

**Special Report: Review
Regarding DHS OIG's
Retraction of Thirteen
Reports Evaluating FEMA's
Initial Response to
Disasters**





DHS OIG HIGHLIGHTS

Review Regarding DHS OIG's Retraction of Thirteen Reports Evaluating FEMA's Initial Response to Disasters

May 23, 2019

Why We Did This Special Report

After Congress raised concerns about the accuracy of the findings and conclusions in DHS OIG's report on *FEMA's Initial Response to Catastrophic Flooding in Louisiana* (OIG-17-80-D), we conducted an internal review to determine the root causes of the deficiencies identified in that report and twelve similar DHS OIG reports purporting to evaluate the Federal Emergency Management Agency's initial response to certain declared disasters.

What We Recommend

We recommend that DHS OIG take steps to improve its internal controls and quality assurance processes to safeguard against the deficiencies identified by the internal review.

For Further Information:

Contact our Office of Public Affairs at (202) 981-6000, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov.

What We Found

The thirteen reports DHS OIG retracted and removed from its website were not compliant with applicable standards. The deficiencies in the retracted reports were the result of: (a) several key changes to DHS OIG's approach to early deployment oversight work that were poorly communicated and managed by senior leaders, (b) a flawed report model, and (c) internal control failures, including in the areas of audit planning, supervision, and independent referencing. This combination of factors led DHS OIG to publish thirteen reports concluding that the Federal Emergency Management Agency's initial response to certain declared disasters was efficient and/or effective despite lacking sufficient and appropriate evidence to support that conclusion.

DHS OIG's Response

DHS OIG concurred with the five recommendations in this report and described corrective actions it has taken, is taking, and plans to take, to address them. Appendix B provides DHS OIG's management response in its entirety.



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Department of Homeland Security

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

May 23, 2019

MEMORANDUM FOR: Jennifer L. Costello
Deputy Inspector General

FROM: Diana R. Shaw 
Assistant Inspector General
for Special Reviews and Evaluations

SUBJECT: Special Report: *Review Regarding DHS OIG's
Retraction of Thirteen Reports Evaluating FEMA's
Initial Response to Disasters*

In July 2017, the Department of Homeland Security (DHS) Office of Inspector General (OIG) retracted an Emergency Management Oversight Team (EMOT) report after the House Committee on Oversight and Government Reform (HOCR) raised concerns about the accuracy of the report's findings and conclusions. After conducting a preliminary quality assurance review of similar EMOT reports, DHS OIG retracted an additional twelve reports in March 2018 due to similar concerns.

At a meeting with HOCR members in March 2018, Acting Inspector General John V. Kelly stated that DHS OIG would conduct an internal review of the circumstances surrounding the retracted reports to better understand the factors giving rise to the deficiencies identified in them. Because Mr. Kelly was involved in overseeing the EMOT work at issue, he recused himself from the matter and delegated authority to me as the then-Acting Counsel to conduct the internal review and help develop a corrective action plan.

The following report summarizes the results of our internal review. This report, along with your management response, is being distributed to the DHS Secretary and our congressional oversight committees, and will be posted on DHS OIG's website.



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BACKGROUND

Congress established Offices of Inspector General to ensure integrity and efficiency in government through independent and objective oversight of Federal agencies. Since 2003, DHS OIG has provided oversight for the operational and support components comprising the Department of Homeland Security. DHS OIG's former Office of Emergency Management Oversight (EMO) conducted audits and other reviews of DHS' disaster response efforts.¹ EMO's oversight work included auditing Federal Emergency Management Agency (FEMA) grants awarded to state and local governments, conducting performance audits of FEMA's operations, and sending Emergency Management Oversight Teams (EMOT) to evaluate FEMA's initial response to declared disasters.

Between fiscal years 2010 and 2017, EMO issued a series of EMOT reports. In July 2017, DHS OIG retracted and removed from its website an EMOT report regarding FEMA's initial response to catastrophic flooding in Louisiana (OIG-17-80-D) after the House Committee on Oversight and Government Reform (HOCR) raised concerns about the accuracy of the report's findings and conclusions. After conducting a preliminary quality assurance review of similar EMOT reports, DHS OIG retracted and removed from its website an additional twelve reports in March 2018 due to similar concerns.²

On March 6, 2018, members of HOCR met with DHS OIG's Acting Inspector General John V. Kelly to discuss the retracted reports. They asked whether the deficiencies that necessitated the retraction of the reports were the result of a "people problem," a "process problem," or

¹ In 2017, EMO's staff and portfolio of work was absorbed within DHS OIG's Office of Audits.

