1 welcome today's presenter, Assistant Secretary Cook,
2 members of the public, members of the press in our
3 audience, and those viewing our proceedings
4 electronically.
5 In accordance with the Board's practice,
6 and as stated in the Federal Register notice, we will
7 welcome comments from interested members of the public
8 at the conclusion of the testimony, and that concludes
9 my opening remarks. Dr. Eggenberger?
10 VICE CHAIRMAN EGGENBERGER: I have no
11 questions at this time.
12 CHAIRMAN CONWAY: Okay. Questions?
13 DR. MATTHEWS: No, no questions at this
14 time. I think I'm okay.
15 CHAIRMAN CONWAY: With that, Bev, we turn
16 to you.
17 MS. COOK: Thank you, Mr. Chairman and
18 members of the Board, for the opportunity to address
19 you today. You have invited me to speak on roles and
20 responsibilities of the Office of Environment, Safety
21 and Health in the oversight process. But in keeping
22 with some of the questions you have sent to me, I would
23 like to expand my remarks somewhat to the role of EH in
24 assuring safety operations of the Department of Energy.
25 I will speak to both of my role personally, and also

1 that of my office. I will also address the efforts
2 underway to improve DOE's safety performance and where
3 I continue to be concerned.
4 But I would like to start with some overall
5 assumptions. I absolutely believe that our workforce
6 does not come to work with the intention of hurting
7 themselves or others around them. These people live
8 with their families in these communities. They don't
9 intend to harm the environment in which they live, and
10 they are not self-destructive people. I also believe
11 that the companies that DOE has hired do not intend to
12 harm the workers that they have employed or the
13 environment surrounding their workplace. These are
14 good people trying to do the jobs that we have hired
15 them to do.
16 However, many factors drive behavior.
17 These same people worry about keeping their jobs so
18 they can support their families. Therefore, if we
19 communicate mixed signals about what is important to
20 us, then we will drive performance in unexpected ways.
21 The same is true of the companies that we hire. If we
22 are not clear about our expectations, they may exhibit
23 behavior that is unacceptable to us. And that is what
24 I want to talk about today. How do we, the federal
25 workforce, drive their behavior, and what is my role in

1 that process.

2 First, you have asked about my roles and
3 responsibilities as the DOE Corporate Safety Officer
4 and the Assistant Secretary for Environment, Safety and
5 Health. EH responsibilities are listed in a variety of
6 DOE rules, directives, and other documents. This is
7 just a short summary of what those responsibilities
8 include. Developing and maintaining the ES&H
9 [Environment, Safety and Health] policies, regulations,
10 technical standards, and other directives;
11 investigating and, enforcing nuclear safety and more
12 recently, worker safety violations; analyzing ES&H
13 performance and providing feedback and lessons learned;
14 maintaining the safety database systems; providing
15 subject matter experts on ES&H matters; assisting in
16 investigations of accidents; assisting in the
17 Operational Readiness Reviews; and providing
18 independent assessments of ES&H matters when it's
19 requested.

20 I am specifically identified in Executive
21 Orders as the Agency Environmental Executive, and also
22 the Designated Agency Safety and Health Officer, and
23 that is for the federal workforce. The Deputy
24 Secretary has also identified that I act as his agent
25 in identifying, evaluating, monitoring, managing and

1 resolving crosscutting safety issues. I will describe
2 how I and the ES&H organization fulfill these roles in
3 the context of the overall safety structure of the
4 Department.
5 The safety structure I refer to here
6 consists of several parts, and it looks very much like
7 ISM [Integrated Safety Management] in a larger context.
8 That is, first, clearly setting those goals that we
9 want to follow, setting the requirements for meeting
10 those goals, setting the performance measures and
11 measuring that performance, implementing those
12 requirements through the line organizations, performing
13 independent oversight, and then feedback and
14 improvement. Now, I will speak to each of these steps
15 and my role and the role of my organization in these
16 steps.
17 First, I would like to talk about setting
18 goals. I have submitted as backup the Deputy
19 Secretary's letter defining the 2004 management
20 challenges. This is the list of challenges that our
21 Deputy Secretary feels are very important for his
22 managing of the Department's operations. The first
23 challenge in that list is safety, and the first item on
24 that list is setting goals. It is the manner in which
25 the entire organization knows what is expected of them.

1 In the past, DOE has defined those safety goals in a
2 variety of ways, including, as we all remember, keeping
3 risk levels below a certain level to just saying things
4 like, "Be Safe."
5 Secretary Abraham has been very clear about
6 his goals. In our DOE 2002 Annual Report on
7 Environment, Safety and Health, the Secretary committed
8 to keeping our workers safe, protecting the environment
9 at and around our sites, and being proactive in
10 evaluating trends and safety vulnerabilities to prevent
11 reoccurrence of events. He stated that the Department
12 is committed to accomplishing work in a safe and
13 environmentally responsible manner. He has restated
14 this goal in almost every venue that I have heard, and
15 especially states this when he is speaking to the DOE
16 workforce.
17 This is a high standard. However, it is
18 the topic of heated discussions within the Department.
19 It is well recognized that setting the wrong detailed
20 goals or communicating those goals incorrectly will
21 drive the wrong behavior. For example, saying things
22 like "no incidents" or "no near misses" drives non-
23 reporting.
24 Therefore, in the context of the Deputy
25 Secretary's management challenges, we will continue to

