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The Special Counsel

January 28, 2021

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-20-000537

Dear Mr. President:

I am forwarding reports transmitted to the Office of Special Counsel (OSC) by the U.S. Department of Health and Human Services (HHS), Office of General Counsel (OGC) in response to disclosures of wrongdoing at the Administration for Children and Families (ACF), Washington, D.C. The whistleblower, [redacted], who consented to the release of her name, disclosed improprieties related to the deployment of ACF personnel to assist Americans repatriated from Wuhan, China, at the onset of the COVID-19 pandemic. I have reviewed the disclosure, HHS OGC's reports, and [redacted] comments, and in accordance with 5 U.S.C. §1213(e) provide the following summary of HHS OGC's reports, the whistleblower's comments, and my findings.

[redacted] allegations were referred to former HHS Secretary Alex M. Azar II pursuant to 5 U.S.C. § 1213. HHS OGC investigated and provided a report signed by former HHS General Counsel Robert Charrow. Despite OSC's requests, HHS OGC did not provide the statutorily required delegation from then-Secretary Azar authorizing Mr. Charrow to review and sign the report on the Secretary's behalf. After repeated requests, HHS OGC provided a supplemental report, which also lacked the necessary delegation from then-Secretary Azar. As explained below in my findings, if not for HHS OGC's failure to obtain delegation from then-Secretary Azar and the unnecessary and offensive addendum included in the supplemental report, the report would have been considered statutorily compliant. However, due to these deficiencies, I find HHS OGC's report to be insufficient and unreasonable.

The Allegations

[redacted] disclosed three allegations. First, [redacted] alleged that Office of Human Services Emergency Preparedness and Response (OHSEPR) Director [redacted] improperly deployed approximately 44 ACF, Emergency Support Function (ESF)-6 personnel for ESF-8 missions to the March Air Force Base (AFB) in January 2020 and the Travis AFB in February 2020. She explained that ACF personnel perform only ESF-6 missions, which generally include providing social work services to assist low-income populations during natural disasters. ACF personnel are not properly trained in handling public health crises. She stated that

ESF-8 missions, including responses to public health crises, are performed by employees in other HHS entities, such as the Office of the Assistant Secretary for Preparedness and Response, because they are trained in how to respond to these types of situations. According to [redacted], the deployment of ACF personnel in an ESF-8 mission was outside the scope of ACF's mission and training.

Second, [redacted] alleged that during their deployments, the 44 ACF personnel were in direct contact with repatriated Americans from Wuhan, China, without proper training or personal protective equipment (PPE) for COVID-19 infection control. [redacted] explained that on February 9, 2020, she received written reports of the March AFB and Travis AFB missions from personnel present during these deployments. According to the reports, OHSEPR leadership positioned ACF staff inside the aircraft hangar, where they were in direct contact with two waves of repatriated Americans. She explained that the ACF personnel did not receive PPE upon arrival or PPE training until the end of their deployment. Moreover, [redacted] asserted that OHSEPR leadership bypassed agency protocol when they authorized the deployment of ACF personnel.

Third, [redacted] alleged that upon completion of the deployments, the exposed ACF personnel returned to normal locations and duties with no follow-up from agency or public health officials. After she became aware of the deployments, [redacted] informed HHS officials, including ACF Assistant Secretary [redacted] and Principal Deputy Assistant Secretary [redacted], of these missions and the potential exposure of agency personnel to COVID-19. However, they did not respond. [redacted] stated that none of the 14 exposed ACF personnel were contacted by agency or public health officials for follow-up or underwent self-quarantining. [redacted] also explained that some personnel took commercial airline flights to return to their offices around the country.

The Initial Report

HHS OGC's initial report, dated April 24, 2020, stated that the January 2020 mission at March AFB had no designated agency official leading the repatriation effort. Additionally, the report confirmed that there were no procedures in place at the March AFB to ensure uniform infection-control and infection-prevention measures, including the proper use of PPE. There were no safety officers designated and in place from the outset of the deployment, and there was no Infection Prevention Control (IPC) Plan in place, which according to the report, is required for deployments of this nature. Moreover, the report stated that clear instructions for proper PPE use were neither disseminated nor posted at the March AFB until three days after the evacuees arrived. For these three days, Centers for Disease Control and Prevention (CDC) personnel, who were also present during these missions, failed to provide formal training or written guidance regarding proper PPE use for ACF personnel. The report further stated that CDC personnel set inconsistent examples with respect to their own personal use of PPE.

The report also found that multiple containment issues occurred at the March AFB. Specifically, a vendor supplying food to evacuees broke the quarantine area without permission. Also, although the report does not expand on the extent of the issues, it does make clear neither training on nor the use of PPE was sufficient. Additionally, ACF personnel were in proximity to

and had contact with evacuees at the March AFB without proper PPE safeguards in place and were instructed to remove PPE to avoid "bad optics." Furthermore, the report concluded that while safety protocols were not followed during the March AFB mission, it was due to the unprecedented nature of the crisis. As for the allegations made against Travis AFB, the report concluded that in contrast to the findings concerning the March AFB mission, there were no deficiencies associated with the Travis AFB mission, and the HHS OGC report did not recommend any further action.

