

United States Government Accountability Office Washington, DC 20548

January 10, 2008

The Honorable Peter J. Visclosky Chairman The Honorable David L. Hobson Ranking Member Subcommittee on Energy and Water Development Committee on Appropriations House of Representatives

Subject: Los Alamos National Laboratory: Information on Security of Classified Data, Nuclear Material Controls, Nuclear and Worker Safety, and Project Management Weaknesses

The Los Alamos National Laboratory (LANL),¹ which is operated by the National Nuclear Security Administration (NNSA),² is responsible for, among other things, designing nuclear weapons. Over the past decade, we have documented numerous security, safety, and project management weaknesses at NNSA's nuclear weapons complex, including LANL. In particular, LANL has experienced a series of high-profile security incidents that have drawn attention to the laboratory's inability to account for and control classified information and maintain a safe work environment.

In July 2004, LANL's director declared a suspension—or stand-down—of laboratory operations to address immediate concerns, including the loss of classified computer disks. During the stand-down, laboratory teams identified more than 3,400 security and safety issues.

As a result of systemic management concerns, and the fact that the laboratory contractor—the University of California—did not adequately address these problems,

¹The laboratory operates and manages numerous nuclear facilities and operations. Critical activities include plutonium, uranium, and tritium processing; research and development operations with special nuclear material; high-energy radiography; radiation measurement; packaging of nuclear materials; and radioactive and hazardous waste management. The laboratory covers 40 square miles, including 2,700 buildings covering an area of 9.4 million square feet, and employs more than 12,000 personnel. It has an annual operating budget of approximately \$2 billion.

²NNSA was established in 2000 in response to management difficulties with the Department of Energy's nuclear weapons program. These difficulties included security problems at the department's national laboratories and significant cost overruns in the management of projects. NNSA is a separately organized agency within the department with responsibility for the nation's nuclear weapons, nonproliferation, and naval reactors programs.

the Department of Energy (DOE) decided in 2003 to allow other organizations to compete for the management contract at LANL. The University of California, which had been the exclusive management and operating contractor since the 1940s, was replaced in June 2006 by Los Alamos National Security, LLC, (LANS). LANS is a consortium of contractors that includes Bechtel National, Inc.; the University of California; BWX Technologies, Inc.; and the Washington Group International, Inc.

In this context, you asked us to provide information detailing recent security, safety, and management problems at LANL. We provided your staffs with information on these issues. This report summarizes and formally transmits the information provided to your staffs (see enc. I). As requested, this report provides information on (1) security incidents that compromised or potentially compromised classified information, (2) incidents involving the loss of or failure to properly account for special nuclear material (highly enriched uranium or plutonium) and radiological material, (3) nuclear safety concerns at the laboratory, (4) safety accidents involving LANL employees or contractor personnel, and (5) project management weaknesses that may have resulted in significant cost overruns.

To document security incidents relating to classified information, we obtained and analyzed data from LANL's Office of Safeguards and Security and DOE's Incident Tracking and Analysis Capability (ITAC) database. We relied on security incident data provided by ITAC because it is DOE's primary repository for tracking security incidents. To assess the reliability of these data, we interviewed DOE security officials responsible for compiling these data and performed reasonableness checks on the data. Regarding incidents involving the loss of or failure to properly account for special nuclear or radiological material, we met with departmental program officials, analyzed data from ITAC, and obtained and analyzed reports on material control and accountability from DOE's Office of Independent Oversight and the DOE Inspector General, Regarding nuclear safety concerns, we obtained information from DOE and LANL, and interviewed Defense Nuclear Facilities Safety Board (Safety Board) representatives at Los Alamos. Regarding safety accidents, we obtained and analyzed accident investigation reports from DOE's Office of Health, Safety and Security and the Los Alamos Site Office,³ including federal and contractor-led investigations from October 1, 2002, through June 30, 2007. In addition, we confirmed with DOE officials that we had obtained the complete list of accident investigations conducted during this period. To document project management weaknesses that resulted in significant cost overruns, we reviewed pertinent project information and interviewed project management officials at DOE headquarters and at Oak Ridge National Laboratory (ORNL). We also reviewed contract requirements and LANL's annual performance appraisals for fiscal years 2003 through 2006. To ensure consistency and comparability of the data, we obtained and analyzed information, to the extent possible, from October 1, 2002, through June 30, 2007. We determined that the data we obtained were sufficiently reliable for the purposes of this report. We conducted this performance audit from August 2007 through January 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence

³The Los Alamos Site Office is responsible for administering LANL's contract, providing oversight, and managing federal activities.

to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, LANL experienced 57 reported security incidents involving the compromise or potential compromise of classified information from October 1, 2002, through June 30, 2007, according to DOE's ITAC database. Thirty-seven (or 65 percent) of these reported incidents posed the most serious threat to U.S. national security interests.⁴ Of the remaining 20 incidents, 9 involved the confirmed or suspected unauthorized disclosure of secret information, which posed a significant threat to U.S. national security interests. The remaining 11 reported security incidents involved the confirmed or suspected unauthorized disclosure of confidential information, which posed threats to DOE security interests. Examples of the most serious types of security incidents reported by DOE include the following:

- LANL could not account for nine classified removable electronic media items, including data disks, during the relocation of these items to a different on-site facility. DOE concluded that these items were likely destroyed prior to their relocation (November 2003).
- A law enforcement search of a LANL subcontractor's home in Los Alamos, New Mexico, recovered classified information in the form of a USB "thumb drive" and documents. The subcontractor, who possessed a DOE security clearance, had removed the information from a highly classified facility at the laboratory (October 2006). In response to this incident, in July 2007, enforcement actions were taken by DOE, including the issuance of (1) a preliminary notice of violation to the University of California with a proposed civil penalty in the amount of \$3 million, (2) a separate preliminary notice of violation to LANS with a proposed civil penalty in the amount of \$300,000, and (3) a Secretarial Compliance Order to LANS. The preliminary notice of violation cited both the University of California and LANS for serious violations of DOE's classified information and cyber security requirements.

In response to security weaknesses in the handling and processing of classified data, LANL officials told us they have implemented a number of measures to strengthen controls since June 2006, including the following:

• destroying an estimated 1.4 million "legacy" classified documents,

⁴DOE has established four categories of security incidents on the basis of the relative severity of the incident. These categories are identified by an impact measurement index (IMI) number. IMI-1 incidents involve events that pose the most serious threats to U.S. national security interests and/or critical DOE assets, create serious security situations, or could result in deaths in the workforce or general public; IMI-2 incidents involve events that pose threats to U.S. national security interests and/or critical DOE assets or that potentially create dangerous situations; IMI-3 incidents involve events that pose threats to DOE security interests or potentially degrade the overall effectiveness of DOE's safeguards and security program; and IMI-4 incidents involve events that could pose threats to DOE by adversely affecting the ability of organizations to protect DOE safeguards and security interests.

- reducing the number of accountable electronic classified items from 87,000 to 4,472,
- reducing the number of vaults and vault-type rooms holding classified data from 142 to 114, and
- consolidating classified material and classified processing operations into a "Super Vault Type Room."

There were no reported incidents involving the loss or diversion of special nuclear or radiological material from LANL from October 1, 2002, through June 30, 2007. However, a number of security concerns with the inventory and accounting of these materials have been documented, most recently in a DOE Inspector General report issued in September 2007.⁵ Although the Inspector General concluded that, in general, LANL provides timely and accurate information on its inventory of accountable nuclear material, ⁶ it highlighted several areas of concern, including the following:

- Several inventories of nuclear materials were not completed in a timely manner.
- A storage vault containing over 11,000 individual containers of accountable nuclear material had not undergone a 100 percent inventory in over a decade.
- The creation of a new container of accountable nuclear material was not documented within the required time frame. This nuclear material could have been diverted without any record showing that it had ever existed.

