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NUCLEAR REGULATION

**Emergency Preparedness
Issues at the Indian Point 2
Nuclear Power Plant**

Statement of Jim Wells, Director
Natural Resources and Environment





Highlights of [GAO-03-528T](#), a report to the Subcommittee on National Security, Emerging Threats and International Relations, Committee on Government Reform, House of Representatives

Why GAO Did This Study

After the September 11, 2001, terrorist attacks, emergency preparedness at nuclear power plants has become of heightened concern. Currently, 104 commercial nuclear power plants operate at 64 sites in 32 states and provide about 20 percent of the nation's electricity. In July 2001, GAO reported on emergency preparedness at the Indian Point 2 nuclear power plant in New York State (*Nuclear Regulation: Progress Made in Emergency Preparedness at Indian Point 2, but Additional Improvements Needed* [[GAO-01-605, July 30, 2001](#)]). This testimony discusses GAO's findings and recommendations in that report and the progress the plant, the Nuclear Regulatory Commission (NRC), and the Federal Emergency Management Agency (FEMA) have made in addressing these problems. GAO also provides its thoughts on the findings of a soon-to-be-issued report (the Witt report) on emergency preparedness at Indian Point and the Millstone nuclear power plant in Connecticut, and the implications of that report for plants nationwide.

Since 2001, the Entergy Corporation has assumed ownership of the Indian Point 2 plant from the Consolidated Edison Company of New York (ConEd).

www.gao.gov/cgi-bin/getrpt?GAO-03-528.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Jim Wells at (202) 512-3841 or wellsj@gao.gov.

NUCLEAR REGULATION

Emergency Preparedness Issues at the Indian Point 2 Nuclear Power Plant

What GAO Found

In 2001, GAO reported that, over the years, NRC had identified a number of emergency preparedness weaknesses at Indian Point 2 that had gone largely uncorrected. ConEd had some corrective actions underway before a 2000 event raised the possibility of a leak of radioactively contaminated water into the environment. ConEd took other actions to address problems during this event. According to NRC, more than a year later, the plant still had problems similar to those previously identified—particularly in the pager system for activating emergency personnel. However, NRC, in commenting on a draft of GAO's report, stated that ConEd's emergency preparedness program could protect the public. Four counties responsible for responding to a radiological emergency at Indian Point 2 had, with the state and ConEd, developed a new form to better document the nature and seriousness of any radioactive release and thus avoid the confusion that occurred during the February 2000 event. Because they are the first responders in any radiological emergency, county officials wanted NRC and FEMA to communicate more with them in nonemergency situations, in addition to communicating through the states. However, NRC and FEMA primarily rely on the states to communicate with local jurisdictions.

Since GAO's 2001 report, NRC has found that emergency preparedness weaknesses have continued. For example, NRC reported that, during an emergency exercise in the fall of 2002, the facility gave out unclear information about the release of radioactive materials, which had also happened during the February 2000 event. Similarly, in terms of communicating with the surrounding jurisdictions, little has changed, according to county officials. County officials told GAO that a videoconference system—promised to ensure prompt meetings and better communication between the plant's technical representatives and the counties—had not been installed. In addition, NRC and FEMA continue to work primarily with the states in nonemergency situations. Although they note that there are avenues for public participation, none of these is exclusively for the county governments.