1 look for ways to articulate the safety goals of the
2 Department in a manner that improves performance. This
3 is a work in progress. I am the lead for coordinating
4 this effort throughout the Department. I will continue
5 to work that over the next several months.
6 In addition, all of the Department elements
7 must articulate the goals relevant to their portion of
8 the work, and most of the organizations have tried to
9 do that. I will discuss some of those efforts in my
10 discussion on performance measures. For our part, the
11 EH staff has looked at outside organizations and
12 companies for examples for setting safety goals that
13 might work for DOE and will drive the kind of
14 performance that we insist on and not drive the wrong
15 things.
16 There are goals that may be relevant to our
17 workforce, but that may not be relevant to others. For
18 instance, I have often expressed to the complex that my
19 goal is "zero legacies," and I mean by that no
20 environmental legacies, no health legacies, and no
21 safety legacies, and that means performing work in a
22 manner that may be safe for the current workforce, but
23 sets up a condition in the long term that may be very
24 unsafe for someone that has to deal with it later.
25 The goals must be effectively communicated

1 and the rewards and punishments must follow consistent
2 with those goals. It takes both setting the goals and
3 showing you are serious about it to drive the right
4 behavior. And one of my jobs is also to assist line
5 programs in identifying and communicating the rewards
6 and punishments that show consistency with those goals.
7 More importantly, to explain to the line management
8 when they are, in fact, providing rewards and
9 punishments that are inconsistent with those goals.
10 Let me talk next to setting those
11 requirements. The goals need further definition based
12 on the type of work performed. And as you know, EH has
13 the primary responsibility for establishing and
14 maintaining DOE's Regulations and Directives relating
15 to Environment, Safety and Health. EH interacts with
16 other government agencies and health and safety
17 organizations and organizations that develop standards.
18 We strive to incorporate into the DOE directives and
19 standards current industry best practices and policies.
20 The DOE Directives contain four levels of
21 documents: policies, requirements, which are the Rules,
22 the orders and the manuals, guides and Technical
23 Standards. You have asked that I describe how EH
24 ensures that the ES&H policy, requirements, and
25 standards are understood and properly implemented in

1 the field. We utilize a variety of methods.
2 We first ensure awareness of the issues in
3 the setting of those standards and policies by
4 participating in the established DOE development and
5 review process and the practices for requirements and
6 standards, and that includes everything from formal
7 rulemaking to our REVCOM [Review and Comment] system
8 that allows for input from all of the complex on any
9 new issues.
10 We issue Nuclear Safety Technical Positions
11 and Directives Interpretations when they are needed.
12 We maintain telephone "hot lines" and websites to tee
13 up the concerns and facilitate resolutions. We conduct
14 training on rule and directive requirements and
15 guidance, and we will continue to do that. We
16 participate in the Energy Facilities Contractor's Group
17 [EFCOG], in their workshops, so that we are available
18 to answer questions and clarify directions to the DOE
19 contractors.
20 We facilitate and develop implementation of
21 Functional Area Qualification Statements and Standards
22 for safety analysts, implementers, and reviewers. We
23 participate in assessments of implementation as subject
24 matter experts at the request of the DOE field
25 organizations, that is in areas like criticality, fire

1 safety, explosive safety, etcetera.
2 We maintain the safety database systems,
3 collect information on ES&H performance, and analyze
4 that operation performance, the occurrences, and the
5 reports and indicators to determine whether there are
6 implementation issues, and we share lessons learned,
7 and we provide the feedback to the Program Offices. We
8 conduct independent assessments of the safety issues
9 and concerns at the request of the line management and
10 participate and assess Operational Readiness Reviews.
11 We provide safety basis support to the DOE
12 line organizations and Field Offices on nuclear safety
13 and review the adequacy of the Safety Evaluation
14 Reports that they generate. And we analyze Unreviewed
15 Safety Questions [USQ] across the complex for cause and
16 corrective actions.
17 All of these actions together provide EH
18 with the information to relate to the understanding and
19 proper implementation of the policies, requirements,
20 and standards. You have asked what actions are
21 available to EH to correct the implementation issues.
22 That depends on what the root cause of the problem is.
23 The actions we can take are directly
24 related to root cause, is related to the failure of the
25 understanding and the implementation. If there is a

1 lack of understanding, we can issue Nuclear Safety
2 Technical Positions, Interpretations, and Safety
3 Notices, and you will find many of those on our
4 website.
5 If it's a lack of qualifications of the
6 staff, we establish and facilitate safety Functional
7 Area Qualification Standards [FAQS] and we conduct
8 training. If it is clear that the policy, requirement,
9 or standard does not result in the outcome we want,
10 then we will revise the DOE directives and standards.
11 And often is that case: if there is a lack of
12 understanding of what the root cause is or there is a
13 significant difference in opinion of what that root
14 cause is, we manage and facilitate resolution through
15 ES&H managers meetings, DOE crosscutting technical
16 working groups, and interactions with EFCOG until we do
17 get down to what the root cause is and take the
18 appropriate action to correct it.
19 EH has the responsibility to investigate
20 and report on accidents and to investigate and enforce
21 nuclear safety violations. A critical part of those
22 investigations is to determine the root cause of an
23 accident or violation, including identifying if the DOE
24 requirements are unclear.
25 There have been many initiatives over the

