



Report to Congressional Requesters

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July 2020

# SOUTHWEST BORDER

## CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of Deaths

Accessible Version

# GAO Highlights

Highlights of [GAO-20-536](#), a report to congressional requesters

View [GAO-20-536](#). For more information, contact Rebecca Gambler at (202) 512-8777 or [gablerr@gao.gov](mailto:gablerr@gao.gov), or Mary Denigan-Macauley at (202) 512-7114 or [deniganmacauleym@gao.gov](mailto:deniganmacauleym@gao.gov).

## Why GAO Did This Study

Three children died in CBP custody between December 2018 and May 2019, prompting questions about CBP's medical care for those in its custody. In July 2019, an emergency supplemental appropriations act was enacted, providing additional funds to CBP, including funds for consumables and medical care.

GAO was asked to review CBP's medical efforts for individuals in its custody along the southwest border. This report examines (1) the extent to which CBP obligated and oversaw funds for consumables and medical care, (2) steps CBP took to enhance medical care, (3) the extent to which CBP implemented and oversaw its medical care efforts, and (4) the extent to which CBP has reliable information on, and reported, deaths, serious injuries, and suicide attempts of individuals in custody.

To conduct this audit GAO reviewed CBP documentation, including financial reports; directives, policies, and training related to screening individuals for medical issues; and directives and policy documentation on reporting deaths in custody. GAO interviewed CBP officials in headquarters and two field locations, and observed medical efforts in facilities in field locations, selected on the basis of volume of apprehensions.

July 2020

## SOUTHWEST BORDER

### CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of Deaths

## What GAO Found

As of May 2020, U.S. Customs and Border Protection (CBP) within the Department of Homeland Security (DHS) had obligated nearly \$87 million of the approximately \$112 million it received specifically for consumables and medical care in a 2019 emergency supplemental appropriations act. CBP obligated some of these funds for consumable goods and services, like food and hygiene products, as well as medical care goods and services such as defibrillators, masks, and gloves. However, CBP obligated some of these funds for other purposes in violation of appropriations law. For example, CBP obligated some of these funds for goods and services for its canine program; equipment for facility operations like printers and speakers; transportation items that did not have a primary purpose of medical care like motorcycles and dirt bikes; and facility upgrades and services like sewer system upgrades.

GAO identified two factors that contributed to CBP's violations—insufficient guidance to CBP offices and components before obligations were made, and a lack of oversight roles and responsibilities for reviewing obligations once made.

- After the 2019 emergency supplemental was enacted, CBP did not provide sufficient guidance explaining how offices and components could obligate funds for consumables and medical care and, as a result, some offices and components may not have understood that there were limitations on how they could use those funds. For example, officials from one CBP component stated they believed they could use the consumables and medical care funds for any goods or services they considered to be in the interest of individuals in custody or that would help ensure the efficient processing of individuals.
- Once obligations were made, CBP did not provide oversight across its offices and components, such as by reviewing obligations, to ensure the obligations were consistent with the purpose of the funds.

Until CBP develops and implements additional guidance, and establishes oversight roles and responsibilities, the agency does not have assurance that the remainder of funds appropriated for consumables and medical care—about \$25 million as of May 2020—will be obligated consistent with the purpose of the funds.

CBP took various steps to enhance medical care and services for individuals in its custody, including, among other things, increasing its use of contracted medical providers (see figure on the next page), issuing new health screening policies, and requesting the Centers for Disease Control and Prevention assess conditions and make recommendations for the reduction of influenza in its facilities. In particular, in January 2019 CBP issued an interim directive which, among other things, required health interviews and medical assessments for certain individuals in its custody. CBP updated this directive in December 2019 and issued corresponding implementation plans in March 2020.

Contracted Medical Provider Office at a U.S. Customs and Border Protection Facility

## What GAO Recommends

GAO is making 10 recommendations to CBP, including to:

- develop and implement additional guidance for ensuring supplemental funds are obligated consistent with their purposes;
- establish oversight roles and responsibilities to ensure supplemental funds are obligated consistent with their purposes;
- develop and implement oversight mechanisms for CBP's policies and procedures relating to medical care for individuals in its custody, to include performance targets and roles and responsibilities for taking corrective action, among other things;
- document what information it is using to assess whether to offer the influenza vaccine to individuals in custody;
- provide additional guidance to field personnel to ensure they classify reports on deaths, serious injuries, and suicide attempts in accordance with CBP policy;
- update its internal reporting system to include categories on serious injuries and suicide attempts; and
- ensure reliable information on deaths in custody is reported to Congress and appropriate documentation on such reporting is maintained.

DHS concurred with all 10 recommendations.



Source: U.S. Customs and Border Protection. | GAO-20-536

GAO identified gaps related to CBPs implementation and oversight of its medical care efforts. For example:

- CBP has not consistently implemented enhanced medical care policies and procedures at southwest border facilities. Through facility visits and analysis of data, GAO found that some locations were not consistently conducting health interviews and medical assessments, as required by the medical directives. Further, while CBP's implementation plans call for oversight of medical efforts, such as metrics to assess compliance, the plans do not include some elements necessary for effective oversight, such as performance targets and roles and responsibilities for corrective actions. Until CBP develops and implements oversight mechanisms that include targets, roles, and responsibilities, the agency is not well-positioned to ensure consistent implementation of medical efforts.
- CBP decided not to implement a recommendation from the Centers for Disease Control and Prevention to offer influenza vaccines to individuals in custody, but did not document how it arrived at this decision. CBP officials stated that vaccinating apprehended individuals for influenza would pose operational, medical, legal, and logistical challenges. CBP officials stated they made this decision in consultation with others in the Department of Homeland Security, and this group continues to meet on public health issues, and will use such meetings to reassess whether to offer influenza vaccines. Documenting what information it uses in reassessing this decision, such as how it weighs the costs and benefits, would help provide CBP, Congress, and the public assurance that the agency has taken all relevant factors into account.

CBP does not have reliable information on deaths, serious injuries, and suicide attempts and has not consistently reported deaths of individuals in custody to Congress. CBP officials attributed this to several reasons, including that CBP's directive on significant incident reporting does not include a definition of suicide attempts and its automated reporting system does not have categories specific to serious injuries or suicide attempts. Instead, these incidents are classified together with less serious incidents and included as general "injuries or illnesses" in reports to senior leadership. Without additional field guidance and updates to its reporting system, CBP will continue to lack reliable information on the number of incidents that occur in its custody. Further, from fiscal year 2014 through fiscal year 2019, CBP was directed to report on deaths of individuals in its custody to Congress. GAO's review of CBP documentation and reports to Congress showed that 31 individuals died in custody along the southwest border from fiscal years 2014 through 2019, but CBP documented only 20 deaths in its reports. Ensuring that deaths in custody are reported to Congress and documented appropriately would help CBP improve transparency with Congress.

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### Abbreviations

AAP	American Academy of Pediatrics
Border Patrol	U.S. Border Patrol
CBP	U.S. Customs and Border Protection
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
CPR	cardiopulmonary resuscitation
DHS	Department of Homeland Security
FAR	Federal Acquisition Regulation
HHS	Department of Health and Human Services
ICE	U.S. Immigration and Customs Enforcement
OFO	Office of Field Operations
OPR	Office of Professional Responsibility
TEDS	National Standards on Transport, Escort, Detention, and Search

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July 14, 2020

Congressional Requesters

Beginning in fall 2018, the Department of Homeland Security’s (DHS) U.S. Customs and Border Protection (CBP) experienced a significant increase in the number of individuals apprehended at or between U.S. ports of entry along the southwest border, resulting in overcrowding and difficult humanitarian conditions in its facilities.<sup>1</sup> For example, apprehensions by the U.S. Border Patrol (Border Patrol), within CBP, increased from nearly 400,000 individuals in fiscal year 2018 to over 850,000 in fiscal year 2019, an increase of 115 percent, according to CBP data. From December 2018 through May 2019, three children—ages 7, 8, and 16—died in CBP custody, prompting questions about CBP’s medical screening and care of those in its custody. Moreover, the threat and spread of infectious diseases, such as Coronavirus Disease 2019 (COVID-19) and influenza, have highlighted the importance of understanding medical care for detained populations, such as individuals held in CBP custody.<sup>2</sup>

CBP is the lead federal agency charged with, among other things, ensuring the detection and interdiction of persons unlawfully entering or exiting the United States.<sup>3</sup> Within CBP, Border Patrol apprehends

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<sup>1</sup>See, for example, Department of Homeland Security, Office of Inspector General, *Management Alert – DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley (Redacted)*, OIG-19-51 (Washington, D.C.: July 2, 2019); *Management Alert - DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center (Redacted)*, OIG-19-46 (Washington, D.C.: May 30, 2019); and *Acting Secretary McAleenan’s Prepared Remarks to the Council on Foreign Relations* (Washington, D.C.: Sept. 23, 2019).

<sup>2</sup>On March 11, 2020, an outbreak of respiratory disease caused by a newly discovered coronavirus—COVID-19—was characterized as a pandemic by the World Health Organization. A pandemic is a global outbreak of disease that occurs when a when a new virus emerges to infect people and spreads between people sustainably. Because there is little to no preexisting immunity against the new virus, it spreads worldwide. Also see *Covid-19: Opportunities to Improve Federal Response and Recovery Efforts*, [GAO-20-625](#) (Washington, D.C.: June 25, 2020).

<sup>3</sup>Among other responsibilities, CBP is responsible for facilitating the flow of legitimate travel and trade at our nation’s borders and detecting and interdicting terrorists, drug smugglers, human traffickers, and other threats to the security of the United States. See 6 U.S.C. § 211(c).



individuals between ports of entry, dividing responsibility for southwest border security operations geographically among nine sectors, each with its own sector headquarters: San Diego, El Centro, Yuma, Tucson, El Paso, Big Bend, Del Rio, Laredo, and Rio Grande Valley. CBP's Office of Field Operations (OFO) encounters inadmissible individuals who arrive at ports of entry.<sup>4</sup> OFO has four southwest border field offices—El Paso, Laredo, San Diego, and Tucson—that are responsible for 24 land ports of entry.

Border Patrol and OFO detain individuals at short-term holding facilities to complete processing and determine the next appropriate course of action, such as transfer of custody to another agency, removal from the country, or release. During processing, CBP officers and agents are to collect information about the apprehended individual, including any potential health concerns.

Citing the increase of apprehensions along the southwest border, in May 2019 the White House requested emergency supplemental appropriations for, among other things, consumables necessary to provide care and custody of individuals held by CBP.<sup>5</sup> In July 2019, an emergency supplemental appropriations act (2019 Emergency Supplemental) was enacted, providing additional funds to CBP to respond to the significant increase in southwest border apprehensions, including approximately \$112 million for “consumables and medical care.”<sup>6</sup>

You asked us to review issues related to CBP's care and custody of adults and children along the southwest border. This report examines (1) the extent to which CBP obligated and oversaw the use of funds provided for “consumables and medical care” in the 2019 Emergency

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<sup>4</sup>Ports of entry are facilities that provide for the controlled entry into or departure from the United States. According to CBP officials, OFO encounters individuals (instead of apprehending them) because individuals do not enter the United States at ports of entry until OFO officers have processed them. For the purposes of this report, we use the term “apprehend” to describe both Border Patrol and OFO's first interactions with individuals at the border. In addition, OFO and Border Patrol may also detain individuals, including U.S. citizens, suspected of crimes such as terrorism, drug smuggling, and human trafficking.

