

DHS' Ebola Response Needs Better Coordination, Training, and Execution





DHS OIG HIGHLIGHTS

DHS' Ebola Response Needs Better Coordination, Training, and Execution

January 6, 2016

Why We Did This Audit

In 2014, West African countries experienced the largest Ebola virus disease (Ebola) outbreak to date. As part of the Department of Homeland Security's (DHS) response to prevent the spread of Ebola in the United States, DHS instituted additional screening at U.S. ports of entry for passengers traveling from Ebola-affected countries. We conducted this audit to determine whether DHS has effectively implemented its enhanced screening measures to respond to an Ebola outbreak.

What We Recommend

We made 10 recommendations to address the coordination, guidance, and training involved with DHS' response to Ebola. These recommendations, when implemented, should improve the efficiency and effectiveness of the program.

For Further Information:

Contact our Office of Public Affairs at (202) 254-4100, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

Although the Department responded quickly to implement domestic Ebola screening with the Department of Health and Human Services (HHS), it did not ensure sufficient coordination, adequate training, and consistent screening of people arriving at U.S. ports of entry. Coordination between DHS, HHS, and other DHS components was not sufficient to ensure all passengers received full screening. Components did not ensure all personnel received adequate training on the screening process or the use of certain protective equipment. Component personnel also did not always follow established Ebola procedures and ensure all identified passengers completed required screening. As a result, some passengers with potential risk of Ebola exposure may have entered the United States without having their temperatures taken or otherwise cleared by health professionals, and the DHS workforce performing the response was not always appropriately protected.

DHS Response

The Department concurred with all 10 recommendations and has initiated corrective actions that should improve the effectiveness of the Department's response to Ebola when implemented. We consider seven recommendations resolved and open. However, for three recommendations, the Department needs to identify additional steps to address the findings and resolve these recommendations.



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Washington, DC 20528 / www.oig.dhs.gov

January 6, 2016

MEMORANDUM FOR: The Honorable Alejandro Mayorkas
Deputy Secretary
Department of Homeland Security

Dr. Kathryn Brinsfield
Assistant Secretary and Chief Medical Officer
Office of Health Affairs

FROM:

John Roth *John Roth*
Inspector General

SUBJECT:

*DHS' Ebola Response Needs Better Coordination,
Training, and Execution*

Attached for your action is our final report, *DHS' Ebola Response Needs Better Coordination, Training, and Execution*. We incorporated the formal comments from the U.S. Customs and Border Protection, United States Coast Guard, Transportation Security Administration, and the Office of Health Affairs in the final report.

During the course of this audit, we encountered significant delays, cooperation issues and opposition from both components and Departmental offices. Audited groups were unwilling to provide requested information in response to briefings and audit findings. The continued delays and resistance to providing responses during this engagement have violated the spirit of *the Inspector General Act* and have prevented our office from delivering a timely report to Congress. We expect improved cooperation and dialogue during future projects with the Department and components as we all seek to make DHS a more effective and efficient agency.

The report contains 10 recommendations aimed at improving the Department's Ebola response. Your office concurred with 10 recommendations. Based on information provided in your response to the draft report, we consider recommendations 2, 7, and 10 open and unresolved. As prescribed by the Department of Homeland Security Directive 077-01, *Follow-Up and Resolutions for the Office of Inspector General Report Recommendations*, within 90 days of the date of this memorandum, please provide our office with a written response that includes your (1) agreement or disagreement, (2) corrective action plan, and (3) target completion date for each recommendation. Also, please include responsible parties and any other supporting documentation necessary to inform us about the current status of the recommendation. Until your response



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is received and evaluated, the recommendations will be considered open and unresolved. We consider recommendations 1, 3, 4, 5, 6, 8, and 9 open and resolved. Once your office has fully implemented the recommendations, please submit a formal closeout letter to us within 30 days so that we may close the recommendations. The memorandum should be accompanied by evidence of completion of agreed-upon corrective actions and of the disposition of any monetary amounts.

Please send your response or closure request to
OIGAuditsFollowup@oig.dhs.gov.

Consistent with our responsibility under the *Inspector General Act*, we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact Mark Bell, Assistant Inspector General for Audits, at (202) 254-4100.

Attachment

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Table of Contents

Background	1
Results of Audit	3
DHS Ebola Response Coordination	3
Training for Ebola Response	6
Implementation of Ebola Response	10
Recommendations.....	13

Appendixes

Appendix A: Objective, Scope, and Methodology	22
Appendix B: DHS Comments to the Draft Report	25
Appendix C: Office of Audits Major Contributors to This Report	33
Appendix D: Report Distribution.....	34

Abbreviations

CBP	U.S. Customs and Border Protection
CBRN	Chemical, Biological, Radiological, and Nuclear
CDC	Centers for Disease Control and Prevention
DHS	Department of Homeland Security
FEMA	Federal Emergency Management Agency
HHS	Department of Health and Human Services
HQ	Headquarters
HRM	Human Resources Management
ILSP	Integrated Logistics Support Plan
MOU	memorandum of understanding
OFO	CBP Office of Field Operations
OHA	Office of Health Affairs
OIG	Office of Inspector General
OSC	USCG Office of Specialized Capabilities
OSHA	Occupational Safety and Health Administration
PPE	personal protective equipment
PSC	Port State Control
TSA	Transportation Security Administration
USCG	U.S. Coast Guard



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Background

This audit is one of a series related to Department of Homeland Security's (DHS) pandemic preparedness and response. We previously reported on DHS' management of pandemic supply of personal protective equipment and antiviral countermeasures. We conducted this audit on DHS' response to the Ebola virus disease (Ebola) outbreak to determine whether it effectively implemented DHS' screening measures.

In 2014, West African countries experienced the largest Ebola outbreak to date. In response, the Centers for Disease Control and Prevention (CDC) initiated exit screening in countries experiencing the Ebola outbreak. As part of the domestic response, DHS partnered with the CDC to prevent the spread of Ebola by instituting additional screening at U.S. ports of entry for passengers traveling from Ebola-affected countries.

In September 2014, the CDC, which is part of the Department of Health and Human Services (HHS), confirmed the first case of Ebola in the United States. DHS coordinated with Federal agencies, including HHS and the National Security Council, to develop strategies for DHS' domestic response to Ebola. DHS' Office of Health Affairs (OHA) led the Department's Ebola response activities and coordination efforts.

Within approximately 2 weeks of the first identified Ebola case in the United States, DHS, in coordination with the CDC, began screening for Ebola at the following five U.S. airports:

- John F. Kennedy International Airport (JFK) in New York;
- Washington-Dulles International Airport (IAD) in Virginia;
- Newark Liberty International Airport (EWR) in New Jersey;
- Chicago O'Hare International Airport (ORD) in Illinois; and
- Hartsfield-Jackson Atlanta International Airport (ATL) in Georgia.

Authorities selected these five airports because DHS identified that more than 94 percent of travelers from the Ebola-affected countries arrived in the United States at these airports. OHA provided guidance to DHS personnel on implementing screening and provided training at the five airports. Once the screening began at these airports, DHS quickly expanded screening for Ebola to all ports of entry. DHS identified U.S. Customs and Border Protection (CBP) as the component to perform screening for Ebola at U.S. ports of entry. CBP reported screening more than 20,000 people between October 2014 and June 2015.