² *FEMA's Initial Response to Hurricane Isaac in Louisiana was Effective and Efficient* (OIG-13-84); *FEMA's Initial Response in New Jersey to Hurricane Sandy* (OIG-13-117); *FEMA's Initial Response in New York to Hurricane Sandy* (OIG-13-124); *FEMA's Initial Response to the Oklahoma Severe Storms and Tornadoes* (OIG-14-50-D); *FEMA's Initial Response to the Colorado Flood* (OIG-14-111-D); *FEMA Provided an Effective Response to the Napa, California, Earthquake* (OIG-15-92-D); *FEMA's Initial Response to the 2014 Mudslide near Oso, Washington* (OIG-15-102-D); *FEMA's Initial Response to Severe Storms and Flooding in Michigan* (OIG-15-105-D); *FEMA's Initial Response to the Severe Storms and Flooding in South Carolina* (OIG-16-53-D); *FEMA's Initial Response to the 2015 Texas Spring Severe Storms and Flooding* (OIG-16-85-D); *FEMA was Generally Effective in its Initial Response to the Severe Wildfires in California* (OIG-16-106-D); and *FEMA's Initial Response to the Severe Storms and Flooding in West Virginia DR-4273* (OIG-17-37-D).



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some combination of the two. Mr. Kelly assured the Committee that DHS OIG would undertake an objective internal review of the matter and report its findings to the Committee.

An internal review team (Review Team) consisting of investigative counsel and analysts was established in March 2018 to investigate and report on the root causes giving rise to the deficiencies identified in the reports.³ The Review Team also engaged the services of an auditing firm to get an outside evaluation of the reports at issue and independent guidance on industry standards and best practices related to auditing. The following sections summarize the Review Team's findings and recommendations for corrective action.

SUMMARY OF FINDINGS

The Review Team evaluated the entire series of EMOT reports published by DHS OIG through 2017.⁴ That review revealed that DHS OIG had historically done early deployment work on disaster response without the concerns raised by the withdrawn EMOT reports. A leadership change in EMO in late 2011, however, led to four notable changes in how EMOT deployments were conducted. Those changes were poorly communicated to staff and not well managed by EMO's senior leaders, including Mr. Kelly and several former DHS OIG employees, and resulted in a flawed approach to this work that lacked necessary planning and criteria. As that new EMOT model was cemented into place, EMO personnel began to think of EMOT reports as "feel good" reports — i.e., generally positive reports that typically concluded that FEMA's initial response to a disaster was effective. Deficiencies in EMO's internal controls system and quality assurance processes — including in the areas of audit planning, supervision, and independent referencing — resulted in a failure to identify and correct the issues with the EMOT product line, thus necessitating retraction of the thirteen reports.

³ Because Mr. Kelly was involved in overseeing the EMOT work at issue, he recused himself from the matter and delegated authority to then-Acting Counsel, Diana Shaw, to make all decisions with respect to the review and to perform all functions necessary to complete the review, including developing and issuing recommendations for potential corrective action.

⁴ DHS OIG has not published any EMOT reports since 2017.



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A. The Evolution of EMOTs

OIGs have historically recognized that an important part of oversight work involves evaluating emergency preparedness and response operations. For instance, FEMA OIG deployed personnel to New York City in the immediate aftermath of the 9/11 terrorist attack in 2001, and DHS OIG deployed personnel to various sites on the Gulf Coast after Hurricane Katrina in 2005.

After Katrina, and coinciding with Congress' enactment of the *Post-Katrina Emergency Management Reform Act of 2006*, DHS OIG started to formalize an early deployment model for disaster oversight. This early deployment model envisioned sending a skilled team of DHS OIG personnel to the site of a disaster to observe FEMA's on-the-ground activities. This work also sought to deter fraud, waste, and abuse by establishing an on-site presence during the disaster response phase of FEMA's work. The goal was to help FEMA get out ahead of issues before they became multi-million-dollar problems years later.

The first deployments under this early deployment model were not treated as OIG audits, which are subject to the U.S. Government Accountability Office's Government Auditing Standards (also referred to as "Yellow Book" standards), nor did they always result in the issuance of a report to FEMA. Their stated objective was to promote effectiveness and efficiency in FEMA's response. The three reports DHS OIG issued under this early model identified concerns and contained recommendations for action by FEMA.⁵ The reports did not purport to be audit reports prepared to Yellow Book standards.

B. Four Notable Changes to the EMOT Model Led to a Flawed Approach

In late 2011, a leadership change in EMO brought about four notable changes to the EMOT model that, ultimately, set the work off course and resulted in a flawed product line.

⁵ DHS OIG, *Management Advisory Report: FEMA's Response to Hurricane Ike* (OIG-09-78); DHS OIG, *Management Advisory Report: Permanent Housing Construction on American Samoa* (OIG-10-74); DHS OIG, *American Samoa 2009 Earthquake and Tsunami: After-Action Report* (OIG-11-03).



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First, the new Assistant Inspector General (AIG) for EMO, D. Michael Beard, and the new Acting Deputy AIG for EMO, Mr. Kelly,⁶ decided that EMOT deployments would always result in the issuance of a report to FEMA, which had not been the case previously.⁷

Second, Mr. Kelly decided that reports issued following EMOT deployments should be issued under Yellow Book standards. However, the first few teams whose work was impacted by this change were not aware of this decision when they deployed. As a result, while performing their fieldwork, they did not know they were expected to conduct the work to the Yellow Book's audit requirements. Further, these teams used EMOT-related guidance documents that were not designed to be an audit guide and were not designed to result in a Yellow Book-compliant audit report. For instance, these guidance documents directed teams simply to answer five questions, such as, "What were the most pressing challenges FEMA faced in this disaster?" Even though DHS OIG undertook thirteen EMOT deployments between 2012 and 2017, these documents were not revised to ensure they would result in Yellow Book-compliant audit work and audit reports.