<sup>5</sup>In briefing materials CBP submitted to Congress describing its needs for supplemental funding, it included items such as clothing, diapers, formula, and blankets, as well as showers and contracts for meals and caregivers.

<sup>6</sup>See Pub. L. No. 116-26, title III, 133 Stat 1018, 1019-1020 (2019). Supplemental appropriations are laws enacted to address needs that arise after annual appropriations have been enacted.



Supplemental; (2) steps CBP took to enhance medical care at its facilities along the southwest border in 2019; (3) the extent to which CBP has implemented and overseen its enhanced medical care efforts; and (4) the extent to which CBP has reliable information on and reported deaths, serious injuries, and suicide attempts of individuals in custody.<sup>7</sup>

To address all four objectives, we interviewed CBP headquarters officials, including officials from Border Patrol and OFO. We also conducted site visits to CBP facilities along the southwest border in Texas and New Mexico.<sup>8</sup> During our site visits, we observed facility operations, including the administration of health interviews and medical assessments for individuals held at those facilities.<sup>9</sup> We also conducted interviews with local Border Patrol and OFO officials and CBP's onsite contracted medical providers and their managers.<sup>10</sup>

We selected locations for site visits based on growth in the number of Border Patrol apprehensions from fiscal year 2017 through fiscal year 2019, as well as high overall Border Patrol apprehension volume by sector. We visited the El Paso sector in Texas and New Mexico in September 2019 and observed operations at five Border Patrol facilities and three ports of entry. In November 2019, we visited the Rio Grande Valley region in south Texas and observed operations at seven Border Patrol facilities and three ports of entry.<sup>11</sup> We based our selection on

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<sup>7</sup>In general, an obligation is a commitment by the government that creates a legal liability to pay for goods or services it orders or receives.

<sup>8</sup>We focused our audit on CBP operations along the southwest land border because it accounts for the majority of CBP apprehensions.

<sup>9</sup>According to the governing directive, a health interview is a standardized medical questionnaire for individuals in CBP custody. A medical assessment is an evaluation of an individual by a health care provider to assess medical status.

<sup>10</sup>As we discuss later in this report, pursuant to a medical services agreement, medical provider contractors are stationed at select CBP facilities along the southwest border. For the purposes of this report, we refer to these individuals as contracted medical providers. In total, during our site visits we conducted interviews with CBP officials and contracted medical providers at 20 CBP facilities. Some interviews involved multiple officials and a mix of contracted medical providers and CBP officials.

<sup>11</sup>From fiscal year 2017 through fiscal year 2019, the El Paso sector experienced a 623 percent increase in apprehensions. From fiscal year 2017 through fiscal year 2019, the Rio Grande Valley sector accounted for 41 percent of all southwest Border Patrol apprehensions that occurred. Cumulatively, the El Paso and Laredo Field Offices, which are responsible for ports of entry in south Texas, were responsible for about 25 percent of all inadmissible determinations nationwide in fiscal year 2018.

Border Patrol apprehensions because they generally account for the majority of all CBP apprehensions. We also visited CBP facilities both with and without onsite contracted medical providers. While these site visits, observations, and interviews are not generalizable and may not be indicative of medical care provided at all CBP facilities, they provided us with perspectives on the care individuals receive in CBP facilities.

To address the first objective on the extent to which CBP obligated and oversaw the use of funds provided for “consumables and medical care” in the 2019 Emergency Supplemental, we reviewed financial documents, including documentation on the types of goods and services for which CBP obligated the “consumables and medical care” line item of the 2019 Emergency Supplemental. We also reviewed a previously issued GAO legal decision related to the “consumables and medical care” line item of the 2019 Emergency Supplemental.<sup>12</sup> We further met with officials from CBP’s Office of Finance, as well as other offices and components within CBP that made obligations using the “consumables and medical care” line item, to understand CBP’s processes and procedures for making obligations, including roles and responsibilities for providing guidance and oversight. We assessed the reliability of obligation information by interviewing officials from CBP’s Office of Finance and reviewing agency documentation, including briefing materials CBP submitted to Congress, spending plans CBP developed after enactment, and status reports on the extent of obligations made by each CBP office or component. We determined that the data were sufficiently reliable for the purposes of reporting CBP’s obligations from the 2019 Emergency Supplemental. We compared processes and procedures for making obligations to *Standards for Internal Control in the Federal Government* related to control activities, communication, and monitoring.<sup>13</sup>

To address the second objective on steps CBP took to enhance medical care at its facilities along the southwest border in 2019, we reviewed agency documentation, interviewed officials at CBP headquarters, and met with officials and representatives from external entities. Specifically, we reviewed relevant CBP directives, contractor staffing reports, acquisitions documentation, and issue papers related to the development

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<sup>12</sup>GAO, *U.S. Customs and Border Protection—Obligations of Amounts Appropriated in the 2019 Emergency Supplemental*, B-331888 (Washington, D.C.: June 11, 2020). This decision is reprinted in app. I of this report.

<sup>13</sup>GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

of an electronic medical record system. We also met with CBP's Senior Medical Advisor and officials from Border Patrol's Special Operations Headquarters to obtain information on how CBP developed directives to enhance medical care, CBP's efforts to increase onsite contracted medical providers, and the agency's efforts to develop an electronic medical record system. We also reviewed documentation and met with officials and representatives from other entities, including the Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) to understand how CBP engaged with these entities to enhance medical care.<sup>14</sup> Specifically, we reviewed CDC documentation, including a report that provided recommendations to CBP related to influenza control and prevention.

To address the third objective on the extent to which CBP has implemented and overseen its enhanced medical care efforts, we reviewed CBP policy documents—including medical directives—and training materials. We also interviewed CBP headquarters officials on their expectations for how these directives and other medical care efforts were to be carried out by CBP components. We used information gathered through our site visits and Border Patrol data to analyze the extent of implementation of CBP's medical care efforts. Specifically, we reviewed record-level data on children apprehended during a 1-week period in February 2020 to determine the extent to which Border Patrol agents provided health interviews and medical assessment referrals as required.<sup>15</sup>

We assessed the reliability of these data by performing electronic testing for obvious errors in accuracy and completeness, such as running logic tests and reviewing existing information about the data and the systems that produced them, such as relevant training materials; and interviewing relevant CBP and Border Patrol officials. We determined that the data

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<sup>14</sup>CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States. The AAP is a professional membership organization comprised of 67,000 pediatricians and pediatric specialists.

<sup>15</sup>Border Patrol began recording health interview responses in its electronic apprehension records system in January 2020. We reviewed apprehension data covering a 1-week period in February 2020 to obtain insights into Border Patrol's implementation of health interviews and medical assessments after the agency began using the electronic system.

were sufficiently reliable for the purposes of reporting information about health interviews and medical assessment referrals provided to children at selected Border Patrol stations during initial processing. We then compared CBP's implementation and oversight of its medical care efforts to CBP directives on enhancing medical care; CBP's 2015 *National Standards on Transport, Escort, Detention, and Search policy*; standards promulgated by the Project Management Institute; and *Standards for Internal Control in the Federal Government* related to documentation, monitoring, and corrective actions.<sup>16</sup>

In addition, to address the third objective, we reviewed documentation related to CBP's medical services agreement through which CBP provides onsite medical services at CBP facilities and spoke with officials from CBP's Office of Acquisition. We compared this information to the Federal Acquisition Regulation (FAR), which outlines requirements for completing annual reviews of service agreements.<sup>17</sup>

To address the fourth objective, on the extent to which CBP has reliable information on and reported deaths, serious injuries, and suicide attempts of individuals in custody, we reviewed CBP directives and procedures on reporting significant incidents.<sup>18</sup> We reviewed records from fiscal year 2014 through fiscal year 2019 on deaths, serious injuries, and suicide

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<sup>16</sup>U.S. Customs and Border Protection, *CBP Directive No. 2210-003: CBP Interim Enhanced Medical Efforts* (Washington, D.C.: Jan. 28, 2019). In addition, this directive was updated in December 2019; *CBP Directive No. 2210-004: Enhanced Medical Support Efforts* (Washington, D.C.: Dec. 30, 2019). Project Management Institute, Inc., *The Standard for Program Management*, 4<sup>th</sup> ed. (Newtown Square, Pa.: 2017); and *A Guide to the Project Management Body of Knowledge (PMBOK® Guide)*, 6<sup>th</sup> ed. (Newtown Square, Pa.: 2017). Also, see [GAO-14-704G](#).

<sup>17</sup>See FAR § 8.405-3(e). FAR is the primary regulation used by all federal executive agencies to acquire supplies and services with appropriated funds. See FAR § 1.101.

<sup>18</sup>U.S. Customs and Border Protection, *CBP Directive No. 3340-025E: Reporting Significant Incidents to the Commissioner's Situation Room* (Washington, D.C.: May 21, 2018). In addition, a preceding directive had similar reporting requirements; *CBP Directive No. 3340-025D: Reporting Significant Incidents to the Commissioner's Situation Room* (Washington, D.C.: Sept. 30, 2010); and *CBP Interim Procedures on Notification of a Death in Custody* (Washington, D.C.: Dec. 17, 2018).

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attempts in custody maintained by CBP's Situation Room and interviewed officials from this office.<sup>19</sup>

We also took steps to determine the number of deaths that occurred in CBP custody along the southwest border from fiscal year 2014 through fiscal year 2019. Specifically, we compared records maintained by CBP's Situation Room to those maintained by CBP's Office of Professional Responsibility (OPR).<sup>20</sup> We then compared these records to reports CBP provided to Congress and CBP public press releases. To corroborate our understanding of both of these sources, we interviewed officials from the CBP Situation Room and OPR on their offices' practices for collecting and storing this information. We determined that the steps we took resulted in sufficiently reliable information on the number of deaths that occurred in CBP custody along the southwest border from fiscal year 2014 through fiscal year 2019. We discuss limitations in CBP's processes for maintaining this information later in this report. We compared information we gathered through this process to CBP internal directives and procedures, congressional reporting directives, and *Standards for Internal Control in the Federal Government* related to using quality information and maintaining documentation.<sup>21</sup>

We conducted this performance audit from June 2019 through July 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>19</sup>The CBP Situation Room is located in CBP headquarters and operates 24 hours a day, 7 days a week, as an incident notification and information coordination center. The Situation Room is the primary point of contact for significant incident reporting CBP enterprise-wide to include, but not limited to, all CBP operational components and offices, ports of entry, sectors, stations, Air and Marine branches, international offices, and CBP headquarters.

<sup>20</sup>OPR is responsible for ensuring compliance with all CBP-wide programs and policies relating to corruption, misconduct, or mismanagement and for executing CBP's internal security and integrity awareness programs.

<sup>21</sup>[GAO-14-704G](#).

