Report on the Oversight Investigation of the EPA's Response to the World Trade Center Collapse

Conducted by the staff of Chairman Inhofe of the U.S. Senate Committee on Environment and Public Works

September 23, 2003

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Senate Environment and Public Works staff interviewed seven officials from the four government entities most closely involved with the issue:
EPA Inspector General's office:

Kwai-Cheung Chan, Assistant Inspector General for program Evaluation
Rick Beusse, Director for Program evaluation, Air
Jim Hatfield, Project manager
Chris Dunlap, Staff Member

EPA Acting Administrator Marianne Horinko
Council of Environmental Quality Chairman James Connaughton
Occupational Safety and Health Administration Assistant Administrator John Henshaw

Summary Conclusion:

- EPA acted properly in its response to the World Trade Center collapse, as well as in its communications with the public regarding exposure risks faced by workers and residents near the catastrophe.
- The Administration did not suppress any public health information or data. EPA's communications reflected the prevailing coordinated views expressed by agencies weighing in on the risks posed by asbestos.
- EPA went beyond its statutory obligations in its attempts to protect public health.
- The Council on Environmental Quality's "influence" on EPA's communications was a proper function delegated to it by the President for coordinating environmental health and safety decisions and information between EPA and OSHA.
- On matters of indoor air in the Fall of 2001, it was proper for EPA to defer to New York City, which was assigned the lead role.

Background

On August 21, 2003, EPA Inspector General Nikki Tinsley issued an evaluation report entitled "EPA's Response to the World Trade Center Collapse: Challenges, successes, and Areas for Improvement." The report evaluates EPA actions during the 9-11 crisis, but also makes a number of policy recommendations based on its findings during the two years since 9-11.

The press coverage of the report has focused on the dissemination of information via press releases that the OIG has highlighted. The report and subsequent news articles raised concerns by Members of Congress. Specifically, Members of the EPW Committee requested a hearing due to their concerns about what they characterized as *"the findings…which stated that local citizens received inadequate information from EPA about the safety of their air. Furthermore, we are deeply troubled by the OIG's determination that the White House Council on Environmental Quality appears to have*

pressured EPA to downplay risks to public health." In response to these concerns, Chairman Inhofe initiated a review of the issues surrounding the controversy.

Three major conclusions of the OIG report have been the focus of criticisms of EPA and the Council of Environmental Quality (CEQ):

1. EPA did not have sufficient information to conclude the air was "safe" to breathe in its September 18 press release.
2. CEQ influenced the "information that EPA communicated to the public through its early press releases when it convinced EPA to add reassuring statements and delete cautionary ones."
3. EPA could have acted in a more proactive manner on indoor air issues for which New York City had the lead role.

Oversight Investigation conclusions:

In viewing this issue, the magnitude and nature of what the residents of New York, rescue workers, and government officials faced in those early days after 9-11 cannot be dismissed or discounted. Not only was the magnitude of the rescue efforts unprecedented, it was also believed that additional attacks were imminent. This wartime mentality pervaded every action and decision made by officials in attempting to respond to the collapse of the World Trade Center. This takes on even higher significance given that the OIG, when questioned whether EPA's World Trade Center response had been a success or failure, answered by pointing to a New York City official's statement that EPA's response was "phenomenal" and that EPA's response crews were on top of every issue.

In the days following the attack, the informational flow and decision-making process was done with little of the usual memorializing that often takes place within government deliberation. Much had to be decided in very short time frames. To coordinate this, the President gave CEQ the role of coordinating public health and safety information between OSHA and EPA. EPA and OSHA were in turn coordinating with State and local officials. In its interactions with EPA, CEQ was fulfilling its obligation as the coordinating agency to ensure that the message conveyed by EPA reflected a wider view, including those of OSHA.

Information flowed through numerous channels. The primary conduits of information to the public were direct flyers (in three languages) and one-on-one communications to residents and workers in the affected area. Numerous meetings were held with a multitude of groups, which met with smaller groups such as building managers and resident leaders, who could in turn pass on the most necessary information. In addition, data was put on EPA's website and press releases were released that reflected the result of numerous meetings, phone conversations and conference calls.

Ground zero was a difficult issue for federal officials. Early on in the crisis, it was determined that New York would be in charge of the response. OSHA and EPA employees were not given authority over the city response crews. These workers were, in the early days, still digging as quickly as possible for hoped-for survivors. Workers

would often take off their masks. While company employees subject to OSHA standards complied fairly well, the same was not always true of other first responders. Nevertheless, EPA went beyond their mandate by attempting a creative solution to improve environmental conditions for workers. EPA set up a tent away from the site where workers could take off their masks safely, wash off, eat, drink, and be reminded before returning of the need to wear their masks.

What the OIG did not find is telling. The OIG concluded, "in regard to the monitoring data, we found no evidence that EPA attempted to conceal data results from the public." The OIG also stated that there was neither a conspiracy nor an attempt to suppress information.

The most controversial issue centers around whether it was appropriate for EPA's press releases to assert the air was safe and for CEQ to influence EPA's public communications. The investigators find that this criticism stems from a disagreement over how risk from asbestos should be communicated to the public. The pollutant that posed the most concern among officials was asbestos. Essentially, the OIG appears to believe that it was inappropriate to reassure the public and that, instead, it was appropriate to keep more cautionary statements about the dangers of asbestos in the press releases. Both OSHA and CEQ believed that the central issue was the extent to which residents and workers were actually exposed to asbestos, and the risk posed by that exposure. It is important to note the OIG investigation did not include interviews with OSHA nor CEQ. This dramatically limited the OIG's ability to convey a complete picture. The report, in fact, only provides a minority view of the entire information process. The Committee staff notes that this is not due to the lack of thoroughness on the part of the OIG, but instead is due to the limitation of authority of an agency OIG.

What should not be lost in assessing the issue is that no short-term nor long-term health impacts have been found to residents. While it is true that the health affects of asbestos exposure can take years to manifest, at this point there is no evidence it will. Much of the disagreement may well center on what is the appropriate standard to use in assessing these risks, as different federal agencies use different standards. The EPA Inspector General office appears to have assessed the appropriateness of the press release edits based on EPA's benchmarks, and to have found the EPA standards to have limitations. The standard that informed the press release edits, however, was an OSHA standard.

There may be no "right answer" in this type of situation. Judgment calls were made, and there are differences of opinion as to the quality of those judgment calls. It is important to note, however, that the OSHA and CEQ officials involved in the interagency discussions were very experienced in matters of asbestos exposure and risk. In fact, the only existing asbestos standard that was applicable to ground zero was an OSHA standard. When asked during this review to compare the statements in the final press releases to those in the draft releases, the OSHA official in every instance believed the changed or added language more clearly communicated the real risks of asbestos exposure than the draft.

Although the OIG concluded that EPA could have acted in a more proactive manner on indoor air issues, EPA did not in fact have authority for indoor air until February 2002. This responsibility resided with the City of New York until that time. The OIG found that, while New York City was lead, EPA could have done more to alert the public. For instance, EPA was criticized for referring to the New York City website for information. The OIG criticism is unfounded. EPA was not lead agency. The agency reported to FEMA and New York City. An agency has a duty to "stick with the decision made by the incident commander" and not to "free-lance."

The OIG report makes many helpful suggestions to prepare EPA for any other potential disasters in the future and the entirety of the report should be viewed as a very valuable learning tool. EPA has, separately, engaged in a fairly robust review of "lessons learned." The lessons learned from the World Trade Center was already put to the test and assisted in the federal response to the Columbia Shuttle disaster. It is important to put in perspective that the ability to look back and make improvements in the way federal agencies respond to emergencies should not be construed as an indictment of past performance. It is possible both to have done well in the past and to do better in the future.

Recommendations:

Many lessons have been learned from the terrible events of 9-11. Among the lessons is the enormous challenges posed to all levels of government concerning communication of health risks to the public. Risk communications have been a challenge for decades, and the level of that challenge was raised significantly by the events of 9-11. The communication of health risks was a major challenge during Love Canal in the 1970's and remains so today. The Nation would greatly benefit from a more systematic approach to risk communications, especially during times of crisis. Therefore, though this investigation finds absolutely no evidence of wrongdoing, the Committee urges the Department of Homeland Security to develop a task force to work with the various federal agencies (including, but not limited to, EPA and OSHA) and state and local governments to develop a uniform and coordinated system of risk communications.