Third, the objective of EMOTs shifted from *promoting* effectiveness and efficiency to *evaluating* whether FEMA's initial disaster response was effective and efficient. Notwithstanding this change in the objective, DHS OIG did not identify criteria that would have allowed it to adequately evaluate FEMA's effectiveness and efficiency. Audit "criteria" provides a baseline against which a program or activity can be evaluated, and the identification of suitable criteria is an essential component of conducting a Yellow Book-compliant audit.⁸

Fourth, several factors led to a formulaic approach to the drafting of EMOT reports that resulted in reports with a generally positive focus. As

⁶ Mr. Kelly became the permanent Deputy AIG for EMO in 2012. In 2013, he became the AIG for EMO.

⁷ DHS OIG has determined that, in light of the issues addressed in this report, the public interest in disclosure outweighs the personal privacy interest of certain of the individuals referenced herein. Accordingly, because significant public benefit would result from disclosure of the information contained in this report, DHS OIG has released the names of the senior-most decision-makers associated with this matter.

⁸ U.S. Government Accountability Office, *Government Auditing Standards* (2018 Revision), at pp. 113-115. An example of criteria in the disaster response context could be, for instance, how many individuals received assistance within the first 72 hours of a disaster.



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the new approach to EMOT work was being refined, there was a common view within EMO leadership that FEMA handled its disaster response duties especially well, even if it tended to fall short in other areas. Specifically, a former DHS OIG employee who led early EMOT work under this new approach and later oversaw all EMOTs after being promoted by Mr. Kelly (referred to herein as Senior Employee 1 (“SE1”)), was particularly impressed with FEMA’s dedication and work ethic in responding to disasters, and conveyed that view to staff.

Mr. Kelly similarly shared this view about FEMA’s disaster response work and conveyed that view to staff. For instance, prior to deploying to a disaster, one EMOT staff member recalled Mr. Kelly telling him he would see “FEMA at her best,” a statement the staff member later repeated to other EMO staff. Statements like this risked fueling a preconceived notion among staff that FEMA’s response on any given disaster was likely to be effective and efficient, which could have impaired their objectivity while performing their oversight work.

In addition to espousing a general opinion that FEMA typically handled the initial response to a disaster well, Mr. Kelly made a critical decision about what information would and would not be included in EMOT reports, which further fueled the notion that EMOT reports were intended to be positive. He decided that if EMOTs identified significant systemic issues while deployed, those issues would be carved out of the report on the initial response, and DHS OIG would issue separate “spin-off” reports on those issues. When asked by the Review Team why he decided to carve out such issues, he stated that believed it was preferable to issue a “clean report” for EMOTs because he thought a report with a single message would be clearer and less likely to get lost or be ignored by FEMA. However, it does not appear that he explained his rationale to EMO staff, who did not understand why they were being instructed not to include some of the more significant findings in their EMOT reports.

According to Mr. Kelly, he also believed “spin-off” reports could better address systemic issues within FEMA that were not specific to the initial local disaster response effort, since DHS OIG’s EMOT reports after a deployment were often addressed to the FEMA region involved in the disaster, not FEMA Headquarters. He reasoned it would not be appropriate to make recommendations regarding systemic issues to regional personnel. However, at least some reports issued under this new EMOT model opined on “FEMA’s” disaster response without limiting the conclusion to the particular FEMA region under review.



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Ultimately, because the more serious and significant issues were “spun-off” into later reports, EMOT deployment reports were left communicating a largely positive message.

C. Implementation of Those Notable Changes

To understand how these decisions were communicated to EMOT personnel and impacted EMOT work, the Review Team examined the histories of each EMOT report produced under the new approach. This retrospective review revealed a pattern across EMOT projects — while the EMOT teams deployed to the field did not always set out to perform “feel good” work, when the time came to issue a report, the reports unerringly reached the same positive conclusion. The following examples of particular EMOT projects illustrate how this pattern began and perpetuated, ultimately resulting in a flawed product line.

1. Hurricane Isaac EMOT, 2012

In the fall of 2012, an EMOT deployed to Louisiana in response to Hurricane Isaac. The team initially planned to report on several issues that they believed supported recommendations for corrective action. However, the EMOT director, SE1, instructed the team that Mr. Kelly wanted to “downplay all the negatives” in the report because FEMA’s “overall” response to the disaster was “good.”⁹ The team was therefore instructed to “[t]alk about the things [FEMA] did right and their accomplishments, then maybe list the negatives in bullets — no recommendations unless you have evidence that these things are systemic.” SE1 further instructed the team that Mr. Kelly wanted the EMOT report “to be positive with no recommendations.” Based on these instructions, the team produced a report that concluded that FEMA’s initial response to Hurricane Isaac was overall effective and efficient, and contained no recommendations.¹⁰ This report served as a model for subsequent EMOT reports.