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## Background

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### CBP Processing and Care for Apprehended Individuals

Individuals come into CBP custody either through apprehension by Border Patrol agents or after being deemed inadmissible to the United States at a port of entry by an OFO officer.<sup>22</sup> Border Patrol apprehends individuals along U.S. land borders and between ports of entry for suspected violations of immigration law or suspected criminal activity. Apprehended individuals are then transferred to short-term holding facilities for further processing. OFO inspects all individuals arriving to the United States to determine their citizenship or nationality, immigration status, or other grounds for admission into the United States. Based on this inspection—as well as random selection—OFO officers refer some individuals to secondary inspection. During secondary inspection, travelers may be denied admission into the United States and taken into temporary custody at the port of entry while awaiting repatriation to a foreign country or while awaiting transfer or referral to another agency.

While individuals are held at CBP facilities—either by Border Patrol or by OFO—CBP personnel conduct a number of activities in managing the custody of individuals, including (1) processing, (2) care, and (3) monitoring.

**Processing.** During processing, CBP personnel gather and record information from apprehended individuals. Specifically, CBP personnel collect and record information on individuals in agency databases; take fingerprints, if applicable; and conduct record checks.<sup>23</sup>

**Care.** CBP personnel typically place individuals in a secure holding cell or room while these individuals await transfer of custody to another agency, removal from the country, or release into the United States. CBP's *National Standards on Transport, Escort, Detention, and Search* (TEDS), established in 2015, sets policies related to CBP personnel's interaction

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<sup>22</sup>The Immigration and Nationality Act lists grounds upon which a noncitizen or nonnational of the United States may be determined to be ineligible for a visa or inadmissible to the United States. See 8 U.S.C. § 1182.

<sup>23</sup>According to Border Patrol and OFO officials and documents, CBP does not typically collect fingerprints for children under the age of 14. However, on a case-by-case basis, CBP may fingerprint children under age 14 in certain instances, such as when they suspect the child may be the victim of trafficking or involved in smuggling.

with, and care of, individuals while they are detained in CBP short-term facilities. For example, among other things, TEDS sets standards related to how and when detained individuals should receive meals, showers, and outside medical care and the frequency with which CBP personnel should monitor detention areas.

**Monitoring.** CBP policy requires personnel to monitor detention areas to ensure they meet CBP standards. For example, TEDS requires CBP personnel to conduct physical checks of detention areas at various intervals throughout the day to ensure proper occupancy levels, safety, hygiene, and the availability of drinking water. CBP personnel maintain electronic custody logs to document care provided to apprehended individuals and may also conduct more frequent monitoring activities for at-risk individuals who show signs of distress, hostility, or other unusual behavior. For example, in a May 2019 memorandum, the acting CBP Commissioner stated that all individuals with a known or reported contagious disease, illness, or injury, or who have been isolated or quarantined within a CBP facility, are to be considered “at-risk” and are to be checked at least once every 15 minutes.<sup>24</sup>

CBP policy states that individuals should generally not be held for longer than 72 hours in CBP custody. CBP refers individuals to DHS’s U.S. Immigration and Customs Enforcement (ICE) for long-term detention. ICE officers have the authority to accept or deny a referral of an individual from CBP for detention in one of ICE’s detention facilities. If CBP apprehends a child that is designated as an unaccompanied alien child, that child is transferred to the custody of the Office of Refugee Resettlement within HHS.<sup>25</sup> HHS provides interim care for unaccompanied alien children at its shelters and identifies qualified sponsors in the United States to take custody of the child while awaiting immigration proceedings.

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<sup>24</sup>U.S. Customs and Border Protection, “Memorandum on the Clarification of At-Risk Population and Hold Room Monitoring Provisions in the CBP National Standards on Transport, Escort, Search, and Detention” (Washington, D.C.: May 24, 2019).

<sup>25</sup>An unaccompanied alien child is defined as a child who (1) has no lawful immigration status in the United States, (2) has not attained 18 years of age, and (3) has no parent or legal guardian in the United States or no parent or legal guardian in the United States available to provide care and physical custody. 6 U.S.C. § 279(g)(2). Under the Trafficking Victims Protection Reauthorization Act of 2008, these children must be transferred to HHS within 72 hours of determining that they are unaccompanied alien children, absent exceptional circumstances. 8 U.S.C. § 1232(b)(3).



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When an individual dies, becomes seriously ill, or attempts suicide in CBP custody, components are required to report this event using CBP's Significant Incident Reporting System—a web-based application maintained by the CBP Situation Room, which is responsible for expeditiously and accurately informing DHS and CBP leadership of significant incidents that affect CBP personnel and operations.<sup>26</sup> Since 2013, CBP has been required to collate certain information on deaths in custody to report annually to the Attorney General.<sup>27</sup> Additionally, from fiscal years 2014 through 2020, CBP was directed to report to Congress on deaths in custody within specific time frames.<sup>28</sup>

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## DHS Funding for Medical Care of Individuals in CBP Custody

Obligations for medical care of individuals in CBP custody have historically been charged to two appropriation accounts, depending on whether the medical care is provided onsite in CBP facilities or offsite in a local hospital, emergency room, or urgent care clinic. For onsite medical care, CBP has historically charged costs to CBP's annual operations and support appropriation. For offsite medical care, CBP has historically charged costs to ICE's annual operations and support appropriation by submitting claims from offsite medical providers through ICE's Medical

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<sup>26</sup>See U.S. Customs and Border Protection, *CBP Directive No. 3340-025E: Reporting Significant Incidents to the Commissioner's Situation Room*.

<sup>27</sup>U.S. Customs and Border Protection, *CBP Interim Procedures on Notification of a Death in Custody*, dated December 17, 2018; see also Death in Custody Reporting Act of 2013, Pub. L. No. 113-242, 128 Stat. 2860 (codified as amended at 18 U.S.C. § 4001 note).

<sup>28</sup>See H. Rep. No. 116-9 (2019) (Conf. Rep.); H.R. Rep. No. 115-239 (2017); H.R. Rep. No. 114-668 (2016); H.R. Rep. No. 114-215 (2015); H.R. Rep. No. 113-481 (2014); H.R. Rep. No. 113-91 (2013). These directives varied in the exact amount of time and detail that CBP was to provide in reporting certain deaths to Congress from once per year to within 24 hours of each death. For example, for fiscal year 2014, the committee report directed DHS to provide annual statistics on, among other things, deaths in CBP custody; while for fiscal year 2016 and 2017, the committee report directed DHS to report the deaths in custody to the Appropriations Committees within 24 hours, including the circumstances of the death, and to also report annually on the status or results of investigations related to such deaths. Additionally, the committee report accompanying DHS's fiscal year 2020 appropriation continued a directive for reporting on deaths in custody within a 24-hour period. See H.R. Rep. No. 116-180 (2019). We did not review the extent to which CBP has reported deaths in accordance with this directive for fiscal year 2020.

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Payment Authorization Request system.<sup>29</sup> From fiscal year 2015 through fiscal year 2019, CBP paid approximately \$38 million for contracted medical providers to provide onsite care at CBP facilities out of its annual operations and support appropriation. According to ICE documentation, ICE paid \$55.5 million in claims related to offsite medical care for individuals in CBP custody in fiscal years 2018 and 2019—representing one-third of its spending on medical claims for these years as of April 2020.

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## CBP Obligated Nearly \$87 Million of Funds It Received for Consumables and Medical Care but Obligated Some Funds for Other Purposes in Violation of Appropriations Law

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### CBP Received Approximately \$112 Million for Consumables and Medical Care in July 2019 and Obligated 78 Percent of These Funds as of May 2020

On May 1, 2019, the White House requested an additional \$4.5 billion in emergency supplemental appropriations for various federal agencies, including CBP, to address increased apprehensions along the southwest border. In a June 2019 letter to Congress, the acting Secretary of Homeland Security stated that if DHS did not receive additional funding to address these apprehensions, the department would be forced to take drastic measures that would impact other critical programs that support DHS missions throughout the country. CBP also submitted information to

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<sup>29</sup>ICE generally provides for offsite medical services for individuals in DHS custody—including CBP. Specifically, ICE manages the development, implementation, operation, and maintenance of related business processes for the provision of offsite medical care for all individuals in DHS custody—including CBP—and since at least fiscal year 2011, ICE has also funded the costs of offsite medical care. In fiscal year 2013, a House Report accompanying DHS's annual appropriation recognized ICE's role in this area; recommended moving additional amounts to provide for offsite medical costs; and directed ICE, in future years, to include an estimate of the cost of offsite medical care for individuals in CBP's custody in ICE's annual budget request. See H.R. Rep. 112-492, at 37 (2012); see also "Memorandum from Assistant Director, ICE Health Service Corps, to U.S. CBP Agents and Staff" (Washington, D.C.: Sept. 12, 2013), which recognizes ICE's responsibility for facilitating the reimbursement of authorized health care services for individuals in the custody of ICE and CBP. For additional information on ICE's Medical Payment Authorization Request system and reimbursement, see GAO, *Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care*, [GAO-16-231](#) (Washington, D.C.: Feb. 29, 2016).

Congress detailing its proposed use of the requested funds. Specifically, CBP requested additional funding in several areas, including funds for “consumables – migrant care,” to purchase general supplies such as clothing, diapers, formula, and blankets, as well as showers and contracts for meals and caregivers.

On July 1, 2019, the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019 (the 2019 Emergency Supplemental) was enacted. The act provided \$4.59 billion in emergency supplemental appropriations for necessary expenses to address the significant rise in aliens at the southwest border and related activities, including an additional \$1.1 billion for CBP, divided into two appropriation accounts: (1) operations and support; and (2) procurement, construction, and improvements.<sup>30</sup> Of the approximately \$1 billion appropriated for CBP’s operations and support, the 2019 Emergency Supplemental required that CBP use certain amounts for specific purposes (referred to as “line items”), including approximately \$112 million for “consumables and medical care.”<sup>31</sup> (See table 1.)

**Table 1: Appropriations for U.S. Customs and Border Protection from the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019**

Appropriation	Line item	Amount (in dollars)
Operations and Support	Establishing and operating migrant care and processing facilities	\$708,000,000
	Consumables and medical care	111,950,000
	Temporary duty and overtime costs, including reimbursements	110,481,000
	Mission support data systems and analysis	50,000,000
	Transportation	35,000,000
Procurement, Construction, and Improvements	Migrant care and processing facilities	85,000,000
<b>Total</b>		<b>\$1,100,431,000</b>

Source: GAO analysis of the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019, Pub. L. No. 116-26, title III, 133 Stat. 1018, 1019-20 (2019). | GAO-20-536

<sup>30</sup>See Pub. L. No. 116-26, tit. III, 133 Stat 1018, 1019-1020 (2019).

<sup>31</sup>The annual Operations and Support appropriation for CBP did not include the same line items, such as for “consumables and medical care.” CBP’s annual appropriation for Operations and Support generally provides examples of expenses related to CBP’s operations, such as transportation of unaccompanied minor aliens, without directing specific amounts to these purposes. See Pub. L. No. 116-6, tit. II, 133 Stat. 13, 17 (2019).

Note: Of the funds appropriated to U.S. Customs and Border Protection for Operations and Support, \$819,950,000 is available through September 30, 2020; and the \$85,000,000 appropriated for Procurement, Construction, and Improvement is available through September 30, 2023.

After Congress enacted the 2019 Emergency Supplemental, CBP utilized a spend plan to allocate funding across components.<sup>32</sup> As of May 2020, five entities within CBP had cumulatively obligated \$86.9 million—78 percent— of the nearly \$112 million provided for consumables and medical care. These five entities—(1) Border Patrol, (2) Office of Facilities and Asset Management, (3) Office of Human Resources Management, (4) Office of Information and Technology, and (5) Office of Finance—also identified another \$15.2 million in open commitments.<sup>33</sup> Table 2 provides a breakdown of obligations, open commitments, and funds available by CBP entity as of May 2020.

