welcome today's presenter, Assistant Secretary Cook, members of the public, members of the press in our audience, and those viewing our proceedings electronically.

In accordance with the Board's practice, and as stated in the Federal Register notice, we will welcome comments from interested members of the public at the conclusion of the testimony, and that concludes my opening remarks. Dr. Eggenberger?

VICE CHAIRMAN EGGENBERGER: I have no questions at this time.

CHAIRMAN CONWAY: Okay. Questions?

DR. MATTHEWS: No, no questions at this time. I think I'm okay.

CHAIRMAN CONWAY: With that, Bev, we turn to you.

MS. COOK: Thank you, Mr. Chairman and members of the Board, for the opportunity to address you today. You have invited me to speak on roles and responsibilities of the Office of Environment, Safety and Health in the oversight process. But in keeping with some of the questions you have sent to me, I would like to expand my remarks somewhat to the role of EH in assuring safety operations of the Department of Energy. I will speak to both of my role personally, and also

that of my office. I will also address the efforts underway to improve DOE's safety performance and where I continue to be concerned.

But I would like to start with some overall assumptions. I absolutely believe that our workforce does not come to work with the intention of hurting themselves or others around them. These people live with their families in these communities. They don't intend to harm the environment in which they live, and they are not self-destructive people. I also believe that the companies that DOE has hired do not intend to harm the workers that they have employed or the environment surrounding their workplace. These are good people trying to do the jobs that we have hired them to do.

However, many factors drive behavior. These same people worry about keeping their jobs so they can support their families. Therefore, if we communicate mixed signals about what is important to us, then we will drive performance in unexpected ways. The same is true of the companies that we hire. If we are not clear about our expectations, they may exhibit behavior that is unacceptable to us. And that is what I want to talk about today. How do we, the federal workforce, drive their behavior, and what is my role in

that process.

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

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

resolving crosscutting safety issues. I will describe how I and the ES&H organization fulfill these roles in the context of the overall safety structure of the Department.

The safety structure I refer to here consists of several parts, and it looks very much like ISM [Integrated Safety Management] in a larger context. That is, first, clearly setting those goals that we want to follow, setting the requirements for meeting those goals, setting the performance measures and measuring that performance, implementing those requirements through the line organizations, performing independent oversight, and then feedback and improvement. Now, I will speak to each of these steps and my role and the role of my organization in these steps.

First, I would like to talk about setting goals. I have submitted as backup the Deputy Secretary's letter defining the 2004 management challenges. This is the list of challenges that our Deputy Secretary feels are very important for his managing of the Department's operations. The first challenge in that list is safety, and the first item on that list is setting goals. It is the manner in which the entire organization knows what is expected of them.

In the past, DOE has defined those safety goals in a variety of ways, including, as we all remember, keeping risk levels below a certain level to just saying things like, "Be Safe."

Secretary Abraham has been very clear about his goals. In our DOE 2002 Annual Report on Environment, Safety and Health, the Secretary committed to keeping our workers safe, protecting the environment at and around our sites, and being proactive in evaluating trends and safety vulnerabilities to prevent reoccurrence of events. He stated that the Department is committed to accomplishing work in a safe and environmentally responsible manner. He has restated this goal in almost every venue that I have heard, and especially states this when he is speaking to the DOE workforce.

This is a high standard. However, it is the topic of heated discussions within the Department. It is well recognized that setting the wrong detailed goals or communicating those goals incorrectly will drive the wrong behavior. For example, saying things like "no incidents" or "no near misses" drives non-reporting.

Therefore, in the context of the Deputy Secretary's management challenges, we will continue to

look for ways to articulate the safety goals of the Department in a manner that improves performance. This is a work in progress. I am the lead for coordinating this effort throughout the Department. I will continue to work that over the next several months.

In addition, all of the Department elements must articulate the goals relevant to their portion of the work, and most of the organizations have tried to do that. I will discuss some of those efforts in my discussion on performance measures. For our part, the EH staff has looked at outside organizations and companies for examples for setting safety goals that might work for DOE and will drive the kind of performance that we insist on and not drive the wrong things.

There are goals that may be relevant to our workforce, but that may not be relevant to others. For instance, I have often expressed to the complex that my goal is "zero legacies," and I mean by that no environmental legacies, no health legacies, and no safety legacies, and that means performing work in a manner that may be safe for the current workforce, but sets up a condition in the long term that may be very unsafe for someone that has to deal with it later.