GAO did not evaluate the draft Witt report or verify the accuracy of its findings. The draft Witt report is a much larger, more technical assessment than the 2001 GAO report. While both reports point out difficulties in communications and planning inadequacies, the draft Witt report concludes that the current radiological response system and capabilities are not adequate to protect the public from an unacceptable dose of radiation in the event of a release from Indian Point, especially if the release is faster or larger than the release for which the programs are typically designed. GAO is aware that, in commenting on a draft of the Witt report, FEMA disagreed with some of the issues raised but said the report highlights several issues worth considering to improve emergency preparedness in the communities around Indian Point and nationwide. NRC concluded that the draft report gives "undue weight" to the impact of a terrorist attack.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss emergency preparedness at operating commercial nuclear power plants. Twenty-four years ago, in March 1979, the accident at the Three Mile Island nuclear power plant in Pennsylvania created considerable alarm and uncertainty in the surrounding areas about the plant's safety and the adequacy of emergency planning. On the broader front, the American public focused not only on Three Mile Island but also on safety and emergency preparedness at nuclear power plants nationwide. With the September 11, 2001, terrorist attacks, public concern about the plants has increased again. Concerns have focused principally on ensuring the plants' physical security and then on emergency preparedness in case terrorists are successful in their attacks. The nation currently has 104 commercial nuclear power plants licensed to operate at 64 sites in 32 states. These plants provide about 20 percent of the nation's electricity.

To protect the public should a commercial nuclear power plant accidentally release radiation to the environment, the Nuclear Regulatory Commission (NRC) requires the plant owner/operator to prepare for NRC's approval a radiological emergency preparedness plan. This on-site plan describes what is to be done in an emergency, how it is to be done, and who is to do it. Among other things, the plan identifies the process for notifying and communicating with the operator's own personnel as well as with federal, state, and local agencies and the media during an emergency. The plan also identifies the circumstances and the actions—such as evacuating the local population—the plant owner would recommend that off-site officials take to protect the public. NRC conducts inspections to ensure that the plant owner can effectively implement the on-site plan. In addition, the Federal Emergency Management Agency (FEMA) is responsible for ensuring that state and local communities develop emergency preparedness plans to address the off-site effects of a radiological emergency. FEMA oversees the conduct of periodic exercises to determine whether the off-site response would adequately protect public health and safety.

My testimony today is grounded in a report we issued in July 2001 to the Chairman of the House Committee on Government Reform and to Representatives Gilman, Kelly, and Lowey on emergency preparedness at

the Indian Point 2 plant in New York State.¹ The Indian Point facility is located within the Village of Buchanan in upper Westchester County, approximately 24 miles north of New York City along the east bank of the Hudson River. About 300,000 people live within 10 miles of the plant and millions more live in New York City and within 50 miles in Connecticut, New Jersey, New York, and Pennsylvania. Concerns that nuclear power plants may be targets for terrorists and Indian Point's close proximity to these large populations have increased public interest in the adequacy of the plant's security and emergency preparedness—leading some to call for closing the plant. A draft report (the Witt report) commissioned by the Governor of New York questions the adequacy of emergency preparedness at Indian Point and raises broader issues about emergency preparedness at other nuclear power plants.²

In my testimony today, I will discuss the (1) findings and recommendations of our 2001 report on emergency preparedness at the Indian Point 2 plant and (2) subsequent progress made by the plant, NRC, and FEMA in addressing problems noted in our report. You also asked for our thoughts on the findings of the draft Witt report and its potential implications for emergency planning at other facilities. To follow up on the progress made to address the problems we identified in 2001, we reviewed relevant NRC inspection reports prepared since our 2001 report and held discussions with officials of NRC, FEMA, and the four counties responsible for emergency preparedness in the surrounding areas. We did not conduct a comprehensive update of emergency preparedness at the Indian Point 2 plant nor verify the accuracy of the draft Witt report's findings and conclusions. We should also note that, since our 2001 report, the Entergy Corporation has assumed ownership of the facility from the Consolidated Edison Company of New York.

In summary:

- In 2001, we reported that, over the years, NRC had identified a number of emergency preparedness weaknesses at Indian Point 2 that had gone

¹ *NUCLEAR REGULATION: Progress Made in Emergency Preparedness at Indian Point 2, but Additional Improvements Needed*, GAO-01-605 (Washington, D.C., July 30, 2001).