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The Ebola screening process began by identifying travelers who had been to an Ebola-affected country within the previous 21 days, or had other links to one of the countries, such as a passport or visa. Identified travelers were then referred for additional Ebola screening. CBP officers reviewed travel documents, conducted health-screening interviews, and documented the traveler's temperature. In cases where an Ebola risk was identified or where travelers were exhibiting Ebola-like symptoms, CBP officers referred the traveler to the CDC for screening.

The CDC screening consisted of an in-depth public health assessment. If no CDC personnel were on site, the CBP officer was supposed to contact the CDC Emergency Operation Center for further instruction. The CDC maintained jurisdiction to determine whether to isolate, quarantine, or issue monitoring orders for a person entering the United States from an Ebola-affected country. CBP officers could have been called upon to help enforce such orders or to provide law enforcement support, if necessary, when transporting a person to a medical facility. In addition to screening passengers at airports, CBP also conducted screening at land ports of entry and seaports.

Other DHS components were involved during the Ebola response efforts in 2014 and 2015, including the Federal Emergency Management Agency (FEMA), the U.S. Coast Guard (USCG), and the Transportation Security Administration (TSA).

- FEMA assisted HHS in interagency planning and facilitated the implementation of Ebola screening at the five airports.
- The USCG initially assisted CBP with the temperature screening of passengers at the five airports previously discussed, until contractors were put in place. Additionally, the USCG monitored vessels en route from Ebola-affected countries. This monitoring was done by email and radio prior to the vessel reaching a U.S. port of entry. If there were suspected cases of Ebola onboard maritime vessels, the USCG could have been asked to provide transportation for medical personnel or perform evacuations. Once in port, the USCG conducted its normal inspections for vessels.
- TSA coordinated with the CDC to restrict individuals with communicable diseases from boarding an aircraft through the "Do Not Board List" program. The "Do Not Board List" prevents travelers from purchasing a ticket or obtaining a boarding pass. TSA used this list to restrict travel of suspected or confirmed Ebola cases. TSA was also responsible for issuing



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Department of Homeland Security

Ebola awareness information with recommended precautionary measures to airline carriers.

The final audit in this series will focus on reviewing DHS pandemic preparedness plans. Results from that audit will appear in a separate report.

Results of Audit

Overall, DHS did not ensure sufficient coordination, adequate training, and consistent screening of people arriving at U.S. ports of entry during its response to Ebola. Coordination between DHS, HHS, and other DHS components was not sufficient to ensure all passengers received full screening. Components did not ensure all personnel received adequate training on the screening process or on the use of certain protective equipment. Component personnel also did not always follow established Ebola procedures and ensure all identified passengers completed required screening.

- For example, CBP officers did not always refer passengers to Ebola screening, even when the travelers had self-declared their travel to an Ebola-affected country.
- Diplomats, United Nations workers, U.S. Government employees, or other dignitaries were not thoroughly scrutinized or were incorrectly assumed to be exempt from Ebola screening.
- Passengers with known travel to an Ebola-affected country were not properly escorted to Ebola screening when required and departed into the U.S. without completing Ebola screening.
- CBP officers did not always receive proper medical clearance from CDC, when required, before releasing the traveler.

As a result, some passengers with potential risk of Ebola exposure may have entered the United States without thorough screening, and the DHS workforce performing the response was not always appropriately protected.

DHS Ebola Response Coordination

Coordination between DHS and HHS

DHS and HHS did not establish documented roles and responsibilities for domestic Ebola screening. The memorandum of understanding (MOU) between DHS and HHS, dated October 2005, established specific cooperation mechanisms to enhance the Nation's preparedness against quarantinable and serious communicable diseases. The MOU was specific to an HHS-initiated



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response to an influenza threat. However, it did not identify response roles for initiating the DHS Ebola screening process.

The MOU required DHS to assist HHS during an influenza outbreak, but the MOU did not include specific operational guidelines for a response to Ebola. During the Ebola response in 2014 and 2015, the MOU was not updated and no other formal agreement was documented that explained the roles of DHS and HHS. The Assistant Secretary for Health Affairs and Chief Medical Officer reported that although Ebola screening began after consultation and agreement at the highest levels of government, no formalized agreement was documented.

DHS established procedures to screen passengers for Ebola at U.S. ports of entry. These procedures contained roles for CBP and CDC, including obtaining passengers' temperatures and transporting sick passengers. Although CBP's procedures outlined CDC's responsibility for arranging transportation, this was not included in the formal MOU between the agencies. By not determining and documenting these responsibilities beforehand, the agencies risk missing necessary precautions or delaying agencies' response.

Furthermore, CBP headquarters arranged for only contracted personnel to take temperatures at the five airports where the majority of passengers from Ebola-affected countries entered the United States. From October 2014 through July 2015, CBP spent more than \$4 million for these contractors. Yet, CBP did not always have contractors in place at other ports of entry to take passengers' temperatures and did not allow CBP officers to perform the procedure. CBP released 169 passengers with recent travel to an Ebola-affected country into the public from October 2014 through June 2015, without ensuring passengers had their temperatures taken, or were otherwise cleared by health professionals.

CBP reported 100 percent of travelers it identified as flying directly from the affected countries went through Ebola screening. While we agree with CBP's focus on passengers posing the greatest risk, the 169 passengers identified above, traveled from one of the affected countries and were not fully screened. DHS asserted that these passengers presented no overt risk factors and were released after consultation with CDC or local public health officials. However, CBP was unable to provide sufficient documentation to substantiate these passengers were not a risk to the public and should have been excluded from screening. CBP also conducted a separate review and reported instances where full screening did not take place and passengers were released without receiving medical clearance by CDC. Without documentation, we cannot verify how CBP determined these 169 passengers were not a risk to public health.



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In addition, CBP reported the discovery of multiple errors in CBP Ebola screening data. CBP attributed these errors to inconsistent understanding, variances in data entry, and differences in activity summarized by CBP personnel. As a result, the data is unreliable and CBP cannot determine how many passengers were not fully screened.

As part of the Ebola screening process, CBP's procedures required CBP to depend on local medical personnel to take temperatures at ports where contractors were not hired. In these instances, CBP officials stated they would have relied on the CDC to take temperatures. However, CDC officials stated they did not have sufficient personnel to respond to CBP's request. The CDC recommended having passengers take their own temperatures at these locations, but CBP did not include this in its procedures.

As screening of passengers continued, CBP did not update its screening procedures to ensure temperatures were taken at locations where CDC would not respond and contractors were not stationed. Instead, CBP provided guidance to all ports of entry that allowed passengers to be released without temperatures being taken. This increased the risk of an infected individual entering the country.

According to the Assistant Secretary for Health Affairs and the Chief Medical Officer, "DHS and HHS (including the Centers for Disease Control and Prevention) are in the process of further clarifying cooperative mechanisms, which will be memorialized in either annexes to the 2005 MOU or stand-alone MOUs."

Coordination between DHS Components

DHS did not establish policies and procedures to ensure coordination between CBP and USCG for boarding vessels from Ebola-affected countries. CBP boarded these vessels to conduct Ebola screening, as well as to complete its normal customs inspections. The USCG also boarded vessels from Ebola-affected countries to perform inspections as part of enforcing port safety, security, and environmental regulations.¹ However, the USCG did not require employees to ensure CBP completed its Ebola screening prior to them boarding these vessels. At three USCG locations we visited, officials indicated they did not coordinate with CBP prior to USCG performing their on-vessel work. In its formal response, the USCG reported CBP did not screen all vessels, passengers, or crew prior to most USCG boardings. Rather, the USCG relied on regulations that require vessel operators to report ill passengers.