**Table 2: U.S. Customs and Border Protection (CBP) Obligations, Open Commitments, and Funds Available for the 2019 Emergency Supplemental Consumables and Medical Care Line Item as of May 2020**

CBP office or component	Obligations (in dollars)	Open commitments (in dollars)	Funds available (in dollars)
U.S. Border Patrol	\$50,213,371	\$10,981,676	\$2,140,841
Office of Facilities and Asset Management	29,999,284	3,963,602	6,232,602
Office of Human Resources Management	3,414,139	77,090	8,771
Office of Information and Technology	2,362,275	165,000	563,691
Office of Finance	906,117	0	14,820
<b>Total</b>	<b>\$86,895,185</b>	<b>\$15,187,368</b>	<b>\$8,960,725</b>

Source: GAO analysis of CBP data. | GAO-20-536

Note: In general, an obligation is a commitment by the government that creates a legal liability to pay for goods or services it orders or receives. CBP defines an open commitment as funding reserved against a planned obligation and unavailable for use elsewhere. CBP defines funds available as funds not yet obligated or committed. Numbers may not sum due to rounding.

<sup>32</sup>CBP reported that it shared the initial spend plan with Congressional appropriations committee staff in August 2019.

<sup>33</sup>In general, an obligation is a commitment by the government that creates a legal liability to pay for goods or services it orders or receives. CBP defines an open commitment as funding reserved against a planned obligation and unavailable for use elsewhere. CBP defines funds available as funds not yet obligated or committed.

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## CBP Obligated Some Consumables and Medical Care Funds in Violation of Appropriations Law Due in Part to Insufficient Guidance and Oversight

In June 2020, we concluded that CBP violated an appropriations law, known as the purpose statute, when it obligated funds from the 2019 Emergency Supplemental consumables and medical care line item appropriation for some goods and services that were not consistent with the purpose of that appropriation.<sup>34</sup> Under the purpose statute, appropriations are to be used only for the purposes for which they are made, except as otherwise provided by law. In reaching our conclusion regarding the obligations, we found that the goods and services did not clearly fall within the ordinary meaning of the terms “consumable” or “medical care,” nor did those goods and services bear a reasonable and logical relationship to the purpose of the consumables and medical care line item appropriation.<sup>35</sup>

In our June 2020 legal decision, we found that while some of CBP’s obligations of the consumables and medical care line item were properly obligated, others were not properly obligated and represented a violation of the purpose statute. For example, some obligations—such as those for hygiene products, food, clothing, and medical supplies—fell squarely within the ordinary meanings of “consumable” or “medical care” and were therefore properly obligated.<sup>36</sup> However, we also found that CBP violated the purpose statute when it obligated the consumables and medical care line item appropriation for other expenses, including those associated with its canine program, the CBP-wide vaccination program for CBP personnel, and various upgrades to computer networks used for border enforcement activities (see fig. 1).<sup>37</sup> CBP also obligated the consumables and medical care line item for transportation-related items, including

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<sup>34</sup>[B-331888](#).

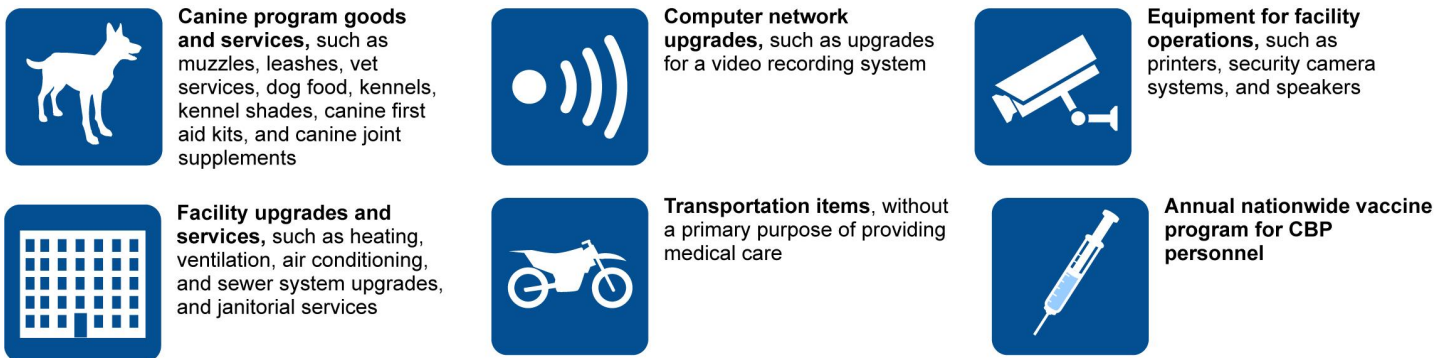
<sup>35</sup>In the context of CBP’s appropriation, the term “consumable” refers to goods that are exhausted by use, and the phrase “medical care” includes goods and services used to provide assistance related to the diagnosis and treatment of disease or injury and maintaining health. [B-331888](#), June 11, 2020, at 4.

<sup>36</sup>Other obligations, including obligations for medical supplies such as defibrillators, masks, ointments, and gloves, relate to the treatment of disease or injury and fell squarely within the plain meaning of “medical care.” [B-331888](#), June 11, 2020, at 4.

<sup>37</sup>[B-331888](#), June 11, 2020, at 5.

vehicles such as all-terrain vehicles, motorcycles, dirt bikes, boats, passenger vans, and small utility vehicles. We concluded that obligations for certain transportation-related items violated the purpose statute because those items were not primarily used to provide medical services.<sup>38</sup> Similarly, we concluded that CBP improperly obligated funds when it used this line item appropriation for building equipment and services, such as heating, ventilation and air conditioning systems, and sewer system upgrades.<sup>39</sup> The decision, reprinted in appendix I, stated that CBP should adjust its accounts to obligate the appropriation properly available for these obligations and, if CBP lacks budget authority to make the adjustments, then it should report a violation of the Antideficiency Act as required by law.

**Figure 1: Obligations U.S. Customs and Border Protection (CBP) Charged to the Consumables and Medical Care Line Item That GAO Determined Violated the Purpose Statute**



Source: GAO analysis of U.S. Customs and Border Protection information. | GAO-20-536

Note: The 2019 Emergency Supplemental was appropriated specifically for “necessary expenses to respond to the significant rise in aliens at the southwest border and related activities.” Pub. L. No. 116-26, tit. III, 133 Stat. 1018, 1019–20 (2019). We concluded that the above obligations were not proper, including transportation items such as all-terrain vehicles, motorcycles, dirt bikes, boats, passenger vans, and small utility vehicles without a primary purpose of providing medical care.

In addition to the categories evaluated as part of our legal decision, DHS and CBP officials identified other obligations that they determined should not have been charged to the “consumables and medical care” line item. For example, DHS and CBP officials noted that they identified other obligations—such as for temporary portable structures, law enforcement

<sup>38</sup>B-331888, June 11, 2020, at 5-6.

<sup>39</sup>We also found that CBP violated the purpose statute when it obligated amounts from the “establishing and operating migrant care and processing facilities” for other purposes. See B-331888, June 11, 2020, at 7.

equipment, and tactical gear—that were improperly charged to this account and stated that they planned to adjust these obligations to other accounts, as appropriate.<sup>40</sup> In July 2020, after we provided DHS with our draft report, CBP reported that it had completed a review of obligations that it considered pertinent to the legal decision. DHS further reported moving a number of obligations from the “consumables and medical care” line item appropriation to other line items in the 2019 Emergency Supplemental or to CBP’s annual appropriation, and identifying other obligations for additional review.<sup>41</sup> Given the timeframe associated with our review, we could not assess the information reported by CBP. We continue to believe CBP should make adjustments consistent with our legal decision.

We identified two factors that contributed to CBP’s purpose statute violations: (1) insufficient guidance on the purpose of the funds to CBP offices and components before obligations were made, and (2) a lack of oversight roles and responsibilities for reviewing obligations once made to ensure those obligations were consistent with the purpose of the line item.

**Insufficient guidance on the purpose of the funds.** After the 2019 Emergency Supplemental was enacted, CBP did not provide guidance explaining the purpose for which funds under the “consumables and medical care” line item could be used to ensure that components made obligations consistent with the line item. Specifically, neither CBP’s Office

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<sup>40</sup>As stated in our decision, CBP plans to adjust its accounts to ensure that obligations charged to the “consumables and medical care” line item in the 2019 Emergency Supplemental that violate the purpose statute are instead charged to a more appropriate line item in the 2019 Emergency Supplemental, such as transportation, or the CBP annual Operations and Support appropriation account, which does not have the same line items specifying purposes for which funds can be used. If CBP lacks sufficient budget authority to make the adjustments, then it should report a violation of the Antideficiency Act, as required by law. In addition to the obligations for which we sought CBP’s legal views, CBP identified in its response other obligations for which CBP plans to take additional action, including adjusting its accounts for obligations to the consumables and medical care line item for items including, among others, law enforcement equipment and temporary portable structures. See [B-331888](#), June 11, 2020. As of May 2020, CBP was continuing to review obligations under this line item in order to adjust accounts. Because CBP had not completed its review of obligations, the agency could not provide information on the total dollar amount of obligations that violated the purpose statute.

<sup>41</sup>Based on this review, CBP reported in July 2020 that it planned to move at least \$13 million in obligations between the various line items within the 2019 Emergency Supplemental and that it planned to move at least \$3.9 million in obligations from the “consumables and medical care” line item to CBP’s annual appropriation.



of Finance nor CBP's Office of Chief Counsel provided components with guidance on how to obligate funds in accordance with the purposes specified in the enacted line items.<sup>42</sup> CBP's Office of Finance communicated with CBP components on various aspects of managing the funds. For example, among other communications, CBP's Office of Finance emailed budget updates to all CBP components explaining that the 2019 Emergency Supplemental funds were provided along line items and providing relevant accounting codes.

However, while these communications acknowledged the existence of line items, they did not explain that the line items limited how these funds could be used. Therefore, some components may not have understood that there were limitations on how they could use "consumables and medical care" funds. For example, Border Patrol officials stated they believed they could use the "consumables and medical care" funds for any goods or services they considered to be in the interest of individuals in custody or that would help ensure the efficient processing of individuals. Border Patrol officials stated they reviewed and approved sectors' planned obligations based on this understanding. For instance, they approved payment of one sector's jail bill using funds from the "consumables and medical care" line item as a means of preventing overcrowding in that sector's facilities, which they considered to be in the general interest of individuals in custody.<sup>43</sup> CBP officials acknowledged that there exists an opportunity to provide more robust and detailed guidance post-enactment to CBP program office personnel ultimately obligating the funds.

**Lack of oversight roles and responsibilities.** CBP took some steps to oversee obligations from the 2019 Emergency Supplemental funds, but we identified gaps in CBP's oversight roles and responsibilities for reviewing obligations once made that limited CBP's ability to identify obligations inconsistent with the line item in a timely manner.<sup>44</sup>

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<sup>42</sup>CBP Office of Finance officials told us that they created codes in CBP's financial system of record to monitor 2019 Emergency Supplemental funding amounts executed at a high level. However, these codes did not give CBP Finance insight into the goods and services for which the funds were used.

