

**STATEMENT OF GREGORY H. FRIEDMAN
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BEFORE THE
UNITED STATES SENATE
COMMITTEE ON ENERGY AND NATURAL RESOURCES

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Mr. Chairman and members of the Committee, I am pleased to be here today to respond to your request to testify regarding recent allegations associated with occupational medical services and tank farm vapor exposures at the Hanford Site. During the Cold War, the United States' nuclear weapons complex generated large amounts of hazardous and radioactive waste. The Department of Energy is responsible for the cleanup of numerous contaminated sites and facilities that supported nuclear weapons production activities. Associated with this is the need to protect the safety and health of the Department's workforce and the citizens in the communities surrounding these cleanup sites. For several years, my office has identified environmental cleanup and worker and community safety as significant challenges facing the Department.

In 2003, the Office of Inspector General initiated an audit addressing whether the Department's Computerized Accident/Incident Reporting System (CAIRS) contained accurate data. CAIRS is used by the Department to track occupational injuries and illness data, and it provides management with the ability to calculate workplace safety indicators. In addition, in conjunction with this audit, we conducted a limited review of accident and injury records to determine whether Hanford Site contractors had correctly classified 45 chemical vapor exposure incidents that had been made public in September 2003. Further, in February 2004, at the request of the Secretary of Energy, we initiated an investigation to address allegations of criminal misconduct associated with occupational medical services provided to Department and contractor employees at the Hanford Site.

Today, I will discuss the results of these reviews.

Department's Reporting of Occupational Injuries and Illnesses (DOE/IG-0648)

On May 21, 2004, the Office of Inspector General issued an audit report that addressed the accuracy of data in CAIRS. The Hanford Site was among the sites included in the review. We found that there were inaccuracies in CAIRS data for a number of contractors. We concluded that this occurred because of weaknesses in the Department's quality assurance process over injury and illness reporting to CAIRS. Specifically, errors were not promptly corrected and there was no standard procedure for the Department or its contractors to reconcile data.

With respect to the Hanford Site, we found that in 2002, Bechtel National Incorporated, the contractor responsible for managing and operating the Waste Treatment and Immobilization Plant at the Hanford Site, internally recorded 1,113 days of restricted work activity for its workforce while CAIRS listed only 552 days, a discrepancy of 561 days. Similarly, in 2002, CH2M Hill Hanford Group, Incorporated (CH2M Hill), the Department contractor that manages the tank farms at Hanford, internally recorded 404 days away from work while CAIRS only listed 303, a discrepancy of 101 days. In conducting our review, we noted that CH2M Hill had not performed any reconciliation of its data in CAIRS with Occupational Safety and Health Administration (OSHA) logs. In addition, CH2M Hill did not routinely review data contained in logs utilized for workers' compensation purposes. In this regard, we identified eight workers' compensation claims that were not reported in CAIRS for the period January 1, 2000, to March 31, 2003.

During the audit, Department management advised us that efforts were underway to address many of the data accuracy issues we identified. For example, shortly after a draft of our audit

report was issued, the Department published the *Environment, Safety and Health Reporting Manual*, which required electronic reporting of data to CAIRS, strengthened verification procedures, and clarified roles and responsibilities.

Our report recommendations included that the Department revise its policy to improve the accuracy and usefulness of data in CAIRS by requiring quarterly reconciliation of the various sources of contractor data with CAIRS.

Management generally concurred with our recommendations, but advised us that it believed the report overstated the implications of CAIRS data errors. In our opinion, data quality problems such as those observed during our audit had the potential to affect the accuracy of occupational injury and illness indicators. These indicators provide the Department with the ability to assess the complex-wide effectiveness of its safety programs and to modify procedures to resolve recurring occupational injury and illness issues.

***Review of Selected Issues Pertaining to Vapor Inhalation Allegations at the
Hanford Site (OAS-L-04-14)***

As part of our audit of CAIRS, we conducted a limited review of accident and injury records to determine whether Hanford contractors had correctly classified 45 chemical vapor exposure incidents that had been made public in September 2003. Our review involved the examination of data drawn from employee records and contractor-maintained occupational injury and illness files. We concluded that Hanford contractors had, for the most part, correctly classified the

chemical vapor exposure cases. Of the 45 items examined:

- Thirty-five cases appeared to have been appropriately classified;
- Two exposures were incorrectly classified as non-recordable;
- Four cases were not discrete incidents and duplicated other cases; therefore, they were excluded from the universe of cases we reviewed; and
- Four purported exposures could not be appropriately evaluated because we were unable to obtain sufficient information as to their existence and/or nature.

