GOVERNMENT ACCOUNTABILITY PROJECT

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December 16, 2024

The Honorable Hampton Dellinger
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, #300
Washington, DC 20036
Attn: Chelsey Hartford
Tracy Biggs

Re: OSC Files Nos. DI-24-000591, DI-24-000960, and DI-24-001051

Dear Special Counsel Dellinger:

Through undersigned counsel, Whistleblower [REDACTED], [REDACTED], Customs and Border Protection (CBP); Whistleblower [REDACTED], [REDACTED], CBP Office of the Chief Medical Officer (OCMO)[1]; and Confidential Whistleblower 1, who remains anonymous due to fear of retaliation, submit these comments to the U.S. Office of Special Counsel (OSC) in response to the CBP Office of Professional Responsibility (OPR) report on OPR's investigation of the OSC's referral of the above-captioned disclosures.

In February 2024, Whistleblowers [REDACTED], [REDACTED], Confidential Whistleblower 1 (together, "the Whistleblowers"), and additional federal employee whistleblowers represented by Government Accountability Project, disclosed to the OSC, Department of Homeland Security (DHS) Office of the Inspector General (OIG), Congress, and others serious and ongoing wrongdoing by CBP OCMO Acting Chief Medical Officer (ACMO) [ACMO].[2] The wrongdoing whistleblowers reported included, among other things, [ACMO]'s improper creation of a narcotics policy in an attempt to procure fentanyl and his improper efforts to replace the CBP Electronic Medical Records system (EMR).[3]

[1] OPR's report mistakenly identifies [REDACTED] as DHS OCMO [REDACTED].
[2] Government Accountability Project, "Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting CBP Chief Medical Officer," (Feb. 16, 2024), https://whistleblower.org/wp-content/uploads/2024/02/02-16-2024-CBP-Medical-Services-Whistleblower-Disclosure.pdf. Following this public disclosure, [REDACTED] additionally filed his disclosure through the OSC Online Filing Portal in February, as did [REDACTED] and Confidential Whistleblower 1 in May 2024.
[3] Importantly, the information whistleblowers disclosed showed that [ACMO]'s wrongdoing occurred within the broader context of poor performance and mismanagement related to OCMO's mission. Specifically, the CBP Office of Acquisition (OA) failed to take corrective action against CBP's medical contractor, Loyal Source Government Services (LSGS), for serious performance failures on the CBP Medical Services Contract for the provision of medical services to individuals in CBP custody. OA and LSGS's gross waste, gross mismanagement, abuse of authority, and substantial and specific danger to public health and safety took place before, during, and after the death of Anadith Reyes Alvarez, the eight-year-old child whose death in CBP custody could have been prevented had she received adequate medical attention. Prior to this preventable death in custody, OCMO personnel made repeated reports to CBP leadership about OA and LSGS's deficiencies, to no avail. Many of the systems-failure root causes behind Anadith's death—shortfalls in medical services contractor performance at the Southern border and lack of oversight—continue, warranting immediate investigation and remedial action. *See id.*

On July 12, 2024, having made a determination that the disclosures evidenced a substantial likelihood of wrongdoing, in accordance with 5 U.S.C. § 1213(b) and (c), the OSC referred four allegations against [ACMO] to DHS:

> (1) that [ACMO] improperly attempted to replace the CBP EMR;[4]
>
> (2) that [ACMO] improperly created an agency-wide narcotics policy to personally procure fentanyl;
>
> (3) that [ACMO] repeatedly consumed alcohol while carrying his agency-issued firearm; and
>
> (4) any additional allegations of wrongdoing emerging from the investigation of the foregoing allegations.

DHS, in turn, assigned CBP OPR to investigate the allegations. On October 1, 2024, the OSC sent CBP OPR's Case Closing Report on allegation #3 to whistleblowers represented by Government Accountability Project who had disclosed information regarding [ACMO]'s repeated consumption of alcohol while armed. Those whistleblowers submitted comments on OPR's report to the OSC on November 5, 2024 and requested that the OSC find OPR's report on allegation no. 3 unreasonable. On October 15, 2024, the OSC sent to the Whistleblowers, who disclosed information related to allegations nos. 1 and 2, CBP OPR's second and apparently final Case Closing Report on these matters. This report responds to OSC-referred allegations nos. 1, 2, and 4 and is the subject of the Whistleblowers' comments presented herein.

For the reasons detailed below, the Whistleblowers ask the OSC to find OPR's report unreasonable, as it fails to adhere to the requirements of 5 U.S.C. § 1213 and its conclusions lack credibility, consistency, and completeness.[5]

**Summary of Comments**

First, regarding [ACMO]'s improper creation of a narcotics policy to procure fentanyl, OPR failed to consider their previous investigation into [ACMO]'s unauthorized attempts to procure fentanyl and other controlled substances in 2020 and 2021, an investigation that may have *also* involved an unauthorized narcotics control policy fabricated by [ACMO]. In the comments below, the Whistleblowers provide facts that OPR's report should have included. Nevertheless, despite OPR's hole-ridden narrative, in the present investigation OPR found that [ACMO] *did* violate policy (Table of Penalties – I02 (Failure to follow applicable laws, rules, regulations, or policies in the performance of duties)) when he wrote and signed a narcotics policy without authorization in an attempt to procure fentanyl in September 2023. Yet, OPR's report indicates that CBP has failed to take any administrative or disciplinary action against [ACMO].[6]

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[4] While the allegation refers to the "OCMO EMR," the EMR system that pertains to these allegations is a CBP-wide system not limited to OCMO.

[5] 5 U.S.C. § 1213 (d); The OSC will find an agency's report in response to an OSC referral reasonable "if the report's findings and conclusions are credible, consistent, and complete, based upon all the information presented by all parties." U.S. Office of Special Counsel, "What Happens When an Employee Files a Disclosure Claim?" (last visited Nov. 27, 2024), https://osc.gov/Services/Pages/DU-Process.aspx#:~:text=When%20OSC%20refers%20allegations%20for,summary%20of%20the%20evidence%20gathered.

[6] The agency's failure to hold [ACMO] accountable for violations of policy is especially concerning in light of a recent Government Accountability Office (GAO) report which found that supervisors were less likely to face discipline at

OPR's substantiation of [ACMO]'s policy violation followed by inaction on the part of CBP now demonstrates a pattern in which the agency rubber-stamps [ACMO]'s wrongdoing. Indeed, in their October 1, 2024 report to the OSC, OPR similarly sustained the allegation that [ACMO] violated CBP policy by consuming alcohol while armed, and yet the agency took no corrective action. In fact, instead of holding [ACMO] accountable for repeated violations of policy, reports indicate that CBP has now offered [ACMO] the permanent CBP Chief Medical Officer (CMO) position, highlighting his impunity to date and making his accountability paramount. As detailed further below, [ACMO]'s impunity appears to come at the behest of multiple personnel in DHS and CBP leadership, including Acting DHS Chief Medical Officer Dr. Herb Wolfe; CBP Senior Official Performing the Duties of the Commissioner Troy Miller; Executive Assistant Commissioner, Operations Support, [redacted]; and Deputy Executive Assistant Commissioner, Operations Support, [redacted].

Second, as the Whistleblowers demonstrate, OPR's failure to find that [ACMO] engaged in wrongdoing through his crusade to replace OCMO's EMR with a commercial off-the-shelf alternative is unreasonable. Specifically, OPR's framing of the allegation as a misunderstanding by sensitive employees overly invested in the EMR is not only incorrect but dangerous. In fact, the Department of Veterans Affairs (VA) is suffering through the aftermath of a debacle nearly identical to that which whistleblowers are trying to prevent; the VA's adoption of a commercial off-the-shelf electronic health records system has resulted in years of delay and is estimated to cost taxpayers close to *$50 billion* in all.[7]

OPR's flippant presentation of the situation glosses over the impending gross waste of taxpayer dollars to purchase, customize, and integrate a new system and whisks attention away from the underlying issues that elevate medical risks to children and adults in CBP custody, namely, shortfalls in contractor performance coupled with contract oversight failures.[8] Herein, the Whistleblowers explain how [ACMO]'s attempts to replace the CBP EMR do not represent a mere policy disagreement, but rather gross waste and mismanagement that, left unthwarted, will advance at taxpayers' great expense and without indication that CBP medical services will improve.

In addition to refuting OPR's unreasonable conclusions on these allegations, the Whistleblowers highlight significant procedural shortcomings apparent in OPR's report, including OPR's failure to identify any additional wrongdoing to investigate in accordance with the OSC referrals, and, as in their October 1st report, the glaring omission of relevant witness testimony, and imprecise language that undermines transparency and accountability around the facts that OPR's investigation substantiated.

In all, the Whistleblowers are highly concerned that this report evidences a pattern of improper response from CBP OPR to OSC referrals of alleged wrongdoing arising from protected whistleblower disclosures. The Whistleblowers call on the OSC to find this report unreasonable; instruct the agency to rewrite their

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DHS, and that of the four agency components evaluated, CBP was an outlier in that it had, "not developed a policy that documents the disciplinary adjudication policy for all employees." Government Accountability Office, "DHS Employee Misconduct: Actions Needed to Better Assess Differences in Supervisor and Non-Supervisor Discipline," Feb. 2024, https://www.gao.gov/assets/d24105820.pdf at 16.

[7] VA OIG, "VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents" (Sept. 23, 2024), https://www.vaoig.gov/reports/audit/va-needs-strengthen-controls-address-electronic-health-record-system-major at i, referencing testimony of expert analyst Brian Q. Rieksts before the Senate Committee on Appropriations, 117th Cong. (Sep. 21, 2022).

[8] Critically, CBP's review of the circumstances surrounding the 2023 death in custody of eight-year-old Anadith Reyes found that the Loyal Source provider failed to properly use the EMR in to adequately care for Anadith. U.S. Customs and Border Protection, "June 1, 2023 Update: Death in Custody of 8-Year-Old in Harlingen, Texas," (June 1, 2023), https://www.cbp.gov/newsroom/national-media-release/june-1-2023-update-death-custody-8-yearold-harlingen-texas.

response to allegations no. 1, 3, and 4 in separate reports, based on all available evidence; explain how the agency will hold [ACMO] accountable; and address CBP OPR's clear pattern of shoddy investigations that wholly miss the mark, at the cost of accountability that is sorely needed for supervisors at CBP.[9]

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## I. OPR's Report Critically Omits Relevant Information Reported to the Agency and Investigated by OPR in 2021 Regarding [ACMO]'s Prior Actions Improperly Obtaining Narcotics at DHS.

As Troy Miller, CBP Senior Official Performing the Duties of the Commissioner, stated in the agency cover letter accompanying OPR's report, OPR's investigation sustained the allegation that "[ACMO] improperly created an agency-wide narcotics policy to personally procure Fentanyl […] against the recommendations of his staff and without proper authority." Indeed, OPR found that "[ACMO]'s disregard of CBP's normal policymaking procedures led to the improper issuance of this policy both in terms of substance and procedure […]" when he wrote and signed a policy in an attempt to procure controlled substances for an air mission at the United Nations General Assembly (UNGA) in September 2023. What OPR's report fails to state, is not only what appropriate disciplinary action the agency will take, but also that this is not the first time [ACMO] has improperly attempted to procure fentanyl at the agency, nor was it his first time creating an agency-wide narcotics policy without apparent authority.[10]

In their Case Closing Report, OPR excludes any reference to their previous investigation into allegations of improper attempts by [ACMO] to procure fentanyl and other controlled substances in his former position as Senior Medical Officer – Operations at DHS.[11] In 2021, CBP OPR investigated [ACMO]'s attempted and actual procurement of scheduled narcotics for purported official use at the agency during 2020 and 2021, in the apparent absence of (1) an applicable operational medicine policy authorizing the circumstances under which controlled substances could be procured at DHS and/or (2) a CBP component-specific narcotics control policy allowing for the handling, transport, and storage of controlled substances in accordance with Drug Enforcement Administration (DEA) rules.[12]

Indeed, the Whistleblowers attach as exhibits documentary evidence of what they aptly call "Fentanyl 1"—[ACMO]'s unauthorized efforts to procure fentanyl and other controlled substances in 2020 and 2021 and OPR's related investigation in 2021. Whistleblowers, including CBP staff who provided information to OPR during "Fentanyl 1," are dismayed that [ACMO]'s impunity continues in "Fentanyl 2," another documented unauthorized attempt by [ACMO] to procure fentanyl and midazolam, this time in 2023, that OPR's report responds to now. OPR's failure to consider this history in their most recent investigation involving similar allegations is, at best, a striking error in OPR's institutional memory related to serious allegations of misconduct by [ACMO]. At worst, it constitutes a corrupt coverup of the extent of [ACMO]'s

[10] Of note, although the OSC-referred allegation #2 regards only fentanyl, as explained below, in both "Fentanyl 1," in 2020-2021, and "Fentanyl 2," in 2023, [ACMO] attempted to procure other controlled substances in addition to fentanyl, without proper authority. Indeed, in "Fentanyl 1," [ACMO] ordered, without authorization, fentanyl, morphine, midazolam, and ketamine; in "Fentanyl 2," he wrote and signed a policy to facilitate his procurement of fentanyl and midazolam. *See* Evidence available with Government Accountability Project upon request.

[11] CBP OPR is aware of this investigation because it is the CBP OPR that conducted it. Additionally, the Whistleblowers referenced this investigation in their public disclosures and submissions to the OSC. *See* Government Accountability Project, *supra* FN 2 at 12-13.

[12] As a prescribing physician likely registered with the DEA, the Whistleblowers do not dispute [ACMO]'s authority to prescribe and order controlled substances as a medical doctor. It is [ACMO]'s attempted procurement of bulk controlled substances as a DHS employee without clear authority under a governing operational medicine policy that determines *who* may procure controlled substances at DHS and *when* and *how* they may do so that is problematic. Additionally at issue is [ACMO]'s attempted procurement of controlled substances in the absence of policy provisions on narcotics control, which are related but distinct from the narcotics procurement authority provisions and govern the transport, storage, inventory, disposition, and disposal of controlled substances in accordance with DEA regulations to prevent misuse or diversion.

wrongdoing. Either way, OPR's failure to include this context undermines the report's credibility and prospects for legitimate accountability.

A. *In 2020 and 2021, [ACMO] attempted to procure scheduled narcotics for purported official use, circumventing agency policy, and ignoring DEA regulations.*

In early 2020, [ACMO], then the DHS Combatting Weapons of Mass Destruction (CWMD) Senior Medical Officer for Operations, was on detail to the Federal Emergency Management Agency (FEMA) when he began traveling around the country to speak publicly about DHS's response capabilities related to COVID-19. Beginning in or around March 2020 and throughout that summer, [ACMO]'s friend [REDACTED], a paramedic and helicopter pilot with the Air and Marine Emergency Medical Service (AMEMS), Air and Marine Operations (AMO), CBP, accompanied [ACMO] on many of these speaking trips and transported [ACMO] in an AMO helicopter. During this time, [ACMO] and [REDACTED] made numerous attempts to obtain scheduled narcotics for these missions through CBP AMO.[13]

For example, in March 2020, [REDACTED] obtained a quote from BoundTree, an AMO vendor, for controlled substances and medical supplies, for purported use while [REDACTED] and [ACMO] were on travel. [REDACTED] subsequently asked his supervisor, [REDACTED], [REDACTED], who was responsible for approving all purchases of AMEMS supplies,[14] to approve [REDACTED]' BoundTree order. [REDACTED] denied [REDACTED]' request based on the absence of a CBP narcotics control policy and corresponding AMO procedures that would ensure compliance with DEA regulations.[15]

Notably, [REDACTED] knew or should have known that CBP did not have DEA compliant policies and procedures in place to properly handle controlled substances because [REDACTED], who at the time was based at the local AMO air branch in Manassas, Virginia, previously held [REDACTED]' position coordinating emergency medical services at AMO. Similarly, while [ACMO] likely had prescribing authority for the narcotics he and [REDACTED] sought to obtain for their missions, the actual procurement of these controlled substances for such missions would have required agency approval and oversight consistent with DEA-compliant narcotics control procedures. [ACMO]'s efforts to order controlled substances through CBP AMO in collusion with [REDACTED] indicate that [ACMO] did not have authorization to make these purchases under FEMA, CWMD, or DHS; otherwise, he presumably would have done so.

After [REDACTED] denied [REDACTED]' request in March 2020, [REDACTED] continued to flood [REDACTED] with demands for so-called "pharma" over the subsequent months. In fact, in June 2020, [REDACTED] plainly stated in a text message conversation [REDACTED], held on government cell phones, that should [REDACTED] continue to deny [REDACTED]' requests for narcotics procurement to support his missions with [ACMO], [REDACTED] and [ACMO] would find an "alternative" method to

[13] *See* Evidence available with Government Accountability Project upon request.

[14] Notably, CBP AMO established AMEMS to integrate Emergency Medical Technicians (EMT) "as aircrew members when conducting rescue operations." "Medically-Trained Air and Marine Operations Agents Prove Critical to Law Enforcement Missions," U.S. Customs and Border Protection (Jan. 27, 2021), https://www.cbp.gov/newsroom/national-media-release/medically-trained-air-and-marine-operations-agents-prove-critical. As a primarily EMT-focused program, AMEMS has a limited scope of practice, and AMEMS personnel work with a correspondingly limited set of pharmaceuticals that they are authorized to use for basic life support. This limited set of pharmaceuticals generally excludes advanced life support material that includes narcotics, and administration of controlled substances typically falls outside AMEMS's scope of practice.

[15] *See* Evidence available with Government Accountability Project upon request. *See also* Evidence available with Government Accountability Project upon request.

obtain the controlled substances. The following excerpts [REDACTED] in June 2020, below, speak for themselves.[16]

> *[REDACTED]: I've already had to decline a few missions due to not having those [controlled substances], so if there is anything I can do to help move it along, just say the word.*
>
> *[REDACTED]: Just stuff that has come up while we've been out and about traveling the country. Heads turn and look at me to see if we can support and I have to shake my head and find alternatives. I can't even begin to socialize it without drugs. If the order isn't going to happen, I can either seek an alternative or adjust focus entirely. Let me know...*
>
> *[REDACTED]: Your thoughts are accurate. We are not doing medicine but the subject of most all of our discussions is medicine related. Folks know what I do for a living so when the subject of AirMedical transportation comes up people turn and look at me for guidance. There are missions we could get involved in if we were adequately equipped but I am turning them to other folks. We also pretty much solved the National Beef Crisis in Kansas and the Seafood Crisis in Alaska amongst other things...* [laughing crying emoji]
>
> [separate thread]
>
> *[REDACTED]: Just got a request for PM support for USSS CAT AQRF OPS.[17] Status of pharmaceutical order?*

Seven months later, on January 15, 2021, [REDACTED], then a CWMD employee,[18] called to arrange a large BoundTree order on a CBP AMO account number, without AMO's notice or authorization, but at the apparent request of [ACMO] and [REDACTED].[19] Records indicate that [REDACTED], on [ACMO] and [REDACTED]' behalf, placed three unauthorized BoundTree orders on the AMO account that day, totaling $7,475.88. The first order did not contain controlled substances and the corresponding purchase order shown in Exhibit A does not list the name of the person who placed the order. It does however, list "[REDACTED]/[ACMO]" as the shipment recipients, at the address of the Manassas Air Branch, the CBP facility where [REDACTED] was stationed.[20] Documentation of the second and third orders, both of which were for controlled substances, state that the orders were placed by "[ACMO]" and list "[REDACTED]/[ACMO]" as the shipment recipients, at the Manassas Air Branch.[21] Not only do these purchase orders clearly show that [ACMO] and [REDACTED] ordered scheduled narcotics on an AMO account without AMO's authorization, the fact that the controlled substances were ordered separately in two distinct purchases from a larger order of medical supplies suggests that [ACMO] and [REDACTED] may have intended for the narcotics purchases to slip by AMO accounting oversight undetected.

The following controlled substances, including but not limited to fentanyl, were included in these unauthorized orders.[22]

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[16] Evidence available with Government Accountability Project upon request.
[17] This acronym appears to be a reference to a group within the United States Secret Service Counter Assault Team. United States Secret Service, Special Operations Division, Counter Assault Team, (last visited Dec. 5, 2024), https://www.secretservice.gov/careers/special-agent/CAT.
[18] [REDACTED], (last visited Dec. 5, 2024), [REDACTED].
[19] Evidence available with Government Accountability Project upon request.
[20] *Id*.
[21] *Id*. A typo in Order #102416930 lists [REDACTED]' name as "[redacted]."
[22] *Id*.

| **Controlled Substance** | **Drug Classification**[23] |
|---|---|
| Morphine | Class II |
| Fentanyl | Class II |
| Midazolam | Class IV |
| Ketamine | Class III |

These unauthorized orders, placed on a Friday, were too large for BoundTree to fill in the expedited timeframe requested. It was not until the BoundTree account representatives received a weekend call from a superior in the company advising them to fill and rush the orders because "[ACMO] is a good friend and needs it ASAP" that they moved forward with fulfilment.[24] While the representatives complied, they remained concerned about the order, referencing "legal issues in shipping scheduled drugs to and from certain parts of the U.S." and an understanding that "federal law mandates that schedule II drugs must be shipped to the address on file for the medical director (which is in Dallas, TX) yet they were instructed to ship it to Manassas, VA instead."[25]

When [REDACTED] learned of the unauthorized orders on January 22, a week after their placement, he immediately cancelled what had not yet been shipped.[26] In an email chain with the former CBP Chief Medical Officer, [REDACTED] stated: [27]

> *"I have attached the invoices of all the unauthorized orders, placed by [ACMO] and delivered to [REDACTED]. At this time, I have no knowledge of where these drugs are, who is in possession of them, nor how they are being stored.*
>
> *The AMO account number with Boundtree will be cancelled and a new one generated with limited access to myself and [REDACTED] (purchase card holder). The Licensed Authorized Physician form for [ACMO] has been removed from the AMO account and will be replaced with a LAF*[28] *from [REDACTED] when available- this action will allow only [REDACTED] to authorize purchases under the AMO account under his prescribing authority. These are unfortunate, yet necessary steps to prohibit any further unauthorized utilization of the account for pharmaceutical purchases."*

[23] Each of these controlled substances were clearly labeled as classified in the purchase order. *See* Evidence available with Government Accountability Project upon request.
[24] *Id*.
[25] *Id*.
[26] Evidence available with Government Accountability Project upon request.
[27] Evidence available with Government Accountability Project upon request.
[28] This acronym likely refers to the aforementioned "licensed authorized physician form." It is unclear why such a form was on file for [ACMO] in this context, but even if one were properly in place, [ACMO] was not part of AMO, and such a form would not have provided authority for him to order narcotics on AMO's account without AMO's knowledge or approval—let alone have them shipped to a location without DEA compliance mechanisms in place at the point of delivery.

[REDACTED] a new account was established on or around January 27, 2021, under which all canceled orders were reordered and delivered to the Manassas Air Branch, where DEA-compliant policies and procedures were not in place.[29]

To be clear, in January 2021 when these orders were placed, CBP had no overarching narcotics control policies or procedures in place that would allow for DEA-compliant transport, storage, inventory, disposition, and disposal of controlled substances at the Manassas Air Branch or elsewhere.[30] Additionally, to the knowledge of [REDACTED] the former CBP Chief Medical Officer, there was no operational medicine policy in place that would have allowed for [ACMO] to procure or authorize procurement of controlled substances for AMO missions.

B. *CBP OPR investigated allegations related to [ACMO]'s irregular procurement of narcotics in 2021 but evidently stopped short of completion once OPR received a previously unheard-of policy that appeared to retroactively authorize, in part, [ACMO]'s attempts to obtain narcotics.*

During OPR's "Fentanyl 1" investigation in 2021, OPR staff interviewed several individuals including the former CBP Chief Medical Officer at the time, and other whistleblowers who provided information regarding [ACMO] and [REDACTED]' unauthorized attempts to procure controlled substances in 2020 and 2021. However, email documentation suggests that OPR terminated their investigation when, in or around May 2021, OPR was supplied with a document purported to be a CWMD operational medical support policy. This document, provided in Exhibit E as an email attachment from OPR staff in the context of their investigation, purports to have been signed by "DAS" on December 15, 2020 and "implemented by [ACMO]."[31]

As written, this document, which OPR shared with the former CBP CMO in May 2021, states that CWMD may provide medical support to any DHS component at any time and that the policy covers the "procurement and utilization of specialized pharmaceuticals and equipment in support of the direct operational medical support mission."[32] Conveniently, the purported policy gives the CWMD Senior Medical Officer – Operations, i.e. [ACMO], seemingly blanket authority over medical support requests from any DHS component *and* the authority to approve sites for "specialized pharmaceuticals" to be delivered and stored.[33] For example, the document states: "The Senior Medical Officer – Operations is responsible for adjudicating any requests for operations medical support and determining the most appropriate resource package to deliver and meet the needs of the requestor."[34] This would seemingly allow [ACMO] to take requests from any member of any DHS component and bypass authorized procurement channels i.e. take a "request" from [REDACTED] and use an AMO account over which he does not have

[29] *See* Evidence available with Government Accountability Project upon request. *See also* Evidence available with Government Accountability Project upon request.

[30] If Manassas Air Branch had DEA-compliant procedures in place for the handling of controlled substances, [REDACTED], [REDACTED], would not only have known about them but would have been instrumental in their implementation. [REDACTED] did not know of or implement any related policies or procedures at the time these substances were ordered and delivered in January 2021, nor in the fall of 2023, when, without the proper authority to do so, [ACMO] created a policy to procure narcotics at OCMO. *See* Evidence available with Government Accountability Project upon request. *See also* Evidence available with Government Accountability Project upon request.

[31] Evidence available with Government Accountability Project upon request; *See id*., Evidence available with Government Accountability Project upon request.

[32] *Id*., attachment at 4, Section 1.3.4.

[33] *Id*.

[34] *Id*., attachment at 5, Section 1.7.1.3.

authority. This would be unheard of at the agency, especially if such a policy were approved in December 2020 and then not disseminated or communicated to CBP OCMO or AMEMS AMO at that time, which it was not. Strikingly, the first time the former CBP CMO and his colleagues at OCMO and AMO were made aware of the policy was when CBP OPR sent the document to the former CBP CMO in May 2021, asking for his analysis of it.[35]

Furthermore, this CWMD policy document, which to whistleblowers' knowledge OPR never confirmed was valid during their "Fentanyl 1" investigation, appears to be a poor attempt at a conflated operational medicine and narcotics control policy. The policy states that the Senior Medical Officer can authorize "specialized pharmaceuticals" procurement to support operational medicine at any DHS component, including but not limited to CBP. However, rather than outlining actual policies that would ensure compliance with DEA regulations on controlled substances, the policy merely states "all applicable laws and DEA regulations regarding the above specialized pharmaceuticals will be followed."[36] Also of note, "specialized pharmaceuticals" is not a term of art; the proper terminology would be "controlled substances" or "narcotics." The use of this vague language may suggest an attempt to avoid the scrutiny that the proper terminology would bring.

Additionally, the sudden appearance of this policy in May 2021 suggests that either (1) it did not actually exist until May 2021 and was therefore an attempt to retroactively provide justification for [REDACTED] and [ACMO]'s unauthorized narcotics orders in 2020 and January 2021, or (2) it was issued quietly in December 2020, without proper approval, communication with impacted DHS components, or the implementation of requisite narcotics control requirements at so-called "secure locations" where the policy states that controlled substances may be delivered. No matter the case, if the December 2020 policy actually existed and had hypothetically authorized [ACMO]'s procurement of controlled substances in January 2021, it would not have authorized [ACMO] and [REDACTED]' procurement attempts before December 2020. Additionally, it would not have authorized use of AMO's BoundTree account without AMO knowledge or approval, and it would not have automatically made the Manassas Air Branch compliant with DEA regulations.

Furthermore, both possible scenarios indicate potential wrongdoing by Dr. Wolfe, who OPR interviewed in the context of "Fentanyl 2" and apparently failed to ask relevant follow-up questions related to both instances. Dr. Wolfe held the role of CWMD Deputy Assistant Secretary for Health Security before the Office of Health Security (OHS), likely when a Deputy Assistant Secretary, "DAS," purportedly signed the CWMD policy in December 2020.[37] Additionally, page five, section 1.7.1.3 of the policy references Dr. Wolfe's position in the context that the "Senior Medical Officer – Operations will clear all approvals with the Deputy Assistant Secretary for Health Security."[38] These facts either underscore [ACMO]'s egregious wrongdoing with respect to the CWMD policy, by (1) potentially having forged the signature of Dr. Wolfe as "DAS" and/or (2) by creating a policy that referenced Dr. Wolfe without his knowledge, or it indicates that Dr. Wolfe was at least complicit, if not actively involved, in the creation of this policy document.

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[35] *See id*.
[36] *Id*.
[37] In the absence of evidence to the contrary, it appears that Dr. Wolfe held this position in December 2020; his publicly available DHS bio states that he joined the agency in September 2019 and "Prior to the establishment of OHS [in July 2022], Dr. Wolfe served as the Deputy Assistant Secretary for Health Security in the Department's Countering Weapons of Mass Destruction Office." U.S. Dep't of Homeland Security, "Dr. Herbert (Herb) Wolfe," (last updated March 26, 2024), https://www.dhs.gov/person/dr-herbert-herb-wolfe; U.S. Dep't of Homeland Security, "Office of Health Security," (last updated October 23, 2023), https://www.dhs.gov/office-health-security, stating that the Office of Health Security was established in July 2022.
[38] Evidence available with Government Accountability Project upon request.

In all, OPR's failure to consider "Fentanyl 1" in their evaluation of the present allegation, which OPR sustained, that [ACMO] created an unauthorized policy to procure fentanyl for the 2023 UNGA, reveals a grossly inadequate investigation that prevented them from considering the broader conduct and thereby conducting an analysis that considered [ACMO]'s apparent recidivism. The omission is also an injustice to the CBP employees who witnessed and reported [ACMO]'s previous actions to skirt narcotics policy, many of whom faced retaliation as a result. Those employees have not only seen the agency fail to hold [ACMO] accountable time and again but have also seen him promoted from DHS Senior Medical Officer – Operations to CBP OCMO Acting Chief Medical Officer; they now anticipate his imminent promotion to permanent CBP CMO.

## II. OPR's Report Misconstrues the Facts Surrounding [ACMO]'s Unauthorized Creation of a Narcotics Policy in 2023.

In September 2023, [ACMO], who had by this time become the Acting CBP CMO (ACMO), was set to join an air mission to the UNGA in New York City, although it had not been explained to OCMO staff why the ACMO's presence on a joint AMO-Secret Service mission to the UNGA was necessary. The helicopter pilot for the UNGA mission was none other than [ACMO]'s friend [REDACTED], with whom [ACMO] had previously attempted to irregularly procure narcotics. A week before the UNGA, on September 1, 2023, [ACMO] alerted OCMO staff that he urgently needed to order fentanyl and midazolam to have onboard the UNGA mission helicopter.[39] Over the course of the week, [ACMO] directed more than a half dozen OCMO staff members to help him procure this Schedule II narcotic. OCMO senior leadership were immediately concerned about these efforts, which they communicated to Operations Support leadership via email on September 5, 2023.[40]

### *A. [ACMO] provided a draft, rather than the final version, of the purportedly approved December 2020 CWMD narcotics policy when he attempted to purchase narcotics in September 2023.*

When [ACMO]'s purchase request for fentanyl and midazolam reached CBP budget personnel on September 5, 2023, they asked [ACMO] for additional information regarding the purpose of his presence at UNGA and the purpose of the requested narcotics purchase. Lead Budget Analyst [REDACTED] told [ACMO] that such a purchase could not be made in the absence of applicable policy guidance "on what is allowed […] and directions on how to place orders for the drugs."[41] [ACMO] then created and signed his own policy, without authorization.[42] As a template for this policy that [ACMO] was not authorized to create, [ACMO] used what appears to have been a draft—with track changes by CWMD employee [REDACTED] still in place—of the December 2020 CWMD operational medicine policy that, as discussed in the preceding section, may have been forged.[43]

This is particularly concerning because, if the December 2020 policy that OPR received in May 2021—in purportedly final form—was legitimate, it is unclear why [ACMO] would have not simply furnished this approved policy to CBP OCMO and procurement employees who questioned under what authority [ACMO] believed he could order fentanyl in September 2023. Instead of providing an approved policy, he could only offer an incomplete draft. This plainly indicates that no such policy was ever finalized and approved in December 2020 and may instead have been subsequently fabricated and provided to OPR in

[39] *See* Evidence available with Government Accountability Project upon request.
[40] Evidence available with Government Accountability Project upon request.
[41] Evidence available with Government Accountability Project upon request.
[42] *See* Evidence available with Government Accountability Project upon request.
[43] *See* Evidence available with Government Accountability Project upon request.

May 2021 to retroactively provide some cover for [ACMO] and [REDACTED]' irregular controlled substances orders in January 2021.

Additionally, it is odd that when faced with evidence that [ACMO] used a draft policy to justify his inappropriate 2023 policy, Dr. Wolfe made no mention of the supposedly approved 2020 policy. OPR's summary of the information Dr. Wolfe provided on this topic says only: "Following a whistleblower report DHS CMO raised issues with the policy and its implications, raising concerns about proper storage and control of the CSA Schedule II Narcotics. DHS CMO also expressed concerns concerning a draft policy from the DHS CWMD being used to create the CBP policy, without proper approval. Concerning the OCMO Operational Medicine Policy created by OCMO staff at ACMO's direction, *DHS CMO explained how the CBP policy appeared to be based on an unapproved, draft format from the DHS Office of CWMD*" (emphasis added).[44] This would again indicate the policy was not properly finalized and approved in 2020.

At the same time, evidence indicates that Dr. Wolfe had knowledge of the inappropriate 2020 policy. First, as noted in section I.B. above, reference to Dr. Wolfe's position in the 2020 policy, and a potential signature by Dr. Wolfe suggest Dr. Wolfe's knowledge of [ACMO]'s inappropriate creation of a policy in 2020-2021. Additionally, on September 6, 2023, Dr. Wolfe's Chief of Staff, [redacted], replied to [ACMO]'s request for "that policy we wrote about AQRF drug purchases," after which [ACMO] used a draft of the CWMD policy as a template for the new policy.[45] Not only is this essentially an admission by [ACMO] that the policy was never in fact approved in 2020, but it also further indicates that Dr. Wolfe most likely knew about [ACMO]'s 2020 efforts if his own Chief of Staff was able to furnish [ACMO] with the 2020 draft. It is, therefore, either an oversight or omission by OPR that Dr. Wolfe's summary makes no mention of the 2020 incident, or, alternatively, suggests that Dr. Wolfe was intentionally hiding his knowledge of the 2020 incident.

*B. [ACMO] removed language inserted by OCMO staff from the draft policy that was necessary for compliance with DEA policy.*

When OCMO received the draft policy from [ACMO] in September 2023, they noted the exclusion of language related to DEA diversion policies in the draft and wrote in language to this effect. Oddly, [ACMO] then removed this language, signed the policy himself, and failed to obtain proper review and approval of the policy, despite warnings from OCMO senior staff that [ACMO]'s authorization of such policy without higher approval could be illegal. Notably, the policy gave [ACMO] as CBP ACMO, and OCMO personnel who have his written approval seemingly unchecked authority to "provide Operational Medical Support to an operational component of CBP, to any other appropriate Department of Homeland Security operation or in support of another federal, state or local law enforcement agency upon an approved request […]." The policy describes such support as "including but not limited to […] procurement, use and storage of […] pharmaceuticals and controlled substances."[46] With this self-signed policy, [ACMO] then directed OCMO staff to order fentanyl and midazolam for his trip. Despite the urgent effort by [ACMO], commandeering staff time, ultimately, the narcotics were not ordered because a vendor could not be found in time.

Even after [ACMO]'s frantic attempts to obtain controlled substances for the UNGA were thwarted, he charged ahead with what appears to have been a broader attempt to circumvent agency policy and DEA regulations. As Exhibits L and M show plainly, in October 2023, a month after the UNGA, [ACMO] evidently attempted to strongarm OCMO and AMO staff into complying with his narcotics procurement

[44] U.S. Customs and Border Protection Office of Professional Responsibility Investigative Operations Directorate, "Case Closing Report, Case No. 202400798," (agency cover letter dated Oct. 15, 2024), at 7.
[45] *See* Evidence available with Government Accountability Project upon request.
[46] Evidence available with Government Accountability Project upon request.

requests despite their insistence on adherence to applicable law and policy that still applied, even after [ACMO] issued his self-signed policy.[47] In fact, in an email dated October 25, 2023, [ACMO] dismissed [REDACTED]' clear warning that AMO did not have DEA compliant procedures in place for the handling of controlled substances and brazenly misrepresented that DEA regulations did not apply to customs officers.[48] [ACMO] propped up this claim by referencing inapplicable exceptions to DEA regulations under 21 C.F.R. §1301.24, a provision permitting DEA registration compliance to be foregone in a narrow set of circumstances, *e.g.* when an official procures controlled substances "in the course of an inspection" or "in the course of any criminal investigation."[49] Strikingly, OPR either failed to investigate [ACMO]'s continued attempts to procure narcotics after his unauthorized policy creation in September 2023, or they failed to report on these findings, an unacceptable oversight.