¹ 33 CFR § 1.01-30



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In addition, CBP and USCG personal protective equipment (PPE) usage requirements when boarding vessels from Ebola-affected countries were inconsistent. The CBP maritime standard operating procedure for Ebola screening required mandatory use of PPE for all CBP personnel who process travelers from Ebola-affected countries in accordance with DHS guidance.² USCG issued a planning order for Ebola preparedness and response, which included a risk assessment for PPE usage.³ For a vessel entering from an Ebola-affected country, USCG members were not required to wear PPE unless there was a suspected or known Ebola case. However, according to the USCG, PPE use depended on the situation and was the responsibility of the operational commander to make the determination. Unlike CBP, the USCG did not base the level of PPE protection solely on the vessel's country of origin.

DHS or component headquarters did not review the level of PPE required for boarding a vessel from an Ebola-affected country for consistency. As a result, USCG personnel may not have been equally protected when boarding these vessels if they boarded prior to CBP completing its Ebola screening. By not coordinating with CBP to ensure Ebola screening had been completed, the USCG may have been at a higher risk of exposure to Ebola from either unreported or unknown sick persons.

Training for Ebola Response

CBP Training on Ebola Screening

CBP did not ensure that all officers conducting Ebola screening received timely and adequate training on established procedures and use of PPE. Given the increased risk of potential close contact with those infected with Ebola, training was needed to protect frontline personnel.

The Department of Labor Occupational Safety and Health Administration (OSHA) recommended workers show competency in hands-on donning (putting on) and doffing (removing) of PPE for Ebola response. All CBP officers were required to take an online Ebola PPE training; however, it did not involve demonstrating competency in donning and doffing per OSHA's recommendation. CBP headquarters identified it had provided hands-on training for donning and doffing of PPE to 19 ports of entry. However, not all of the remaining ports that conducted Ebola screening received this training.

² CBP, *Maritime Environment Standard Operating Procedures – Enhanced Screening of Passengers with Travel Nexus to Ebola Affected Countries*.

³ *Ebola Virus Disease Planning Order Change 1*



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In addition, the training that was provided was not always timely. CBP began screening for Ebola at five airports in early October 2014, without ensuring personnel at these airports received sufficient training. Only two of the five initial airports received in-person training prior to beginning Ebola screening. It took another month to complete the training at the three remaining airports. Additional ports did not begin in-person training until 2 months later and, as previously stated, not all of those personnel received the training. These lapses put CBP personnel at increased risk of Ebola exposure.

USCG Chemical, Biological, Radiological, and Nuclear Training Oversight

The USCG did not ensure that all applicable employees completed training for Chemical, Biological, Radiological, and Nuclear (CBRN) protective equipment needed to safely respond to Ebola. CBRN is specialized PPE used by USCG members to prevent exposure from potential deadly hazards. USCG determined that CBRN equipment was the only PPE sufficient to protect members from Ebola exposure in the maritime environment. The CBRN training was meant to ensure members could safely use the equipment, including how to properly don, doff, and decontaminate in a hazardous environment. Without sufficient training on CBRN equipment, USCG members may not have been adequately protected when performing USCG's missions.

USCG headquarters established a requirement for members to complete CBRN training and delegated oversight of this requirement to local offices. In response to the 2014 Ebola epidemic, local offices were required to perform audits to confirm members completed CBRN training. Only one of the three offices we visited reported having met this requirement; however, the office could not provide documentation. In addition, USCG headquarters did not verify completion of these audits and did not perform its own review to determine whether members met CBRN qualifications. Without overseeing members' CBRN training qualifications, USCG cannot be sure of its true readiness to respond to chemical, biological, radiological, or nuclear events, including Ebola. Table 1 illustrates the number of members lacking CBRN training at the three Sectors we visited. The records we reviewed also included CBRN training records from the Sectors' supporting units. Of the training records we reviewed, 69 percent of USCG members were not current with required CBRN training.



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Table 1: USCG CBRN Training at Local Offices and Supporting Units

Local Offices	Members Not Current with CBRN Training
New Orleans	68/140 (49%)
Corpus Christi	92/95 (97%)
Houston	51/70 (73%)
Overall	211/305 (69%)

Source: Office of Inspector General (OIG) analysis of USCG data

USCG provides three types of CBRN training, and members should receive training on the type of CBRN equipment used at their local office. However, the USCG training records system did not differentiate between the types of CBRN training members received. Due to this limitation, USCG could not determine whether members received the specific training for the type of CBRN equipment used at each local office. USCG identified this issue as a capability gap and reported that it is working to better track the type of CBRN training completed.

In response to CBRN training needs, USCG headquarters hired contractors to provide training at local offices. However, this contract did not provide sufficient training capacity to ensure all members received the required CBRN training. Specifically, 450 units were required to receive the Domestic Egress CBRN training every 2 years. However, USCG's contract capacity cannot ensure they meet this requirement. As a result, not all local units will be adequately trained to use CBRN equipment during a response.

USCG also did not conduct training exercises while using CBRN equipment in a maritime setting. The CBRN training available to USCG members was limited to a classroom setting. As a result, members may have been unfamiliar with the challenges encountered when using CBRN equipment because training did not occur in conditions experienced when performing missions.

USCG personnel at a port we visited performed a live demonstration of CBRN in which members had difficulty using the equipment. During the demonstration, pieces of a CBRN suit fell into the water instead of being properly disposed. Additionally, a USCG member improperly discarded a mask rather than following decontamination procedures. Figure 1 shows USCG members demonstrating the decontamination process for CBRN equipment, and Figure 2 shows the removal of decontaminated equipment.



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Figure 1: CBRN Decontamination Demonstration



Source: OIG photographs

Figure 2: CBRN Removal



Source: OIG photographs

The USCG identified improvements for its CBRN training program, including updating its policy to require local offices demonstrate the proper use of CBRN. Additionally, the USCG is considering incorporating exercises using CBRN in scenario-based training simulating the real-world environment.



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Implementation of Ebola Response

CBP Compliance with Screening Requirements

CBP officers did not always follow established requirements for Ebola screening, such as maintaining the recommended distance, wearing required PPE, and ensuring all necessary passengers completed required screening. CBP headquarters also did not provide sufficient oversight to ensure screening requirement compliance. Without sufficient guidance, training, and oversight, CBP cannot be sure its employees are adequately prepared to protect themselves from exposure to Ebola.

The *DHS Ebola Entry Screening Guidance* advises that to the extent feasible, CBP officers should maintain a distance of not less than 3 feet between themselves and travelers, absent a physical barrier. In addition, the DHS guidance outlines the PPE requirements for the Ebola screening intended to ensure personal protection and minimize risk. Figure 3 shows some of the PPE used during the CBP Ebola screening process.

Figure 3: PPE Used During Ebola Screening



Source: Medscape and CDC websites

During our site visits, CBP officers did not always maintain the distance recommended by DHS between themselves and travelers from Ebola-affected countries. Specifically, at three of the airports we visited, CBP officers did not



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Department of Homeland Security

keep 3 feet of distance or wear additional PPE when conducting Ebola screening. According to CBP, although it understands the importance of “safe-distancing” to minimize potential exposure to a communicable disease, operational application of a standardized procedure is subject to “real-world” environmental constraints. The result being that the officer must close the recommended safe-distance to accomplish the mission objective of escorting the traveler to an area for isolation. Although CBP Ebola screening procedures referred to DHS guidance, it did not specify the 3-foot requirement. As a result, CBP officers may have overlooked this requirement and did not always maintain the recommended distance or wear additional PPE as required. Figure 4 illustrates the use of PPE during the Ebola screening process.

