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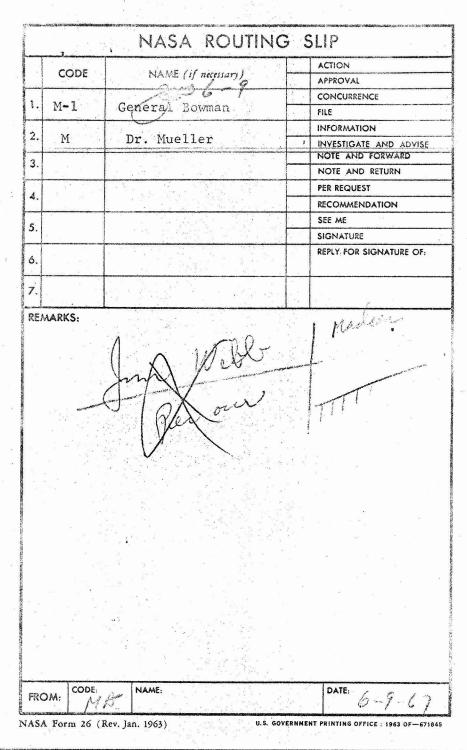
"..... criticized the Agency for inferior quality control, a lack of coordination with North American on inspection procedures"

References in the Board report to inferior quality control and inadequate inspection procedures should be viewed in a broader light as related to engineering and manufacturing to see the real relation between quality control and the Apollo 204 accident. While both NASA and NAA have admitted to deficiencies in quality control, it should be recognized that problems originate in incorrect engineering information or improper manufacturing processes. Deficiencies in quality control and inspection then allow the problem to persist.

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It is our opinion that the assignment of the Florida Facility to the Test and Quality Assurance organization creates an anomaly since the Florida activities clearly relate to direct program responsibilities. We recognize that the existence of both CSM and S-II activities at KSC may require the establishment of a single unit for administrative purposes. However, it is our view that the management of this unit is an executive function, rather than one connected with a functional responsibility. We suggest NAA consider a "mirror image" organizational relationship between S&ID and the Florida operation, with the top man at Florida reporting to the S&ID President and the two program organizations reporting to the S&ID Program Managers.



8 June 1967

NAA Organization at KSC

The NAA review team headed by General Phillips made the recommendation that the Florida Facility be upgraded in organizational status by being removed from the NAA/Downey Test and Quality Assurance organization, and report directly to the S&ID President.

The Committee believed that by elevating the organizational placement of the Florida Facility, more top level attention would be focused on Cape checkout and test activities and result in stronger control over the CSM and S-II test activities by the respective program managers.

The Committee <u>did</u> not recommend that the Florida Facility be headed by a Vice President, nor did it recommend that the Florida Facility be split into three organizational entities as <u>Business</u> Week magazine infers. The present organizational structure of the Florida Facility was a NAA prerogative and justifiably so. The separation of the Florida Facility from the Test and Quality Assurance Office was in line with the recommendations of the NAA review team.

The CSM and S-II programs at the Cape represent an "optical change" in that three separate organizations exist on the Florida Facility organizational chart whereas previously there was only one.

The CSM and S-II Cape Test and Checkout people at the Cape report "hard line" to their respective program managers at Downey. Previously they reported "hard line" to the Manager of the Florida Facility, however, they were always under the operational control of their respective Downey Program Managers. Therefore, the change is more "optical" than real; the significant change was that the Manager of the Florida Facility no longer reports to the Director of Test and Quality Assurance.

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