⁹ The Review Team found no written documentation confirming that Mr. Kelly had, in fact, issued instructions consistent with SE1’s representations. However, when interviewed as part of this internal review, Mr. Kelly did not disagree with SE1’s representations; rather, his statements established that SE1’s representations were generally consistent with his thinking about how EMOT work should be reported. He acknowledged, however, that the statement “downplay all the negatives” could be problematic if taken out of context.

¹⁰ OIG-13-84.



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2. Hurricane Sandy EMOTs, 2013

While the Isaac EMOT report was being drafted, two other EMOTs were on deployments to New York and New Jersey to evaluate FEMA's response to Hurricane Sandy. After the Sandy teams completed their fieldwork, Mr. Kelly emailed the draft Isaac report to the directors of those teams, stating: "[g]iven that FEMA's initial response was generally good for both disasters at all locations it would be best if all three reports were similar."

The Review Team found that sharing the Isaac report with the Sandy teams and encouraging them to prepare similar reports for each of their deployments contributed to the development of the concept of "feel good" reporting on EMOTs. Indeed, three months after Mr. Kelly sent the email about the Isaac report, a team member on the New York Sandy EMOT referred to the New York report as a "feel good" report.¹¹

Eventually, EMOT reports came to be commonly understood throughout EMO as "feel good" reports. While never officially defined, the notion of a "feel good" report came to serve as shorthand for four key elements:

- (1) the overall conclusion of an EMOT report would be that FEMA's disaster response was "effective and efficient";
- (2) the report would not include recommendations;
- (3) if the report identified challenges, it would note how FEMA overcame them; and
- (4) other negative information, if systemic, would be removed from the report and placed in a separate report.

Both Sandy teams produced reports along the above lines, concluding that FEMA provided an effective and efficient response and containing no recommendations.¹² Consistent with Mr. Kelly's instructions, however, three spin-off reports were issued as a result of the Sandy deployments related to housing and management issues, two of which contained recommendations.¹³

¹¹ This is the earliest reference to this term identified by the Review Team.

¹² OIG-13-117; OIG-13-124.

¹³ See DHS OIG, *FEMA's Sheltering and Temporary Essential Power Pilot Program* (OIG-13-15); DHS OIG, *The State of New York Needs To Sign Mission Assignment More*



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3. Oklahoma EMOT, 2013

The next EMOT was deployed to evaluate FEMA's response to a disaster in Oklahoma. Upon completing its fieldwork, the team initially drafted a report containing findings and recommendations. However, SE1 instructed the team to remove systemic issues from the report so they could be addressed in a spin-off report.¹⁴ In an email on which Mr. Kelly was copied, SE1 instructed the EMOT director to "read the other EMOT reports – Isaac, Sandy NY, Sandy NJ. These are feel-good reports to tell the public how well FEMA initially responds to disasters. Yes, we will identify some problems, but the point is – how did FEMA overcome them?" The email further states that "EMOT deployments present wonderful opportunities to identify systemic problems, but the EMOT report is not the place to discuss the problems in detail. These opportunities allow us to write quick, meaningful reports that actually help FEMA, and FEMA usually loves the reports." Mr. Kelly did not respond to this email to clarify or correct any of the statements in it.¹⁵

Much like the Isaac and Sandy reports, the conclusion of the Oklahoma report was that FEMA's initial disaster response was effective.¹⁶ The report contained no recommendations. The report stated OIG would issue separate reports, which it did. The spin-off reports contained recommendations.¹⁷

Quickly (OIG-13-85); DHS OIG, *FEMA's Process for Selecting Joint Field Offices Needs Improvement* (OIG-15-128-D).

¹⁴ By this time, SE1 had been promoted by Mr. Kelly to a position overseeing all EMOT work.

¹⁵ This is the only document the Review Team identified indicating that Mr. Kelly was on notice of the use of the term "feel good" in connection with EMOT reports. The Team did not uncover any evidence that he used the phrase "feel good" (or anything similar) in writing. The Team received conflicting testimonial evidence as to whether Mr. Kelly ever used the phrase in conversation, with one employee recalling that he did, and other OIG personnel stating that he did not. Mr. Kelly stated that he may have heard the term "feel good" in reference to EMOT reports, but he did not believe use of the term necessarily indicated that the reports were not truthful and accurate. With respect to this particular email, however, he stated that, upon re-reading it, it seemed to indicate a potential impairment of independence on the part of SE1.

¹⁶ OIG-14-50-D.

¹⁷ See DHS OIG, *FEMA's Dissemination of Procurement Advice Early in Disaster Response Periods* (OIG-14-46-D); DHS OIG, *Mitigation Planning Shortfalls Precluded FEMA Hazard Mitigation Grants to Fund Residential Safe Room Construction During the Disaster Recovery Phase* (OIG-14-110-D); DHS OIG, *FEMA Can Enhance Readiness with Management of Its Disaster Incident Workforce* (OIG-16-127-D).