1 last few years to set better requirements. It has been
2 recognized that DOE's requirements sometimes have been
3 confusing, conflicting, and not properly applied. Even
4 with the advent of our current contracting method,
5 where the set of applicable requirements are negotiated
6 and documented in the contract, the contracts often
7 contain items that were not relevant to the work at
8 hand. This has led to a system of waivers, exceptions
9 and inconsistent practices in holding our contractors
10 accountable for the items in their contracts.
11 Therefore, there has been an effort
12 underway to streamline the requirements. The purpose
13 is not to lower the standards for safety performance,
14 but rather to come to a concise, relevant set of
15 requirements and then hold contractors fully
16 accountable for meeting those requirements. We would
17 like to set the requirements and follow the
18 requirements. Waivers should be at a minimum.
19 The extensive use of waivers was noted in
20 the Columbia report. The Department has continued to
21 look for ways to reduce the need for waivers by better
22 articulating requirements, so they are more generally
23 applicable to the variety of work in the Department,
24 and by providing the methods for tailoring the set of
25 requirements up front for a specific operation. Once

1 the right requirements are identified, compliance
2 should be strictly enforced, not changed as it comes up
3 when something is not relevant to the work.
4 One of the difficult issues though is how
5 to hold all work on a site accountable to an
6 appropriate set of standards. EH is aware of the
7 proposed changes to DOE Order 251.1A [DOE Directives
8 System] and its associated Manual, and we are actively
9 engaged with the Office of Primary Interest [OPI], that
10 is ME [Office of Management Communications], and the
11 Defense Board staff on concerns related to the proposed
12 limitations of the applicability of DOE directives to
13 site and facility management contracts.
14 The challenge continues to be how to define
15 the appropriate set of standards and apply them to the
16 appropriate operations. There still remains several
17 options, and EH will continue to aggressively work
18 resolution on this issue so that the correct outcomes
19 are achieved.
20 There is also a proposed revision to DOE
21 Manual 251.1 that would change the exemption authority
22 for DOE Orders from the Program Secretarial Office
23 [PSO] to the Office of Primary Interest, the person who
24 wrote that rule or directive. Currently in the
25 directives process, the PSO is the exemption authority

1 under the overarching DOE policy that line management
2 is responsible for safety.
3 The Office of Primary Interest has 30 days
4 to provide comments to the PSO. DOE is currently
5 evaluating this change. I will not tell you, at this
6 point, that I have come to a conclusion about whether I
7 agree with this policy or that there may be some
8 options where sometimes, it should be one way, and
9 sometimes the other.
10 Let me talk some about setting performance
11 measures. As part of setting the right requirements
12 and driving the right behavior, you must know, in fact,
13 the requirements give you the outcome that's desired.
14 Therefore, performance must be measured. Performance
15 measurement is very difficult, as you all know.
16 Picking the right measurements that indicate overall
17 performance is important, but the act of measuring in
18 and of itself will drive performance.
19 People pay attention to what you measure.
20 Over time, an organization should be able to identify
21 the precursor indicators that lead to unacceptable
22 events and be able to monitor those indicators, rather
23 that being event driven. And DOE continues to strive
24 to move in this direction.
25 In the past, EH assumed responsibility for

1 collecting and monitoring ISM performance measures for
2 the Department. These included things like Total
3 Recordable Case Rate, Occupational Safety and Health
4 Cost Index, Radiation Doses to the Public, Worker
5 Radiation Dose, and such items. It became apparent
6 that improvements were needed. However, it was a
7 consensus that most of the ISM [Integrated Safety
8 Management] indicators were lagging significantly and
9 were not used to drive improvement. We were awash in
10 data, but very weak on information, and it was not well
11 utilized.
12 Therefore, we have expanded our efforts in
13 EH. I have elevated the Office of Corporate
14 Performance Assessment to the Deputy Assistant
15 Secretary level, and I have increased resources within
16 EH to this office. We continue to work with the line
17 programs to develop a more meaningful set of indicators
18 for safety performance. We have revised the DOE
19 Occurrence Reporting [and Processing] System [ORPS] in
20 order to capture more relevant data and then provide
21 analysis of that data.
22 The Under Secretary for Energy, Science and
23 Environment conducts quarterly safety meetings with his
24 direct reports. That is the Assistant Secretaries and
25 the office directors, and they all attend. EH is

1 responsible for evaluating performance and the cost
2 cutting trends at all EM [Environmental Management],
3 Science, NE [Nuclear Energy], FE, [Fossil Energy], RW
4 [Civilian Radioactive Waste Management], and EE [Energy
5 Efficiency] sites.
6 The Assistant Secretaries are held
7 accountable for the safety performance at their sites.
8 The NNSA [National Nuclear Security Administration]
9 safety representative also attends these quarterly
10 safety meetings. We begin the discussion with the key
11 indicators, Total Recordable Rates, Lost Work Cases,
12 Near Misses, and a variety of other significant
13 occurrences and trends over 10 different functional
14 areas, including nuclear safety, fire safety, safety
15 basis and such. EH communicates lessons learned and
16 best practices at this meeting and provides an
17 independent assessment at the meetings.
18 These meetings have been proven to be very,
19 very useful. The sharing of best practices is the
20 issue that I feel is the most important that occurs at
21 these meetings. There have been very in depth
22 conversations between the different Assistant
23 Secretaries on what actions they take to drive
24 performance and what effect they are getting from those
25 actions.