Concerns about nuclear safety at LANL are long-standing. Problems include the following:

• <u>Criticality concerns</u>.⁷ For example, since 2003, the laboratory reported 19 incidents raising nuclear criticality concerns, such as storage or transportation of dangerous material in quantities that exceeded or potentially exceeded criticality limits. In the plutonium facility (TA-55) in July 2007, for example, an area of the facility containing spent trichloroethylene exceeded the criticality safety limit for such material by 40 percent. As recently as September 2007, operations were suspended in the plutonium facility over nuclear safety concerns.

⁵DOE Inspector General, *Material Control and Accountability at Los Alamos National Laboratory*, DOE/IG-0774, Sept. 2007.

⁶This refers to nuclear material that LANL is required to account for and control according to its strategic and monetary importance and the consequences of its loss.

⁷Criticality involves an inadvertent nuclear chain reaction. To prevent such an occurrence from happening, DOE's regulations and directive require contractors to evaluate potential accident conditions and put in place appropriate controls and safety measures.

- <u>Noncompliant safety documentation</u>. The laboratory has been out of compliance with safety documentation requirements, which require developing and annually updating an analysis of hazards and mitigating controls. Under a new contract with LANS, which went into effect in June 2006, LANL committed to having all but one of its nuclear facilities operating under compliant safety documentation by the end of 2007. However, only 2 of the laboratories' 19 nuclear facilities are currently under compliant safety documentation as of November 2007.
- <u>Inadequate safety systems</u>. The Safety Board and DOE have raised concerns about the inadequacies of safety systems at the laboratory, including weak or missing drawings for important safety system, missing procedures that systems should be operating under, and failure to properly maintain these systems to ensure they will work in an emergency. The Safety Board stated it lacks confidence in the laboratory's efforts to improve the reliability of safety systems.
- <u>Radiological exposures</u>. Since fiscal year 2003, the laboratory has reported 21 incidents involving exposure to radiological materials, including contamination of face, hands, or other body parts from working in situations such as glove boxes; unusually high, unexplained dosage reading for workers; and unanticipated intake of contaminants, such as plutonium, from inadvertent release.
- <u>Nuclear safety violation enforcement actions</u>. Since fiscal year 2003, LANL has received four enforcement actions containing civil penalties totaling nearly \$2.5 million for significant violations of nuclear safety requirements. The enforcement actions include a June 2004 penalty of \$770,000 for violations that resulted in two workers being exposed to radiation doses exceeding annual allowable limits, and a February 2007 penalty of \$1.1 million for 15 separate violations of nuclear safety rules, reflecting continuing safety performance deficiencies over the past several years.

From October 1, 2002, through June 30, 2007, LANL experienced 23 reported safety accidents serious enough to warrant investigation.⁸ Although no fatalities occurred

⁸DOE categorizes safety accidents according to their severity. Type A is the most serious type of incident, involving one or more of the following: a fatality; three or more injured workers or members of the public; radiation exposure of 25 rem or more; property damage equal to or exceeding \$2.5 million. Type B is a serious incident which includes at least one of the following: one or more injured workers or members of the public; radiation exposure of greater than 10 roentgen equivalent man (rem)—the absorbed dose of radiation adjusted for the relative biological effect of the type of radiation—but less than 25 rem; or property damage of more than \$1 million but less than \$2.5 million. We included all Type A and Type B accident investigations conducted by DOE, as well as the most serious accidents investigated by LANL contractors. We included all investigations of events resulting in injury or property damage as well as those considered near misses that were serious enough to warrant an investigation. If one investigation included more than one incident, we counted each incident separately.

during this period, workers involved in these accidents were seriously injured.⁹ Examples of safety accidents include the following:

- A package in which plutonium-238 residues had been stored since 1996 degraded and ruptured when being handled, releasing airborne plutonium. Two workers were each exposed to about one-half of DOE's annual allowable radiation dose for occupationally exposed workers (August 2003).
- A student was partially blinded after receiving a laser flash to her eye during an experiment because a LANL researcher in charge failed to ensure that the student was wearing required eye protection (July 2004).
- After opening a package of radioactive material contaminated during shipping, a LANL employee contaminated himself and his clothing. Over the next few days, the worker spread contamination to his home, to relatives' homes in Kansas and Colorado, and to other sites at LANL. The contamination went undetected for 11 days (July 2005).
- Laboratory workers were exposed to plutonium on two occasions while performing routine operations inside protective glove boxes that contained sharp tools (January 2007).

Weaknesses in project management have affected or threatened to affect project cost and schedules at LANL. NNSA and others have expressed concern for years about the adequacy of project management at the laboratory. In January 2001, when the contract for the laboratory was extended, new contract provisions stressed five key areas that needed improvement, including project management. In response, the University of California implemented DOE's new project management order and requirements and standardized formats for monthly reporting on projects. Despite these changes, LANL has continued to have project management problems. From fiscal year 2003 to fiscal year 2005, the laboratory has only achieved a "satisfactory" rating in overall project management.

Project management weaknesses at LANL have led to problems on projects.¹⁰ We identified one project in particular at LANL —the Dual Axis Radiographic Hydrodynamic Test (DARHT) program—that has experienced significant cost overruns, and has been the subject of a DOE Inspector General report¹¹ and an NNSA "lessons learned" evaluation.¹² DARHT will be the nation's first hydrodynamic test

⁹For further information on worker safety at LANL, see GAO, *Nuclear and Worker Safety: Actions Needed to Determine the Effectiveness of Safety Improvement Efforts at NNSA's Weapons Laboratories*, GAO-08-73 (Washington, D.C.: Oct. 31, 2007).

¹⁰In January 2007, we reported on other NNSA-wide project management weaknesses. See GAO, *National Nuclear Security Administration: Additional Actions Needed to Improve Management of the Nation's Nuclear Programs*, GAO-07-36 (Washington, D.C.: Jan. 19, 2007).

¹¹DOE Inspector General, *Dual Axis Radiographic Hydrodynamic Test Facility*, DOE/IG-0599, May 2003.

¹²National Nuclear Security Administration, *DARHT Construction Project Lessons Learned Report*, March 2005.

facility capable of producing three-dimensional X-ray photographs of a nuclear weapon and is expected to play an important role in DOE's Stockpile Stewardship Program. Original plans for DARHT's construction called for the development of two single-pulse axes with similar capabilities. The original estimated cost of the project, in 1998, ranged between \$30 million and \$54 million.

The first axis was completed following the original design and has been operational for 5 years. However, with DOE approval, LANL changed the scope of the second axis, and subsequently, major problems have occurred with its design and construction. In May 2003, the DOE Inspector General reported that DARHT's budget estimates were not realistic given the project's technical complexity. Furthermore, the Inspector General reported that the project's contingency fund was insufficient and at least \$57.5 million in actual project costs had been transferred to other DOE programs or projects, which made it appear that DARHT was within budget when it was not. DOE then estimated that the costs for the Second Axis Recovery and Commissioning Project to complete the second axis totaled about \$90 million. The project is scheduled to be completed in May 2008.

Project management weaknesses at LANL also threatened schedule delays on a multilab project led by ORNL, called the Spallation Neutron Source project. LANL was responsible for two portions of this project, specifically, the linear accelerator and a low-level radio-frequency control system. Due to fabrication problems in 2002 with the linear accelerator, including leaky tubing, rework was required, and resulted in a cost impact of approximately \$8 million (which was funded through \$1.8 million in contingency and the remainder in offsets). LANL's design problems with the radio-frequency control system resulted in potential schedule delays. As a result, ORNL took over management of this project and, using a simpler design already in use at one of the other DOE laboratories, brought the project in within cost and schedule. The former ORNL Spallation Neutron Source program manager, who is now the laboratory director, told us that problems with these two projects led by LANL could have significantly delayed the overall project.