<sup>43</sup>According to Border Patrol officials, Border Patrol sectors may pay for detention space in local jails to alleviate overcrowding in Border Patrol facilities.

<sup>44</sup>While CBP officials stated that individual components had processes in place to review individual obligations before they were made, the agency had not provided guidance regarding the purpose of the individual line items, as noted above.

CBP Office of Finance officials stated that they were responsible for ensuring that components did not spend more than what they were allotted and that components categorized obligations using the correct accounting codes. Additionally, these officials said that the spend plan provided information on proposed obligations at a summary level. However, CBP Office of Finance officials stated that they were not responsible for determining whether obligations were consistent with the purpose of the line item and relied on components to make such determinations.

Only one of the five entities that obligated funds from the consumables and medical care line item reviewed its obligations to determine whether they were consistent with the purpose of the line item. Specifically, in November 2019, Border Patrol headquarters officials reviewed sectors' fiscal year 2019 obligations made using the "consumables and medical care" line item to determine whether obligations were appropriate based on Border Patrol's understanding of the line item and took corrective actions as needed. For example, Border Patrol headquarters officials determined that one sector had used "consumables and medical care" funds to purchase restraints and advised the sector that this was an inappropriate use of the funds and that the obligation would need to be transferred to another account. However, Border Patrol's review was limited in nature because it did not include all Border Patrol offices. For example, Border Patrol did not request obligation data on goods and services purchased by its canine program office.<sup>45</sup>

Further, the remaining four entities within CBP that obligated funds from the consumables and medical care line item—the Office of Facilities and Asset Management, Office of Human Resources Management, Office of Information Technology, and Office of Finance—did not review their obligations to determine whether they were consistent with the purpose of the line item. As a result, CBP did not have insight into the extent to which those entities' obligations of the consumables and medical care line item—a cumulative \$36.7 million as of May 2020—were consistent with the purpose of the line item.

DHS and CBP officials stated that the agency experienced challenges overseeing some aspects of the funds from the 2019 Emergency Supplemental due to a lack of experience with these line items and the

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<sup>45</sup>The CBP canine program furthers CBP's mission through terrorist detection and apprehension and the detection and seizure of controlled substances and other contraband.

large increase of apprehensions on the southwest border occurring at the time. Specifically, officials from DHS’s Office of the General Counsel and CBP’s Office of Chief Counsel noted that CBP typically receives an annual lump-sum Operations and Support appropriation, which provides the agency with broader discretion in determining the use of funds as compared to the 2019 Emergency Supplemental, which specified how CBP could use the funds through line items. As such, these officials stated that CBP did not have systems in place to ensure that the funds were obligated consistent with the purpose of the line item.

Despite these challenges, CBP has a responsibility to ensure that funds are used only for the purposes for which they were appropriated.<sup>46</sup> Standards for Internal Control in the Federal Government call for agencies to implement control activities to help achieve objectives and ensure accountability for stewardship of government resources.<sup>47</sup> These control activities could take the form of guidance or procedures for stakeholders. Furthermore, they state that oversight, such as regular monitoring, is needed on an ongoing basis and that management should document in policies the internal control responsibilities.

When CBP is appropriated funds for specific purposes—such as specific line items—additional guidance could help CBP components understand how funds may or may not be used. Additionally, establishing oversight roles and responsibilities would provide CBP with a means of determining whether components adhere to its guidance and would position the agency to take corrective actions—such as adjusting accounts—in a timely manner, if needed. Without additional guidance and oversight roles and responsibilities, CBP cannot ensure that the remainder of the \$112 million appropriated for “consumables and medical care”—\$25.1 million as of May 2020—will be obligated consistent with the purpose of the line item.<sup>48</sup> Moreover, without taking such steps, CBP cannot ensure that future appropriations for specific purposes will be obligated according to their purpose.

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<sup>46</sup>31 U.S.C. § 1301(a)

<sup>47</sup>[GAO-14-704G](#).

<sup>48</sup>Further, CBP may have less funds remaining available due to funds reserved as open commitments.

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## CBP Took Steps to Enhance Medical Care in 2019 by Increasing Contracted Medical Providers, Issuing New Screening Policies, and Engaging Entities with Medical Expertise

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### CBP Increased the Number of Facilities with Contracted Medical Provider Support and Issued New Health Screening Policies, among Other Efforts

Throughout 2019, CBP took various steps to enhance medical care and services to individuals apprehended and held at its facilities. These steps included increasing the number of facilities that have onsite contracted medical providers; issuing new health screening policies; and other efforts, such as receiving temporary medical support from other federal agencies and undertaking efforts to develop an electronic medical record system.

**Contracted medical providers.** CBP increased the number of its facilities that have onsite contracted medical providers from six in December 2018 to 42 locations in December 2019, including facilities in all nine southwest Border Patrol sectors and three OFO field offices (see fig. 2). Previously, in fiscal year 2015, CBP competitively awarded a single award blanket purchase agreement to deploy medical providers to its facilities along the southwest border.<sup>49</sup> Officials said they utilized a blanket purchase agreement because it could provide the agency with

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<sup>49</sup>CBP established a blanket purchase agreement for medical services under an existing Veterans Affairs General Services Administration Federal Supply Schedule. This type of blanket purchase agreement is an agreement established by a government buyer with a schedule contractor to fill repetitive needs for supplies or services and is established following the procedures described in FAR § 8.405-3. Blanket purchase agreements are not contracts but rather agreements between government agencies and vendors with terms and conditions flowing from the Federal Supply Schedule, including prices, in place for future use. When a buyer establishes a blanket purchase agreement against a schedule contract, orders placed under the blanket purchase agreement meet Competition in Contracting Act of 1984 requirements for full and open competition when the General Services Administration Federal Supply Schedule blanket purchase agreement establishment and ordering procedures are followed, at 8.405-3. Throughout this report, when we refer to blanket purchase agreements, we refer to Federal Supply Schedule blanket purchase agreements. The blanket purchase agreement CBP established in 2015 expires in September 2020. CBP is in the process of awarding a new blanket purchase agreement, which its acquisition time line reflects should be completed by the time its current agreement expires.

flexibility to increase or decrease the number of contracted medical providers in its facilities, as needed, in response to changes in the number of apprehensions. Through this agreement, CBP initially deployed contracted medical providers to three facilities in the Rio Grande Valley sector in 2015 and obtained services in three additional sectors in 2018. According to CBP officials, CBP finalized a plan in January 2019 to deploy contracted medical providers at dozens of additional facilities across the southwest border, including some ports of entry.

**Figure 2: Contracted Medical Provider Office at a U.S. Border Patrol Station**



Source: U.S. Customs and Border Protection. | GAO-20-536

CBP officials said they prioritized facilities to receive onsite contracted medical providers based on several factors, including volume of apprehensions, demographics of apprehended individuals, and each facility's proximity to outside medical care. As of April 2020, officials said they planned to continue expanding the number of locations with onsite contracted medical providers.

Contracted medical providers at CBP facilities generally include one advanced practice provider (nurse practitioner or physician assistant) and

one or two assistant-level providers (emergency medical technician, certified nursing assistant, certified medical assistant, or paramedic). However, the exact number and types of providers may vary by facility.<sup>50</sup> Contracted medical providers' duties include, among other things, examining and treating apprehended individuals for lice and scabies; conducting health interviews and medical assessments; diagnosing and treating minor conditions, such as low-grade fevers and allergic reactions; dispensing medication; and referring individuals to the local health system (for example, an urgent care clinic, hospital, or emergency room), as needed.

**New health screening policies.** In January 2019, CBP issued an interim directive to further enhance medical care at its facilities to mitigate risk to, and improve care for, individuals in CBP custody along the southwest border.<sup>51</sup> Among other things, this directive established new health screening policies for all children in CBP custody (those under age 18).<sup>52</sup> Specifically, the interim medical directive called for all children to receive a standardized medical questionnaire, known as a health interview, and an evaluation of their health status, known as a medical assessment, during initial processing.<sup>53</sup> The directive also required adults in custody at

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<sup>50</sup>Other types of contracted medical providers available for telephonic consultation include physicians, pediatricians, and clinical psychologists.

<sup>51</sup>U.S. Customs and Border Protection, *CBP Directive No. 2210-003: CBP Interim Enhanced Medical Efforts* (Washington, D.C.: Jan. 28, 2019). According to the directive, the policies and procedures were interim and in effect until CBP issued an updated medical directive.

<sup>52</sup>The Tucson sector has been subject to a preliminary injunction since November 2016 that required all Border Patrol stations in the Tucson sector to use a medical screening form. See *Doe v. Johnson*, No. 15-00250 (D. Ariz. Nov. 18, 2016). In April 2020, the court in this case issued a permanent injunction requiring that all Tucson sector detainees who have completed processing and who have spent more than 48 hours in detention must be provided a medical assessment by a medical professional. See *Doe v. Wolf*, No. 15-00250 (D. Ariz. Apr. 17, 2020).

<sup>53</sup>Health interviews were conducted using different forms in different locations prior to the issuance of a health interview form that was standardized across the southwest border, which we discuss later in this report.

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ports of entry to receive health interviews and a medical assessment, if needed, based on their health interview responses.<sup>54</sup>

According to CBP officials, contracted medical providers are to conduct health interviews for those locations where they are available on site; otherwise, agents or officers are to conduct the interviews. Contracted medical providers we spoke with during our November 2019 site visits said they conducted health interviews with all individuals in custody, including adults at Border Patrol stations where health interviews with adults were not required by the interim medical directive. CBP officials and contracted medical providers said these health interviews are conducted in a language that apprehended individuals understand (such as Spanish for native Spanish-speakers), and, if a child is apprehended with a parent, then a parent participates in the child's health interview.

Similarly, CBP officials said that contracted medical providers are to conduct medical assessments at those locations where they are available on site; otherwise, agents or officers are to refer those who need a medical assessment to a local hospital, emergency room, or urgent care clinic.<sup>55</sup> Contracted medical providers we spoke with in November 2019 said that they take vital signs—including temperature, heart rate, respiration rate, blood pressure, and blood oxygen levels—as part of the routine medical assessment of children and that they take temperatures

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<sup>54</sup>As discussed previously, ports of entry are facilities run by OFO that provide for controlled entry into or departure from the United States, whereas Border Patrol stations are facilities run by Border Patrol that are assigned certain geographic areas of responsibility. In fiscal year 2019, OFO found about 126,000 individuals along the southwest border to be inadmissible, and Border Patrol apprehended about 850,000 individuals along the southwest border. CBP officials said that while the interim directive did not require that adults at Border Patrol stations receive health interviews, adults were not precluded from receiving them, when feasible. At both Border Patrol stations and ports of entry we visited with contracted medical providers, providers said adults in custody received a health interview and, if needed, a medical assessment.