1 The Program Offices have also articulated
2 their specific safety goals at these meetings. For
3 example, EM has initiated a 4.0 Program of Performance
4 Indicators. They focus on the indicators that are most
5 relevant to the EM sites, including, for instance,
6 transportation events, very important to them. The
7 Office of Science has established goals for injury and
8 illness rates in order to drive their performance to
9 the top 25 percentile of the best in class private
10 industry laboratories.
11 I will tell you that Dr. Orbeck is very,
12 very serious about that, and he does not view any
13 incident as routine. I am on distribution for his
14 emails when he talks to his field organizations about
15 incidents. One I saw recently, where they had cut into
16 a piece of conduit thinking it was rebar, he sent the
17 Field Office a note that said, "I'm not sure that these
18 contractors are qualified to do scientific research for
19 me if they don't know the difference between rebar and
20 conduit." So he is unaccepting of any kind of incident
21 in his area of purview.
22 EH is currently working with NNSA to
23 further refine similar indicators at their sites, and I
24 understand that Ambassador Brooks plans to begin
25 holding quarterly safety reviews with his senior staff

1 also. I believe that the Department has significantly
2 evolved in its ability to track and trend performance
3 at the corporate level. EH not only looks at the
4 "numbers;" we also want to understand exactly what is
5 driving certain performance. What we are seeing are
6 things like a site may have a good Total Recordable and
7 Lost Work Case rates, but the near misses are
8 increasing, and the significant events are increasing.
9 We need to understand why and ensure that line
10 management is taking the appropriate corrective
11 actions.
12 We continue to look at ways to improve our
13 ability to identify precursors and leading indicators.
14 As NASA [National Aeronautics and Space
15 Administration] discovered, we must pay attention to
16 the small events and evaluate what our safety systems
17 are telling us. Dr. Howard from the Columbia Accident
18 Investigation Board stated in his presentation to us
19 that "the system is talking to you." Those numbers
20 mean something.
21 Please, be assured that EH is not
22 overlooking nuclear safety performance, but if we are
23 stumbling on the small things, it may be an indicator
24 that we have problems with rigor and operations that
25 could result in more significant consequences, like

1 with those systems, the nuclear safety systems, that
2 are predicting our nuclear operations. An area for
3 improvement in 2004 is the tracking and trending of
4 nuclear safety performance. EH is currently working on
5 better defining the nuclear safety indicators, and we
6 welcome the Board's insight into this area.
7 Recently, EFCOG developed a proposal for
8 the top ES&H and Quality Indicators. They have been
9 provided to EH for consideration and comment. I am
10 optimistic since the proposal recognizes the need to
11 develop leading indicators. We will work closely with
12 our line programs and with EFCOG to further develop
13 these indicators.
14 Normalization of deviants is a major issue
15 in the Columbia Accident Investigation Board report.
16 NASA had conditioned themselves to expect deviations
17 and didn't consider them serious. The Department is
18 improving the use of daily operating experience events.
19 ORPS events are published daily and distributed to a
20 large group of Headquarters and field personnel for the
21 purpose of fostering a continued awareness and
22 evaluation of operational information.
23 Biweekly Operating Experience Summaries are
24 published and distributed throughout the complex that
25 focus primarily on discreet, operational deviations

1 that are precursors to more serious events. Also, EH
2 provides weekly summary reports of significant events
3 and trends to the Under Secretary Card and Ambassador
4 Brooks. Many times Under Secretaries require further
5 evaluation from the line programs after they receive
6 those weekly reports. This sends a strong signal to
7 the entire complex not to ignore or to accept
8 deviations from normal performance, and they have done
9 this in a very regular manner.
10 Next is line implementation and oversight.
11 Once the framework is set, that is the goals and the
12 rules and the measures, the line organizations are
13 responsible to make it work. They adapt this framework
14 to the specific work, the work environment, and their
15 workforce. The line organizations are responsible for
16 implementing the rules in a manner that ensures that
17 the goals are met. Therefore, the first "oversight,"
18 if you will, is performed by the line organization
19 closest to the work, that being the local DOE offices.
20 The line programs must have the expertise to fulfill
21 that role and to know when to ask for help.
22 EH has an interest in all the initiatives
23 underway by the Program Offices to best fulfill their
24 responsibility to implement the Department's safety
25 requirements and provide oversight. The programs are

1 evaluating the methods for fulfilling the role that
2 will best work for their operations.
3 Specifically, I have been briefed and asked
4 to provide feedback and concurrence on many of the
5 organizational changes within the Program Offices. I
6 have had the opportunity to freely express my questions
7 and concerns, including my interest in how those
8 Program Offices are identifying the level of expertise
9 that is required in any given Area Office. They have
10 not fully answered those questions for me yet; I will
11 tell you that.
12 EH has been involved in working groups at
13 the staff level on most initiatives identified to the
14 Board during the public hearing, including the new
15 federal management and oversight policies being
16 developed by DOE and NNSA for the defense nuclear
17 facilities; new approaches to contract reform,
18 contractor self-assessment, and federal oversight;
19 field applications of federal management and oversight
20 policies being developed for the defense nuclear
21 facilities, applying lessons learned and corrective
22 actions resulting from the reviews of the Columbia
23 Accident; and identifying technical competence
24 requirements to ensure effective management and
25 oversight activities.