Figure 4: Ebola Screening Process



Source: CBP photographs



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Department of Homeland Security

CBP's procedures for Ebola screening required mandatory use of PPE for all CBP personnel who process travelers from Ebola-affected countries. During our site visits, we found CBP officers did not always use the PPE required for protection. For example, at two airports, when CBP officers did not maintain 3 feet of distance they were not wearing all the additional PPE required. At another airport, a CBP officer escorted a passenger to the CDC for additional screening without wearing the required face shield or non-ventilated goggles. At several other airports, CBP officers indicated they might not wear the surgical masks, face shields, or non-ventilated goggles when conducting Ebola screening unless the passenger appeared symptomatic.

CBP headquarters implemented a Crisis Action Team to lead in the Ebola response that was in charge of reporting, answering requests for information, and CDC follow-up. However, CBP headquarters did not provide sufficient oversight to ensure correct implementation of screening as intended. CBP headquarters also identified instances where personnel did not always follow procedures to ensure passengers received Ebola screening when required. Examples included:

- CBP officers did not always refer passengers to Ebola screening, even when the travelers had self-declared their travel to an Ebola-affected country.
- Diplomats, United Nations workers, U.S. Government employees, or other dignitaries were not thoroughly scrutinized or were incorrectly assumed to be exempt from Ebola screening.
- Passengers with known travel to an Ebola-affected country were not properly escorted to Ebola screening when required and departed into the United States without completing Ebola screening.
- CBP officers did not always receive proper medical clearance from CDC, when required, before releasing the traveler.

Once CBP headquarters identified these issues, it required field offices to take corrective actions, including retraining personnel and reviewing and updating local standard operating procedures to ensure they included requirements for Ebola screening. However, as previously noted, deficiencies in the Ebola screening process still existed at the time of our audit field work.

TSA's Inventory/Purchases of Ebola Response Equipment

In responding to the Ebola threat, TSA made PPE purchases that were unnecessary. Specifically, TSA made the decision to purchase 500 face shields at a cost of \$1,350 for TSA officers at the five airports where CBP established Ebola screening. However, TSA was not involved in the screening of travelers



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Department of Homeland Security

from the Ebola-affected countries. Therefore, their risk level was essentially the same as any government employee in a customer service role dealing with the U.S. public. Furthermore, TSA's Ebola Screening PPE Assessment determined that its screening procedures were appropriate for the Ebola response and personnel did not need additional PPE beyond nitrile gloves. However, the purchase still occurred and, as a result, TSA has stored the 500 face shields at airports without an identified need.

Recommendations

Recommendation 1: We recommend that the Deputy Secretary of DHS ensure DHS coordinates with HHS to update the current infectious disease MOU or create a new formalized document between the Departments that:

- a. is applicable to more infectious diseases than influenza, and
- b. fully outlines the agreed upon roles and responsibilities of each Department and component in the infectious disease response.

Recommendation 2: We recommend that the Deputy Secretary of DHS ensure CBP provides all ports of entry with the necessary guidance and resources to complete required infectious disease screenings, including Ebola.

Recommendation 3: We recommend that the Deputy Secretary of DHS ensure USCG update its *Ebola Virus Disease Planning Order* to include coordination with CBP, specifically ensuring CBP completes its Ebola screening before USCG boards vessels within 21 days of visiting Ebola-affected countries.

Recommendation 4: We recommend that the Deputy Secretary of DHS ensure USCG revises training requirements to ensure its required members train in the use of CBRN equipment within conditions they may experience while performing missions.

Recommendation 5: We recommend that the Deputy Secretary of DHS ensure USCG updates its training capacity to meet its CBRN equipment training requirements within the required timeframes.

Recommendation 6: We recommend that the Deputy Secretary of DHS ensure USCG establishes CBRN training oversight to ensure all designated members have met CBRN equipment training requirements.



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Department of Homeland Security

Recommendation 7: We recommend that the Deputy Secretary of DHS ensure CBP updates guidance and screening procedures to consistently outline the distance recommendations and PPE usage when necessary distance cannot be maintained during Ebola screening.

Recommendation 8: We recommend that the Deputy Secretary of DHS ensure CBP enhances its oversight process to ensure that reporting on Ebola screening is accurate and complete to meet screening requirements.

Recommendation 9: We recommend that the Deputy Secretary of DHS ensure CBP completes in-person PPE donning and doffing training at the remaining ports meeting CBP's risk-based criteria.

Recommendation 10: We recommend that the Deputy Secretary of DHS ensure components make PPE purchases based on component risks.

Management Comments and OIG Analysis

In its response to our draft report, the Department concurred with all 10 recommendations. The Department identified issues it believed were not appropriately characterized in the report, which we have addressed below. During the audit, we reviewed DHS' response to the Ebola outbreak and the implementation of Ebola screening. DHS quickly mobilized its response to Ebola; however, it did not ensure all DHS staff conducting screening had the necessary training prior to the commencement of the Ebola screening. Although the screening and monitoring of passengers from Ebola-affected countries has declined, this report outlines deficiencies within the DHS Ebola screening process conducted during the Ebola outbreak. These deficiencies allowed passengers to enter the country without being fully screened and put DHS screening employees at a higher risk of exposure to Ebola.

DHS worked with the airline carriers and implemented a targeting system to funnel at-risk passengers from one of the Ebola-affected countries to five designated airports for Ebola screening. DHS protocols also required Ebola screening at all other ports of entry, not just those five airports. More than 2,000 passengers arrived at ports other than the five designated airports and were identified by CBP's targeting system or other referrals. However, not all ports received the enhanced Ebola training to conduct such screenings. DHS identified Ebola screening as the final check in a multi-layered approach in its response to Ebola. DHS invested significant resources for medical personnel to take temperatures, PPE, and other expenses. Yet the agency did so without ensuring adequate and timely training for necessary personnel, consistent guidance, and appropriate oversight. Although it is not DHS' mission to



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Department of Homeland Security

perform medical screening, it took on the responsibility to assist CDC and implement Ebola screening procedures as part of the United States domestic response. DHS should ensure it has provided sufficient training, guidance, and oversight to the employees involved in the screening process in order to protect themselves and the United States against the spread of Ebola.

DHS also criticized the OIG's identification of 169 passengers who did not undergo full Ebola screening. CBP provided information regarding these passengers, but could not provide sufficient documentation for us to verify that the passengers went through full Ebola screening. In addition, CBP identified inconsistencies and errors in the information entered into CBP's Ebola screening reporting tool. As a result, CBP cannot be assured its reporting of completed Ebola screening is accurate. Furthermore, in a separate review conducted by CBP, it identified several instances where full screening did not take place as required.

Recommendation 1: We recommend that the Deputy Secretary of DHS ensure DHS coordinates with HHS to update the current infectious disease MOU or create a new formalized document between the Departments that:

- a. is applicable to more infectious diseases than influenza, and
- b. fully outlines the agreed upon roles and responsibilities of each Department and component in the infectious disease response.

DHS Response: Concur. DHS Headquarters Office of General Counsel, in coordination with relevant Department components, including the Office of Health Affairs and CBP's Office of Field Operations (OFO), is working with HHS to update or replace the current infectious disease MOU, as appropriate. Estimated Completion Date (ECD): January 31, 2016.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that DHS and HHS have updated or replaced the current infectious disease MOU. The Department should also provide a copy of the new agreement, once implemented.