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4. **Colorado EMOT, 2013**

Around the same time as the Oklahoma EMOT, a separate team was working on drafting a report in connection with FEMA’s response to a disaster in Colorado. As with the Oklahoma EMOT, members of the team sought to include concerns in the report, but those efforts were ultimately rebuffed. One member reached out to Mr. Kelly directly to advocate for a different, harder-hitting approach on the Colorado EMOT report. He memorialized the discussion in an email, stating that he had explained to Mr. Kelly that he was “on track to generate an EMOT report full of significant (and systemic) issues and actionable recommendations (alongside positive aspects). I told [Mr. Kelly] that it will not resemble the first two EMOT reports. He said, ‘Okay,’ so I’m proceeding with working toward that goal.”

A few weeks later, however, the team was instructed by SE1 that Mr. Kelly “really does not want serious issues discussed in the EMOT report. He prefers we issue a ‘feel-good’ report with no recommendations on FEMA’s initial response – not that you cannot mention problems, but focus on how FEMA dealt with problems to respond as its mission demands. He wants several smaller [reports] issued on immediate issues” The team member who had initially wanted to prepare a report full of significant issues and actionable recommendations ultimately acquiesced, writing to SE1: “Yes – we remember and that’s our priority for this report. We commend FEMA on a job well done. We identify various problems and how FEMA overcame those challenges (which also establishes opportunities for future reports). There will be no recommendations.”

Much like the four EMOT reports before it, the conclusion of the Colorado report was that FEMA’s disaster response was effective and efficient. As with the earlier reports, it contained no recommendations. This work led to separate reports on FEMA’s Disaster Assistance Helpline and staffing issues, which did include recommendations.¹⁸

¹⁸ See DHS OIG, *FEMA Should Take Steps To Improve the Efficiency and Effectiveness of the Disaster Assistance Helpline for Disaster Survivors That Do Not Speak English or Spanish* (OIG-14-118-D); DHS OIG, *FEMA Can Enhance Readiness with Management of Its Disaster Incident Workforce* (OIG-16-127-D).



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D. Subsequent EMOTs

Each of the five EMOT reports discussed above shared the common elements of a “feel good” report: (1) the conclusion that FEMA’s disaster response was effective and efficient; (2) no recommendations; (3) challenges discussed in terms of how they were overcome; and (4) systemic issues carved out for spin-off reports. The teams who worked on an additional eight EMOTs between 2015 and 2017 subscribed to this same approach for EMOT reporting.¹⁹

The final report in this series, *FEMA’s Initial Response to Catastrophic Flooding in Louisiana* (OIG-17-80-D), was issued in June 2017. The team who prepared the report was instructed that EMOT reports typically did not have findings or recommendations, and that they should stick to the same format in their reporting. Although the team discussed producing a robust report, the draft the team produced fit the mold of earlier EMOT reports — it contained a positive conclusion and no recommendations. Additionally, as the draft was being revised, the EMOT director made several material changes to the draft without ensuring that the changes were supported by sufficient and appropriate evidence. For instance, he added superlative language like “aggressively,” “remarkable,” and “creatively” to describe FEMA’s disaster response efforts, and changed the overall conclusion of the report from “generally efficient and well organized” to “effective.” He also added language discounting complaints about FEMA’s disaster response. None of the DHS OIG senior leaders who reviewed and approved this report corrected these issues.

When the report was published, HOCR staff members, who also happened to be in Louisiana to observe FEMA’s response to the disaster, could not reconcile the report’s conclusion about the effectiveness of FEMA’s response with their own observations. Upon learning of their concerns, DHS OIG conducted a quality assurance review of the EMOT report in question and determined that it did not comply with Yellow Book auditing standards. The report was retracted and withdrawn from DHS OIG’s website on July 19, 2017. Thereafter, DHS OIG’s Office of Integrity and Quality Oversight conducted a preliminary quality assurance review of DHS OIG’s other EMOT reports. Following that review, DHS OIG retracted an additional twelve EMOT reports in March 2018 due to similar concerns.

¹⁹ OIG-15-92-D, OIG-15-102-D, OIG-15-105-D, OIG-16-53-D, OIG-16-85-D, OIG-16-106-D, OIG-17-37-D, OIG-17-80-D.



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E. EMO Internal Control Deficiencies

A strong system of internal controls should have caught and corrected the issues described above, but failed to do so. EMO's internal controls system included layers of managers and supervisors who were required to oversee and guide EMO's audit work. However, the Review Team, in consultation with its outside auditing firm, found that EMO management and supervision were deficient in ensuring adequate planning that would have established achievable audit objectives. EMOTs generally stated that their objective was to evaluate the effectiveness of FEMA's response to the disaster, but there were no defined criteria or steps for impartially conducting this assessment.