<sup>55</sup>Because medical assessments can only be conducted by medical providers, individuals at CBP facilities without medical providers must be referred to a medical provider in the local health system if they need a medical assessment. CBP emergency medical services personnel are also permitted to conduct medical assessments in exigent circumstances. CBP emergency medical services personnel are agents or officers who are also certified as paramedics or emergency medical technicians. CBP officials said emergency medical service duties are considered collateral duties to agents' and officers' primary duties as law enforcement officials. Officials said that CBP emergency medical services personnel were reassigned from their field law enforcement duties to solely conduct medical assessments at CBP facilities to accommodate an increased number of apprehensions in 2019.



of all adults upon entry into a facility.<sup>56</sup> These providers explained that they only take additional vital signs from adults as needed in response to a medical complaint or health interview question. According to these providers, the required medical assessments are conducted as soon as possible—generally within 24 hours of an individual’s arrival to the facility. If an individual indicates a medical concern during the health interview, that individual is given a medical assessment immediately; otherwise, contracted medical providers conduct routine medical assessments after all health interviews are completed.

Additionally, the January 2019 interim medical directive called for Border Patrol and OFO to develop a standardized health interview form. Prior to the development of the standardized health interview form, Border Patrol and OFO used different forms across the southwest border to collect health information from apprehended individuals. CBP officials said these forms collected similar information, but they wanted a standardized form to ensure that sectors collected uniform information. CBP officials told us that after initially pilot-testing the standardized health interview form in two sectors, CBP rolled out the form to be used by agents, officers, and contracted medical providers across the entire southwest border in November 2019.<sup>57</sup>

In December 2019, CBP also updated its medical care directive. Table 3 provides a summary of the differences between the two directives related to health interviews and medical assessments.<sup>58</sup>

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<sup>56</sup>Contracted medical providers we spoke with stated that there could be some variation in which vitals they took as part of a child’s routine medical assessment, such as if an infant’s finger was too small for the pulse oximeter (to measure blood oxygen levels) or if the blood pressure cuff caused distress to the child.

<sup>57</sup>Border Patrol and OFO officials said the standardized health interview form has been distributed to their facilities throughout the nation and is available for use anywhere, though its use is only required at facilities along the southwest border.

<sup>58</sup>U.S. Customs and Border Protection, *CBP Directive No. 2210-004: Enhanced Medical Support Efforts* (Dec. 30, 2019).

**Table 3: Health Interview and Medical Assessment Requirements in Customs and Border Protection’s (CBP) Interim and Updated Medical Directives**

		Interim medical directive requirements (Issued January 2019)		Updated medical directive requirements (Issued December 2019)	
		Health interview	Medical assessment	Health interview	Medical assessment
U.S. Border Patrol	Adults	No	No	No	No
	Children aged 13 to 17	Yes	Yes	Yes	No
	Children under 13	Yes	Yes	Yes	Yes
Office of Field Operations	Adults	Yes	No	No	No
	Children aged 13 to 17	Yes	Yes	Yes	No
	Children under 13	Yes	Yes	Yes	Yes

Source: GAO analysis of CBP documentation. | GAO-20-536

Note: A health interview is a standardized medical questionnaire conducted with individuals in custody, and a medical assessment is an evaluation of an individual’s health status. Officers and agents can conduct health interviews but generally cannot conduct medical assessments, whereas medical personnel may conduct both. The interim medical directive was effective January 28, 2019, and was superseded by the updated medical directive, which went into effect December 30, 2019. CBP officials stated that when a directive does not require individuals—such as adults—to receive health interviews or medical assessments on a routine basis, it does not preclude this from occurring when facilities have the capacity to do so.

Among other changes, the updated medical directive clarifies that officers and agents are to observe all individuals for medical issues when they are initially encountered. Based on this observation, individuals with an observed medical issue may receive a health interview, medical assessment, or a referral to the local health system, as needed. CBP officials said that officers and agents have been required to observe individuals for medical issues since TEDS was established in 2015 and that the update to the medical directive was intended to clarify that officers’ and agents’ initial observation is part of the broader screening process.

Additionally, the updated medical directive continues to require health interviews and medical assessments for children under age 13 but (1) no longer requires health interviews for adults detained at ports of entry, and (2) no longer requires Border Patrol and OFO to routinely provide medical assessments for children aged 13 through 17. CBP officials said they changed the requirements for health interviews to focus on children because it can be more difficult for children to communicate medical concerns and they are less likely than adults to communicate such concerns. Similarly, CBP officials said they changed the requirements for medical assessments to focus on children ages 12 and younger because

children ages 13 through 17 years old are better able to communicate medical concerns and less prone to rapid changes in their health.

Officials stated that while the updated medical directive does not require other individuals—such as adults—to receive health interviews and medical assessments on a routine basis, it only specifies minimum requirements and does not preclude this from occurring when facilities have the capacity to do so. For example, CBP officials said that the contracted medical providers' practices had not changed in response to the issuance of the updated medical directive. In March 2020, an official with the contracted medical providers told us that, at facilities with onsite providers, they continue to conduct health interviews with all adults and both health interviews and medical assessments with all children at CBP facilities, exceeding the requirements of the updated medical directive.

**Other efforts to enhance medical support.** In addition, some CBP facilities received temporary medical support from other federal agencies as CBP was in the process of increasing support from contracted medical providers. Specifically, in December 2018, DHS requested assistance from the U.S. Public Health Service Commissioned Corps.<sup>59</sup> Medical providers with the U.S. Public Health Service were subsequently deployed to CBP facilities from December 2018 to October 2019.<sup>60</sup> In addition, officials said the Secretary of Homeland Security directed the U.S. Coast Guard to deploy medical providers to CBP facilities during the first half of calendar year 2019.<sup>61</sup> Per instructions from their agencies, medical providers from other federal agencies served the same role as contracted medical providers by conducting health interviews and medical assessments; diagnosing and treating minor conditions; dispensing medication; and referring individuals to the local health system, as needed. CBP officials said medical providers from other federal agencies

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<sup>59</sup>Within HHS, the U.S. Public Health Service Commissioned Corps is comprised of more than 6,500 full-time public health professionals—including a range of medical providers—with the mission to protect, promote, and advance the health and safety of the United States.

<sup>60</sup>Officials said CBP determined which facilities needed U.S. Public Health Service support based on several factors, including volume of apprehensions, demographics of apprehended individuals, and each facility's proximity to outside medical care.

<sup>61</sup>CBP officials said that during 2019, CBP also received nonmedical support from detailees from other DHS agencies, as well as from the Department of Defense. We currently have ongoing work on the Department of Defense's operations along the southern border.

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transitioned out of facilities as CBP was able to bring contracted medical providers on site and the numbers of individuals in custody decreased.

Finally, according to CBP officials, CBP is taking steps to develop an electronic medical record system to be used by contracted medical providers to electronically record responses to health interviews and medical assessments with a tablet computing device. In our visits to CBP facilities in south Texas, contracted medical providers used paper forms and discussed several potential benefits to using an electronic medical record, such as improved accessibility of medical records and monetary savings through reduced paper and toner costs. As of June 2020, officials said the system was being tested with users.

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### CBP Engaged with the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and Other Entities

As part of its efforts to enhance medical care in 2019, CBP engaged with various entities to leverage their expertise and coordinate efforts. According to CBP officials, the agency engaged with other federal entities both within and outside of DHS, as well as with state and local government agencies and nonprofit entities. For example, an official with the Association of State and Territorial Health Officials said DHS and CBP held a series of meetings with state health officials from California, Arizona, New Mexico, and Texas to provide an update on the increased volume of southwest border apprehensions and to hear about states' needs and challenges. With regard to two specific entities with medical expertise—CDC and AAP—CBP engaged with those entities and received recommendations or assistance with the development of training, as described below.<sup>62</sup>

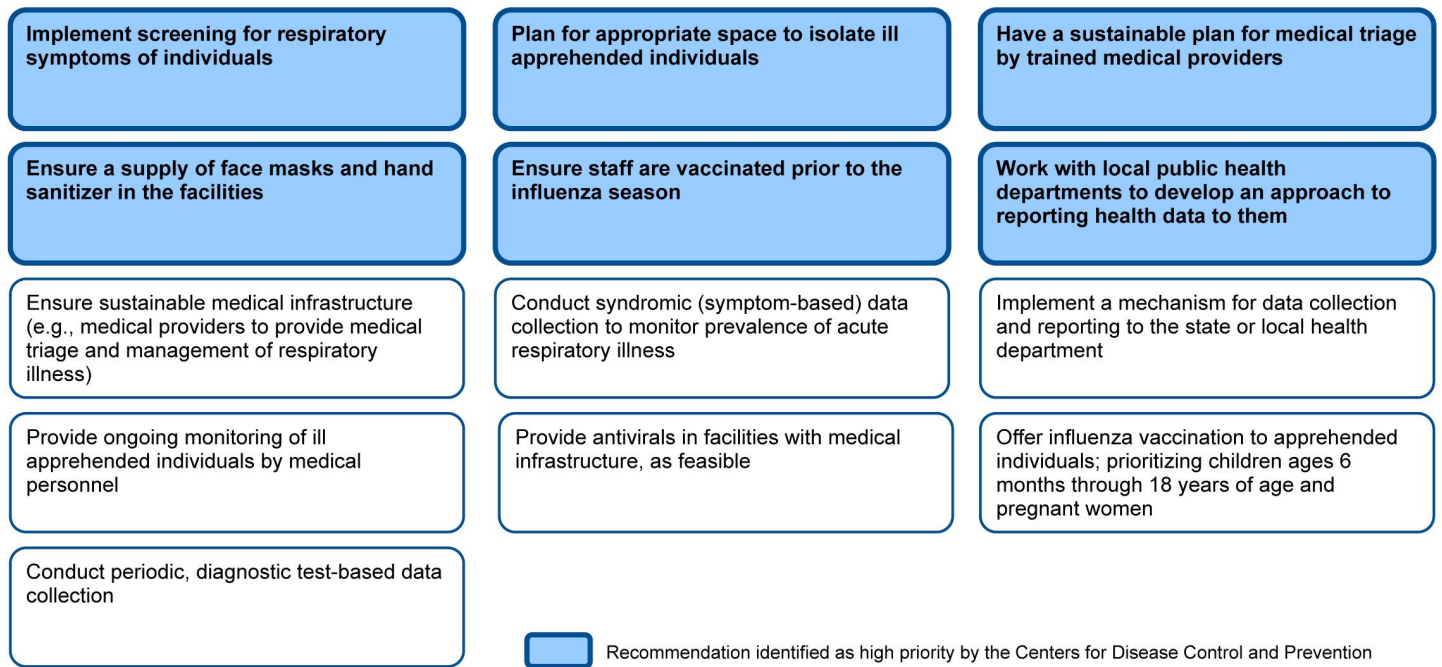
**CDC.** At the request of DHS, three CDC teams visited Border Patrol facilities in El Paso, Texas, and Yuma, Arizona, in December 2018 and January 2019 to assess conditions and make recommendations for the collection of data on, and to reduce the spread of, infectious diseases, particularly respiratory diseases such as influenza. During one of these visits, CDC personnel also collected data to provide information on the prevalence of respiratory diseases in Border Patrol facilities. Based on

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<sup>62</sup>For the purposes of this review, we focused on CBP's engagement with entities with substantial medical expertise and that resulted in recommendations or assistance with the development of training.

these visits, CDC provided DHS with a written set of recommendations in late January 2019 and a final report in late March 2019 for CBP to use to address immediate needs and plan for future influenza seasons. These recommendations related to, among other things, providing protection and care related to respiratory infections. CDC identified some of these recommendations as high priority. (See fig. 3).