The Whistleblower's Comments

[redacted] vehemently disagreed with the initial report and its findings. First, the report indicated that the findings were based on interviews of 65 individuals and a review of "tens of thousands of documents." [redacted] stated that she was neither interviewed by HHS OGC nor requested to provide documentation as part of the investigation. She stated that several subordinate staff members present for the deployments relayed to her that the HHS OGC interviews were unproductive and that they felt threatened during their interviews.

Second, [redacted] took issue with HHS OGC's report's contention that while safety protocols were not followed, it was due to the unprecedented nature of the crisis. [redacted] noted that HHS is responsible for the national preparedness and charged with responding to any emergency, disaster, or health threat, including a pandemic. Thus, she stated that a crisis does not excuse the agency's failure to perform its mission and delegated responsibilities appropriately and safely.

Third, [redacted] asserted that ACF personnel should never have been deployed for these missions. Specifically, she explained that HHS has ESF-8 personnel to provide the mechanisms for coordinated federal assistance in response to public health disasters. Alternatively, she stated that ACF personnel, who perform ESF-6-related duties, lack public health and medical expertise and training to respond to public health emergencies. Therefore, the agency's use of ACF personnel for these missions endangered the health and safety of staff, the evacuees, and the American public.

Fourth, [redacted] expressed concerns with HHS OGC's findings that similar deficiencies did not occur at the Travis AFB mission in February 2020. She explained that despite [redacted] recommendation that ACF staff provide only virtual case management support for the Travis AFB mission, ACF leadership unnecessarily exposed ACF staff to COVID-19 on multiple occasions. According to [redacted], ACF staff were ordered to directly interact with evacuees at Travis AFB, including distributing room keys, handling luggage, and physically touching evacuees and their belongings. Additionally, she maintained that all U.S. government (USG) employees at the Travis AFB deployment received inconsistent training and guidance on PPE and observed CDC officials failing to wear proper PPE during the Travis AFB deployment. Finally, according to [redacted], the deployed ACF staff were not tested for COVID-19 or monitored for symptoms and moved freely on and off Travis AFB throughout the mission.

Fifth, the report concluded that no USG employees involved in the March AFB repatriation efforts tested positive or contracted COVID-19 as a result of that deployment. However, [redacted] asserted that while no ACF personnel tested positive, it is also true they did not test negative, as no ACF personnel were tested either during or immediately after the deployments period of January 29 to February 12, 2020. According to [redacted], ACF leadership did not offer tests to the exposed personnel until mid-March 2020, well past the COVID-19 incubation period. She fears that ACF personnel may have been asymptomatic or even symptomatic carriers of the disease and contributed to its spread amongst the general public. She noted that on February 26, 2020, the CDC reported the first U.S. community transmission case in Solano County, California, where Travis AFB is located.

The Supplemental Report

After repeated requests from OSC, HHS OGC issued a supplemental report on November 12, 2020, which provided a more extensive and substantive review of the investigation and its conclusions. Primarily, the supplemental report concluded that when the repatriated Americans arrived at the March AFB on January 29, 2020, there was no designated agency or official assigned to lead the repatriation effort, and that an Incident Management Team (IMT) was not deployed until three days after the repatriated Americans arrived. Moreover, the supplemental report fully explained that the March AFB mission did not have established infection control and prevention measures, designated safety officers, or an IPC Plan in place.

Even more concerning, HHS OGC's report substantiated that the March AFB mission did not have sufficient PPE or clear, written instructions for proper PPE usage. As a result, USG personnel did not have PPE for the first three days of the mission, and received "confusing, incomplete, and contradictory" PPE information. The report also found that CDC personnel set inconsistent examples for other USG personnel in how they used their own PPE.

However, the most troubling finding within HHS OGC's supplemental report is that the March AFB mission increased the risk of infection transmission not only to deployed USG personnel, but also to the American public as a whole. Specifically, the report determined that USG personnel exposed the public to COVID-19 transmission through the use of commercial flights following the deployment, a lack of agency guidance on self-monitoring for symptoms, and leadership authorizing USG personnel and repatriated Americans to leave the March AFB for various activities. Ultimately, no repatriated Americans tested positive for COVID-19, and while infection transmission apparently did not occur from the deployment, the report found that, "USG leadership was reckless with respect to the risk of endangering the broader public."