1 As involvement in these initiatives is a
2 part of normal course of work for EH, that is what we
3 do, I have not kept a record of the amount of time that
4 was spent by my staff and I in reviewing these
5 initiatives, but I will tell you we continue to be
6 cautiously optimistic. I find especially that the
7 Program Offices are acutely aware that making changes
8 while continuing current operations is very, very
9 difficult, and they are trying to pay a lot of
10 attention to that. It's hard to keep doing work while
11 you're trying to make the changes.
12 I would like to talk for a minute, though,
13 about the self-assessment programs that we are pushing.
14 I believe there is a misunderstanding in our efforts
15 to strengthen the contractor self-assessment programs.
16 The purpose is to hold our contractors accountable for
17 their performance. They should be responsible for
18 having programs in place that catch those precursor
19 events and failures in their safety systems and to fix
20 them. It should not be the responsibility of DOE line
21 oversight.
22 One role of the DOE line oversight
23 organizations should be to check to make sure that the
24 contractor has adequate self-assessment programs in
25 place and to verify that those programs are working.

1 DOE should not be the only line of defense, and let me
2 give you an example.
3 We had gotten ourselves into a very
4 difficult situation with Operational Readiness Reviews
5 [ORR], and you are all acutely aware of that. in fact,
6 the contractors were not always ready. And we have
7 gotten into the habit where DOE would come in, review
8 the readiness, and pick up items that should have been
9 found and fixed before DOE showed up. When EH staff is
10 asked to participate in an Operational Readiness
11 Review, they are now directed to leave if it is
12 apparent that the contractor is not ready, and that is
13 the case with a lot of the DOE Program Offices, also.
14 We had slipped into bad habits, both as
15 contractors and DOE as a customer. We are regrouping
16 and setting our roles appropriately. This does not
17 mean that DOE is counting on the contractor to oversee
18 themselves, and we will just take their word for it.
19 It does mean that we have raised our expectations. It
20 is the contractor's job to prove they are ready to
21 perform work, and they will continue to perform work,
22 not DOE's job to prove that they are not.
23 CHAIRMAN CONWAY: We have known that. We
24 have said that for a long, long time.
25 MS. COOK: I know that, sir.

1 CHAIRMAN CONWAY: And these contractors
2 continue to come in, say they are ready, and they are
3 not ready. So, I don't give a lot of faith and
4 confidence in turning over to the contractors. They
5 are setting what standards they are going to be held
6 to, and then the DOE decides whether or not they will
7 go along with it. We have decided in the future, we're
8 going to have the contractors set the standards by
9 which they will work. That's nothing that history up
10 to now would give me confidence in. Go ahead.
11 MS. COOK: And you have asked for a
12 briefing on worker safety and health standards in the
13 next 30 days, and we will come and talk more about how
14 we agreed to the set of standards that are appropriate,
15 as we do now in the contract, and we'll discuss that
16 more.
17 CHAIRMAN CONWAY: And I'm going to have
18 some questions. I'm going to have some specific
19 questions on that today.
20 MS. COOK: Okay. EH is often asked to
21 provide technical assistance to DOE and NNSA on health
22 and safety concerns that may require remedial actions
23 at the request of the Program Office. I have included
24 a list of 12 of those recent items in my testimony,
25 which I will not read to you at this time.

1 My biggest concern on some of these actions
2 is that we are providing assistance at times for events
3 and conditions that we have seen before. I will speak
4 more later when I discuss feedback and improvement.
5 We're getting feedback. We're not very good on
6 improvement.
7 A continued concern of the Department is
8 technical competency of the staff, and I know that is a
9 concern of yours. EH is involved in several ways in
10 addressing technical competency within DOE and NNSA in
11 the area of ES&H. In the role of managing a Technical
12 Standards Program, EH coordinates review and approval
13 of the Functional Area Qualification Standards that
14 support the Technical Qualification Program.
15 A senior manager in EH is actively involved
16 in the Federal Technical Capabilities Panel [FTCP] and
17 as such, provides input and feedback on technical
18 competence issues. Subject matter experts in EH
19 participate in the development and implementation of
20 Functional Area Qualification Standards. EH provides
21 and supports technical training in ES&H areas, such as
22 safety basis, criticality safety, and accident
23 investigation.
24 My biggest concern regarding technical
25 competency of the DOE staff is, in fact, the average

1 age of our workforce. Many of our staff, both federal
2 staff and contractor staff, are retirement age. We are
3 continuing to work with the human resources
4 organizations within the DOE to identify unique
5 strategies to assure that we have competent staff in
6 the future.
7 I have also spent significant time recently
8 discussing with Congressional staff about the role of
9 EH within DOE. There, apparently, has not been many
10 conversations with Congressional staff on that subject
11 in the past. The funding for my staff has been cut by
12 Congress significantly in the last several years. I do
13 not believe that my current staffing levels are
14 sufficient to fulfill the requirements of my
15 organization, and the Department is actively working to
16 rectify this situation. But my job is to communicate
17 to Congress the critical role of Corporate Safety
18 Office in an agency like DOE, so that sufficient
19 funding is forthcoming. I am working very hard on
20 that, especially in the last couple of weeks.
21 EH is responsible for reviewing operating
22 contracts and Requests for Proposal to ensure that the
23 essential ES&H requirements are presented and determine
24 if adequate resources are planned for ES&H activities.
25 Specifically, we look at the list of applicable