*C. OPR's investigative summaries indicate either [ACMO] or his superiors were not truthful about the superiors' knowledge of [ACMO]'s attempts to procure fentanyl in September 2023.*

Additionally, OPR's witness interview summaries show that either [ACMO] lied about having prior unofficial approval of his plan to procure narcotics for the UNGA mission or that his superiors untruthfully denied having known about [ACMO]'s improper policy creation in 2023. In his interview with OPR on April 25, 2024, [ACMO] stated that he "discussed his plan to procure the narcotics with his supervisor, DHS CMO [Dr. Wolfe]."[50] According to OPR, Dr. Wolfe recalls otherwise. In an interview on June 26, 2024, OPR reports that Dr. Wolfe said "ACMO's desire to procure CSA Schedule II Narcotics for the UNGA security mission in September 2023 was only discussed after media reports." OPR notes that Dr. Wolfe later reiterated this point expressly: "He emphasized [that with ACMO] there was no direct conversation about procuring controlled substances without proper authorization."[51]

Additionally, when [ACMO] rushed to create and sign his own narcotics policy before the UNGA, he first told OCMO staff that there was no need to seek approval for the procurement from Executive Assistant Commissioner for Operational Support (EAC), and that it would set "bad precedent."[52] However, after [REDACTED] raised concerns about [ACMO]'s plan to not seek EAC's approval on September 11, [ACMO] replied, "Sorry I think I didn't communicate well," and told OCMO staff via email the following day that he was "awaiting DEAC input" and that "aEAC concurs in principle with the direction."[53] Evidently, [ACMO] did not ever actually share this policy with EAC [redacted] and lied to OCMO staff, or EAC [redacted] was untruthful in her interview with OPR, as OPR's summary of an interview with her states: "EAC [redacted] indicated she was never provided the Operational Medicine policy for review."[54]

Additionally, as messages documented in Exhibit N make clear, Deputy Executive Assistant Commissioner for Operational Support [redacted] knew about [ACMO]'s self-authorized creation of a narcotics policy before his trip to the UNGA.[55] DEAC [redacted] had also been informed that [ACMO] removed reference to DEA regulations before signing the policy.[56] As noted below, OPR inexplicably failed to

[47] Evidence available with Government Accountability Project upon request.
[48] *See* Evidence available with Government Accountability Project upon request.
[49] *Id*.
[50] U.S. Customs and Border Protection Office of Professional Responsibility Investigative Operations Directorate, *supra* FN 44 at 7.
[51] *Id*. at 8-9.
[52] Evidence available with Government Accountability Project upon request.
[53] Evidence available with Government Accountability Project upon request.
[54] U.S. Customs and Border Protection Office of Professional Responsibility Investigative Operations Directorate, *supra* FN 44 at 6.
[55] See Evidence available with Government Accountability Project upon request.
[56] *Id*.

interview DEAC [redacted] in relation to these allegations, or, if he was interviewed, OPR failed to include the information he provided in their Case Closing Report, which would have been critical to a thorough analysis of the facts.

*D. Not only did [ACMO] engage in wrongdoing by self-authorizing a policy, OPR's report indicates he also violated a DHS OHS directive.*

Finally, OPR's report notes that there was also a specific directive, Delegation to the Chief Medical Officer/ director of the Office of Health Security Delegation 26000, that [ACMO] was aware of and flagrantly disregarded. In fact, as the OPR report notes, Dr. Wolfe had personally provided this policy to all staff of OHS.[57] Additionally, OPR's report glosses over the fact that even worse than creating a policy that he knew he was not authorized to create himself, [ACMO] directed his subordinates to help him do so, even after they expressed concern about creating such a policy unilaterally and without DEA compliant language or procedures in place. This is especially dangerous because [ACMO] has a documented, OPR-substantiated history of violating policy and has now been offered the permanent CMO role, which will make him head of OCMO, a position of authority that he has already demonstrably abused, particularly by taking retaliatory actions against those who challenged him for his narcotics policy violations and other wrongdoing.

*E. OPR's report minimizes [ACMO]'s wrongdoing in creating a policy he did not have the authority to create and indicates that CBP has taken no corrective action against him.*

The Whistleblowers, some of whom witnessed these events, and some of whom were directed to assist with this unauthorized attempted procurement of fentanyl and midazolam in September 2023, object to OPR's minimization of [ACMO]'s actions in their report. For example, in the executive summary, OPR highlights witness testimony that "ACMO's proposed CBP OCMO policy *would* have been in violation of OHS DHS Delegation Number 26000," (emphasis added). However, [ACMO]'s policy was not a proposal—he signed it and presented it as official—and it *did* violate OHS DHS Delegation Number 26000. Similarly, the agency cover letter states: "Dr. Wolfe specifically noted that [ACMO] would have been in violation of policy if he had actually procured the controlled substances." However, as OPR's own findings illustrate, [ACMO]'s unauthorized actions were only tempered by a supplier's backorder that prevented him from carrying his plan to fruition. Plainly put, [ACMO] both violated policy and attempted to violate policy; the gravity of his actions should not be dismissed because of his apparent lack of success.

In light of the above, the agency must explain why OPR's report excluded information about their 2021 investigation into [ACMO]'s improper procurement of fentanyl and other controlled substances and explain how it will hold [ACMO] accountable for the "Fentanyl 1" episode as well as the policy violation they sustained related to "Fentanyl 2." The Whistleblowers call on the OSC to request that the agency rewrite the report, including all relevant information, and present it separately from their report allegation nos. 1 and 4. The new report must include all relevant information from related interviews OPR has conducted. Indeed, as noted, Government Accountability Project is aware of several interviews with OPR about the narcotics policy [ACMO] created in "Fentanyl 2" that were not included in OPR's Case Closing Report.

[57] While OPR's report does not explicitly state as much, the implication is that [ACMO], who was on detail from DHS OHS to CBP in his role as ACMO, would have received a copy of this policy and knew or should have known that he was beholden to it.

## III. OPR's Report Evidences a Cursory Investigation into the Allegation that [ACMO] Improperly Sought to Replace the CBP EMR and Inaccurately Presents Facts, in Violation of 5 U.S.C. § 1213(d)(3).

OPR unreasonably concluded that [ACMO]'s attempts to replace OCMO's EMR did not constitute gross mismanagement or waste. Below, the Whistleblowers demonstrate that their disclosures about [ACMO]'s improper attempts to replace the EMR are far beyond a mere difference in policy preference. This disconnect shows that OPR failed to thoroughly investigate OSC-referred allegation no. 1, and that their conclusions are unreasonable.

### *A. OPR's report fails to recognize the unique context for which the CBP EMR was built and the expertise that led to its inception.*

Around the time of OCMO's initiation, the former CBP CMO led a coordinated multi-stakeholder effort to identify CBP requirements to inform the strategic development of an EMR system. Following this process, OCMO custom built the current EMR, which has since been recognized for its effectiveness.[58] The CBP EMR approach was predicated on two critical factors: the unique operational medical support requirements faced by CBP, and lessons learned from EMR challenges faced by other agencies.

It must be noted that when it was created, OCMO was a novel office performing a function that had never existed before within CBP; for this reason early analysis determined that the CBP EMR needed to be custom built. CBP needed a system to be specifically programmed to align with CBP medical support processes, procedures, and forms, while being flexible and nimble enough to allow adaptation in real-time to evolving operational requirements.

Additionally, the distinctive environment in which CBP provides medical support cannot be overstated. It is different from any other domestic medical setting, including hospitals, medical care in long-term custody situations like prisons and Immigration and Customs Enforcement (ICE) detention facilities, and even short-term custody situations like jails. Unlike all these environments, CBP's medical operations must be prepared to screen and triage medical needs for up to hundreds of people at a time of all age ranges who are in short term federal custody. Many individuals whose information is entered into the CBP EMR are transferred to the custody of other federal components, including ICE and the Office of Refugee Resettlement of the Department of Health and Human Services. In such circumstances, interoperability between a medical records system and federal enforcement databases is paramount, and the team designing the EMR worked with other DHS components to ensure interoperability was baked into the system from the start. Such interoperability would be a significant challenge, if even achievable, with a commercial system.

To understand EMR lessons and challenges faced by other agencies, the former CBP CMO and OCMO team reviewed publicly available information and interfaced with numerous stakeholders across the U.S. government and in the private sector. Through this process, OCMO learned from other agencies' experiences that there would be expected, and significant, challenges and shortcomings that would cost years of time and millions if not billions of taxpayer dollars if OCMO were to attempt to adapt a commercial "off-the-shelf" (COTS) system, and that such a system would be unlikely to ever meet CBP's needs.

[58] Aaron Boyd, "CBP Built and Deployed an In-House Electronic Health Record System in Under 2 Years," NextGov (July 21, 2022), https://www.nextgov.com/modernization/2022/07/cbp-built-and-deployed-house-electronic-health-record-system-under-2-years/374777/.

For example, OCMO learned of the significant challenges and costs associated with the Department of Veterans Affairs' (VA) ongoing and fraught deployment of a commercial EHR system which has consumed years of effort and billions of dollars, and which has been critiqued in an Inspector General Audit.[59] OCMO similarly learned of substantial challenges and growing pains faced by the Department of Defense in its use of a commercial EHR also requiring years of transition and billions of dollars.[60] In OCMO's review, concerns were discovered about ICE's commercial system, and OCMO also learned of shortcomings and pitfalls in the U.S. Coast Guard's prior commercial EHR system which was critiqued for wasting years of time and millions of dollars while delivering ineffective performance.[61] In contrast, CBP was able to achieve initial functionality within six months of a tailor-made EMR at a fraction of the cost; less than five million dollars. Indeed, some personnel from other agencies have sought advice from OCMO on how to pursue an approach in their health records systems similar to that of the CBP EMR.

Initiated in the first quarter of 2020, the CBP EMR system was designed to be continually enhanced through ongoing development cycles.[62] OCMO, working with stakeholders, has overseen dozens of enhancements and regularly pursues and receives feedback from various stakeholders, including medical providers who use the system in CBP facilities, for additional developments. Indeed, OCMO staff currently oversee a team of three full-time developers contracted to update the system as issues arise and updates are incorporated. The CBP EMR system has been recognized by the DHS Chief Medical Information Officer (CMIO) as one of the best systems within the agency.