EMO management and supervision were also deficient in ensuring teams adequately assessed the evidence obtained during fieldwork. For instance, EMOTs did not evaluate FEMA's own internal controls in order to objectively determine the reliability and validity of data they received from FEMA, and instead almost exclusively relied on testimonial evidence (most of which was provided by FEMA personnel) without taking steps to independently confirm assertions made and to protect against bias.

Further, EMO's internal quality control procedures did not function as intended due to weaknesses in EMO's Independent Reference Reviewer (IRR) process. In the IRR process, an employee who is not a member of the audit team is supposed to confirm that a draft report's statements of fact are accurate, the report's findings are adequately supported by evidence in the audit documentation, and the report's conclusions and recommendations flow logically from the evidence. This process did not flag EMOT deficiencies. Instead, it was more focused on confirming basic facts and figures, rather than on ensuring that supporting conclusions and auditor opinions were adequately supported.

There were also deficiencies identified in EMO's use of DHS OIG's Supervisory Review Checklist. The Checklist is the process by which directors, managers, and supervisors certify that they have reviewed audit work and determined that the work met Yellow Book standards. This process also failed to flag EMOT deficiencies. For instance, in connection with the EMOT report titled *FEMA's Initial Response to Catastrophic Flooding in Louisiana* (OIG-17-80-D), the Checklist indicates that the team verified the validity and reliability of the data obtained from FEMA during the audit. In fact, the team only verified that the data came



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from a FEMA data system, not that the data contained in the system was valid and reliable.

A recent U.S. Environmental Protection Agency (EPA) OIG peer review of DHS OIG — which included in its scope the final report in the EMOT series, *FEMA’s Initial Response to Catastrophic Flooding in Louisiana* (OIG-17-80-D) — reached similar conclusions about deficiencies in EMO’s system of quality controls. Specifically, EPA OIG concluded that “weaknesses in the DHS OIG’s Office of Emergency Management Oversight (EMO) control structure did not assure compliance with GAGAS [Generally Accepted Government Auditing Standards] for sampled audit OIG-17-80-D. We identified issues with audit planning, assessment of evidence, supervision, indexing and reporting disclosures necessary for understanding the audit scope and methodology.”²⁰

As a result, DHS OIG was given a “*pass with deficiencies*” rating by EPA OIG, which concluded that “except for the deficiency described above [regarding report OIG-17-80-D], the system of quality control in effect for the DHS OIG’s audit organization for the year ending September 30, 2017, has been suitably designed and complied with to provide the DHS OIG with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects.” DHS OIG concurred with all four recommendations made by EPA OIG.²¹

CONCLUSION

While the Review Team did not find that EMOT members always set out to perform “feel good” work when deployed to the field, when the time came to issue a report, the EMOT reports unerringly took the same shape and reached the same conclusion. The Review Team determined that the issues with the thirteen retracted EMOT reports were the result of: (1) several key changes made to the EMOT model that were poorly communicated and managed; (2) a flawed report model; and (3) deficiencies in EMO’s internal controls.

Had the EMOT work been performed as originally intended — as a tool for collecting and analyzing information to identify issues for future audit work — it could have provided valuable insight on FEMA’s disaster

²⁰ EPA OIG, System Review Report of DHS OIG (Aug. 27, 2018), https://www.oig.dhs.gov/sites/default/files/OIG_SystemReviewReport_082718.pdf.

²¹ *Id.*



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response efforts and presented opportunities to prevent issues from developing into more serious, costly problems. However, the decision to move away from “promoting” efficiency and effectiveness in FEMA’s initial disaster response to “evaluating” that response, coupled with DHS OIG’s failure to develop appropriate criteria to measure efficiency and effectiveness, flawed the work from the start.

RECOMMENDATIONS

We recommend that the Deputy Inspector General:

1. Confirm that all DHS OIG reports bearing the four signature traits of a “feel good” report have been retracted and removed from DHS OIG’s website.
2. Ensure that all future early deployment work conducted by DHS OIG, if any, is performed in accordance with applicable standards.
3. Design and implement improvements to DHS OIG’s quality assurance processes to resolve the internal controls deficiencies identified by the internal review.
4. Close all open recommendations outlined in the EPA OIG peer review.
5. Refer this report to the Council of Inspectors General on Integrity and Efficiency for whatever action it deems appropriate.

CORRECTIVE ACTIONS

Upon completing fact development and consulting with its outside auditors, members of the Review Team briefed HOCR on the findings of the internal review on October 19, 2018. On October 25, 2018, members of the Review Team provided the same briefing to the Senate Homeland Security and Governmental Affairs Committee. Immediately following these congressional briefings, Mr. Kelly was briefed on the findings of the review. Over the next few months, DHS OIG’s senior leaders — including Deputy Inspector General, Jennifer Costello; Assistant Inspector General for Audits, Sondra McCauley; and Assistant Inspector General for Integrity and Quality Oversight, Thomas Salmon — began



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developing and implementing a corrective action plan to address the deficiencies identified in the review.²² That plan built on corrective actions DHS OIG had already begun implementing after retracting the thirteen EMOT reports.

As reflected in the management response produced in full in Appendix B, the Deputy Inspector General concurred with our recommendations and outlined proposed corrective actions for all recommendations. We agree with the proposed actions and consider the recommendations open with corrective actions ongoing.

²² Because of Mr. Kelly's recusal, he delegated authority for the development and implementation of corrective actions to the above-referenced DHS OIG senior leaders.



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APPENDIX A

Objective, Scope, and Methodology

DHS OIG was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*.

The objective of this review was to determine the factors that led to DHS OIG retracting thirteen EMOT reports regarding FEMA's initial response to specific disasters. DHS OIG retracted one of these reports, *FEMA's Initial Response to Catastrophic Flooding in Louisiana* (OIG-17-80-D), in July 2017 after the House Committee on Oversight and Government Reform raised concerns about the accuracy of the report's findings and conclusions, and retracted an additional twelve reports in March 2018, after a preliminary quality assurance review identified similar concerns.

To conduct this review, DHS OIG assembled an internal review team (Review Team) in March 2018 consisting of investigative counsel and analysts. Because Acting Inspector General John V. Kelly was involved in overseeing the EMOT work at issue, he recused himself from the matter and delegated authority to then-Acting Counsel Diana R. Shaw to conduct the internal review and help develop a corrective action plan.

The Review Team collected and analyzed thousands of pages of emails, draft and final audit reports, audit work papers, and other documents related to the thirteen retracted reports. We also reviewed historical DHS OIG guidance and other documents concerning the creation and development of the EMOT concept. Additionally, the Review Team interviewed 26 current and former DHS OIG employees, including DHS OIG personnel involved in each of the thirteen retracted EMOT reports. Those interviewed included line and supervisory auditors and audit directors, and other current and former management in DHS OIG's Office of Audits and its former Office of Emergency Management Oversight. The Review Team also engaged the services of an auditing firm to get an outside evaluation of the EMOT work at issue and independent guidance on industry standards and best practices related to auditing.

This special report was prepared according to the *Quality Standards for Federal Offices of Inspector General* issued by the Council of the Inspectors General on Integrity and Efficiency, and reflects work



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performed between March 2018 and September 2018 pursuant to Sections 2-2 and 2-3 of the *Inspector General Act of 1978*, as amended.²³

This special report summarizes the Review Team's findings regarding the factors that led to a series of deficient DHS OIG audit reports for the purpose of keeping the Secretary of DHS and the Congress fully and currently informed about problems and deficiencies relating to the administration of DHS programs and operations and the necessity for corrective action. This report is designed to promote the efficient and effective administration of, and to prevent and detect fraud, waste, and abuse in, the programs and operations of DHS.

²³ Under Section 2-2 of the Act, DHS OIG is charged with providing leadership and coordination and recommending policies for activities designed (A) to promote economy, efficiency, and effectiveness in the administration of, and (B) to prevent and detect fraud and abuse in DHS programs and operations. Under Section 2-3 of the Act, DHS OIG is charged with keeping the DHS Secretary and the Congress fully and currently informed about problems and deficiencies relating to the administration of DHS programs and operations and the necessity for and progress of corrective action.



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APPENDIX B
DHS OIG'S MANAGEMENT RESPONSE



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

May 21, 2019

MEMORANDUM FOR: Diana Shaw
Assistant Inspector General
for Special Reviews and Evaluations

FROM: Jennifer Costello *Jennifer Costello*
Deputy Inspector General

SUBJECT: Management Response to Special Report:
*Review Regarding DHS OIG's Retraction of
Thirteen Reports Evaluating FEMA's Initial
Response to Disasters*

Thank you for the opportunity to comment on this report. You and your team conducted an extremely thorough and objective review and I believe your findings accurately describe the circumstances surrounding the retraction of the Emergency Management Oversight Team (EMOT) reports. Your findings are also consistent with the conclusions reached by the outside auditing firm that provided an independent evaluation.

For an Office of Inspector General (OIG), retracting publicly issued reports because they are unreliable is not an insignificant matter. Those 13 EMOT reports represent millions of wasted taxpayer dollars and understandably cast doubt on our credibility. However, these products represented just 1.3 percent of the audit and inspection reports issued between fiscal years 2010 and 2017. In that same period, we also issued hundreds of hard hitting reports identifying fraud, waste, and abuse at the Department of Homeland Security (DHS). With respect to the Federal Emergency Management Agency (FEMA) in particular, we questioned \$4.4 billion in costs and identified \$2.5 billion in funds that could be put to better use. Nonetheless, our prior EMOT approach resulted in unacceptable failures. As a result, I fully support and concur with all of your recommendations to improve DHS OIG's internal processes and controls. Our completed and planned actions are described in the attachment to this memo.



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In addition to enhancing the quality of our processes, it is critically important that we focus on addressing the quality of our leadership. Good leaders seek to communicate clearly and frequently, listen carefully to the concerns of the employees that they oversee, and display equal measures of self-awareness and accountability. The results of this review, along with our past Federal Employee Viewpoint Survey scores and my own conversations with staff, make clear that renewed focus on these areas is warranted. To that end, I am working to promote a culture of continuous introspection and improvement here at DHS OIG, and I can unequivocally state that our current executive team also embraces this philosophy.

Having briefed interested congressional committees and our own staff on the results of this review, we are now able to report our findings publicly. I feel that it is critical that we hold ourselves to the same standards to which we hold the Department when conducting oversight of its programs and operations. In that work, we seek to promote transparency and accountability—we can do no less when the focus is turned on ourselves. In all that we do, the men and women of DHS OIG strive to earn the reputation for reliable, fact-based, and impactful audits, inspections, investigations, and special reviews. In the rare instances where we fall short of our high standards, we will take responsibility for our actions and do everything in our power to ensure that we do not repeat the same mistakes going forward.

Attachment



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Attachment: Management Response to Recommendations

Recommendation 1: Confirm that all DHS OIG reports bearing the four signature traits of a “feel good” report have been retracted and removed from DHS OIG’s website.

Response: Concur. As noted in your report, between July 2017 and March 2018, DHS OIG removed all EMOT reports sharing the problematic traits described in the report (a total of thirteen reports). We have not identified any additional reports that require removal.

Recommendation 2: Ensure that all future early deployment work conducted by DHS OIG, if any, is performed in accordance with applicable standards.

Response: Concur. We have determined that the purpose of DHS OIG’s early deployment work most closely aligns with work undertaken pursuant to Section 2-2 of the *Inspector General Act of 1978*, as amended. Section 2-2 calls on OIGs to provide leadership, coordination, and recommendations to (1) promote economy, efficiency, and effectiveness in the administration of Departmental programs and operations and (2) deter fraud and abuse in such programs and operations. Under Section 2-2, as with *Generally Accepted Government Auditing Standards* (GAGAS), accuracy, objectivity, and independence are paramount.

To the extent DHS OIG continues to perform this type of oversight, it will do so in a manner consistent with the original purpose of the work: to collect preliminary information in order to identify potential issues for future audits or inspections. An early deployment will result in a public report pursuant to Section 2-2 only when a serious issue requiring immediate attention is identified. Further, to better demonstrate DHS OIG’s independence and differentiate our role from that of FEMA, the OIG staff deployed following a disaster will better communicate to those on the ground OIG’s responsibilities in disaster oversight.

Recommendation 3: Design and implement improvements to DHS OIG’s quality assurance processes to resolve the internal controls deficiencies identified by the internal review.



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Response: Concur. As noted in your report, DHS OIG began developing and implementing a corrective action plan to address the deficiencies identified in the review upon learning of the findings. While I expect improvements to our quality assurance process to be an ongoing effort, we have instituted a series of immediate structural and procedural changes. For instance, the Office of Audits:

- introduced auditor rotations across different functional areas to promote the objectivity and independence of auditing personnel;
- strengthened controls by reducing auditors' reliance on testimonial evidence and increasing reliance on source documentation, substantive testing, and analytical techniques; and
- enhanced auditor training to focus on auditing fundamentals, compliance with standards, and independence.

The Office of Audits also established a Quality Management and Training (QMT) Branch, which conducts quality control reviews of ongoing audits and evaluations prior to report publication to assess compliance with GAGAS, the DHS OIG Audit Manual, and Office of Audits best practices. For fiscal year 2019, QMT will review a sample of at least 10 percent of all ongoing audits and recommend corrective actions where necessary. Upon completing a review, QMT will provide follow-up oversight to ensure Office of Audits teams fully address these recommendations prior to report issuance. The Office of Audits is also in the process of evaluating all audit reports issued in fiscal year 2018 for compliance with GAGAS. If any reports are identified as non-compliant, appropriate corrective action will be taken.

DHS OIG has also strengthened quality control efforts throughout the entire organization. For instance, in August 2018, we implemented a job planning process in which all of our executives review and approve new work to ensure that we are conducting oversight of the Department's most critical programs and operations and choosing the most effective and appropriate methodologies to do so. Furthermore, in October 2018, DHS OIG restructured its Office of Integrity and Quality Oversight (IQO) to allow for greater employee involvement in quality assurance through detail opportunities and participation in an employee pool. These detail and pool assignments provide employees an opportunity for greater exposure to and understanding of our professional standards and internal policies. Once employees have completed a rotational or



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collateral assignment with IQO, they will take their enhanced knowledge back to the teams in their home offices, thereby improving the quality of work throughout the agency.

Recommendation 4: Close all open recommendations outlined in the EPA OIG peer review.

Response: Concur. DHS OIG plans to take action on the recommendations to improve our internal processes by December 30, 2019. In addition, DHS OIG will schedule an off-cycle peer review with the Council of the Inspectors General on Integrity and Efficiency (CIGIE) and coordinate with CIGIE on a completion date.

Recommendation 5: Refer this report to the Council of Inspectors General on Integrity and Efficiency for whatever action it deems appropriate.

Response: Concur. I will refer the report to CIGIE on the same day it is publicly issued.



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APPENDIX C
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