Recommendation 2: We recommend that the Deputy Secretary of DHS ensure CBP provides all ports of entry with the necessary guidance and resources to complete required infectious disease screenings, including Ebola.

DHS Response: Concur. As part of its preparations for the Ebola response, CBP OFO, in coordination with the CDC, began sending guidelines to CBP officers in the field regarding the Ebola crisis in West Africa and what to look for months before Ebola became a significant event in the United States. As the



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Department of Homeland Security

outbreak evolved, so did CDC and DHS guidance and training to CBP officers. The guidance and training information is available via an electronic reference library and online tutorials for application in current and future infectious disease response planning and implementation. Supporting documentation substantiating these actions was previously provided to the OIG. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation does not address the intent of the recommendation. This recommendation is unresolved and will remain open until the Department provides evidence that it has consolidated and integrated its guidance to ensure consistency and has provided the guidance to all ports of entry for Ebola screening.

Recommendation 3: We recommend that the Deputy Secretary of DHS ensure USCG update its *Ebola Virus Disease Planning Order* to include coordination with CBP, specifically ensuring CBP completes its Ebola screening before USCG boards vessels within 21 days of visiting Ebola-affected countries.

DHS Response: Concur. The USCG Deputy Commandant for Operations and Deputy Commandant for Mission Support have already initiated an update to the *Ebola Virus Disease Planning Order* and established a February 2016 target to review, update, and promulgate a revised planning order. In the interim period before the revised planning order is released to the field, the USCG will continue to exercise its proven risk-based assessment methodology to protect its workforce.

The August 2015 USCG Office of Commercial Vessel Compliance monthly Port State Control (PSC) message recommended that USCG PSC examiners coordinate with CBP prior to conducting any PSC examination on a vessel that visited an Ebola-affected country within its last five ports of call prior to arriving to the United States.

In 2014, more than 79,000 foreign vessels arrived in the United States. During the West African Ebola outbreak, less than 1 percent (200) of those vessels arriving in the United States had visited an Ebola-affected country within its last five ports of call.

Additionally, the majority of these arrivals were made after an oceanic voyage greater than the 21-day monitoring period as established by the CDC. USCG agrees that DHS should continually improve on unity of effort across the Department's components. DHS has established a "Unity of Effort" initiative in its 5-year strategic plan. The initiative is designed to improve overall



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

cooperation to best identify, investigate, and interdict any threat as early as possible.

The USCG has already implemented a significant framework of collaboration with other DHS Components to support key areas of effort to ensure the safety and security of the maritime transportation system. This effort also supports state, local, tribal, territorial, and regional governments while working closely with non-governmental organizations and the private sector to help leverage the resources they can bring to bear. The USCG will continue to leverage its Command Centers, Area Maritime Security Committees, Area Committees Intelligence community, liaison officers, and a contingent of skilled, professional, and dedicated uniformed service members to ensure the highest level of inter-department collaboration. ECD: March 31, 2016.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that the USCG has revised its *Ebola Virus Disease Planning Order* and a copy of the new planning order, once implemented.

Recommendation 4: We recommend that the Deputy Secretary of DHS ensure USCG revises training requirements to ensure its required members train in the use of CBRN equipment within conditions they may experience while performing missions.

DHS Response: Concur. The USCG Office of Specialized Capabilities (OSC) will include revised training and exercise requirements in a pending major revision of USCG CBRN Policy. USCG has already developed specific competencies and tasks related to CBRN PPE training. ECD: November 30, 2016.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that the USCG has revised and implemented its USCG CBRN Policy to allow USCG personnel to train in CBRN equipment within the conditions they may experience while performing missions.

Recommendation 5: We recommend that the Deputy Secretary of DHS ensure USCG updates its training capacity to meet its CBRN equipment training requirements within the required timeframes.

DHS Response: Concur. The USCG Maritime Law Enforcement Academy's Force Command will assess and modify training support contracts to increase



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Department of Homeland Security

the output in response to the *Ebola Virus Disease Planning Order*, as appropriate. USCG has already developed specific competencies and tasks related to CBRN PPE training. ECD: November 30, 2016.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that the USCG has modified its support contracts to increase training capacity to meet CBRN training requirements.

Recommendation 6: We recommend that the Deputy Secretary of DHS ensure USCG establishes CBRN training oversight to ensure all designated members have met CBRN equipment training requirements.

DHS Response: Concur. The USCG OSC has already developed specific competencies and tasks related to CBRN PPE training and individual personal competencies are documented in USCG's new training management system in order to track individual and unit readiness. ECD: February 29, 2016.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that the USCG has implemented revisions to its training management system in order to track individual and unit CBRN training requirements.

Recommendation 7: We recommend that the Deputy Secretary of DHS ensure CBP updates guidance and screening procedures to consistently outline the distance recommendations and PPE usage when necessary distance cannot be maintained during Ebola screening.

DHS Response: Concur. CBP OFO has already provided sufficient guidance to officers regarding the screening protocols, as well as scientifically factual information on Ebola. DHS guidance does not mandate a single distance requirement for all operational biological threat situations. DHS and CBP Ebola-specific guidance recommends a distance of 3 feet, if feasible, between employee and traveler, which aligns with CBP's Standard Operating Procedures for Serious Communicable and Quarantinable Diseases guidance of 6 feet or as directed, based on CDC guidance. The risk of infection for Ebola was low in the non-febrile individuals, and there was interagency support for CBP's decisions on distancing in the airports. Supporting documentation substantiating these actions was previously provided to OIG. We request that OIG consider this recommendation resolved and closed.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

OIG Analysis: The Department's response to this recommendation does not address the intent of the recommendation. This recommendation is unresolved and will remain open until the Department provides evidence that CBP has updated guidance and screening procedures to consistently outline the distance recommendations and PPE usage when necessary distance cannot be maintained during Ebola screening.

Recommendation 8: We recommend that the Deputy Secretary of DHS ensure CBP enhances its oversight process to ensure that reporting on Ebola screening is accurate and complete to meet screening requirements.

DHS Response: Concur. In November 2015, CBP OFO established a working group to create the oversight procedures described in this recommendation. According to the draft report, data provided by CBP indicate that 169 passengers with recent travel to an Ebola-affected country, who had arrived at outlying ports, were admitted into the United States without ensuring their temperatures were taken or otherwise being cleared by health professionals. CBP conducted an internal review of source documentation from the ports of entry for each of the passengers the audit team identified and established that these 169 travelers had been properly admitted after being evaluated by CBP officers and categorized as having:

- no identifiable risk under CDC policy,
- already been entered in CDC's health monitoring system,
- been deemed by CDC as not needing to have their temperature recorded, or
- been declined by the host nation public health authority to have their temperature taken at a preclearance site.

The review also found there were inconsistencies and errors in the manual transcription of source traveler admission data into CBP's data reporting tool, which may have contributed to a lack of clarity regarding the evaluation of these passengers, and CBP is making changes to improve the quality of this data through more robust collection processes. Specifically, OFO will implement a monthly data quality review to assure data integrity and accuracy of reporting. This data review will assist OFO with identifying any screening requirement deficiencies and establishing corrective actions as needed. ECD: December 31, 2015.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that CBP has enhanced its oversight process to ensure that reporting on



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Department of Homeland Security

Ebola screening is accurate and complete to meet screening requirements.

Recommendation 9: We recommend that the Deputy Secretary of DHS ensure CBP completes in-person PPE donning and doffing training at the remaining ports meeting CBP's risk-based criteria.

DHS Response: Concur. CBP OFO provided detailed training and appropriate protective equipment to its officers conducting enhanced Ebola screening, and developed additional online training resources for all CBP employees. CBP worked closely with the CDC to ensure appropriate guidelines and PPE were distributed to the field. CBP delivered hands-on enhanced screening training to approximately 4,500 officers at 25 airports and distributed screening guidance to all domestic and preclearance ports of entry. More than 36,000 CBP officers, agents and employees completed formal Ebola screening and PPE training. Additionally, all officers have standard "universal precautions" infection control training. As a result, not a single DHS employee contracted Ebola in the course of their duties.

In November 2015, CBP OFO conducted a review of all ports of entry using CBP "risk based criteria" as defined in the Ebola Training Plan dated November 20, 2014. CBP has determined its risk-based criteria to be those port of entry airports that have had three or more travelers who entered a U.S. port of entry airport from an Ebola-affected country within the past 21 days would require hands-on training. This "risk-based criteria" was defined by the CBP Office of Human Resources Management (HRM), Office of Safety and Health, the CBP Medical Advisor, and OFO.

Additionally, per the training, PPE needs to be donned and doffed when:

- a 21-day nexus has been established with a traveler,
- a traveler is symptomatic, and
- the officer is within 3 feet of the traveler during the traveler's examination by medical personnel.

CBP identified nine airports that meet the "risk based criteria" threshold as defined by the Ebola Training Plan, and an HRM Occupational Safety and Health safety specialist will provide hands-on training at each of those nine locations. ECD: June 30, 2016

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that the CBP has completed in-person PPE donning and doffing training at the remaining ports meeting CBP's risk-based criteria.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Recommendation 10: We recommend that the Deputy Secretary of DHS ensure components make PPE purchases based on component risks.

DHS Response: Concur. As required by the DHS Pandemic Workforce Protection Plan, Component and Headquarters (HQ) Occupational Safety and Health Managers, and where available, Medical Officers, will coordinate to perform a mission-based pandemic risk assessment once the overarching disease-specific risk assessment guidance is received from the DHS HQ Office of the Chief Human Capital Officer. Subsequent purchases of PPE will be based on the results of the risk assessments across the Department and will reflect the unique environments in which the components operate. To further strengthen this requirement and clearly state the need to base PPE purchases on risk assessments, the requirement was specifically highlighted in the DHS Integrated Logistics Support Plan (ILSP), published by the HQ Office of the Chief Readiness Support Office in July 2015.

The ILSP represents the specific pandemic PPE purchasing guidance that all components are now required to follow. Supporting documentation substantiating these actions was previously provided to OIG. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation does not address the intent of the recommendation. This recommendation is unresolved and will remain open until the Department provides evidence that components will make purchases based on component risks. The Department implemented component risk assessments; however, there is no assurance that components make purchases based upon the risks identified. Once the Department can provide evidence that it has implemented assurances to ensure components have implemented purchase plans aligned with risk assessments, OIG will review this recommendation for resolution and closure.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Appendix A

Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*. This is one of a series of audit, inspection, and special reports prepared as part of our oversight responsibilities to promote economy, efficiency, and effectiveness within the Department.

The objective of our review was to determine whether DHS has effectively implemented DHS' screening measures for a response to the Ebola outbreak. To achieve our objective, we reviewed applicable Federal laws, regulations, guidance, and the DHS memorandum of understanding with HHS. In addition, we reviewed applicable DHS policies and procedures for Ebola screening and identified the specific screening requirements. We identified the offices and components responsible for the Ebola response coordination, planning, and implementation. The audit covered DHS' Ebola response planning and screening efforts from April 2014 through June 2015.

We interviewed DHS officials within the Directorate for Management, the Office of Health Affairs, and the eight operational components to determine their role in the Ebola response. Specifically, we met with component officials from CBP, FEMA, U.S. Immigration and Customs Enforcement, TSA, USCG, National Protection and Programs Directorate, U.S. Citizenship and Immigration Services, and U.S. Secret Service. We met with component officials at field locations for CBP, TSA, and USCG. We also met with personnel from HHS.

To determine whether the Ebola screening requirements were always met, we reviewed CBP's guidance and created a data collection instrument to assist in documenting compliance at airports where screening was observed. We visited and met with CBP at the five airports first set up to conduct Ebola screening and observed screening at three of the five:

- John F. Kennedy International Airport (JFK) in New York;
- Washington-Dulles International Airport (IAD) in Virginia;
- Newark Liberty International Airport (EWR) in New Jersey;
- Chicago O'Hare International Airport (ORD) in Illinois; and
- Hartsfield-Jackson Atlanta International Airport (ATL) in Georgia.

In addition, we met with CBP and USCG at other ports of entry to determine how personnel were implementing Ebola screening at those locations. We



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

selected these additional locations based on the number of travelers from an Ebola-affected country and concerns identified by CBP. We met with CBP at the following domestic and international preclearance airport locations:

- Philadelphia International Airport, Philadelphia, PA;
- Miami International Airport, Miami, FL;
- Los Angeles International Airport, Los Angeles, CA;
- San Francisco International Airport, San Francisco, CA;
- Montreal Trudeau International Airport, Dorval, Quebec, Canada; and
- Toronto Pearson International Airport, Toronto, Ontario, Canada.

We also met with CBP at the Champlain, NY, land border station.

To determine whether DHS established procedures to ensure coordination between components for maritime activities involving vessels from Ebola-affected countries, we met with CBP and USCG at the following seaport locations:

- New Orleans, LA;
- Houston, TX;
- Corpus Christi, TX; and
- Point Comfort, TX.

To determine whether DHS employees received timely and adequate training, we assessed whether components had created training plans. We evaluated the guidance issued on Ebola screening and reviewed training records. We assessed component oversight by determining how component headquarters tracked and monitored training. Finally, we evaluated the effectiveness of the trainings by observing DHS employees perform the skills covered by trainings.

TSA does not have a primary role in the DHS Ebola response efforts; however, we met with TSA during our site visits to determine its role in Ebola response and as part of our ongoing audit of DHS pandemic workforce protection plans.

We relied on components to provide data regarding data on travelers from Ebola-affected countries and the data on training records. We determined these data were sufficient and adequate for the purposes of meeting our audit objective.

We conducted this performance audit between November 2014 and July 2015 pursuant to the *Inspector General Act of 1978*, as amended, and according to generally accepted government auditing standards. Those standards require



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based upon our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based upon our audit objectives.



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Appendix B
DHS Comments to the Draft Report


U.S. Department of Homeland Security
Washington, DC 20528



**Homeland
Security**

November 17, 2015

MEMORANDUM FOR: John Roth
Inspector General

FROM: Jim H. Crumpacker, CIA, CFE 
Director
Departmental GAO-OIG Liaison Office

SUBJECT: OIG Draft Report: "DHS' Ebola Response Needs Better
Coordination, Training, and Execution"
(Project No. 15-108-AUD-DHS)

Thank you for the opportunity to review and comment on this draft report. The U.S. Department of Homeland Security (DHS) appreciates the Office of Inspector General's (OIG) work in planning and conducting its review and issuing this report.

We are pleased to note OIG's recognition that the Department responded quickly to implement domestic Ebola screening through the U.S. Customs and Border Protection (CBP) with its other Federal partners. DHS, however, disagrees with the OIG's overall characterization of the Department's Ebola response as ineffective. It is important to note that not a single traveler with Ebola symptoms is known to have entered the country undetected. DHS does not believe the report acknowledges the thoughtful risk-based approach the Federal Government chose to take, and does not fully recognize the Department's successes in fielding a response that was both appropriate and effective, protecting the homeland—and its employees—from this terrible disease.