² James Lee Witt Associates, LLC, *Review of Emergency Preparedness at Indian Point and Millstone* [Draft] (Washington, D.C., Jan. 10, 2003). The Witt report was commissioned by Governor Pataki to be a comprehensive and independent review of emergency preparedness in the areas around Indian Point and for that portion of New York State in proximity to the Millstone nuclear power plant in Connecticut.

largely uncorrected. For example, in 1998 and again in 1999, NRC identified several communication weaknesses, including delays in activating the pagers used to alert the plant's staff about an emergency. Consolidated Edison had some corrective actions under way before a February 2000 event raised the possibility that radioactively contaminated water would leak into the environment.³ Consolidated Edison initiated other actions to address problems that occurred during this event. However, according to an April 2001 NRC inspection report, the actions were not fully effective. In evaluating Consolidated Edison's response to the February 2000 event, NRC found that critical emergency response personnel were not notified in a timely manner, which delayed the staffing and operation of the on-site emergency response facility. According to NRC, this delay occurred because the process to activate the pagers was complex and not well understood and Consolidated Edison had responded to the earlier problems identified without diagnosing their underlying causes. As a result, NRC found emergency preparedness problems similar to those it had identified before and during the event. Despite these weaknesses, NRC, in commenting on a draft of our report, expressed its view that Consolidated Edison's emergency preparedness program could protect the public.

We reported in 2001 that the four New York counties responsible for responding to a radiological emergency at Indian Point 2 had strengthened their emergency preparedness programs as a result of the lessons learned from the February 2000 event. These lessons included the need for better coordination and communications (1) between the counties in responding to a radiological emergency and in providing the media with information and (2) between Consolidated Edison and the counties about the emergency and its potential impact on the public. We reported that Consolidated Edison had not clearly communicated with the state and counties about whether a radioactive release had occurred and, if so, its magnitude. Consolidated Edison reported that a release had occurred but posed no threat to the public, while county officials reported that no release had occurred. This contradictory information led to credibility problems with the media and the public. Consolidated Edison, the state, and the counties revised

³ In February 2000, a tube ruptured in a steam generator and Consolidated Edison temporarily shut down the plant because of the possibility that radioactively contaminated water could leak into the environment. According to Consolidated Edison and NRC, the total amount of radioactivity released posed no threat.

the plant's radiological emergency data form to more clearly show whether a release had occurred.

As we also reported, county officials suggested changes to improve communications among NRC, FEMA, and nonstate entities. In particular, county officials said that since they are responsible for radiological emergency preparedness for Indian Point 2, NRC and FEMA should communicate directly with them during nonemergency situations. In New York and 16 other states—where more than half of the nation's operating nuclear power plants are located—counties or other local governments are responsible for radiological preparedness, but NRC and FEMA communicated primarily with the states and relied on the states to communicate with local jurisdictions. In response, NRC said that meeting with local officials would require considerable resources, and FEMA said that some states limit its communications with local officials. However, NRC had not assessed the costs and benefits of routinely meeting with local officials, and FEMA's method of communicating with the states had not effectively provided the four counties with information on various initiatives that would affect their programs. Since effective communication is critical to prepare for and respond to a radiological emergency, we therefore recommended that NRC and FEMA reassess their policies for communicating primarily with the state in those instances where other entities have a major role for responding to a radiological emergency.

- Since our 2001 report, NRC inspection reports have continued to show emergency preparedness weaknesses. For example, NRC reported that, during an emergency exercise in the fall of 2002, the facility gave out unclear information about the release of radioactive materials, as it did during the February 2000 event. Similarly, in terms of NRC and FEMA communicating with the surrounding jurisdictions, little has changed, according to county officials. County officials told us that a videoconference system—promised to ensure prompt meetings and better communication between the plant's technical representatives and the counties—had not been installed. During the February 2000 event, these representatives had arrived late at the counties' emergency operations centers. NRC officials said that they meet with state officials concerning emergency preparedness and have instituted various initiatives to improve public communication, in which local officials can participate. FEMA officials told us that it would continue to work with state and local governments on emergency preparedness.

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- The draft Witt report is a much larger, more technical assessment than our 2001 report. While both reports talk to difficulties in communications and planning inadequacies, the draft Witt report concludes that the current radiological response system and capabilities are not adequate to protect the public from an unacceptable dose of radiation in the event of a release from Indian Point, especially if the release is faster or larger than the release for which the programs are typically designed. We are aware that, in commenting on the draft of the Witt report, FEMA disagreed with some of the issues raised but said that the report does highlight several issues worth considering in order to improve preparedness levels in the communities around Indian Point and nationwide. NRC concluded that the report gives “undue weight” to the impact of a terrorist attack. The agency said that it saw no difference between emergency plans for releases caused by terrorist acts and those caused by equipment malfunctions.

Background

Emergency plans for commercial nuclear power plants are intended to protect public health and safety whenever plant accidents cause radiation to be released to the environment. Since the 1979 accident at the Three Mile Island nuclear power plant, significantly more attention has been focused on emergency preparedness. For example, the NRC Authorization Act for fiscal year 1980 established a requirement for off-site emergency planning around nuclear power plants and allowed NRC to issue a nuclear plant operating license only if it determines that there is either a

- related state or local emergency preparedness plan that provides for responding to accidents at the specific plant and complies with NRC’s emergency planning guidelines or
- state, local, or facility plan that provides reasonable assurance that public health and safety are not endangered by the plants’ operation in the absence of a related state or local emergency preparedness plan.

In November 1980, NRC and FEMA published regulations that provided the criteria for radiological emergency plans. The regulations include emergency standards for on- and off-site safety and require that emergency plans be prepared to cover the population within a 10-mile radius of a commercial nuclear power plant. In addition, state plans must address measures necessary to deal with the potential for the ingestion of radioactively contaminated foods and water within a 50-mile radius. NRC and FEMA have supplemented the criteria several times since 1980. For

example in July 1996, the agencies endorsed the prompt evacuation of the public within a 2-mile radius and about 5 miles downwind of the plant, rather than sheltering the public, in the event of a severe accident.

FEMA and the affected state and local governments within the 10-mile emergency planning zone conduct exercises at least every 2 years at each nuclear power plant site. In addition, each state with a nuclear power plant must conduct an exercise within the 50-mile zone at least every 6 years. The exercises are to test the integrated capabilities of appropriate state and local government agencies, facility emergency personnel, and others to verify their capability to mobilize and respond if an accident occurs. Before the exercises, generally, FEMA and state officials not involved in them agree to the accident scenarios and the aspects of emergency preparedness that will be tested. In addition, NRC requires plants to conduct exercises of their on-site plans. According to NRC staff, the plants usually conduct their exercises as part of FEMA's biennial exercises.

Indian Point 2 is one of the 104 commercial nuclear power plants nationwide licensed to operate. The Indian Point site, which is called the Indian Point Energy Center, has one closed and two operating plants. The other operating plant is referred to as Indian Point 3.

In 2001, We Noted That Indian Point 2 Had Struggled to Resolve Emergency Preparedness Weaknesses

Over the years, Consolidated Edison's efforts to improve emergency preparedness at Indian Point 2 were not completely successful, and the company experienced recurring weaknesses in its program, as we reported in July 2001. The four New York counties surrounding the plant made improvements in their emergency response programs but suggested better communication among NRC, FEMA, and nonstate entities in nonemergency situations.

Consolidated Edison Acted to Resolve Emergency Preparedness Weaknesses, but Its Actions Were Incomplete

Beginning in 1996, NRC identified numerous weaknesses with the emergency preparedness program at Indian Point 2. NRC found, for example, that Consolidated Edison was not training its emergency response staff in accordance with required procedures, and some individuals had not taken the annual examination and/or participated in a drill or exercise within a 2-year period, as required. In response, Consolidated Edison disciplined the individuals responsible, developed an improved computer-based roster containing the current status of the

training requirements for emergency response personnel, and began a process to distribute training modules to those employees before their qualifications expired.

NRC relied on Consolidated Edison to take corrective actions for other emergency preparedness problems and weaknesses. However, the company did not correct the weaknesses identified. For example, in 1998 and again in 1999, NRC identified problems with activating the pagers used to alert the plant's staff about an emergency, as well as other communication weaknesses. In 1999, NRC concluded that Consolidated Edison lacked the ability to detect and correct problems and determine their causes, resulting in weak oversight of the emergency preparedness program. In response, NRC staff said that they met with the company's managers to specifically discuss and express NRC's concerns.

Similarly, NRC identified emergency preparedness weaknesses when evaluating Indian Point 2's response to the February 2000 event. For example, NRC found that Consolidated Edison did not activate its emergency operations facilities within the required 60 minutes, primarily because of the complex process used to page the emergency response staff. This problem delayed the on-site response. NRC's Office of the Inspector General also identified emergency preparedness issues, including the state's difficulties getting information about the emergency from Consolidated Edison and the fact that English is a second language for many who lived within 10 miles of the plant. The Office of the Inspector General concluded, and NRC agreed, that recurring uncorrected weaknesses at Indian Point 2 had played a role in the company's response during the February 2000 event. However, NRC concluded that Consolidated Edison had taken the necessary steps to protect public health and safety.

Consolidated Edison subsequently evaluated its entire emergency preparedness program to determine the causes of the deficiencies and to develop corrective actions. Consolidated Edison concluded that senior management did not pay sufficient attention to the emergency preparedness program or problems at Indian Point 2 because these problems were not viewed as a high priority warranting close attention and improvement. As a result, emergency preparedness had relatively low visibility, minimal direction, and inadequate resources. The company also found that (1) the emergency response organization had been stagnant, understaffed, poorly equipped, and consistently ineffective; (2) the emergency manager performed collateral and competing duties; and (3) for a time, a contractor held the manager's position. Furthermore, the

professional development and continuing training of the emergency planning staff had been minimal. The company undertook initiatives to address the deficiencies noted.

Despite these initiatives, in April 2001, NRC reported that it had found problems similar to those previously identified at Indian Point 2. NRC again found weaknesses in communication and information dissemination. It also found that the utility's training program had not prevented the recurrence of these issues during on-site drills and that its actions to resolve other weaknesses had not been fully effective. NRC said that Consolidated Edison had identified the major issues in its business plan, which, if properly implemented, should improve emergency preparedness at the plant. In commenting on a draft of our July 2001 report, NRC noted that its April 2001 inspection report concluded that Consolidated Edison's emergency preparedness program would provide reasonable assurance of protecting the public.

The Four Counties Strengthened Their Emergency Preparedness Programs but Suggested Better Communication Among NRC, FEMA, and Nonstate Entities

The need to improve communication between Consolidated Edison and the counties about the extent of the emergency and the potential impact on the public was highlighted during the February 2000 event. At that time, Consolidated Edison reported that a radioactive release had occurred but that it posed no danger to the public. County officials, on the other hand, reported that no release had occurred. This contradictory information led to credibility problems with the media and the public.

Before the emergency, the counties did not have a defined process to determine what information they needed and how they would present the information to the public. At the time of the February 2000 event, the Radiological Emergency Data Form that Consolidated Edison used to inform local jurisdictions provided for one of three choices about a release of radioactive materials: (1) no release (above technical specification limits), (2) a release to the atmosphere above technical specification limits, and (3) a release to a body of water (above technical specification limits). In April 2000, Consolidated Edison, in partnership with the state and counties, revised the form to ensure that all affected parties were "speaking with one voice" when providing the media and the public with information. The change to the form provided for one of four choices: (1) no release, (2) a release below federally approved operating limits (technical specifications) and whether it was to the atmosphere or to water, (3) a release above federally approved operating limits and whether to the atmosphere or to water, and (4) an unmonitored release requiring evaluation.

The counties had also taken some other actions to improve their radiological emergency programs. For example, all four counties agreed to activate their emergency operation centers at the “alert” level (the second lowest of four NRC classifications). Before the February 2000 event, the counties differed on when they would activate their centers, with one county activating its center at the alert level and the other three counties at the site-area emergency level (the next level above an alert). As a result, once the first county activated its center during the event, the media questioned why the other three counties had not done so. The counties also connected the “Executive Hot Line,” which linked the state, four counties, and governor, to the emergency operations facility at Indian Point 2 to establish and maintain real-time communications during an emergency.

In addition to these actions, county officials suggested to us in 2001 that other changes to improve communications among NRC, FEMA, and nonstate entities could be taken. In particular, county officials said that since they are responsible for radiological emergency preparedness for Indian Point 2, NRC and FEMA should communicate directly with them during nonemergency situations. Absent these direct communications, the counties were not privy to issues or initiatives that could affect their emergency preparedness programs.

NRC staff tried to meet every 5 years with officials from all states that have operating nuclear power plants. NRC staff told us that they met with some states more frequently and that the requests to meet exceeded the agency’s capability. Although NRC’s policy was to meet at the state level, its staff believed that local officials had various options for meeting with NRC. For example, local officials could participate in the meetings held at least every 5 years with the states and could interact with NRC staff during public meetings, including those held annually for all plants. Emergency preparedness officials from the four counties around Indian Point 2 said that they did not believe that public meetings were the appropriate forums for government-to-government interactions. Therefore, the counties suggested that NRC should meet with them at least annually. According to NRC staff, routinely communicating with local officials has resource implications and involves tradeoffs with its other efforts, such as maintaining safety and enhancing the effectiveness and efficiency of operations. However, NRC, at the time of our review, had not assessed the costs and benefits of meeting with local officials nor the impact that such meetings might have.

FEMA generally implements its programs through the states and relies on the states to communicate relevant information to local jurisdictions. County officials responsible for emergency preparedness at Indian Point 2 identified instances in which this method of communicating with local jurisdictions had not been effective. For example, both New York State and county officials told us that the February 2000 event identified the need for flexibility in FEMA's off-site exercises. County officials said they responded to the 2000 event as they would have responded during FEMA's exercises, which are conducted to the general emergency level (the highest of NRC's action level classifications). Yet, they noted, the response for an alert like the one that occurred in 2000 is significantly different from the response needed during a general emergency, when a significant amount of radiation would be released from the plant site. State and county officials suggested that it would be more realistic to periodically conduct biennial exercises at the lower alert level, which, they noted (and NRC data confirmed), occur more frequently than a general emergency. In commenting on a draft of our report, FEMA said that the emergency plans for the four New York counties require them to conduct off-site monitoring and dose calculations at the alert level.

FEMA officials also noted that the agency's regulations allow state and local jurisdictions the flexibility to structure the exercise scenarios to spend more time at the alert level and less at the general emergency level. Nevertheless, county officials who participated in the exercises were not aware of the flexibility allowed by FEMA's regulations, in part because they did not participate in developing the exercise scenarios.

Emergency Preparedness Weaknesses at Indian Point 2 Have Continued

In reviewing NRC's reports on its on-site inspections and evaluations of the plant's emergency preparedness exercises or drills completed since we issued our 2001 report, we found that the facility's emergency preparedness program has continued to experience problems or weaknesses. For example, NRC reported that, in an emergency exercise conducted last fall, the facility gave out unclear information about the release of radioactive materials, which also happened during the February 2000 event. In addition, NRC reported that several actions to correct previously identified weaknesses had not been completed. For example, NRC noted that the timely and accurate dissemination of information was identified as a weakness in the fall 2002 exercise and had been documented previously in drill critique and condition reports.

In addition, in our 2001 report, we noted that NRC's Office of the Inspector General found that, during the February 2000 event, the Indian Point

plant's technical representatives did not arrive on time at the local counties' emergency operations centers. To help address this problem, Consolidated Edison said that it would install a videoconferencing system in the centers to enhance communications between the plant and the off-site officials. According to county officials, the videoconferencing system had not been installed as of February 2003.

With respect to our 2001 recommendation that NRC and FEMA reassess their practices of primarily communicating with state officials during nonemergency situations, federal and local officials indicated that little has changed since our report. NRC officials told us that they did reassess their policy since our report was issued and determined that no changes were needed. According to FEMA officials, the agency will continue to work with state and local officials to carry out its emergency preparedness program but has not made any changes regarding nonemergency communication with state and local officials.

Given this history of inadequate efforts to address weaknesses in Indian Point 2's emergency preparedness program, we continue to believe that both NRC and the plant owner could benefit from being more vigilant in correcting problems as they are identified. In addition to improving the plant's program, a better track record in addressing these problems could go a long way in helping alleviate the heightened concerns in the surrounding communities about the plant's safety and preparedness for an emergency. Similarly, more frequent, direct communication by NRC and FEMA with officials of the surrounding counties could improve local emergency preparedness programs and, in turn, help local officials better communicate with their constituents about the plant's safety and preparedness for an emergency.

The Witt Report Raises Emergency Preparedness Issues at Indian Point and Other Nuclear Power Plants

On August 1, 2002, the Governor of New York announced that James Lee Witt Associates would conduct a comprehensive and independent review of emergency preparedness around the Indian Point facility and for that portion of New York State in proximity to the Millstone nuclear power plant in Waterford, Connecticut.⁴ According to Witt Associates, the review encompassed many related activities that were designed, when taken together, to shed light on whether the jurisdictions' existing plans and capabilities are sufficient to ensure the safety of the people of the state in the event of an accident at one of the plants, and how the existing plans and capabilities might be improved. According to Witt Associates, it has considered and incorporated public comments on a January 2003 draft of its report and plans to issue the final report this month.

We have not evaluated the Witt report or verified the accuracy of its findings and conclusions. We did note that the draft report identifies various issues—such as planning inadequacies; expected parental behavior that would compromise school evacuation; difficulties in communications; the use of outdated technologies; problems caused by spontaneous evacuation in a post September 11, 2001, environment; and a limited public education effort—that may warrant consideration at Indian Point and nationwide. The draft Witt report concludes that NRC and FEMA regulations need to be revised and updated. We understand that FEMA agreed, to an extent, in its review of the draft report. According to the agency, the draft report raises a number of issues that should be considered for enhancing the level of preparedness in the communities surrounding the Indian Point facility, such as better public education, more training of off-site responders, and improved emergency communications. In addition, FEMA stated that some of these issues should be evaluated for their applicability nationwide. However, FEMA also said that a number of the issues raised in the draft report were not supported by its own exercise evaluations, plan reviews, and knowledge of the emergency preparedness program. According to NRC, the draft report gives “undue weight” to the impact of a terrorist attack. The agency said that it saw no difference between emergency plans for releases caused by terrorist acts and those caused by equipment malfunctions.

In summary, Mr. Chairman, the post September 11, 2001, environment clearly presents new challenges for NRC and FEMA. While the public has always had considerable interest in the safety of nuclear power plants, the

⁴ Mr. Witt is a former FEMA Director.

terrorist attacks have brought a level of focus and anxiety that may rival or exceed that caused by the Three Mile Island accident in 1979. NRC and the nuclear industry deserve credit for taking action to strengthen physical security as the result of a changing world, but we are still concerned that, as shown in this hearing today, problems in emergency preparedness remain after being repeatedly identified as needing attention. Mr. Chairman, GAO is currently conducting reviews of physical security at selected nuclear power plants and is looking in-depth at safety issues at the Davis-Besse plant in Ohio. We plan to report the results of our work later this year.

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Mr. Chairman, this concludes our prepared statement. We would be happy to respond to any questions that you or Members of the Subcommittee may have.

Contacts and Acknowledgments

For further information about this testimony, please contact me at (202) 512-3841. Raymond Smith, William Fenzel, Kenneth Lightner, William Lanouette, Jill Edelson, Heather Barker, and Addison Ricks also made key contributions to this statement.