1 directives, and we review that for completeness. We
2 look at the applicable DEAR [Department of Energy
3 Acquisition Regulations] clauses, and we look at some
4 of the novel contracting strategies, that is, using
5 commercial standards for non-nuclear demolition
6 contracts and such, and then we review the entire
7 contract for consistency among ES&H terms and
8 conditions in the various sections. It is amazing to
9 me the number of contracts we have that are
10 inconsistent even within the contract on what it is we
11 require of a contractor to perform work.
12 We have recently put out an interim final
13 rule - it was effective January 9th - on the new
14 Conditional Payment of Fee clause. We hope that this
15 will help fee determining officials better utilize this
16 as an "enforcement" tool. EH will continue to provide
17 support to the Procurement Executive and Field Offices
18 in the interpretation and application of this new
19 clause. We will also monitor the clause applications
20 in the future. We are not part of that fee
21 determination, but we will look at what the
22 effectiveness of that new clause is.
23 Finally, I get to independent oversight.
24 It is very, very important that there is an independent
25 check made to see if the desired outcomes are achieved.

1 Independent oversight is critical. Independent
2 oversight is not, however, the first line of defense
3 for safety. It is the check to assure that the
4 framework and the implementation is achieving the
5 desired results. EH does not perform independent
6 oversight but does have an important interface with
7 those organizations that do perform this function.
8 For instance, we support the Office of
9 Independent Oversight within DOE and their field
10 reviews by providing the analysis of the site and the
11 facility safety performance. This helps the review
12 teams to focus their efforts on likely problem areas
13 and increases the effectiveness of the reviews and the
14 time spent. The next interface with the oversight
15 organizations is related to feedback and improvement,
16 so I will go just immediately to that.
17 I believe that feedback and improvement
18 continues to be the Department's biggest challenge.
19 Valuable information is provided to the Department
20 every time another organization identifies a process or
21 event that the line organization has not already
22 identified and fixed. It sends a variety of messages
23 at that point.
24 We are not effectively utilizing the
25 feedback provided to us by other organizations in order

1 to improve our performance, and then we often get so
2 caught up in the specific corrective actions related to
3 an issue that we lose sight of what the real root cause
4 is of the problems. It is part of EH's role in
5 crosscutting issues to address that issue, in fact.
6 First, I will address the Office of
7 Independent Oversight. We meet with that office and
8 discuss their findings after they have done their
9 audits. We look for root causes. We ask follow-on
10 questions. We ask follow-on questions when they
11 identify things like failure to follow procedures or
12 lack of management attention. I do not believe that
13 either one of those things are a root cause.
14 We also are active in evaluating other
15 reports and audits of the Department to look for issues
16 that may be applicable for organizations other than the
17 direct subject of the report. EH now receives notices
18 of all reports from outside organizations and
19 correspondence, including GAO [General Accounting
20 Office], the DOE IG [Inspector General] and, of course,
21 the Defense Board reports, but Homeland Security and
22 other outside agencies.
23 DOE staff reviews this information to
24 determine whether the site or program-specific issues
25 that are identified could have generic safety and

1 health issues. The conclusions of that review are
2 documented for consideration for action or referral to
3 other DOE elements.
4 As part of this role, EH will strive to
5 enhance our interactions with all of the oversight
6 organizations, including the Defense Board, in order to
7 better understand the underlying issues and to assure
8 that the corrective actions really fix the root cause.
9 Many issues occurred recently. I have often in the
10 past made comments about the Department fixing things
11 with tape and baling wire and, in fact, as you all
12 pointed out, we have done that literally recently.
13 When we are putting our programs in the position where
14 they are taking actions like that to proceed with work,
15 then I think there are some root causes behind that
16 performance that are applicable to a wide range of
17 issues.
18 For EH, the most important information to
19 our specific job is to determine if the regulations,
20 standards, and policies that we are responsible for are
21 driving the right behavior. Therefore, feedback from
22 all the organizations that do oversight are important
23 to us, to know whether the regulations we have written
24 need improvement and to take the actions if they do.
25 However, as you know, it's usually not that

1 simple. The biggest challenge is to understand the
2 drivers of good behavior and the unacceptable behavior.
3 It's easy to assume that it's just bad people or bad
4 company, but that is unrealistic. Other actions drive
5 people and companies to do things that are
6 fundamentally against their nature. The Department has
7 a long way to go in root cause analysis, and DOE will
8 be providing some training in the near future on that
9 subject. We also continue to learn from other
10 organizations, such as INPO [Institute of Nuclear Power
11 Operations] on effective ways to improve root cause
12 analysis.
13 Part of EH's role in coordinating and
14 managing crosscutting issues is to resolving issues
15 across the DOE and the NNSA organizations. The
16 resources needed in EH in accomplishing this task vary
17 depending on the issue. In general, we try to
18 facilitate a corporate view of the outcome that is
19 desired, and then help each individual program
20 understand the implementation and their efforts to meet
21 that commitment and to meet the intended outcomes.
22 This is somewhat new for the Department. We have been
23 very stovepiped. We are continuing to improve our
24 ability to coordinate these crosscutting issues, but it
25 is not where we want it to be.