The goals must be effectively communicated

and the rewards and punishments must follow consistent with those goals. It takes both setting the goals and showing you are serious about it to drive the right behavior. And one of my jobs is also to assist line programs in identifying and communicating the rewards and punishments that show consistency with those goals. More importantly, to explain to the line management when they are, in fact, providing rewards and punishments that are inconsistent with those goals.

Let me talk next to setting those requirements. The goals need further definition based on the type of work performed. And as you know, EH has the primary responsibility for establishing and maintaining DOE's Regulations and Directives relating to Environment, Safety and Health. EH interacts with other government agencies and health and safety organizations and organizations that develop standards. We strive to incorporate into the DOE directives and standards current industry best practices and policies.

The DOE Directives contain four levels of documents: policies, requirements, which are the Rules, the orders and the manuals, guides and Technical Standards. You have asked that I describe how EH ensures that the ES&H policy, requirements, and standards are understood and properly implemented in

the field. We utilize a variety of methods.

We first ensure awareness of the issues in the setting of those standards and policies by participating in the established DOE development and review process and the practices for requirements and standards, and that includes everything from formal rulemaking to our REVCOM [Review and Comment] system that allows for input from all of the complex on any new issues.

We issue Nuclear Safety Technical Positions and Directives Interpretations when they are needed. We maintain telephone "hot lines" and websites to tee up the concerns and facilitate resolutions. We conduct training on rule and directive requirements and guidance, and we will continue to do that. We participate in the Energy Facilities Contractor's Group [EFCOG], in their workshops, so that we are available to answer questions and clarify directions to the DOE contractors.

We facilitate and develop implementation of Functional Area Qualification Statements and Standards for safety analysts, implementers, and reviewers. We participate in assessments of implementation as subject matter experts at the request of the DOE field organizations, that is in areas like criticality, fire

safety, explosive safety, etcetera.

We maintain the safety database systems, collect information on ES&H performance, and analyze that operation performance, the occurrences, and the reports and indicators to determine whether there are implementation issues, and we share lessons learned, and we provide the feedback to the Program Offices. We conduct independent assessments of the safety issues and concerns at the request of the line management and participate and assess Operational Readiness Reviews.

We provide safety basis support to the DOE line organizations and Field Offices on nuclear safety and review the adequacy of the Safety Evaluation Reports that they generate. And we analyze Unreviewed Safety Questions [USQ] across the complex for cause and corrective actions.

All of these actions together provide EH with the information to relate to the understanding and proper implementation of the policies, requirements, and standards. You have asked what actions are available to EH to correct the implementation issues. That depends on what the root cause of the problem is.

The actions we can take are directly related to root cause, is related to the failure of the understanding and the implementation. If there is a

lack of understanding, we can issue Nuclear Safety Technical Positions, Interpretations, and Safety Notices, and you will find many of those on our website.

If it's a lack of qualifications of the staff, we establish and facilitate safety Functional Area Qualification Standards [FAQS] and we conduct training. If it is clear that the policy, requirement, or standard does not result in the outcome we want, then we will revise the DOE directives and standards. And often is that case: if there is a lack of understanding of what the root cause is or there is a significant difference in opinion of what that root cause is, we manage and facilitate resolution through ES&H managers meetings, DOE crosscutting technical working groups, and interactions with EFCOG until we do get down to what the root cause is and take the appropriate action to correct it.

EH has the responsibility to investigate and report on accidents and to investigate and enforce nuclear safety violations. A critical part of those investigations is to determine the root cause of an accident or violation, including identifying if the DOE requirements are unclear.

There have been many initiatives over the

last few years to set better requirements. It has been recognized that DOE's requirements sometimes have been confusing, conflicting, and not properly applied. Even with the advent of our current contracting method, where the set of applicable requirements are negotiated and documented in the contract, the contracts often contain items that were not relevant to the work at hand. This has led to a system of waivers, exceptions and inconsistent practices in holding our contractors accountable for the items in their contracts.

Therefore, there has been an effort underway to streamline the requirements. The purpose is not to lower the standards for safety performance, but rather to come to a concise, relevant set of requirements and then hold contractors fully accountable for meeting those requirements. We would like to set the requirements and follow the requirements. Waivers should be at a minimum.