To determine if the cases were correctly classified, we used rules promulgated by OSHA. The OSHA definition of "recordable" incidents includes work-related injuries and illnesses that result in medical treatment beyond first aid, days away from work, restricted work activity, job transfer, loss of consciousness, cancer, chronic irreversible disease, or death. Recordable injuries and illness are required to be logged onto a *Log of Work-Related Injuries and Illnesses* (Form 300) – also known as OSHA 300 logs.

***Investigation of Allegations Involving Occupational Medical Services and Tank
Farm Vapor Exposures at the Hanford Site (I04RL003)***

In February 2004, in response to a request from the Secretary of Energy, we initiated an investigation of specific allegations of criminal misconduct associated with occupational medical

services provided to Department and contractor employees at the Hanford Site. There were three primary allegations:

- Alteration and destruction of medical records by the Hanford Environmental Health Foundation (the Foundation), the Department contractor that provided occupational medicine and industrial hygiene services to about 11,000 contractor and Federal workers on the Hanford Site;
- False injury reporting by Hanford contractors; and
- Cover-up of ammonia vapor readings at the tank farms by contractor employees.

This was a criminal investigation of specific alleged events and activities. Thus, we did not focus on general concerns with mismanagement, the technical aspects of tank vapor monitoring activities, whether medical services met professional standards, or the merit of individual worker's compensation claims. It was our understanding that these topics were included, either directly or indirectly, in other concurrent reviews involving the Hanford Site. In this regard, during the course of our investigation, we furnished relevant information regarding potential administrative or operational irregularities at Hanford to other offices performing programmatic reviews of these subjects.

As part of our investigation, we conducted extensive interviews of over 70 current and former Department Federal and contractor employees at Hanford and obtained and analyzed volumes of documents. We also retained the services of an independent medical and OSHA regulations specialist to review medical files and safety records. During our investigation, we coordinated

with the United States Attorney's Office for the Eastern District of Washington. At the conclusion of our fieldwork, we provided details of our investigative findings to the United States Attorney, the Chief of the Criminal Division, and an Assistant United States Attorney. The United States Attorney's Office declined to pursue criminal prosecution in this matter. The following are the results of our investigation:

Alleged inappropriate changes to patients' medical files by Foundation personnel

It was alleged that changes were made to patients' medical files by Foundation personnel that resulted in the misrepresentation of the nature, cause, extent, and/or severity of injuries or illnesses. Individuals believed that the changes were often prompted by pressure placed on Foundation physicians by contractor safety representatives. It was also alleged that the Foundation recently shredded documents, presumably to destroy evidence of wrongdoing.

The facts developed during the investigation did not substantiate criminal misconduct with regard to the alteration and destruction allegations. Further, the independent medical and OSHA specialist we retained reviewed a sample of files relating to worker injuries and illnesses at the Hanford Site, including patient medical files, contractor safety files, and related documentation. The sample was drawn from a universe of cases identified—primarily by witnesses we interviewed—as potentially having improper alterations, documents removed, or issues relating to recordability. The specialist reported that: (1) the Foundation medical files were detailed, well-organized, and consistent with standard medical practices; (2) changes and modifications to documents and/or entries in medical files appeared to be reasonable and proper; and (3) no improper alteration, destruction, and/or manipulation of records was identified.

Alleged false injury reporting by Hanford contractors

It was alleged that there was an ongoing conspiracy between the Hanford Site contractors' safety representatives and Foundation management to avoid creating and documenting recordable injuries. Witnesses provided examples in which contractors allegedly required injured workers who should have stayed home to report to work but perform no duties. We also examined aspects of contractor input of data into CAIRS.

The facts developed during the investigation did not substantiate criminal misconduct with regard to injury or illness reporting. However, the investigation did verify a single instance in 1999 where a former Hanford Site subcontractor encouraged an injured employee to report to work following a work-related injury, yet the subcontractor had the employee perform no duties for five days. The employee remained on restricted duty for another 24 days. The subcontractor did not conceal the nature or cause of the injury itself, and it was documented as "recordable." The subcontractor's actions were, nonetheless, troubling.