**Figure 3: Recommendations from the Centers for Disease Control and Prevention to Reduce Respiratory Diseases in U.S. Border Patrol Facilities**



Source: GAO analysis of Centers for Disease Control and Prevention information. | GAO-20-536

**AAP.** According to AAP representatives, CBP initiated outreach to the AAP in January 2019. Representatives described this outreach as consisting of one in-person meeting in El Paso, Texas, with CBP and local pediatricians affiliated with AAP; phone calls between CBP and the AAP from approximately December 2018 through June 2019; and a visit to CBP facilities in McAllen, Texas, in June 2019. Officials further said that during this period of engagement, CBP requested, and the AAP developed, a short training video on recognizing signs of a child in medical distress. CBP issued the training in late September 2019 as part of a 35-minute training for CBP emergency medical technicians and paramedics.

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## CBP's Implementation and Oversight of Enhanced Medical Care Efforts Has Been Inconsistent

CBP has taken steps to improve medical care for those in its custody; however, we found that CBP has not consistently implemented enhanced medical care policies and procedures—including changes based on CDC recommendations. Additionally, CBP decided not to implement one CDC recommendation—offering influenza vaccines to individuals in custody—but did not document how it weighed costs and benefits associated with that decision. Further, CBP requires its officers and agents to monitor children for medical distress but does not provide relevant training to all CBP officers and agents. Finally, CBP did not consistently complete required annual reviews of its medical service agreement, including requests for discounts.

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### CBP Did Not Consistently Implement Enhanced Medical Care Policies and Procedures

During our site visits to CBP facilities in south Texas, we found that CBP was not consistently implementing enhanced medical care policies and procedures—including both the enhanced medical directive procedures and those based on CDC recommendations.

**Inconsistent implementation of enhanced medical directive procedures.** During our November 2019 site visit to CBP facilities in south Texas, we found that while some facilities were conducting health interviews and medical assessments in accordance with the interim medical directive, others were not. Specifically, Border Patrol facilities without contracted medical providers were not providing health interviews

or medical assessments.<sup>63</sup> Further, officials from the Border Patrol Rio Grande Valley sector said they did not expect health interviews or medical assessments would be provided to children at four Border Patrol stations in their area of responsibility because those stations did not have contracted medical providers. When we visited a station without contracted medical providers, agents confirmed that they did not conduct health interviews or send children to the local health system for medical assessments and stated that they were unaware of the interim medical directive or its requirements.

Further, our analysis of Border Patrol records on health interviews and medical assessment referrals found inconsistent implementation of the December 2019 updated medical directive at Border Patrol stations without contracted medical providers.<sup>64</sup> As previously mentioned, this updated directive specifies that all children in CBP custody aged 12 and younger are to receive a health interview and medical assessment. Our review of Border Patrol records from a 1-week period in February 2020 found that more than one-third of apprehended children under age 18 who were processed at Border Patrol stations without contracted medical providers did not receive a health interview or medical assessment referral at those stations. Specifically, across 31 Border Patrol facilities without contracted medical providers along the southwest border, there were 373 children apprehended in a 1-week period from February 1, 2020, through February 7, 2020. Our analysis of apprehension records found that 143 of these 373 children did not receive a health interview or medical assessment referral at that station where they were initially processed—this included 116 of the 137 children under age 13 (see fig.

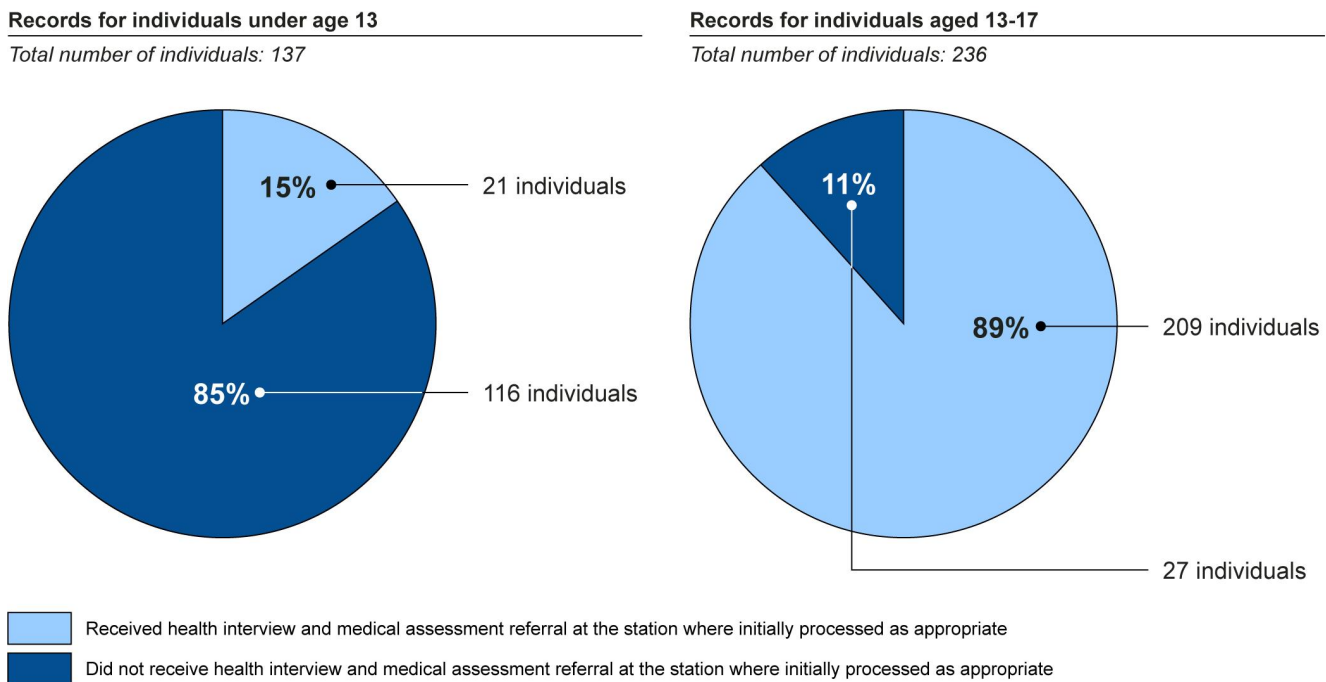
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<sup>63</sup>We visited a total of 10 CBP facilities, seven of which had contracted medical providers. At the seven facilities with contracted medical providers, we observed them conducting health interviews and medical assessments and interviewed contracted medical providers. Of the remaining three CBP facilities, officials at one port of entry without contracted medical providers also said they adhered to the interim medical directive by having officers conduct health interviews and bringing children to a local emergency room for medical assessments. At another Border Patrol station without contracted medical providers, agents said they did not conduct health interviews or send children to the local health system for medical assessments. The remaining Border Patrol station was not holding individuals during our visit. Instead, individuals from that station were sent to a central processing center for processing and detention.

<sup>64</sup>Because medical assessments can only be conducted by medical providers, individuals at CBP facilities without contracted medical providers must be referred to a medical provider in the local health system if they need a medical assessment. We reviewed records from facilities that recorded all health interview responses electronically at the time of our audit.

4).<sup>65</sup> Among children ages 13 through 17, we identified 25 children whose records reflected no health interview where they were initially processed and two children who should have received a medical assessment referral based on their responses to health interview questions (for example, they indicated that they had a cough) but whose records did not reflect one.

**Figure 4: GAO Analysis of Apprehension Records for Children at Select U.S. Border Patrol Facilities, February 1 through 7, 2020**



Source: GAO analysis of U.S. Border Patrol data. | GAO-20-536

<sup>65</sup>We reviewed Border Patrol’s electronic apprehension records for children along the southwest border to assess how many received health interviews and medical assessment referrals during initial processing. We counted a child as having received a health interview if the child’s apprehension record had “Yes” in the field “Health Interview Complete” and having not received one if the record had “No” for that field. We counted a child as having received a medical assessment if the child’s apprehension record had “Yes” for the field “Was the alien referred for a Medical Assessment?” and having not received one if the record had “No” for that field.



**Data Table for Figure 4: GAO Analysis of Apprehension Records for Children at Select U.S. Border Patrol Facilities, February 1 through 7, 2020**

	Records for individuals under age 13		Records for individuals aged 13-17	
	Number of individuals	Percentage	Number of individuals	Percentage
Received health interview and medical assessment referral at the station where initially processed as appropriate	21	15%	209	89%
Did not receive health interview and medical assessment referral at the station where initially processed as appropriate	116	85%	27	11%
<b>Total</b>	<b>137</b>	<b>--</b>	<b>236</b>	<b>--</b>

Note: We analyzed the apprehension records for children at U.S. Border Patrol facilities without contracted medical providers. The updated medical directive requires all children under age 13 to receive a health interview and medical assessment referral, whereas it only requires children aged 13 and older to receive a health interview, unless their responses in the health interview indicate a need for a medical assessment referral as well (for example, if a child indicates that he or she has a cough). The updated medical directive does not specify where the health interviews and medical assessments are to be conducted, but implementation plans issued in March 2020 clarify that they are to be conducted as expeditiously as possible upon arrival at a facility. When we notified CBP of these issues, CBP officials said that they cross-referenced the records we examined with additional records and found that most of the 143 children in question had received a health interview or medical assessment elsewhere, though some children had not. Specifically, officials said that some of the children were sent to the hospital, where officials said they should have received a medical examination, and others received a health interview or medical assessment later, upon transfer to a Border Patrol station with contracted medical providers. While the updated medical directive does not specify that individuals must receive health interviews and medical assessment referrals at the station where they are initially processed, CBP officials noted that they should receive health interviews and medical assessments as expeditiously as possible.<sup>66</sup> CBP officials indicated they were not previously aware of these delays and did not know why agents did not provide health interviews to children at the station where they were initially processed. CBP officials further noted that, as a result, there may have been an unnecessary delay in providing health interviews or medical assessments to those children. In addition, CBP officials confirmed that some children never received a health interview. As a result, CBP officials told us that they reiterated their expectations to the field on conducting and documenting health interviews and medical assessments.

**Inconsistent implementation of new procedures based on CDC recommendations.** In November 2019, CBP headquarters officials told us that the agency had implemented all of CDC’s recommendations that it intended to implement through a combination of existing and new

<sup>66</sup>In March 2020, Border Patrol and OFO issued implementation plans that specify health interviews are to be conducted as expeditiously as possible upon arrival at a facility, preferably prior to entering the holding area of the facility. Officials said that conducting health interviews upon initial arrival and outside the holding area of a facility helps identify infectious conditions individuals may have so that officers and agents may take appropriate action to prevent their spread.

efforts.<sup>67</sup> For example, these officials stated that existing occupational safety and health policies related to vaccinating staff and providing personal protective equipment addressed CDC's related recommendations. CBP officials stated that they implemented other recommendations—such as one to screen for respiratory symptoms in apprehended individuals during initial processing—through the new standardized health interview form.

However, during our visit to CBP facilities, we found that field personnel and contracted medical providers were not consistently aware of their responsibilities to implement some CDC-recommended practices and, as a result, had not implemented those practices. Some of the practices—such as requirements for providing personal protective equipment—had been implemented at all nine facilities with individuals in custody that we visited. However, local CBP leadership and contracted medical providers we interviewed were unaware of CBP's expectations related to other practices recommended by CDC. For example, at a Border Patrol facility in the El Paso sector, Border Patrol officials stated that they were aware CDC had made recommendations but stated that nothing had come of those recommendations and that they had not modified any practices as a result of CDC's recommendations.