The extensive use of waivers was noted in the Columbia report. The Department has continued to look for ways to reduce the need for waivers by better articulating requirements, so they are more generally applicable to the variety of work in the Department, and by providing the methods for tailoring the set of requirements up front for a specific operation. Once

the right requirements are identified, compliance should be strictly enforced, not changed as it comes up when something is not relevant to the work.

One of the difficult issues though is how to hold all work on a site accountable to an appropriate set of standards. EH is aware of the proposed changes to DOE Order 251.1A [DOE Directives System] and its associated Manual, and we are actively engaged with the Office of Primary Interest [OPI], that is ME [Office of Management Communications], and the Defense Board staff on concerns related to the proposed limitations of the applicability of DOE directives to site and facility management contracts.

The challenge continues to be how to define the appropriate set of standards and apply them to the appropriate operations. There still remains several options, and EH will continue to aggressively work resolution on this issue so that the correct outcomes are achieved.

There is also a proposed revision to DOE Manual 251.1 that would change the exemption authority for DOE Orders from the Program Secretarial Office [PSO] to the Office of Primary Interest, the person who wrote that rule or directive. Currently in the directives process, the PSO is the exemption authority

under the overarching DOE policy that line management is responsible for safety.

The Office of Primary Interest has 30 days to provide comments to the PSO. DOE is currently evaluating this change. I will not tell you, at this point, that I have come to a conclusion about whether I agree with this policy or that there may be some options where sometimes, it should be one way, and sometimes the other.

Let me talk some about setting performance measures. As part of setting the right requirements and driving the right behavior, you must know, in fact, the requirements give you the outcome that's desired. Therefore, performance must be measured. Performance measurement is very difficult, as you all know. Picking the right measurements that indicate overall performance is important, but the act of measuring in and of itself will drive performance.

People pay attention to what you measure. Over time, an organization should be able to identify the precursor indicators that lead to unacceptable events and be able to monitor those indicators, rather that being event driven. And DOE continues to strive to move in this direction.

In the past, EH assumed responsibility for

collecting and monitoring ISM performance measures for the Department. These included things like Total Recordable Case Rate, Occupational Safety and Health Cost Index, Radiation Doses to the Public, Worker Radiation Dose, and such items. It became apparent that improvements were needed. However, it was a consensus that most of the ISM [Integrated Safety Management] indicators were lagging significantly and were not used to drive improvement. We were awash in data, but very weak on information, and it was not well utilized.

Therefore, we have expanded our efforts in EH. I have elevated the Office of Corporate Performance Assessment to the Deputy Assistant Secretary level, and I have increased resources within EH to this office. We continue to work with the line programs to develop a more meaningful set of indicators for safety performance. We have revised the DOE Occurrence Reporting [and Processing] System [ORPS] in order to capture more relevant data and then provide analysis of that data.

The Under Secretary for Energy, Science and Environment conducts quarterly safety meetings with his direct reports. That is the Assistant Secretaries and the office directors, and they all attend. EH is

responsible for evaluating performance and the cost cutting trends at all EM [Environmental Management], Science, NE [Nuclear Energy], FE, [Fossil Energy], RW [Civilian Radioactive Waste Management], and EE [Energy Efficiency] sites.

The Assistant Secretaries are held accountable for the safety performance at their sites. The NNSA [National Nuclear Security Administration] safety representative also attends these quarterly safety meetings. We begin the discussion with the key indicators, Total Recordable Rates, Lost Work Cases, Near Misses, and a variety of other significant occurrences and trends over 10 different functional areas, including nuclear safety, fire safety, safety basis and such. EH communicates lessons learned and best practices at this meeting and provides an independent assessment at the meetings.

These meetings have been proven to be very, very useful. The sharing of best practices is the issue that I feel is the most important that occurs at these meetings. There have been very in depth conversations between the different Assistant Secretaries on what actions they take to drive performance and what effect they are getting from those actions.

The Program Offices have also articulated their specific safety goals at these meetings. For example, EM has initiated a 4.0 Program of Performance Indicators. They focus on the indicators that are most relevant to the EM sites, including, for instance, transportation events, very important to them. The Office of Science has established goals for injury and illness rates in order to drive their performance to the top 25 percentile of the best in class private industry laboratories.

I will tell you that Dr. Orbeck is very, very serious about that, and he does not view any incident as routine. I am on distribution for his emails when he talks to his field organizations about incidents. One I saw recently, where they had cut into a piece of conduit thinking it was rebar, he sent the Field Office a note that said, "I'm not sure that these contractors are qualified to do scientific research for me if they don't know the difference between rebar and conduit." So he is unaccepting of any kind of incident in his area of purview.

EH is currently working with NNSA to further refine similar indicators at their sites, and I understand that Ambassador Brooks plans to begin holding quarterly safety reviews with his senior staff

also. I believe that the Department has significantly evolved in its ability to track and trend performance at the corporate level. EH not only looks at the "numbers;" we also want to understand exactly what is driving certain performance. What we are seeing are things like a site may have a good Total Recordable and Lost Work Case rates, but the near misses are increasing, and the significant events are increasing. We need to understand why and ensure that line management is taking the appropriate corrective actions.

We continue to look at ways to improve our ability to identify precursors and leading indicators. As NASA [National Aeronautics and Space Administration] discovered, we must pay attention to the small events and evaluate what our safety systems are telling us. Dr. Howard from the Columbia Accident Investigation Board stated in his presentation to us that "the system is talking to you." Those numbers mean something.

Please, be assured that EH is not overlooking nuclear safety performance, but if we are stumbling on the small things, it may be an indicator that we have problems with rigor and operations that could result in more significant consequences, like

with those systems, the nuclear safety systems, that are predicting our nuclear operations. An area for improvement in 2004 is the tracking and trending of nuclear safety performance. EH is currently working on better defining the nuclear safety indicators, and we welcome the Board's insight into this area.

Recently, EFCOG developed a proposal for the top ES&H and Quality Indicators. They have been provided to EH for consideration and comment. I am optimistic since the proposal recognizes the need to develop leading indicators. We will work closely with our line programs and with EFCOG to further develop these indicators.

Normalization of deviants is a major issue in the Columbia Accident Investigation Board report. NASA had conditioned themselves to expect deviations and didn't consider them serious. The Department is improving the use of daily operating experience events. ORPS events are published daily and distributed to a large group of Headquarters and field personnel for the purpose of fostering a continued awareness and evaluation of operational information.

Biweekly Operating Experience Summaries are published and distributed throughout the complex that focus primarily on discreet, operational deviations

that are precursors to more serious events. Also, EH provides weekly summary reports of significant events and trends to the Under Secretary Card and Ambassador Brooks. Many times Under Secretaries require further evaluation from the line programs after they receive those weekly reports. This sends a strong signal to the entire complex not to ignore or to accept deviations from normal performance, and they have done this in a very regular manner.

Next is line implementation and oversight. Once the framework is set, that is the goals and the rules and the measures, the line organizations are responsible to make it work. They adapt this framework to the specific work, the work environment, and their workforce. The line organizations are responsible for implementing the rules in a manner that ensures that the goals are met. Therefore, the first "oversight," if you will, is performed by the line organization closest to the work, that being the local DOE offices. The line programs must have the expertise to fulfill that role and to know when to ask for help.

EH has an interest in all the initiatives underway by the Program Offices to best fulfill their responsibility to implement the Department's safety requirements and provide oversight. The programs are

evaluating the methods for fulfilling the role that will best work for their operations.

Specifically, I have been briefed and asked to provide feedback and concurrence on many of the organizational changes within the Program Offices. I have had the opportunity to freely express my questions and concerns, including my interest in how those Program Offices are identifying the level of expertise that is required in any given Area Office. They have not fully answered those questions for me yet; I will tell you that.

EH has been involved in working groups at the staff level on most initiatives identified to the Board during the public hearing, including the new federal management and oversight policies being developed by DOE and NNSA for the defense nuclear facilities; new approaches to contract reform, contractor self-assessment, and federal oversight; field applications of federal management and oversight policies being developed for the defense nuclear facilities, applying lessons learned and corrective actions resulting from the reviews of the Columbia Accident; and identifying technical competence requirements to ensure effective management and oversight activities.

As involvement in these initiatives is a part of normal course of work for EH, that is what we do, I have not kept a record of the amount of time that was spent by my staff and I in reviewing these initiatives, but I will tell you we continue to be cautiously optimistic. I find especially that the Program Offices are acutely aware that making changes while continuing current operations is very, very difficult, and they are trying to pay a lot of attention to that. It's hard to keep doing work while you're trying to make the changes.

I would like to talk for a minute, though, about the self-assessment programs that we are pushing. I believe there is a misunderstanding in our efforts to strengthen the contractor self-assessment programs. The purpose is to hold our contractors accountable for their performance. They should be responsible for having programs in place that catch those precursor events and failures in their safety systems and to fix them. It should not be the responsibility of DOE line oversight.

One role of the DOE line oversight organizations should be to check to make sure that the contractor has adequate self-assessment programs in place and to verify that those programs are working.

DOE should not be the only line of defense, and let me give you an example.

We had gotten ourselves into a very difficult situation with Operational Readiness Reviews [ORR], and you are all acutely aware of that. in fact, the contractors were not always ready. And we have gotten into the habit where DOE would come in, review the readiness, and pick up items that should have been found and fixed before DOE showed up. When EH staff is asked to participate in an Operational Readiness Review, they are now directed to leave if it is apparent that the contractor is not ready, and that is the case with a lot of the DOE Program Offices, also.

We had slipped into bad habits, both as contractors and DOE as a customer. We are regrouping and setting our roles appropriately. This does not mean that DOE is counting on the contractor to oversee themselves, and we will just take their word for it. It does mean that we have raised our expectations. It is the contractor's job to prove they are ready to perform work, and they will continue to perform work, not DOE's job to prove that they are not.

CHAIRMAN CONWAY: We have known that. We have said that for a long, long time.

MS. COOK: I know that, sir.

CHAIRMAN CONWAY: And these contractors continue to come in, say they are ready, and they are not ready. So, I don't give a lot of faith and confidence in turning over to the contractors. They are setting what standards they are going to be held to, and then the DOE decides whether or not they will go along with it. We have decided in the future, we're going to have the contractors set the standards by which they will work. That's nothing that history up to now would give me confidence in. Go ahead.

MS. COOK: And you have asked for a briefing on worker safety and health standards in the next 30 days, and we will come and talk more about how we agreed to the set of standards that are appropriate, as we do now in the contract, and we'll discuss that more.

CHAIRMAN CONWAY: And I'm going to have some questions. I'm going to have some specific questions on that today.

MS. COOK: Okay. EH is often asked to provide technical assistance to DOE and NNSA on health and safety concerns that may require remedial actions at the request of the Program Office. I have included a list of 12 of those recent items in my testimony, which I will not read to you at this time.

My biggest concern on some of these actions is that we are providing assistance at times for events and conditions that we have seen before. I will speak more later when I discuss feedback and improvement. We're getting feedback. We're not very good on improvement.

A continued concern of the Department is technical competency of the staff, and I know that is a concern of yours. EH is involved in several ways in addressing technical competency within DOE and NNSA in the area of ES&H. In the role of managing a Technical Standards Program, EH coordinates review and approval of the Functional Area Qualification Standards that support the Technical Qualification Program.

A senior manager in EH is actively involved in the Federal Technical Capabilities Panel [FTCP] and as such, provides input and feedback on technical competence issues. Subject matter experts in EH participate in the development and implementation of Functional Area Qualification Standards. EH provides and supports technical training in ES&H areas, such as safety basis, criticality safety, and accident investigation.

My biggest concern regarding technical competency of the DOE staff is, in fact, the average

age of our workforce. Many of our staff, both federal staff and contractor staff, are retirement age. We are continuing to work with the human resources organizations within the DOE to identify unique strategies to assure that we have competent staff in the future.

I have also spent significant time recently discussing with Congressional staff about the role of EH within DOE. There, apparently, has not been many conversations with Congressional staff on that subject in the past. The funding for my staff has been cut by Congress significantly in the last several years. I do not believe that my current staffing levels are sufficient to fulfill the requirements of my organization, and the Department is actively working to rectify this situation. But my job is to communicate to Congress the critical role of Corporate Safety Office in an agency like DOE, so that sufficient funding is forthcoming. I am working very hard on that, especially in the last couple of weeks.

