaut Christa McAuliffe, in a fiery explosion broadcasted in national television for days after the accident left a mark in the public ... STS-107 (english Space Transportation System) ist die Missionsbezeichnung für einen Flug des US-amerikanischen Space Shuttle Columbia (OV-102) der NASA.Der Start erfolgte am 16. Januar 2003. Die Föhre brach nach zweiwöchigem Flug am 1. Februar 2003 beim Wiedereintritt in die Erdatmosphäre auseinander. Alle sieben Besatzungsmitglieder kamen dabei ums Leben. STS-107 (english Space Transportation System) ist die Missionsbezeichnung für einen Flug des US-amerikanischen Space Shuttle Columbia (OV-102) der NASA.Der Start erfolgte am 16. Januar 2003. Die Föhre brach nach zweiwöchigem Flug am 1. Februar 2003 beim Wiedereintritt in die Erdatmosphäre auseinander. Alle sieben Besatzungsmitglieder kamen dabei ums Leben. Il disastro dello Space Shuttle Columbia è l'incidente che causò la perdita dello Space Shuttle Columbia la mattina (ore 09:00:58) del 1º febbraio 2003, nel corso della missione STS-107 partita il 16 gennaio dello stesso anno.La navicella si disintegrò nei cieli del Texas durante la fase di rientro nell'atmosfera terrestre. Tutti e sette gli astronauti a bordo morirono. 05/11/2021 - The explosion killed all seven crew members aboard. An investigative commission found that a piece of insulating foam had broken off a tank and struck one of the wings, leading to the disaster. The space shuttle program continued until July 2011 when the Space Shuttle Atlantis successfully made its way to the International Space Station. 03/04/2020 - Initially, it was believed that only miniscule bits of foam would come off and hit the orbiter, but actual test flights indicated otherwise. After Columbia made the first-ever shuttle flight in 1981, it was found that the spacecraft had been bombarded by tank foam during its ascent. Over 300 tiles had to be replaced, and engineers remarked that had they known the tank would ... Space Shuttle Columbia (OV-102) was a Space Shuttle orbiter manufactured by Rockwell International and operated by NASA.Named after the first American ship to circumnavigate the upper North American Pacific coast and the female personification of the United States, Columbia was the first of five Space Shuttle orbiters to fly in space, debuting the Space Shuttle launch ...