Alleged cover-up of ammonia vapor readings at the tank farms by contractor employees

It was alleged that employees of CH2M Hill had taken steps to cover up excessively high vapor exposure readings at the tank farms. High exposure readings allegedly were either misrepresented or not documented. Our investigation focused on the two specific vapor exposure incidents provided as examples by witnesses.

The facts developed during the investigation did not substantiate criminal misconduct relating to alleged cover-up of vapor readings. With respect to the first incident, we identified conflicting testimony among various witnesses. We were unable to reconcile the differences through other witnesses or available documentation, and no independent corroborating evidence was found to support either version of events with certainty. With respect to the second incident, two witnesses initially identified to us as having valuable information did not provide such corroborating information.

Other alleged potential violations of law

It was also alleged that: (1) the Foundation artificially inflated results in an annual performance self-assessment report; (2) a Department supervisor improperly removed relevant information from a report that was critical of a contractor's occupational injury and illness reporting and recordkeeping program; (3) the Foundation improperly maintained two sets of medical records; and (4) there was a conspiracy to develop an intentionally vague "Record of Visit," a form that is used by the Foundation to record assorted information about a patient's visit, in order to facilitate the underreporting of injuries and illnesses.

The facts developed during the investigation did not substantiate criminal misconduct with regard to these allegations. However, we received conflicting testimony from various witnesses with respect to the annual self-assessment allegation, and we were unable to reconcile these

differences through other witnesses or available documentation. No facts were developed to support the other allegations in this area.

Although criminal allegations were the focus of our investigation, we observed several worker health and safety protocols that we believed needed to be addressed by Federal managers at the Hanford Site. Specifically, we believed action was needed to ensure that:

- Industrial Hygiene Technicians take vapor exposure readings in a timely manner following reported exposure incidents at the tank farms and document exposure readings in appropriate reports. During an examination of the vapor exposure cover-up allegation, we determined that a Technician failed to record vapor monitoring data on a “Direct Reading Instrument” survey form, as required by the contractor’s tank farm monitoring policies and procedures. The reading was recorded instead in a log book. Additionally, the vapor reading was not taken until approximately two hours after the exposure was reported.
- Site employees on work restriction are assigned meaningful duties. As noted previously, we identified a troubling instance in 1999 where a former Hanford Site subcontractor encouraged an injured worker to show up at the job site but perform no duties, rather than remain at home. Despite the placement of work restrictions on this employee and documenting the injury as “recordable,” the subcontractor’s actions raise questions about its practices.
- Patient care is not inappropriately influenced by whether the care will make an injury or illness “recordable.” We identified internal Foundation e-mails that some recipients

interpreted as encouraging physicians to emphasize recordability of injuries over patient standard of care. We received no confirmation that care was, in fact, improperly compromised. However, unclear communications such as these appear to have led to concerns over the provision of patient care.

- Work restrictions following injuries and illnesses are identified and applied in a timely manner. We identified a particular worker who was not given an immediate work restriction following a diagnosis for beryllium sensitivity, in accordance with standard medical practice.

As noted previously, we interviewed over 70 individuals with knowledge of relevant operations at the Hanford Site. During this process, it became clear that, despite major health and safety efforts by the Department, a significant number of individuals interviewed had unresolved concerns about the safety of the work at Hanford, the potential for health problems as a result of this work, and the quality of occupational health care provided to Hanford employees. Given the challenges at Hanford, where the acknowledged risks to the workforce are significant, some level of concern would be understandable even if the Department's occupational health program worked perfectly. However, the number, scope, and continuing nature of the employee and citizen concerns we heard during our investigation suggest that management needs to intensify its efforts to improve employee confidence in the occupational health and safety program at Hanford. One example of an action we believe would be beneficial is evaluating current mechanisms for receiving, analyzing, and addressing employee complaints about occupational medical services. A more effective and robust program for dealing with employee concerns has the prospect of building employee and public confidence in worker safety at the Hanford Site.

CONCLUSION

The Office of Inspector General has provided its findings and conclusions with respect to these three reviews to the Department for immediate action, as well as for consideration in its overall assessment regarding the serious issues that have been raised regarding worker safety and health at the Hanford Site.

Mr. Chairman and members of the Committee, this concludes my statement. I will be pleased to answer any questions.