1 DOE sponsors and manages monthly meetings
2 between the ES&H managers from all the DOE Headquarters
3 Program Offices with health and safety
4 responsibilities. This collaborative forum enables
5 discussions and notifications and decision-making on
6 methods to address potential safety and health issues
7 that may cut across DOE Program Offices, and to share
8 best practices at a Headquarters level.
9 We also use this forum to provide
10 information on new, revised, and upcoming ES&H
11 requirements or activities that might impact budget
12 decisions. In general, the Department is trying to
13 minimize those budget items that are allocated or
14 shared between Program and Field Offices. As you know,
15 that hasn't worked very well. This goal has not been
16 fully realized, at this time, but we are striving to
17 identify those things more and more and to try to
18 locate funding for specific crosscutting items in a
19 specific office.
20 MR. FORTENBERRY: Bev, excuse me. You
21 said, as you know, that hasn't worked very well. Are
22 you talking about the effort to minimize or the sharing
23 of the budget?
24 MS. COOK: The sharing of budgets.
25 MR. FORTENBERRY: Thanks.

1 MS. COOK: The sharing of budgets for
2 things like QA [Quality Assurance] working group, those
3 sorts of things, things that need to be done, but end
4 up in the noise level in a specific Program Office.
5 Let me just spend a few minutes on some of
6 the lessons learned issues that you asked me to speak
7 on, those lessons learned from the Columbia Accident
8 and the Davis-Besse near miss. There have been several
9 reviews made by EH staff, including me, and there are
10 many lessons to learn from these events. Because the
11 issues identified cover a broad range of topics, EH's
12 role has varied in implementing those lessons learned
13 within the Department.
14 Regarding Davis-Besse, EH will issue a
15 lessons learned publication, in fact, in the near
16 future. Although, the Davis-Besse near miss was
17 somewhat unique, there are generic performance related
18 lessons learned that are applicable to all of the DOE
19 operations. It certainly identified the need for a
20 performance analysis function within the Department.
21 Fortunately, EH has already moved to
22 strengthen that function, as I have already described.
23 In addition, EH and all the Program Offices continue
24 to work towards determining the correct set of
25 performance measures that will truly provide early

1 indicators of performance problems. While the
2 Department is proud of our overall performance, at this
3 time, everyone in every Program Office is concerned
4 about what it is we may not know and whether we're
5 measuring the right things.
6 Let me next touch on some of the issues
7 related to the Columbia Accident. It's important to
8 note that the Program Offices have also reviewed the
9 Columbia Accident. They have discerned applicable
10 lessons learned and are moving forward with certain
11 actions where it's applicable to them, and the
12 priorities in the Columbia lessons learned vary from
13 program to program. They all have different issues.
14 EH staff has provided input to NNSA and EM for their
15 review, for instance, and this included participating
16 working groups and meeting with line management prior
17 to initiating their broad range reviews.
18 Reliance on past successes and treating
19 operations as routine. I have sort of a different
20 perspective on this. As opposed to the overall
21 management perspective, I believe that these two issues
22 are related to workforce issues that we have. Many of
23 the people on our workforce have been doing their jobs
24 for a very long time, and they have been doing so
25 without incident because of their personal knowledge

1 and skill. This issue is coming to a critical point
2 within the Department. As I have said, a large portion
3 of our workforce is retirement age. We must fully
4 document the processes and procedures that we use and
5 start with the assumption right now that every
6 operation is new and unique.
7 I know that Program Offices are looking at
8 this issue, but the changes in the workforce may be the
9 strongest driver we have right now to correct this
10 problem of reliance on past successes and treating
11 operations as routine. We do very unique things. You
12 can't go out and hire somebody off the street and know
13 what it is that the people who have been working 40
14 years in our complex know.
15 Resource constraints and placing the
16 mission before safety. It is the expectation of senior
17 managers in the Department that missions will be
18 accomplished safely. As we all know though, that view
19 is not always communicated correctly throughout the
20 organization. The conversations that occur during
21 these quarterly safety meetings often focus on the
22 actions that are taken by the Program Offices to reward
23 or punish good or bad behavior. We may say that work
24 must be accomplished safely, but often our actions do
25 not communicate that message.

1 We must not reward contractors who take
2 risks to meet the mission goals, and we must fully
3 recognize the contractors who accomplish the mission
4 goals safely. EH continues to strive to bring
5 attention to those contractors who perform work safely
6 through best practices information and identification
7 of those to the Program Offices. Our rewards and
8 punishments must be consistent with our stated goals.
9 Our organizations must learn from past
10 mistakes and failures. I have already said that I
11 believe this is DOE's biggest challenge. We realize
12 that the use of lessons learned must be improved within
13 the Department. We are currently redesigning our
14 process for communicating the information and holding
15 line managers accountable for corrective action.
16 For instance, EH has recently published an
17 operating experience report on hoisting and rigging
18 events and precursors. This report is being forwarded
19 to the Headquarters line management through their
20 Program Offices for action. We need to have better
21 methods for capturing lessons learned in the nuclear
22 safety areas. Lessons learned on nuclear safety have
23 not received as much attention, and EH is working on
24 better methods to improve that information area.
25 Poor organizational structure can be just