Contrary to [ACMO]'s assertion, which OPR's report regurgitates,[63] that the EMR was created by inexperienced staff, the effort was led, from its inception, by a CMO with significant experience in remote medical operations and record keeping along with a team of information technology and systems engineer contractors with expertise in web-based medical records systems. This team planned the development of a customized system that would respond to requirements identified by a qualified team of OCMO personnel with medical, law enforcement, and information technology experience. Together, these teams worked closely with CBP Office of Information and Technology (OIT) experts and the DHS CMIO to build the EMR to respond directly to medical needs in the unique setting of providing medical support to noncitizens in CBP custody.

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[59] Sara Samora, "DOD, VA did not do Enough to Make New Electronic Health Record System Work, IG Audit Finds," Stars and Stripes (May 16, 2022).

[60] Karen Jowers, "Errors in DoD's New Electronic Health Care Records System Raise Concerns Among Providers," Military Times (May 9, 2022), https://www.militarytimes.com/pay-benefits/2022/05/09/errors-in-dods-new-electronic-health-care-records-system-raise-concerns-among-providers/.

[61] *See e.g.* Robert N. Charette, "U.S. Coast Guard's $67 Million EHR Fiasco," IEEE Spectrum (March 9, 2019), https://spectrum.ieee.org/us-coast-guards-67-million-ehr-fiasco.

[62] *See* Aaron Boyd, *supra* FN 58, noting CBP's plan for the EMR to be "a continually evolving resource."

[63] Whistleblowers also note that while OPR failed to include part of its investigative record, as described in section V.B. below, OPR did include misleading statements from personnel who are not subject matter experts. For example, the investigative report includes an interview summary from the Acting Director, Significant Incidents Program, OPR, CBP (DIR SIP) regarding the EMR. The summary attributed to the DIR SIP states: "Specifically, DIR SIP noted a Border Patrol Agent may not be the best person to put in charge of designing a retention system for medical records. Since the in-custody death, DIR SIP stated he was unaware of any changes made to the EMR system." The DIR SIP was likely referring to whistleblower [REDACTED], and the implication of the statement is that a front-line law enforcement officer should not be responsible for the entire EMR. However, [REDACTED], in addition to being a Border Patrol Agent, has nearly two decades of experience in emergency medical care, and, as described in section III.A., was one of many individuals with a broad range of medical and information technology expertise who developed the EMR. The DIR SIP's admitted ignorance of the improvements made to the EMR calls into question why the DIR SIP was consulted to opine on the present effort to replace the EMR.

Despite his claims about OCMO personnel's limited experience, in fact it is [ACMO] who has evinced limited knowledge about the functionality of EMR and EHR systems, CBP's unique EMR requirements, the challenges of adapting commercial systems to remote, operational, non-hospital settings, and the current capabilities of the CBP EMR. As stated below, [ACMO] did not even bother to gain access to the CBP EMR and its full functionality until after public reports about his role in undermining it, and he still regularly demonstrates lack of understanding of CBP EMR capabilities and forthcoming enhancements.

*B. The OPR report parrots [ACMO]'s narrative about the need to replace the EMR without recognition for OCMO's actual medical records needs.*

Upon his appointment as ACMO, [ACMO] asked Acting CBP Commissioner Troy Miller to organize a team to conduct a comparative analysis of the CBP EMR and other COTS systems. CBP's Enterprise Services created a team to begin the alternative analysis, though OCMO staff who created the system and oversee its use were not made aware of this review until a few weeks after the initiation of the analysis in June 2023, when a member of the review team decided it would be wise for OCMO staff working regularly with the CBP EMR to be involved and provide more in-depth information about its use and functionality.

The initial results of the alternative analysis, ranking inter-operability with federal enforcement systems highly in the rubric of comparison — consistent with the conclusions that originally led CBP to create a custom EMR — indicated that the CBP EMR system was the most cost-effective among those compared, and that it could continue to be internally enhanced to meet developing needs. Indeed, the Whistleblowers who participated in this analysis report that in the first evaluation of the current EMR, the system met 78% of performance requirements. While the EMR fell short on clinical decision support functions, that capability had not previously been part of the CBP EMR design requirements because clinical decision support would in effect direct the private contractor's medical treatment; the Federal Acquisition Regulation prohibits the federal government from directing the operations of a contractor.[64]

However, when the review team presented these results at a meeting in early December, 2023, [ACMO] was incredulous that the CBP EMR system could be ranked so highly against COTS products and said that it appeared his team had "cooked the books" to give the in-house system inflated ratings. In a meeting the following day, [ACMO] again accused the team of "cooking the books" and directed them to change course, stating in no uncertain terms that the team needed to make the CBP EMR look worse than it was in order to secure new funding.

[64] Under the Federal Acquisition Regulation (FAR), the government's supervisory authority over independent contractors extends only to the outcome of a contractor's work, for example, in verifying contract deliverables; government supervision stops short of directing a contractor's means of achieving particular outcomes. *See* 48 C.F.R. § 37.104 (2024), safeguarding contractor independence and prohibiting personal service contracts in which an employer-employee relationship is formed between the government and a contractor. Such a relationship occurs when "as a result of (1) the contract's terms or (2) *the manner of its administration during performance, contractor personnel are subject to the relatively continuous supervision and control* of a Government officer or employee," (emphasis added). FAR 37.104(b). *See also id*. at §1.602-2, explaining that government personnel overseeing contracts "[h]a[ve] no authority to make any commitments or changes that affect price, quality, quantity, *delivery*, or other terms and conditions of the contract," (emphasis added). Clinical decision support refers to technology that provides specific alerts and instructions to medical service providers logged into a care support system. Rahul Awati, Megan Charles, and Alex DelVecchio, "Clinical decision support system (CDSS)," Tech Target (last visited Nov. 29, 2024), https://www.techtarget.com/searchhealthit/definition/clinical-decision-support-system-CDSS#:~:text=Another%20potential%20problem%20with%20a,and%20other%20patient%20care%20activities. While clinical decision support functionality could be added to the current OCMO EMR, it would apparently result in government direction of a contractor's administration of medical care, in violation of the FAR.

As OPR's report notes, [ACMO] claims that clinical decision support could have prevented the death of the eight-year-old child Anadith Reyes in CBP custody. As tragic, and preventable, as this death was, [ACMO]'s blame of the EMR is a red herring that distracts from the root causes of the death. If [ACMO] can convince CBP leadership and Congress that the EMR is to blame for the death, he creates the illusion that there is a single quick solution he can pursue to claim he has prevented future deaths without actual accountability or change to the underlying status quo of pervasive systems-failures. As explained in the Whistleblowers February 16, 2024 disclosure, Anadith died because (1) private contractor Loyal Source Government Services (LSGS) was understaffed and unqualified to perform its contract functions (2) CBP's Office of Acquisition repeatedly refused to issue corrective notices to LSGS of these deficiencies, and (3) CBP leadership grossly underinvested in OCMO, stunting its development as initially planned.

Furthermore, clinical decision support would not have ensured that the clinician in charge of Anadith's care provided the care she required. Indeed, that clinician had access to patient care notes in the EMR at the time of Anadith's death, and OCMO had given Loyal Source guidance that Loyal Source staff were to consult on-call pediatric advisors and/or physician supervisors for any patients with complex or serious medical conditions, and to err on the side of referring and transporting such patients to a local health facility for further evaluation. However, the contractor failed on multiple occasions to follow this guidance, and OCMO had been attempting to remediate these failures through ongoing conversations with Loyal Source and CBP OA. In Anadith's case, the Loyal Source provider was apparently unwilling to respond accordingly. Indeed, CBP OCMO's own root cause analysis showed it was the fault of the provider that led to the child's death and that her pre-existing condition was documented in the EMR.[65]

Moreover, clinical decision support may actually be a further impediment to adequate medical care in the fast-paced environment of CBP medical care due to "alert fatigue."[66] While OCMO personnel are adamant that the EMR can and should be continuously improved, as it was designed to be, and that it has changed dramatically since Anadith's death, they are highly concerned that scrapping the custom-built EMR is not in the best interest of noncitizens in CBP custody, providers, or taxpayers.

*C. The OPR report fails to reflect evidence that expenditure on a commercial off-the-shelf electronic health record system is a gross waste of federal funds.*

Despite [ACMO]'s grand efforts to show the need for an EHR model to replace the current EMR, a commercial off-the-shelf system would be inappropriate for the provision of medical care within the context of CBP detention, unnecessarily expensive, and significantly challenging to integrate with government systems. In fact, it represents a red flag for significant gross waste in the future. Indeed, OCMO staff other than [ACMO] are cognizant of the lessons to be learned from the Department of Veteran's Affairs' (VA) disastrous shift from a custom EMR model to a commercial off-the-shelf model, which has been publicly documented. The VA EHR is six years and several billions of dollars into implementation and yet still presents potentially insurmountable challenges for the Department. A VA Office of Inspector General report issued in September 2024 found that since the VA awarded a private contractor to implement an EHR system in 2018, "it has experienced hundreds of major performance incidents," and the "original $16

[65] *See e.g.* U.S. Customs and Border Protection, *supra* FN 8.