While HHS OGC's supplemental report substantiated many significant deficiencies in the March AFB response, it did not substantiate that these deficiencies were repeated during the Travis AFB deployment. Specifically, the report found that USG personnel arrived at the Travis AFB several days in advance of the arrival of the repatriated Americans. Based on the report's findings, it appears that the Travis AFB was a more coordinated and measured mission. For example, the report concluded that the agency worked to ensure the availability of PPE, that USG personnel at the Travis AFB had a distinct understanding of PPE usage for the mission, and

that CDC experts provided necessary training and information regarding safety protocols, PPE usage, and response guidance. Although the report mentions that there may be anecdotal accounts of PPE protocol breaches, these accounts were not corroborated, and in totality, the Travis AFB mission did not encounter the same problems as the March AFB response, primarily due to better preparation and coordination.

Inexplicably, despite substantiating [redacted] allegations regarding the March AFB, HHS OGC issued a nine-page addendum to the supplemental report. The addendum appears to be an effort to discredit [redacted] by highlighting minor inconsistencies in her recollection of the events relative to the missions as a whole. The inclusion of the addendum appears entirely gratuitous and detracts from the serious deficiencies and dire concerns substantiated in HHS OGC's report.

The Whistleblower's Comments to the Supplemental Report

Although [redacted] generally agrees with the substantive findings of the supplemental report, she believes that HHS OGC minimized the misconduct that occurred during the Travis AFB mission. For example, she maintains that ACF personnel at the Travis AFB mission were instructed to directly interact with the repatriated Americans, despite direction from HHS leadership that ACF personnel should perform their duties remotely.

Moreover, [redacted] takes immense exception to the addendum provided by HHS OGC. She described the addendum as an attempt "to distract from and minimize the serious findings in the report about HHS failings" and "to dissuade Government employees from engaging in whistleblowing in the future." [redacted] further stated that she was the last witness to be interviewed for the investigation, and that it was clear that HHS OGC had already formed its conclusions before her interview. She added that while HHS OGC boasted about its 25,000-hour investigation, it used its findings against [redacted] in her interview to challenge her recollections and overemphasize trivial inconsistencies in her recollection of events that occurred eight months prior. In the conclusion of her comments, [redacted] reiterated her position, which has been consistent since her original filing with OSC in February 2020, that she hoped an investigation into these matters would make future repatriation missions safer for HHS personnel and the American public.

The Special Counsel's Findings

I am deeply troubled by the manner in which HHS OGC, under former General Counsel Mr. Charrow, addressed [redacted] allegations. It is reprehensible that HHS OGC would use the investigation as an attempt to discredit [redacted] when she showed tremendous courage in bringing these allegations forward. The attempt to discredit [redacted] is made even more appalling by the fact that the investigation substantiated the grave misconduct associated with the March AFB mission – misconduct that HHS OGC found to be, "reckless with respect to the risk of endangering the broader public." Additionally, HHS OGC weaponized its interview with [redacted] to find inconsistences in her recollection of past events, rather than to use it as an opportunity to add value to its investigation and gain an understanding of the facts. The HHS

OGC addendum to the supplemental report is irrelevant to the investigation, attempts to shame the whistleblower, and attempts to undermine the core principles on the effectiveness of whistleblowing.

Further, it is my conclusion that The General Counsel's (GC) office at HHS in this case failed to effectively serve its own Secretary, the President, and the American People. That is unfortunate. HHS OGC should not have bypassed and ignored the 5 U.S.C. § 1213 statutory process, as it did at every turn. HHS OGC sent copies of both the initial and supplemental report to Congress prior to sending them to OSC. In doing so, HHS OGC disregarded [redacted] statutory right to comment on the reports *prior* to their dissemination to Congress, as well as misrepresented these reports to Congress as final reports with no statutory input from OSC or the whistleblower.

Moreover, I am concerned about the impact of HHS OGC's behavior on future whistleblowers. As [redacted] expressed so eloquently in her comments, "HHS OGC's retaliatory approach will dissuade whistleblowers from coming forward in the future with information showing serious [g]overnment wrongdoing." OSC's primary mission is to serve as a safe conduit for whistleblowers and to protect them when they bring to light such serious allegations, as in this case. I commend [redacted] for bringing her allegations forward and recognize her concerns about the manner in which HHS OGC's reports targeted her, rather than focus on the critical misconduct in missions that affected all Americans.

HHS GC's misconduct aside, in summary, while the supplemental report did substantiate misconduct associated with the March AFB mission, it is fair to recognize the unprecedented nature of the pandemic and that HHS was better prepared for the Travis AFB mission. On its face, the report would be statutorily compliant but for HHS OGC's failure to obtain delegation from then-Secretary Azar and the unnecessary and offensive addendum included in the supplemental report. For these reasons, I find HHS OGC's report to be insufficient and unreasonable.

As required by 5 U.S.C. § 1213(e) (3), I have sent a copy of this letter, HHS OGC's reports, and the whistleblower's comments to the Chair and Ranking Members of the Senate Committee on Health, Education, Labor, and Pensions and the House Committee on Energy and Commerce. I have also filed redacted copies of these documents and the redacted referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures