



*Office of Health Safety  
and Security*



**Partnering Approach for Event  
Analysis**

DOE Accident Investigation Program  
Experience

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# DOE Partners and Regulatory Framework



Office Corporate Safety Programs - Accident  
Investigation and Prevention

Office of Enforcement

Line Programs and Field Elements

O&M Contractors

Other Regulators and Stakeholders



# Event Thresholds



Occurrence Reporting

Federal Accident Investigation

Operating Experience and Lesson Learned

Non-Compliance Tracking System



# Evolution of Accident Investigation Program



- 1990 Investigation program established
- 1995 Enforcement Program established
- 2009 Human Performance Improvement Handbook
- 2010-11 Directive Reform
- 2012 Accident and Operational Safety Analysis Handbook



# Trust and Ownership



- Question of “independence” is addressed each time a Board is appointed. What is best for the Department?
- Continuous improvement is worth the risk
- Line programs own the investigation; they better own the corrective actions



# Control and Flexibility



- DOE is self-regulated and has set requirements
- Directive Reform process was an opportunity to start a change and build consensus
- Quality processes using non-mandatory consensus Technical Standard /Handbook



# Organizational Learning

- Blame and the “Whack-a-mole” reaction vs. Just Culture
- Spanning “information rich events” to highest profile/consequence accidents
- Train investigators and analyst



# Challenges

- Consistently demonstrate learning organization values
- Encouragement and reinforcement at all levels
- Management commitment to lead investigations
- Metrics to measure effectiveness