1 as dangerous as complex technical issues: I absolutely
2 agree with that. I believe that DOE's ISM policy is
3 clear that line management is accountable for safety.
4 We must maintain that emphasis. It should not be an
5 option for line management to reduce attention to
6 safety. It also should not become the role of an
7 outside organization for safety, that is. And in other
8 words, that outside organization could get cut as
9 budgets become tight. Safety is a line management
10 responsibility and should continue to be.
11 The issue of questioning attitude is also
12 interesting. There are many methods, and our Program
13 Offices are looking at those, on ways to increase the
14 questioning attitude on the part of senior management
15 and the Program Offices. One method that was provided
16 to me early in my career was to hold people accountable
17 for their signature.
18 If your signature means you are fully
19 accountable for the content of a document or a
20 decision, you are much less inclined to proceed with
21 just a summary briefing, a PowerPoint presentation, and
22 you are much more inclined to actively seek minority
23 opinions. There are ways we could hold our managers
24 more accountable for what they sign. EH will follow
25 the actions by the Program Offices to address the issue

1 of questioning attitude and to facilitate the sharing
2 of ideas and best practices.
3 In addition, we must continue to
4 communicate to our workers the worker involvement and
5 philosophy. It is a key tenet of ISM, of VPP
6 [Voluntary Protection Program], Behavioral Based
7 Safety, all of those systems that we are currently
8 working with within the Department. We should expect
9 our workforce to raise concerns and report safety
10 problems. It is not just a right, but it is also an
11 obligation and a condition of employment.
12 One of the Deputy Secretary's management
13 challenges that you will see in the letter that I will
14 provide for the record, reinforces the Department's
15 commitment to workers to fully report safety concerns
16 without fear of reprisal. But I will tell you still,
17 when I ask workers in the field what their stop work
18 authority is, they say they have a right to stop work.
19 They do not say they have an obligation to stop work.
20 We have to continue to push that, to take it to the
21 next step.
22 Many of the other issues identified in the
23 Columbia report directly relate to ongoing initiatives
24 in the Department, and we will closely watch how those
25 initiatives proceed and evaluate the effectiveness, and

1 especially share the lessons between organizations on
2 how effectively they implement those issues.
3 Finally, the issue of Integrated Safety
4 Management. You asked about our activities to ensure
5 ISM is being effectively implemented. DOE is committed
6 to ISM. We should not move away from this model. It
7 is how we do work, but there are things that can happen
8 that would drive us away from ISM. I believe first and
9 foremost, we must maintain the first of the guiding
10 principles, which is line management is responsible for
11 safety.
12 This has proven to be one of the most
13 difficult parts of ISM to preserve, however. At every
14 turn, someone wants to remove line management
15 responsibility, accountability, and authority, and once
16 this starts to slip, the entire ISM model is in
17 jeopardy. Line organizations have the responsibility
18 to do work safely. All three of those words matter,
19 do, work, and safely. At no time is it acceptable to
20 say that you can do work, but it won't be safe, or you
21 can be safe, but you can't get work done. I believe
22 that it is the expectation of managers in DOE that work
23 will be done safely. And again, our actions need to
24 follow those goals to make sure that we reward and
25 punish people in that area.

1 We have senior leadership commitment and
2 focus on safety. We have a comprehensive set of safety
3 requirements and contracts that communicate
4 expectations and allow DOE to hold contractors
5 accountable. ISM implementation has been verified in
6 the field by review teams and concurrence by senior
7 managers. ISM should now be how the Department does
8 business. It is not an add-on.
9 We recognize, though, that there are still
10 weaknesses in ISM implementation. We do not always
11 identify all of our hazards adequately, and the
12 feedback and improvement function still needs
13 significant work. However, efforts are well underway
14 to improve the recognition and reporting of
15 occurrences, the associated causal analysis, the use of
16 occurrence information by line management as a means
17 for timely feedback on the ISM implementation, and the
18 corrective actions. How do we know ISM is working? It
19 is our feedback process that has allowed us to identify
20 where we are weak. We are getting the feedback. We
21 just need to make those improvements now.
22 I have not covered all the other items that
23 have concerned me, so let me mention a few others.
24 There are many changes going on in the complex, and
25 that leads to great distraction on the part of our

1 workforce. Our contractors are also concerned about
2 things like competing contracts, which may very
3 significantly distract them from the work at hand.
4 The age of our workforce has brought up
5 issues related to how you judge the ability of workers
6 to do a job. After you have assessed the hazards and
7 determined the appropriate controls, can our workforce
8 actually work within those controls? These are only
9 some of the day-to-day issues that must be addressed.
10 Failure to be mindful of these issues can also have
11 serious complications and consequences on a daily
12 basis.
13 I expect that the Board will come to
14 conclusions and have ideas for the Department on how to
15 better use both independent and line oversight as
16 methods for assuring and improving performance on the
17 part of the Department. I hope that your suggestions
18 include some ideas on the human factors issues that we
19 are currently facing today, and how oversight can help
20 us better focus in on those issues also. I look
21 forward to your conclusions at the end of your
22 hearings, and I thank you for this opportunity today.
23 I would be happy to take any questions that you have at
24 this time.
25 CHAIRMAN CONWAY: Dr. Eggenberger?