[66] Because the provider in the Anadith Reyes case failed to heed the pleas of the patient's mother or review the patients case notes, which were readily available in the EMR and described her preexisting condition, it is not clear that clinical decision support notifications would have changed the outcome, especially given providers' limited bandwidth in chronically understaffed conditions and the prevalence of alert fatigue. *See* Awati, Charles, DelVecchio, *supra* FN 52, noting, "[t]he alerts triggered by a CDSS can overwhelm caregivers who also receive prompts from other technology systems. As a result, they might ignore one or more alerts, which might have significant consequences for diagnosis, decision-making and other patient care activities."

billion price tag" "has grown."[67] In fact, the VA Inspector General is raising the alarm that the VA EHR could cost nearly *$50 billion* in all, according to expert analysts.[68]

In addition to its staggering price tag, the VA EHR poses massive challenges to providers attempting to use it. The VA Inspector General recently issued a management advisory memo titled, "Facility Leaders and Staff Have Concerns about VA's New Electronic Health Record," in which a VA provider stated that the new EHR system's implementation is "the single largest challenge that we have here." Multiple other facility leaders "described notable concerns related to (1) efficiency and loss of productivity, (2) staffing, (3) financial impacts, and (4) patient safety."[69] Unfortunately, VA patients are the hardest hit by the EHR's deficiencies; major EHR performance issues have been linked to negative impacts on veterans' care.[70] As recently as December 12, 2024, the GAO also highlighted the VA EHR's ongoing deficiencies and the need for continual monitoring and improvement.[71]

It is in this context of a potential multi-billion-dollar disaster that the Whistleblowers are particularly concerned that OPR unreasonably determined [ACMO]'s efforts to replace the EMR are not improper. Whistleblowers have raised the above concerns to [ACMO] over the course of his tenure as ACMO, and he has ignored them and spent countless hours of taxpayer dollars pursuing his flawed endeavor.[72] They are therefore concerned about the agency's inaccurate assertion in their cover letter that "except for the use of CBP personnel's time and effort in the review of the EMR and alternatives to it, CBP resources have not been used to change the system." In reality, due to the failures of CBP and DHS leadership to intervene, Whistleblowers report that [ACMO] has set aside close to $7 million to perform a second analysis of the OCMO EMR system. In fact, contracts have already been selected to create an "acquisition program of record" and a "modeling and simulation" with a test environment to see what a new EHR could look like. The Whistleblowers have observed that [ACMO] has earmarked these funds on divided contracts so as not to reach a threshold that is reportable to Congress.

*D. OPR misleadingly represents that [ACMO] was directed to replace the CBP EMR.*

Additionally, Whistleblowers are concerned that part of OPR's justification for finding [ACMO]'s attempts to replace the EMR a policy preference rather than gross mismanagement or waste, is that a review of the

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[67] *See* VA OIG, *supra* FN 7.

[68] *Id*. at i, referencing testimony of analyst Brian Q. Rieksts before the Senate Committee on Appropriations, 117th Cong. (Sep. 21, 2022).

[69] *See* VA OIG, "Facility Leaders and Staff Have Concerns about VA's New Electronic Health Record," (Sept. 23, 2024), https://www.vaoig.gov/reports/management-advisory-memo/facility-leaders-and-staff-have-concerns-about-vas-new-electronic.

[70] VA OIG, "VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents" (Sept. 23, 2024), https://www.vaoig.gov/reports/audit/va-needs-strengthen-controls-address-electronic-health-record-system-major.

[71] Government Accountability Office, "Veterans Affairs: Action Needed to Address Continuing IT Management Challenge," (Dec. 12, 2024, https://files.gao.gov/reports/GAO-25-107963/index.html?_gl=1*a800dg*_ga*MTg2OTY5MzI4Ni4xNzM0MDI5NDIw*_ga_V393SNS3SR*MTczNDEwOTg1NS4yLjEuMTczNDExMTExMy4wLjAuMA..

[72] Reining in federal spending of taxpayer dollars is a bipartisan issue, and one of paramount importance to the incoming presidential administration. Under the Trump administration, the Department of Government Efficiency (DOGE) will confront wasteful government spending, including on federal contracts greenlit through the "badly broken" "federal governmen[t] procurement process." DOGE will thereby address "the sheer magnitude of waste, fraud and abuse that nearly all taxpayers wish to end." Elon Musk and Vivek Ramaswamy, "The DOGE Plan to Reform Government," The Wall Street Journal, (Nov. 20, 2024), https://www.wsj.com/opinion/musk-and-ramaswamy-the-doge-plan-to-reform-government-supreme-court-guidance-end-executive-power-grab-fa51c020?mod=opinion_trendingnow_article_pos1.

system was not [ACMO]'s idea but, rather, a recommendation by Dr. Wolfe in a memo written after the death of Anadith Reyes. Indeed, the agency cover letter accompanying OPR's report states: "It is important to note that [ACMO]'s review of the EMR was not on his own initiative. Rather guidance from the DHS Chief Medical Officer (DHS CMO Dr. Wolfe) and from the Acting Commissioner all suggested that [ACMO] was tasked to carefully review EMR and alternatives." However, the Whistleblowers have heard [ACMO] himself and/or a former Deloitte contractor, who [ACMO] referred to as his senior consultant, [REDACTED], state that they—not Dr. Wolfe—penned the memo recommending the EMR be reviewed and potentially replaced. It was after this apparently self-directed memo that [ACMO] then oversaw the EMR alternative analysis process, in which, as OPR's report documents, [ACMO] exerted improper influence to skew results favoring an EHR.

Finally, had OPR conducted a thorough investigation, they may have asked OCMO to pull [ACMO]'s EMR access log, which, upon review, would show OPR that [ACMO] may not be the best judge of the EMR system's capabilities in the first place. An EMR audit log generated in October 2024 shows that [ACMO]'s first login to the EMR system since he became ACMO in mid-2023 was on February 21, 2024, five days after the Whistleblowers' public disclosures related to his improper attempts to replace the system and months after he began his EMR replacement crusade. Furthermore, according to the audit log, [ACMO] has only logged on to the EMR a handful of times since.

*E. OPR's superficial investigation of potential gross waste in the billions of dollars must be rectified.*

OPR's unreasonable conclusion that [ACMO]'s crusade against the CBP EMR does not constitute gross waste or mismanagement shows that either (1) OPR's investigation was cursory and failed to identify relevant facts or (2) OPR intentionally excluded facts that would have supported a finding of alleged wrongdoing. Either way, OPR's treatment of this OSC-referred allegation is inadequate and must be rectified through the publishing of a revised report.

OPR's refusal to afford this allegation the attention it merits has serious implications for what may ultimately amount to billions of taxpayer dollars spent on a commercial off-the-shelf system that only speculatively may have any impact on CBP medical support, or worse, would create new and long-lasting problems like in the case of the VA's system transition. OPR's conclusion also gives credence to [ACMO]'s mistaken red herring narrative that technological fixes can address the systemic failures that have led to failings in the provision of medical care to noncitizens in CBP custody, including preventable deaths of children.

## IV. OPR's Report Fails to Describe, Pursuant to 5 U.S.C. § 1213(d)(5), what Corrective Action Will be Implemented in Response to the Findings that [ACMO] Violated Policy.

As in their report concluding that [ACMO] violated policy by consuming alcohol while carrying his CBP-issued firearm, here too, OPR found that [ACMO] violated policy by improperly creating a narcotics policy. Despite these findings, both reports state plainly that CBP did *not* take administrative action against [ACMO]. In addition, OPR's report on OSC-referred allegations nos. 1, 2, and 4, taken together with the evidence that the Whistleblowers have provided here and that OPR's investigation should have revealed, indicate that DHS and CBP leadership—including DHS CMO Dr. Herbert Wolfe, EAC [redacted], and DEAC [redacted]—likely knew about [ACMO]'s improper creation of a narcotics policy in September 2023, and not only failed to take action, but in some instances even facilitated [ACMO]'s unauthorized conduct.

As whistleblowers pointed out in their comments responding to OPR's report on allegation no. 3, here too OPR's failure to appropriately respond to policy violations by superiors at CBP reflects the culture of

impunity for leadership that the GAO has identified as a systemic problem.[73] This culture is particularly concerning in light of the Integrity Committee of the Federal Council of Inspectors General's recent findings related to a range of wrongdoing committed by the DHS Inspector General (OIG), the agency's foremost office charged with ensuring accountability.[74] Even still, in their annual report on top management challenges facing DHS released in November 2024, the OIG described that top ongoing challenges at DHS include transparency and accountability, resulting in major potential risks in the agency's execution of their mandate.[75]

In this case, while CBP rescinded the policy that [ACMO] improperly created, it appears that the agency only did so in February 2024, when Whistleblowers' disclosures were made public and the media published stories regarding [ACMO]'s attempt to procure fentanyl for UNGA five months prior. Even still, policy recission is clearly not enough for [ACMO], who has ignored policy in the past—and who may have previously improperly created a narcotics-related policy at DHS for personal benefit.

OPR's failure to seek consequences for their findings signals to [ACMO], and CBP superiors and subordinates alike, that writing one's own policy to procure narcotics, even when one has a history of improperly procuring narcotics, warrants no disciplinary action at CBP, one of the world's largest law enforcement bodies. Not only has [ACMO] faced no consequences for multiple violations of policy that OPR investigations have sustained, but as previously stated, reports indicate that he is soon to be awarded a permanent position as the CBP CMO, the head of OCMO. It is essential that persons in positions of power, at CBP and elsewhere in the U.S. Government, cannot write their own rules, and that they sustain consequences when they are caught doing so. Therefore, the agency must explain how it will hold [ACMO] accountable for the violations that CBP OPR's investigations have sustained and those that they should have sustained when all evidence is considered.

## V. OPR Unreasonably Failed to Identify Additional Allegations of Wrongdoing and Failed to Uphold Professional Investigative Standards, Evidencing a Pattern of Improper Responses to Allegations Referred to DHS by the OSC.

### *A. OPR's failure to identify any additional or related allegations of wrongdoing discovered during their investigations into the referrals by OSC shows that OPR's investigations were improperly superficial.*

In addition to the three specific allegations that the OSC referred to DHS for investigation after determining it was substantially likely that wrongdoing had occurred, the OSC referred to DHS a fourth allegation: any additional or related allegations of wrongdoing discovered during the investigation of the foregoing allegations. OPR's present report makes only a passing reference to allegation no. 4 in the agency cover letter: "no other misconduct was identified." The Whistleblowers contend that this determination is unreasonable—had OPR's investigations been as thorough as the allegations warrant, it would have been impossible for OPR *not* to identify additional potential wrongdoing to investigate. Furthermore, OPR could have reported to the OSC on the multiple investigations it has had into numerous other allegations of his wrongdoing. Below, Whistleblowers provide a non-exhaustive list of additional allegations of wrongdoing,

[73] Government Accountability Office, *supra* FN 6.
[74] Council of the Inspectors General on Integrity and Efficiency, Integrity Committee, Report of Findings for Integrity Committee Case 20-059 (Oct. 2, 2024), https://oversightdemocrats.house.gov/sites/evo-subsites/democrats-oversight.house.gov/files/evo-media-document/2024-10-02-IC20-059-Letter-to-the-President-Redacted-w-Encls.pdf at page 22.
[75] U.S. Dep't of Homeland Security, Office of the Inspector General, "Major Management and Performance Challenges Facing the Department of Homeland Security," (Nov. 8, 2024) https://www.oig.dhs.gov/sites/default/files/assets/2024-11/OIG-25-04-Nov24.pdf.

some of which OPR has purportedly been investigating, and that a reasonable OPR report would have identified in response to allegation no. 4:

- Whether [ACMO] improperly provided insider information to private consulting firm Deloitte during the Request for Information process for a potential commercial off-the-shelf EHR system; whether [ACMO] improperly provided this information to Deloitte contractors he improperly hired into key OCMO positions; and whether, should an EHR be considered to replace the CBP EMR, Deloitte will remain eligible to compete for the contract to customize and integrate the EHR.

- Whether [ACMO] and/or [REDACTED], a Deloitte contractor that [ACMO] hired as his Senior Consultant, improperly wrote or otherwise improperly influenced the memo ostensibly prepared by Dr. Herbert Wolfe, then DHS ACMO, that presented deficiencies in the EMR as one of the primary contributing factors to Anadith Reyes' death in custody.

- Whether [ACMO] retaliated against employees who raised concerns about his actions related to "Fentanyl 1" or "Fentanyl 2" or otherwise created an environment in which subordinate employees may be deterred from raising concerns about his potential wrongdoing.

- Whether [ACMO] engaged in wrongdoing with respect to the draft policy template he provided to OCMO employees for the creation of the unauthorized narcotics policy, for example, by using a CWMD policy that he may have previously forged.

- Why CBP leadership only rescinded the narcotics policy [ACMO] created and signed without authorization five months after the policy was created and after media coverage of whistleblowers' related public disclosures in February 2024, despite OPR's investigation into the matter that began as early as November 2023.

- Whether [ACMO]'s presence on the September 2023 UNGA mission and/or previous missions were properly authorized and/or may constitute gross waste or mismanagement.

- Whether [ACMO] has procured or attempted to procure other controlled substances beyond fentanyl in an authorized manner.

- Whether [ACMO]'s past unauthorized procurement of controlled substances or the unauthorized policy he created violated Drug Enforcement Administration regulations on the transport, use, storage, disposition, and disposal of controlled substances.

- Whether [ACMO] and [REDACTED] at any time conspired to improperly maintain the FDL Group, a private company where [ACMO] was employed as Chief Medical Officer, as a preferred vendor of medical supplies to AMO.

- Whether [ACMO] at any time abused his authority as CBP ACMO by falsely representing that as a customs officer he would be exempt from DEA registration requirements.[76]

- Whether [ACMO] retaliated against a whistleblower for reporting him to OPR for consuming alcohol at a bar while carrying his CBP issued firearm.

[76] *See* Evidence available with Government Accountability Project upon request.

OPR's failure to identify these and/or other allegations shows that their investigations were cursory and that this Case Closing Report is unreasonable. It further shows that CBP leadership should take caution in their plan to appoint [ACMO] as CBP's permanent CMO.

*B. As in their first report on the substantiated allegation that [ACMO] consumed alcohol while carrying his agency-issued firearm, here too OPR failed to meet professional investigative standards by omitting witness testimony and failing to explain the facts with precision.*

The summaries of witness interviews that OPR's report includes indicate that, as in the prior report in which they omitted key witness interviews, here too OPR takes a pick-and-choose approach to the information presented. First, OPR's report misquotes and misrepresents interviews with witnesses, including the interview summaries for Whistleblower [REDACTED] and former CBP CMO.[77] Though the former CBP CMO provided relevant information regarding the EMR to OPR, OPR's report claims he "provided no information regarding the EMR." In fact, OPR cut short a preliminary interview with the former CBP CMO, and informed him that they would schedule a follow-up interview to discuss issues, including the EMR, in more detail. However, OPR canceled the interview subsequently scheduled and failed to again meet with the former CBP CMO, despite the former CBP CMO's repeated attempts to provide information relevant to OPR's investigation.

Second, OPR's report inexplicably omits the interview that OPR Agent [redacted] held with Confidential Whistleblower 1 on December 5, 2023. During this interview, Confidential Whistleblower 1 provided [redacted] information about [ACMO]'s unauthorized attempt to procure fentanyl through the creation of his own narcotics policy, his improper attempts to replace the CBP EMR, an incident involving the Flores Settlement Monitor, and [ACMO]´s insistence to CBP staff that as a customs officer, his procurement, storage, and transport of controlled substances were excepted from DEA registration requirements.[78] Indeed, the report appears to omit all information this Whistleblower provided OPR.

Third, OPR failed to interview or include the interview summaries of key witnesses, like DEAC [redacted] who is mentioned by name in OPR's report as having relevant first-hand knowledge about the allegations investigated. Indeed, OPR's report notes that Whistleblower [REDACTED] reported turning to DEAC [redacted] for guidance when [ACMO] instructed OCMO staff to create the narcotics policy that [REDACTED] was concerned did not comply with DEA regulations.[79] The omission of information provided by DEAC [redacted] in OPR's report can only be explained as a gross oversight or intentional omission to shape the narrative presented at the expense of accountability for CBP leadership.

Additionally, OPR apparently failed to discuss the CBP EMR with leaders in other DHS components including ICE and the Coast Guard, who gave input based on their experiences and lessons learned from their own records systems. Basic information from these components about the development of CBP's EMR would have given OPR the requisite context to reach the logical conclusion that [ACMO]'s crusade against the CBP EMR does not represent a reasonable difference in policy preference, but instead indicates that [ACMO]'s deep misunderstanding of the current EMR system tees him up to engage in gross waste by replacing the custom-made system with an alternative that could unnecessarily cost taxpayers billions of dollars.

[77] OPR's report refers to the former CBP Chief Medical Officer as the "OCMO CMO" in their interview summary though the accurate title is CBP CMO. U.S. Customs and Border Protection Office of Professional Responsibility Investigative Operations Directorate, *supra* FN 44 at 5.
[78] *See* Evidence available with Government Accountability Project upon request.
[79] *See* Evidence available with Government Accountability Project upon request.

Finally, as in their report on allegation no. 3, OPR's present report fails to describe relevant facts with precision or clarity, leading to confusion at the expense of transparency and accountability. OPR's report is poorly written, which has a substantive impact on its function for transparency and accountability. For example, on page 4, in reference to the policy violation that OPR sustained based on [ACMO]'s unauthorized creation of a narcotics policy in September 2023, they state: "The interviews of Chief Medical Officer (CMO), Office of Health Security (OHS), Department of Homeland Security (DHS)(DHS CMO), and Chief of Staff (CoS) OHS, DHS (COS2), revealed ACMO was in receipt of and responsible for adhering to Delegation Number 26000, Delegation to the DHS CMO, which outlined the responsibilities of ACMO's role to include, but not limited to, the procurement of, and proper handling and use of, controlled substances and prescription drugs." It is unclear whether "ACMO" here refers to DHS CMO Dr. Wolfe or CBP ACMO [ACMO]. Presumably, this reference is meant to refer to Dr. Wolfe since OPR's policy violation and numerous witness interview summaries that OPR presents demonstrate that [ACMO] did not have authority under this policy to create his own procurement policy for narcotics. However, a plain reading of this sentence, with "ACMO" referring to the CBP ACMO, *[ACMO]*, would indicate that he did. Not only does this obfuscate the facts for OPR's present purposes of responding to the OSC's allegations, but it also taints the clarity of [ACMO]'s wrongdoing in OPR's historical record.

## VI. OPR's Report is an Affront to the OSC as a Channel for Whistleblower Disclosures Under the Whistleblower Protection Act.

The unreasonableness of OPR's report raises serious concerns for accountability and institutional integrity at CBP. This report flies in the face of CBP OPR's published 2024-2028 Strategy, in which they committed to "[l]ead by example and promote the proper norms, beliefs, high-standards, and core values that reinforce CBP's foundation; and [c]ommunicate the truth and ensure that transparency and accountability remain paramount."[80]

This landscape makes the role of whistleblowers at the agency all the more important, and it heightens whistleblowers' reliance on the OSC to ensure that their disclosures under the Whistleblower Protection Act are not raised in vain. OPR's unacceptable treatment of this OSC-referral cannot stand, as OPR not only failed to adequately address the present allegations but also risks setting a precedent for trivializing whistleblower disclosures, contributing to a culture of impunity and silence.

Respectfully submitted,

/s/Andrea Meza

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[80] U.S. Customs and Border Protection, "Office of Professional Responsibility Strategy 2024-2024," https://www.cbp.gov/sites/default/files/assets/documents/2023-Oct/CBP%20OPR%202024-2028%20Strategy.pdf at 12.