EH is responsible for reviewing operating contracts and Requests for Proposal to ensure that the essential ES&H requirements are presented and determine if adequate resources are planned for ES&H activities. Specifically, we look at the list of applicable

directives, and we review that for completeness. We look at the applicable DEAR [Department of Energy Acquisition Regulations] clauses, and we look at some of the novel contracting strategies, that is, using commercial standards for non-nuclear demolition contracts and such, and then we review the entire contract for consistency among ES&H terms and conditions in the various sections. It is amazing to me the number of contracts we have that are inconsistent even within the contract on what it is we require of a contractor to perform work.

We have recently put out an interim final rule - it was effective January 9th - on the new Conditional Payment of Fee clause. We hope that this will help fee determining officials better utilize this as an "enforcement" tool. EH will continue to provide support to the Procurement Executive and Field Offices in the interpretation and application of this new clause. We will also monitor the clause applications in the future. We are not part of that fee determination, but we will look at what the effectiveness of that new clause is.

Finally, I get to independent oversight. It is very, very important that there is an independent check made to see if the desired outcomes are achieved.

Independent oversight is critical. Independent oversight is not, however, the first line of defense for safety. It is the check to assure that the framework and the implementation is achieving the desired results. EH does not perform independent oversight but does have an important interface with those organizations that do perform this function.

For instance, we support the Office of Independent Oversight within DOE and their field reviews by providing the analysis of the site and the facility safety performance. This helps the review teams to focus their efforts on likely problem areas and increases the effectiveness of the reviews and the time spent. The next interface with the oversight organizations is related to feedback and improvement, so I will go just immediately to that.

I believe that feedback and improvement continues to be the Department's biggest challenge. Valuable information is provided to the Department every time another organization identifies a process or event that the line organization has not already identified and fixed. It sends a variety of messages at that point.

We are not effectively utilizing the feedback provided to us by other organizations in order

to improve our performance, and then we often get so caught up in the specific corrective actions related to an issue that we lose sight of what the real root cause is of the problems. It is part of EH's role in crosscutting issues to address that issue, in fact.

First, I will address the Office of Independent Oversight. We meet with that office and discuss their findings after they have done their audits. We look for root causes. We ask follow-on questions. We ask follow-on questions when they identify things like failure to follow procedures or lack of management attention. I do not believe that either one of those things are a root cause.

We also are active in evaluating other reports and audits of the Department to look for issues that may be applicable for organizations other than the direct subject of the report. EH now receives notices of all reports from outside organizations and correspondence, including GAO [General Accounting Office], the DOE IG [Inspector General] and, of course, the Defense Board reports, but Homeland Security and other outside agencies.

DOE staff reviews this information to determine whether the site or program-specific issues that are identified could have generic safety and

health issues. The conclusions of that review are documented for consideration for action or referral to other DOE elements.

As part of this role, EH will strive to enhance our interactions with all of the oversight organizations, including the Defense Board, in order to better understand the underlying issues and to assure that the corrective actions really fix the root cause. Many issues occurred recently. I have often in the past made comments about the Department fixing things with tape and baling wire and, in fact, as you all pointed out, we have done that literally recently. When we are putting our programs in the position where they are taking actions like that to proceed with work, then I think there are some root causes behind that performance that are applicable to a wide range of issues.

For EH, the most important information to our specific job is to determine if the regulations, standards, and policies that we are responsible for are driving the right behavior. Therefore, feedback from all the organizations that do oversight are important to us, to know whether the regulations we have written need improvement and to take the actions if they do.

However, as you know, it's usually not that

simple. The biggest challenge is to understand the drivers of good behavior and the unacceptable behavior. It's easy to assume that it's just bad people or bad company, but that is unrealistic. Other actions drive people and companies to do things that are fundamentally against their nature. The Department has a long way to go in root cause analysis, and DOE will be providing some training in the near future on that subject. We also continue to learn from other organizations, such as INPO [Institute of Nuclear Power Operations] on effective ways to improve root cause analysis.

Part of EH's role in coordinating and managing crosscutting issues is to resolving issues across the DOE and the NNSA organizations. The resources needed in EH in accomplishing this task vary depending on the issue. In general, we try to facilitate a corporate view of the outcome that is desired, and then help each individual program understand the implementation and their efforts to meet that commitment and to meet the intended outcomes. This is somewhat new for the Department. We have been very stovepiped. We are continuing to improve our ability to coordinate these crosscutting issues, but it is not where we want it to be.

DOE sponsors and manages monthly meetings between the ES&H managers from all the DOE Headquarters Program Offices with health and safety responsibilities. This collaborative forum enables discussions and notifications and decision-making on methods to address potential safety and health issues that may cut across DOE Program Offices, and to share best practices at a Headquarters level.

We also use this forum to provide information on new, revised, and upcoming ES&H requirements or activities that might impact budget decisions. In general, the Department is trying to minimize those budget items that are allocated or shared between Program and Field Offices. As you know, that hasn't worked very well. This goal has not been fully realized, at this time, but we are striving to identify those things more and more and to try to locate funding for specific crosscutting items in a specific office.

MR. FORTENBERRY: Bev, excuse me. You said, as you know, that hasn't worked very well. Are you talking about the effort to minimize or the sharing of the budget?

MS. COOK: The sharing of budgets.

MR. FORTENBERRY: Thanks.

MS. COOK: The sharing of budgets for things like QA [Quality Assurance] working group, those sorts of things, things that need to be done, but end up in the noise level in a specific Program Office.

Let me just spend a few minutes on some of the lessons learned issues that you asked me to speak on, those lessons learned from the Columbia Accident and the Davis-Besse near miss. There have been several reviews made by EH staff, including me, and there are many lessons to learn from these events. Because the issues identified cover a broad range of topics, EH's role has varied in implementing those lessons learned within the Department.

Regarding Davis-Besse, EH will issue a lessons learned publication, in fact, in the near future. Although, the Davis-Besse near miss was somewhat unique, there are generic performance related lessons learned that are applicable to all of the DOE operations. It certainly identified the need for a performance analysis function within the Department.

Fortunately, EH has already moved to strengthen that function, as I have already described. In addition, EH and all the Program Offices continue to work towards determining the correct set of performance measures that will truly provide early

indicators of performance problems. While the Department is proud of our overall performance, at this time, everyone in every Program Office is concerned about what it is we may not know and whether we're measuring the right things.

Let me next touch on some of the issues related to the Columbia Accident. It's important to note that the Program Offices have also reviewed the Columbia Accident. They have discerned applicable lessons learned and are moving forward with certain actions where it's applicable to them, and the priorities in the Columbia lessons learned vary from program to program. They all have different issues. EH staff has provided input to NNSA and EM for their review, for instance, and this included participating working groups and meeting with line management prior to initiating their broad range reviews.

Reliance on past successes and treating operations as routine. I have sort of a different perspective on this. As opposed to the overall management perspective, I believe that these two issues are related to workforce issues that we have. Many of the people on our workforce have been doing their jobs for a very long time, and they have been doing so without incident because of their personal knowledge

and skill. This issue is coming to a critical point within the Department. As I have said, a large portion of our workforce is retirement age. We must fully document the processes and procedures that we use and start with the assumption right now that every operation is new and unique.

I know that Program Offices are looking at this issue, but the changes in the workforce may be the strongest driver we have right now to correct this problem of reliance on past successes and treating operations as routine. We do very unique things. You can't go out and hire somebody off the street and know what it is that the people who have been working 40 years in our complex know.

Resource constraints and placing the mission before safety. It is the expectation of senior managers in the Department that missions will be accomplished safely. As we all know though, that view is not always communicated correctly throughout the organization. The conversations that occur during these quarterly safety meetings often focus on the actions that are taken by the Program Offices to reward or punish good or bad behavior. We may say that work must be accomplished safely, but often our actions do not communicate that message.

We must not reward contractors who take risks to meet the mission goals, and we must fully recognize the contractors who accomplish the mission goals safely. EH continues to strive to bring attention to those contractors who perform work safely through best practices information and identification of those to the Program Offices. Our rewards and punishments must be consistent with our stated goals.

Our organizations must learn from past mistakes and failures. I have already said that I believe this is DOE's biggest challenge. We realize that the use of lessons learned must be improved within the Department. We are currently redesigning our process for communicating the information and holding line managers accountable for corrective action.

For instance, EH has recently published an operating experience report on hoisting and rigging events and precursors. This report is being forwarded to the Headquarters line management through their Program Offices for action. We need to have better methods for capturing lessons learned in the nuclear safety areas. Lessons learned on nuclear safety have not received as much attention, and EH is working on better methods to improve that information area.

Poor organizational structure can be just

as dangerous as complex technical issues: I absolutely agree with that. I believe that DOE's ISM policy is clear that line management is accountable for safety. We must maintain that emphasis. It should not be an option for line management to reduce attention to safety. It also should not become the role of an outside organization for safety, that is. And in other words, that outside organization could get cut as budgets become tight. Safety is a line management responsibility and should continue to be.

The issue of questioning attitude is also interesting. There are many methods, and our Program Offices are looking at those, on ways to increase the questioning attitude on the part of senior management and the Program Offices. One method that was provided to me early in my career was to hold people accountable for their signature.

If your signature means you are fully accountable for the content of a document or a decision, you are much less inclined to proceed with just a summary briefing, a PowerPoint presentation, and you are much more inclined to actively seek minority opinions. There are ways we could hold our managers more accountable for what they sign. EH will follow the actions by the Program Offices to address the issue

of questioning attitude and to facilitate the sharing of ideas and best practices.

In addition, we must continue to communicate to our workers the worker involvement and philosophy. It is a key tenet of ISM, of VPP [Voluntary Protection Program], Behavioral Based Safety, all of those systems that we are currently working with within the Department. We should expect our workforce to raise concerns and report safety problems. It is not just a right, but it is also an obligation and a condition of employment.

One of the Deputy Secretary's management challenges that you will see in the letter that I will provide for the record, reinforces the Department's commitment to workers to fully report safety concerns without fear of reprisal. But I will tell you still, when I ask workers in the field what their stop work authority is, they say they have a right to stop work. They do not say they have an obligation to stop work. We have to continue to push that, to take it to the next step.

Many of the other issues identified in the Columbia report directly relate to ongoing initiatives in the Department, and we will closely watch how those initiatives proceed and evaluate the effectiveness, and

especially share the lessons between organizations on how effectively they implement those issues.

Finally, the issue of Integrated Safety Management. You asked about our activities to ensure ISM is being effectively implemented. DOE is committed to ISM. We should not move away from this model. It is how we do work, but there are things that can happen that would drive us away from ISM. I believe first and foremost, we must maintain the first of the guiding principles, which is line management is responsible for safety.

This has proven to be one of the most difficult parts of ISM to preserve, however. At every turn, someone wants to remove line management responsibility, accountability, and authority, and once this starts to slip, the entire ISM model is in jeopardy. Line organizations have the responsibility to do work safely. All three of those words matter, do, work, and safely. At no time is it acceptable to say that you can do work, but it won't be safe, or you can be safe, but you can't get work done. I believe that it is the expectation of managers in DOE that work will be done safely. And again, our actions need to follow those goals to make sure that we reward and punish people in that area.

We have senior leadership commitment and focus on safety. We have a comprehensive set of safety requirements and contracts that communicate expectations and allow DOE to hold contractors accountable. ISM implementation has been verified in the field by review teams and concurrence by senior managers. ISM should now be how the Department does business. It is not an add-on.

We recognize, though, that there are still weaknesses in ISM implementation. We do not always identify all of our hazards adequately, and the feedback and improvement function still needs significant work. However, efforts are well underway to improve the recognition and reporting of occurrences, the associated causal analysis, the use of occurrence information by line management as a means for timely feedback on the ISM implementation, and the corrective actions. How do we know ISM is working? It is our feedback process that has allowed us to identify where we are weak. We are getting the feedback. We just need to make those improvements now.

I have not covered all the other items that have concerned me, so let me mention a few others. There are many changes going on in the complex, and that leads to great distraction on the part of our

workforce. Our contractors are also concerned about things like competing contracts, which may very significantly distract them from the work at hand.

The age of our workforce has brought up issues related to how you judge the ability of workers to do a job. After you have assessed the hazards and determined the appropriate controls, can our workforce actually work within those controls? These are only some of the day-to-day issues that must be addressed. Failure to be mindful of these issues can also have serious complications and consequences on a daily basis.

I expect that the Board will come to conclusions and have ideas for the Department on how to better use both independent and line oversight as methods for assuring and improving performance on the part of the Department. I hope that your suggestions include some ideas on the human factors issues that we are currently facing today, and how oversight can help us better focus in on those issues also. I look forward to your conclusions at the end of your hearings, and I thank you for this opportunity today. I would be happy to take any questions that you have at this time.

CHAIRMAN CONWAY: Dr. Eggenberger?