Enhanced Screening Protocols

In response to the 2014 Ebola outbreak across several West African countries, the President of the United States declared Ebola a national security priority and ordered his National Security Council (NSC) staff to mobilize a whole-of-government response to limit the risk of the disease reaching our country. This response included efforts by DHS and its component agencies, as well as the Department of Health and Human Services (HHS) and its Centers for Disease Control and Prevention (CDC), the Department of State (DOS), Department of Transportation (DOT), and the Department of Defense (DOD). The Federal Government made a unified decision to funnel passengers from Ebola-affected countries into the five airports where 94 percent of travelers from Ebola affected countries were already arriving, and provide enhanced screening at those at U.S.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

ports of entry. DHS collaborated with the CDC to establish an effective enhanced screening process in a short timeframe through thoughtful analysis and a strategic, risk-based approach. DHS also worked with the airline industry to have all flights with passengers originating from Ebola-affected countries make first entry into the United States at one of the five airports, ensuring that 100 percent of travelers CBP identified as flying directly from the affected countries went through enhanced screening.

Although it is CDC's statutory role and responsibility to provide medical screening at U.S. ports of entry, as applied in a 2005 memorandum of understanding (MOU) between DHS and HHS, the CDC did not have enough capacity to conduct enhanced screening due to overseas support in the Ebola-affected countries, an important first line of defense in the layered screening approach for preventing the spread of this disease. Therefore, DHS assumed the enhanced entry screening responsibility at five designated airports, in partnership with interagency leadership and close coordination with the CDC. Through a rapid but deliberate process overseen by the NSC and in collaboration with CDC and DHS, CBP agreed upon a set of roles and responsibilities for screening that exceeded CBP's traditional law enforcement mission. DHS also worked closely with DOS, DOD, DOT, and HHS to develop, refine, and execute joint protocols and procedures to transport, and process the arrival of, high-risk travelers from Ebola-affected countries.

This Ebola response highlighted some areas in which the MOU between DHS and HHS could be improved for future communicable disease responses, and DHS is working with HHS to make the appropriate adjustments. The report concludes that because enhanced screening is not specifically detailed in the MOU, no effective processes were in place. While specific operational guidelines were not developed for Ebola response as an addendum to the MOU (as was done for H5N1), the various procedural documents and advisories developed by DHS and CDC essentially acted as operational guidelines, meeting the spirit and intent of the MOU. The MOU purposely discusses DHS and HHS coordination with respect to quarantinable and serious communicable diseases broadly, which specifically includes Ebola per Executive Order 13295, "Revised List of Quarantinable Communicable Diseases," dated April 2003, which provides the flexibility needed for its application to a wide variety of potential emerging infectious diseases. Protocols and responsibilities for the U.S. Government's Ebola response were also discussed and agreed upon during numerous interagency meetings.

Risk-Based Approach

Since the enhanced screening protocols were established in October 2014, DHS has screened more than 38,000 travelers from Ebola affected countries, and there have been no known instances of a person with Ebola symptoms entering the country undetected. Passengers at risk of developing Ebola symptoms were identified by CBP, then monitored by CDC and local public health officials using traveler contact information



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

collected by CBP during enhanced screening. The system put in place by DHS and CDC worked as designed to protect the Nation.

DHS's screening at ports of entry was the final check, in conjunction with CDC's efforts in Ebola-affected countries, of a multi-layered approach to protect against the spread of Ebola. This process used a risk-based approach to focus resources where they would have the most impact and greatest likelihood of keeping our Nation safe. Therefore, the primary U.S. effort was directed toward implementing enhanced screening at the five airports, while other risk-appropriate protections were put in place at additional ports of entry. The Federal Government never intended to implement enhanced screening at every U.S. port of entry.

Examples raised by the OIG regarding variation in training and protocol execution at ports of entry other than the five airports conducting enhanced screening were from locations scattered across the country where small numbers of travelers entered, and where travelers were not directly coming from Ebola-affected countries. This relatively small group, which included many travelers holding passports from Ebola-affected countries or those with recent Ebola-affected country travel patterns, were targeted by CBP as a precaution and accounted for only about 10 percent of the travelers identified and screened by CBP.

The draft report states that CBP released 169 passengers with recent travel to Ebola-affected countries from outlying ports without having their temperatures taken. CBP previously provided the OIG with the source documentation showing that each of the 169 passengers presented no overt risk factors. Additionally, these travelers were released only after consultation with CDC or local public health officials, were already being monitored by public health, or were released after CBP officers determined the travelers demonstrated no overt risk factors. Given the small percentage of the traveling population this represents compared to those receiving full enhanced screening at the five designated airports, the OIG's attention to these few isolated low-risk cases seems disproportionate to the overall characterization of DHS's effective Ebola response.

Conclusion

DHS is drafting a comprehensive Ebola after action report to capture lessons learned and improve the Nation's response to emerging infectious diseases, and will consider the recommendations in this report as part of that process. However, based on the great successes of the enormous efforts undertaken by DHS to cover requirements outside of its traditional roles and responsibilities, the Department is justifiably proud of its coordinated, flexible, fast-moving, and quantifiably effective response to this unprecedented public health emergency. DHS was thoughtful, agile, and mission-focused—and we were 100 percent successful in protecting the Nation from Ebola while keeping our employees safe.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

The report contained ten recommendations, with which DHS concurs. Specifically, OIG recommended that the Deputy Secretary of DHS ensure the following:

Recommendation 1: DHS coordinates with HHS to update the current infectious disease MOU or create a new formalized document between the Departments that:

- a) is applicable to more infectious diseases than influenza, and
- b) fully outlines the agreed upon roles and responsibilities of each Department and component in the infectious disease response.

Response: Concur. DHS Headquarters Office of General Counsel, in coordination with relevant Department Components including the Office of Health Affairs and CBP's Office of Field Operations (OFO), is working with HHS to update or replace the current infectious disease MOU, as appropriate. Estimated Completion Date (ECD): To Be Determined (TBD).

Recommendation 2: CBP provides all ports of entry with the necessary guidance and resources to complete required infectious disease screenings, including Ebola.

Response: Concur. As part of its preparations for the Ebola response, CBP OFO, in coordination with the CDC, began sending guidelines to CBP officers in the field regarding the Ebola crisis in West Africa and what to look for months before Ebola became a significant event in the United States. As the outbreak evolved, so did CDC and DHS guidance and training, in turn, to CBP officers. The guidance and training information is available via an electronic reference library and online tutorials for application in current and future infectious disease response planning and implementation.

Supporting documentation substantiating these actions was previously provided to the OIG. We request that OIG consider this recommendation resolved and closed.

Recommendation 3: U.S. Coast Guard (USCG) update its Ebola Virus Disease Planning Order to include coordination with CBP, specifically ensuring CBP completes its Ebola screening on those vessel arrivals meeting CBP's risk-based criteria for Ebola before USCG boards vessels within 21 days of visiting Ebola affected countries.

Response: Concur. The USCG Deputy Commandant for Operations and Deputy Commandant for Mission Support have already initiated an update to the Ebola Virus Disease Planning Order and established a February 2016 target to review, update, and promulgate a revised planning order. In the interim period before the revised planning order is released to the field, the USCG will continue to exercise its proven risk-based assessment methodology to protect its workforce.



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The August 2015 USCG Office of Commercial Vessel Compliance monthly Port State control (PSC) message recommended that USCG PSC examiners coordinate with CBP prior to conducting any PSC examination on a vessel that visited an Ebola-affected country within its last five ports of call prior to arriving to the United States.

In 2014, more than over 79,000 foreign vessels arrived in the United States. During the West African Ebola outbreak, less than 1 percent (~200) of those vessels arriving in the United States had visited an Ebola-affected country within its last five ports of call. Additionally, the majority of these arrivals were made after an oceanic voyage greater than the 21-day monitoring period as established by the CDC.

USCG agrees that DHS should continually improve on unity of effort across the Department's Components. DHS has established a "Unity of Effort" initiative in its 5-year strategic plan. The initiative is designed to improve overall cooperation to best identify, investigate, and interdict any threat as early as possible.

The USCG has already implemented a significant framework of collaboration with other DHS Components to support key areas of effort to ensure the safety and security of the maritime transportation system. This effort also supports state, local, tribal, territorial, and regional governments while working closely with nongovernmental organizations and the private sector to help leverage the resources they can bring to bear. The USCG will continue to leverage its Command Centers, Area Maritime Security Committees, Area Committees Intelligence community, liaison officers, and a contingent of skilled, professional, and dedicated uniformed service members to ensure the highest level of inter-department collaboration. ECD: March 31, 2016.

Recommendation 4: USCG revises training requirements to ensure its members train in the use of chemical, biological, radiological and nuclear (CBRN) equipment within conditions they may experience while performing missions.

Response: Concur. The USCG Office of Specialized Capabilities (OSC) will include revised training and exercise requirements in a pending major revision of USCG CBRN Policy. USCG has already developed specific competencies and tasks related to CBRN PPE training. ECD: November 30, 2016.

Recommendation 5: USCG updates its training capacity to meet its CBRN equipment training requirements within the required timeframes.

Response: Concur. The USCG Maritime Law Enforcement Academy's Force Command will assess and modify training support contracts to increase the output in response to the Ebola Planning Order, as appropriate. USCG has already developed specific competencies and tasks related to CBRN PPE training. ECD: November 30, 2016.



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Department of Homeland Security

Recommendation 6: USCG establishes CBRN training oversight to ensure all its members have met CBRN equipment training requirements.

Response: Concur. The USCG OSC has already developed specific competencies and tasks related to CBRN personal protective equipment (PPE) training and individual personal competencies are documented in USCG's new training management system in order to track individual and unit readiness. ECD: February 29, 2016.

Recommendation 7: CBP updates guidance and screening procedures, to consistently outline the distance recommendations and PPE usage when necessary distance cannot be maintained during Ebola screening.

Response: Concur. CBP OFO has already provided sufficient guidance to officers regarding the screening protocols, as well as scientifically factual information on Ebola. DHS guidance does not mandate a single distance requirement for all operational biological threat situations. DHS and CBP Ebola-specific guidance recommends a distance of three feet, if feasible, between employee and traveler, which aligns with CBP's Standard Operating Procedures for Serious Communicable and Quarantinable Diseases guidance of six feet or as directed, based on CDC guidance. The risk of infection for Ebola was low in the non-febrile individuals, and there was interagency support for CBP's decisions on distancing in the airports.

Supporting documentation substantiating these actions was previously provided to the OIG. We request that OIG consider this recommendation resolved and closed.

Recommendation 8: CBP enhances its oversight process to ensure that reporting on Ebola screening is accurate and complete to meet screening requirements.

Response: Concur. In November 2015, CBP OFO established a working group to create the oversight procedures described in this recommendation. The draft report states that data provided by CBP indicate that 169 passengers with recent travel to Ebola affected countries who had arrived at outlying ports were admitted into the United States without ensuring their temperatures taken or otherwise cleared by health professionals. CBP conducted an internal review of source documentation from the ports of entry for each of the passengers the audit team identified and established that these 169 travelers had been properly admitted after being evaluated by CBP officers and categorized as having:

- no identifiable risk under CDC policy,
- the traveler was already in CDC's health monitoring system,
- CDC deemed the recording of the temperature as unnecessary, or
- the host nation public health authorities declined to take the traveler's temperature at a preclearance site.



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The review also found there were inconsistencies and errors in the manual transcription of source traveler admission data into CBP's data reporting tool, which may have contributed to a lack of clarity over the evaluation of these passengers, and CBP is making changes to improve the quality of this data through more robust collection processes. Specifically, OFO will implement a monthly data quality review to assure data integrity and accuracy of reporting. This data review will assist OFO with identifying any screening requirement deficiencies and establishing corrective actions as needed. ECD: December 31, 2015.

Recommendation 9: CBP completes in-person PPE donning and doffing training at the remaining ports meeting CBP's risk-based criteria.

Response: Concur. CBP OFO provided detailed training and appropriate protective equipment to its officers conducting enhanced Ebola screening, and developed additional online training resources for all CBP employees. CBP worked closely with the CDC to ensure appropriate guidelines and PPE were distributed to the field. CBP delivered hands-on enhanced screening training to approximately 4,500 officers at 25 airports, and distributed screening guidance to all domestic and preclearance ports of entry. Over 36,000 CBP officers, agents and employees completed formal Ebola screening and PPE training. Additionally, all officers have standard "universal precautions" infection control training. As a result, not a single DHS employee contracted Ebola in the course of their duties.

In November 2015, CBP OFO conducted a review of all ports of entry using CBP "risk based criteria" as defined in the Ebola Training Plan dated November 20, 2014. CBP has determined its risk-based criteria to be those port of entry airports that have had three or more travelers who entered a U.S. port of entry airport from an affected Ebola country within the past 21 days would require hands on training. This "risk based criteria" was defined by the CBP Office of Human Resources Management (HRM), Office of Safety and Health, the CBP Medical Advisor, and OFO.

Additionally, per the training, PPE needs to be donned and doffed when:

- A 21-day nexus has been established with a traveler,
- Traveler is symptomatic, and
- The officer is within three feet during examination by medical personnel.

CBP identified nine airports that meet the "risk based criteria" threshold as defined by the Ebola Training Plan, and an HRM Occupational Safety and Health, safety specialist will provide hands on training at each of those nine locations. ECD: June 30, 2016



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Recommendation 10: Components make PPE purchases based on component risks.

Response: Concur. As required by the DHS Pandemic Workforce Protection Plan, Component and HQ Occupational Safety and Health Managers, and where available Medical Officers, will coordinate to perform a mission-based pandemic risk assessment once the overarching disease-specific risk assessment guidance is received from the DHS HQ Office of the Chief Human Capital Officer. Subsequent purchases of PPE will be based on the results of the risk assessments across the Department and will reflect the unique environments in which the Components operate. To further strengthen this requirement, and clearly state the need to base PPE purchases on risk assessments, the requirement was specifically highlighted in the DHS Integrated Logistics Support Plan (ILSP), published by the HQ Office of the Chief Readiness Support Office in July 2015. The ILSP represents the specific pandemic PPE purchasing guidance that all Components are now required to follow.

Supporting documentation substantiating these actions was previously provided to the OIG. We request that OIG consider this recommendation resolved and closed.

Again, thank you for the opportunity to review and comment on this draft report. Technical comments were previously provided under separate cover. Please feel free to contact me if you have any questions. We look forward to working with you in the future.



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Appendix C

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Appendix D **Report Distribution**

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