Agency Comments and Our Evaluation

We requested comments on a draft of this report from LANL, DOE, and NNSA. In response, we received oral comments from LANL officials, including the Deputy Division Leader, Environment, Safety, Health and Quality; the Deputy Division Leader, Office of Safeguards and Security; the DARHT Second Axis Project Director; and the Deputy Division Leader, Technical Cyber Security. Although LANL officials generally agreed with the facts as presented in this report, they noted that the new management and operations contractor-LANS-has taken actions to improve security at the laboratory since June 2006, including reducing the number of individual classified items at the site and consolidating classified material and classified operations. We added this information to our report based on these comments. In addition, LANL officials noted our report showed that the number of security incidents that compromised or potentially compromised classified information had declined from fiscal year 2006 through June 30, 2007, thus demonstrating progress in improving the security of classified information at the site. In our view, this short period of time is not sufficient to provide a basis for meaningful trend analysis. Consequently, it is too soon to tell if this decline in

security incidents is more than temporary. LANL officials also provided technical comments, which we included as appropriate. We also received oral comments from DOE's Director, Office of Security Evaluations, and NNSA's Director, Policy and Internal Control Management. These comments were technical in nature, and we incorporated them in the report where appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Energy, the Administrator of NNSA, the Director of LANL, appropriate congressional committees, and other interested parties. We will also make copies available to others on request. In addition, this report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at 202-512-3841 or aloisee@gao.gov. Contact point s for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report include Allison B. Bawden, Carole J. Blackwell, Nancy L. Crothers, A. Donald Cowan, Janet E. Frisch, Preston S. Heard, Lisa Nicole Henson, Nancy K. Kintner-Meyer, Glen Levis, James D. Noel, and Rachael A. Schacherer.

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Enclosure

Enclosure I: Briefing to the Subcommittee on Energy and Water Development, Committee on Appropriations, House of Representatives

















































- To ensure safe operation of nuclear facilities, DOE regulations and directives require contractors to develop, maintain, and annually update documentation, called a documented safety analysis, that
 - describes the work to be performed;
 - evaluates all potential hazards and accident conditions;
 - contains appropriate controls, including technical requirements, to eliminate or minimize the risk of hazards; and
 - delineates procedures and practices for safe operations.
- DOE regulations also require that radiation doses to workers at DOE facilities be maintained within prescribed limits.
- Violations of nuclear safety rules are enforced through DOE's Office of Enforcement, which levies civil penalties for serious offenses.





Criticality safety:

- In 2005 and 2006, respectively, NNSA and the Safety Board reported that LANL's nuclear criticality safety program was out of compliance, and the laboratory had not fully put in place interim measures to reduce the risk of a criticality event until the program could be brought into compliance.
- Since 2003, the laboratory has reported 19 incidents raising nuclear criticality concerns, such as storage or transportation of dangerous materials in quantities that exceeded or potentially exceeded criticality limits. In the plutonium facility (TA-55) in July 2007, for example, an area of the facility containing spent trichloroethylene exceeded the criticality safety limit for such material by 40 percent.
- Twelve of the 19 reported incidents took place at the laboratory's plutonium facility.



Criticality concerns have persisted:

- In September 2007, operations were suspended at TA-55 over concerns that radiation shielding in the vault containing plutonium and other materials might not be sufficient to prevent a criticality event. Radiation shielding is important because it prevents inadvertent chain reactions in the nuclear material.
- In October 2007, nearly 60 drums containing transuranic waste stored in Area G at the laboratory were found to be overloaded beyond criticality safety limits acceptable at the repository where the drums will be stored. However, because all but 6 of the drums were originally certified as being below criticality safety limits, the laboratory determined that it needed to address only the 6 drums.

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Documented safety analyses:

- The laboratory has been out of compliance with safety documentation requirements, which require annually updating analysis of hazards and mitigating controls and, since 2001, has not met contract requirements to bring safety documentation into compliance.
- In May 2004, the Safety Board noted that many of the laboratory's high-risk facilities were operating with out-of-date safety documentation, including four high-risk facilities operating under documentation that had not been updated for 5-8 years. Under a new contract with LANS, which went into effect in June 2006, the laboratory committed to having all but one of its nuclear facilities operating under compliant safety documentation by the end of fiscal year 2007.
- Nevertheless, as of November 2007, only 2 of LANL's 19 nuclear facilities were operating under compliant safety documentation.



Safety systems:

- Safety systems, such as for ventilation and fire suppression, are vital to ensure that nuclear facilities operate to protect workers and the public.
- Concerns have been raised by the Safety Board and DOE about the inadequacies of safety systems at the laboratory, including:
 - · weak or missing drawings for important safety systems,
 - incomplete or inadequate descriptions of system functions,
 - missing procedures under which systems should be operating, and
 - failure to maintain systems properly to ensure they will work in an emergency.
- Because of these inadequacies, the Safety Board stated that it lacks confidence in LANL's efforts to improve the reliability of safety systems.



Radiological incidents:

- Since fiscal year 2003, the laboratory has reported 21 incidents involving exposure to radiological materials, including:
 - contamination of face, hands, or other body parts from working in situations such as glove boxes;
 - unusually high, unexplained dosage readings for workers; and
 - unanticipated intake of contaminants, such as plutonium, from inadvertent releases.
- For example, in a November 2006 event, a plutonium-239 sample popped from its mount in TA-55, striking and contaminating an employee on the arm and chest before it fell to the floor.
- The laboratory has had a history of significant radiological intakes, in which workers have inhaled quantities of airborne radiological materials.



Nuclear safety violation enforcement actions:

- Since fiscal year 2003, LANL has received four enforcement actions containing civil penalties totaling nearly \$2.5 million.³
- These enforcement actions describe significant violations of nuclear safety requirements, including:
 - December 2002: violations leading to operating an unauthorized nuclear facility for 5 years and storing radioactive waste without proper controls (penalties assessed, \$220,000).
 - April 2003: violations including failure to operate nuclear facilities in accordance with safety documentation and numerous violations of radiological work procedures, resulting in exposure of workers to radioactive material (penalties assessed, \$385,000).

³Because of an exemption under section 234A(d) of the Atomic Energy Act of 1954, as amended, 42 U.S.C. 2282a, under the contractor at the time, the laboratory did not pay the penalties associated with the enforcement actions levied against it.







Safety Accidents at LANL

- DOE categorizes safety accidents according to their severity.
- **Type A, most serious:** The investigation team is appointed by DOE's Chief Health, Safety and Security Officer and is led by staff from DOE headquarters. Threshold criteria for a type A investigation include the following:
 - occurrence of a fatality;
 - three or more injured workers or members of the public requiring hospitalization for more than 48 hours and sustaining serious bodily damage, such as nerve damage;
 - single, individual radiation exposure of 25 rem or more;⁴ or
 - property damage equal to or exceeding \$2.5 million.

⁴Rem = Roentgen equivalent man, which is the absorbed dose of radiation adjusted for the relative biological effect of the type of radiation.









Safety Accidents at LANL

- Two postdoctoral employees inhaled acid vapors when using a mixture of hydrochloric and nitric acids to clean laboratory glassware. One employee was later hospitalized for a lung injury attributable to the accident (June 2005).
- After opening a package of radioactive material contaminated during shipping, a LANL employee contaminated himself and his clothing. Over the next few days, the worker spread contamination to his home, to relatives' homes in Kansas and Colorado, and to other sites at LANL. The contamination went undetected for 11 days (July 2005).
- A subcontractor employee sustained serious injuries to his leg and pelvis when a metal stairway, being hoisted by a crane, slipped from its rigging. The worker's injuries were so serious that he had to be airlifted out of the area for treatment (June 2006).
- Laboratory workers were exposed to plutonium on two occasions while performing routine operations inside protective glove boxes that contained sharp tools (January 2007).



























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