At facilities in the south Texas region, some contracted medical providers did not consistently implement CDC-recommended practices. For example, CDC recommended that contracted medical providers conduct daily walk-throughs of CBP facilities to identify potentially ill persons that need further evaluation and provide ongoing daily monitoring of individuals for any new onset of symptoms related to acute respiratory illness. CBP officials in headquarters stated that they believed this was the practice at CBP facilities but could not provide documentation showing they directed the field to implement the recommendations. At five of the seven CBP facilities we visited in south Texas, contracted medical providers stated this was not a regular practice. Further, the statement of work that identifies required activities for contracted medical providers does not include walking through facilities or monitoring otherwise healthy individuals for the onset of symptoms.

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<sup>67</sup>According to CBP officials, CBP intended to implement all of CDC's recommendations, with the exception of the recommendation to offer the influenza vaccination to individuals in custody, prioritizing children over 6 months of age and pregnant women. We discuss CBP's evaluation of that recommendation later in this report.

Additionally, CBP headquarters officials told us that all CBP facilities were screening for respiratory symptoms in apprehended individuals during initial processing through health interviews, as recommended by the CDC. However, as discussed previously, we found that CBP has not consistently implemented health interviews for children. Further, because the updated medical directive does not require health interviews for adults, it is unclear how CBP will ensure that all apprehended adults are consistently screened for respiratory symptoms during initial processing.

CBP headquarters officials also told us that they did not believe all of the CDC recommendations needed to be implemented on a routine basis because it was their understanding that some recommendations apply only in specific circumstances, such as when there is an influenza outbreak in CBP facilities or CBP facilities are crowded. However, the CDC report states that the recommendations should be applied during influenza season, which occurs in the United States annually from October to February, as well as when CBP facilities are crowded.

With regard to implementation of medical efforts under the directives and the CDC recommendations, we found that CBP has not developed and implemented effective oversight mechanisms for monitoring implementation. CBP's interim medical directive—issued in January 2019—called for the development of implementation plans; however, CBP did not develop those plans. CBP officials told us that the large increase in apprehensions beginning in fall 2018 and continuing through summer 2019 required them to devote significant time and resources to implementing new medical care procedures, leaving them with insufficient resources to develop required implementation plans and oversight mechanisms for those efforts. Instead, officials stated that they conducted oversight through site visits to facilities along the southwest border and verbal instructions.

CBP's December 2019 updated medical directive also called for Border Patrol and OFO to develop implementation plans, which both components completed in March 2020. Among other things, these plans state that Border Patrol, OFO, and CBP will conduct infectious disease management efforts for those in custody and its workforce; work to incorporate medical monitoring and compliance into ongoing review efforts; and emphasize early identification and evaluation for infectious diseases among those in custody. The plans further describe specific metrics to monitor and assess Border Patrol and OFO facilities' compliance with medical practices required in the directive, including

statistics about apprehensions, health interviews, medical assessments, referrals to the local health system, and hospital admissions.

However, we found that CBP's implementation plans have not positioned the agency to fully monitor and ensure consistent implementation of medical efforts at CBP facilities. For example, the implementation plans completed in March 2020 do not include some of the information necessary for CBP to effectively oversee implementation of its enhanced medical care policies and procedures. For example, the implementation plans do not

- specify whether or when certain medical efforts recommended by CDC—including those we found were not consistently implemented at CBP facilities, such as walk-throughs by contracted medical providers—should be conducted. As a result, CBP may not be positioned to oversee consistent implementation of these practices through the implementation plans alone;
- include metrics specific to infectious disease control efforts recommended by CDC, such as the use of isolation for ill individuals in custody. For example, the implementation plans do not identify what information CBP will use to measure the extent to which this is occurring as it intends;
- identify performance targets for the metrics they do include, making it difficult for CBP to use those metrics to determine whether Border Patrol and OFO are implementing enhanced medical care as intended. For example, the implementation plans identify the number and percentage of persons with a health intake interview as a metric for its medical monitoring and assessment but do not identify what performance target is to be achieved, what data are to be used, and how often metrics will be monitored;<sup>68</sup> and
- identify roles and responsibilities for taking corrective action in cases when implementation is inconsistent or if performance targets are not met, making it difficult for CBP to ensure that it can remedy any identified issues. For example, the plans do not identify which entities within CBP are responsible for ensuring that performance targets are achieved.

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<sup>68</sup>As previously described, the updated medical directive calls for Border Patrol and OFO to conduct health interviews on all individuals under age 18 and to provide medical assessments to children under 13 years of age, as well as other children and adults in certain situations.

In addition, CBP does not currently have readily available information to track some of the metrics included in the implementation plans. For example, the implementation plans include metrics for the number and percentage of individuals in custody who receive a health interview and medical assessment and emphasize the need to monitor children. However, as previously discussed, when we informed CBP officials that our analysis of CBP data showed that some children had not received health interviews or medical assessments, CBP officials had to manually cross-reference each Border Patrol record against additional records for each child we identified to determine who had actually received those services. CBP officials said that while they are beginning to implement procedures that would allow them to track these metrics, those procedures have not been fully implemented.

Consensus-based standards for program and project management, such as those disseminated by the Project Management Institute, indicate that once implementation efforts are underway, organizations should oversee those efforts on an ongoing basis to ensure their consistent execution.<sup>69</sup> Those standards further indicate that organizations should document roles and responsibilities, the metrics they will use to assess their implementation efforts, and the performance targets against which those metrics are measured to determine success.<sup>70</sup> Similarly, *Standards for Internal Control in the Federal Government* states that agencies should document policies and procedures for program management and oversight, monitor program performance and progress, ensure that corrective actions are identified and assigned to the appropriate parties on a timely basis, and ensure that corrective actions are tracked until the desired outcomes are achieved.<sup>71</sup> It also states that agencies should define objectives that can be consistently measured and that are not overly reliant on subjective judgment. Further, agencies must have relevant, reliable, and timely information to determine whether their operations are performing as expected.

CBP has developed new medical care policies and procedures in order to better care for ill detainees and limit the spread of infectious disease in its facilities. The danger that infectious diseases, such as influenza and COVID-19, pose to CBP employees and those in its custody underscores

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<sup>69</sup>Project Management Institute, Inc., *The Standard for Program Management*.

<sup>70</sup>Project Management Institute, Inc., *A Guide to the Project Management Body of Knowledge (PMBOK® Guide)*.

<sup>71</sup>[GAO-14-704G](#).

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the importance of CBP ensuring that policies and procedures are being implemented consistently in all of its facilities. Without fully developing and implementing oversight mechanisms that include documentation of expected practices, metrics and corresponding performance targets, and roles and responsibilities for taking corrective action, CBP does not have assurance that its efforts to enhance medical care are being implemented as intended.

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### CBP Did Not Document How It Weighed Costs and Benefits in Its Decision to Not Offer the Influenza Vaccine for Those in Its Custody

As part of its report, CDC recommended CBP offer the influenza vaccination to individuals in custody, prioritizing children over 6 months of age and pregnant women, as soon as possible to allow for maximum protection and reduce the transmission of influenza in CBP facilities. CBP officials stated that they met with a DHS working group and, as of April 2020, had determined not to implement this recommendation; however, CBP did not document how it weighed costs and benefits associated with that decision.

CBP officials stated that vaccinating apprehended individuals for influenza would pose operational, medical, legal, and logistical challenges. For example, CBP documentation cited providing cold storage for influenza vaccines, increasing onsite contracted medical providers, and increasing medical record-keeping as some of the challenges to offering vaccines to individuals in custody. CBP officials told us that they considered and weighed these factors with DHS overall, including individuals with medical expertise, and that the department overall decided not to provide the vaccine to apprehended individuals. However, this document did not include how the agency weighed the costs or potential benefits of offering the influenza vaccine. For example, in terms of costs, CBP could not provide documentation or information on how it weighed the cost of providing cold storage at CBP facilities to support vaccines, the number of additional medical staff that would be needed, or the cost of additional medical record-keeping related to offering influenza vaccination and determined that these costs would be significant, with marginal benefit. Further, CBP did not document that it compared these costs against those that would be incurred with an influenza outbreak among individuals in custody at a CBP facility. CDC officials we spoke with stated that while they considered these challenges

and costs, they believed they could be addressed and made recommendations that were feasible for implementation.

CBP officials noted that they believe the agency addressed other factors that could contribute to the spread of influenza in its facilities. In particular, officials told us that CBP has reduced the overcrowding in its facilities and has practices and procedures to identify and isolate, as appropriate, potentially infectious individuals in its facilities. CBP officials also stated that they believed offering the influenza vaccine to individuals in custody would provide little benefit to the agency, given that it is CBP's goal to transfer individuals out of their custody within 72 hours, while the influenza vaccine takes 14 days to take effect. However, CBP officials also stated that they have no control over how long individuals may remain in CBP custody when there is a lack of capacity at ICE facilities. In May and June 2019, the DHS Office of Inspector General found serious overcrowding and prolonged detention in Border Patrol facilities in Texas because CBP could not transfer individuals in custody out of its facilities in a timely manner, as both ICE and HHS were operating at or above capacity.<sup>72</sup> For example, the DHS Office of Inspector General found that some adults were held as long as a month and some children held for two weeks. Further, under recently implemented CBP initiatives, individuals may be held in CBP custody for at least 7 days and up to 20 days.<sup>73</sup>

CBP officials stated that, rather than providing vaccinations in CBP facilities, they rely on transferring apprehended individuals to ICE and HHS, which have vaccination programs. However, individuals may be transferred to facilities that do not offer vaccines. In particular, ICE does not require that all individuals in its custody be offered an influenza vaccine. More specifically, at those facilities where ICE directly provides medical care, the agency requires and provides influenza vaccines to

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<sup>72</sup>U.S. Department of Homeland Security, Office of Inspector General, *Management Alert – DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center*, OIG-19-46 (Washington, D.C.: May 30, 2019); and *Management Alert – DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley*, OIG-19-51 (Washington, D.C.: July 2, 2019).

<sup>73</sup>In October 2019, CBP initiated the Prompt Asylum Claim Review and the Humanitarian Asylum Review Process. These programs allow CBP to hold individuals in custody for up to 20 days while claims are being adjudicated. GAO has ongoing work reviewing these programs.

detainees through its ICE Health Services Corps.<sup>74</sup> In fiscal year 2019, there were 20 facilities at which ICE Health Services Corps directly provided medical care to detainees, and those facilities housed less than 30 percent of ICE's annual average daily population.<sup>75</sup> For other facilities where ICE does not directly provide medical care for detainees—in which ICE housed more than 70 percent of its average daily population in fiscal year 2019—ICE requires facilities to have written plans that address infectious and communicable diseases management, but the facilities are not required to provide influenza vaccines. Finally, not all individuals apprehended by CBP are ultimately transferred to ICE or HHS custody but may be directly released into the interior of United States without receiving an influenza vaccine.<sup>76</sup>

CBP made its initial decision not to offer vaccines to those in its custody prior to the COVID-19 pandemic. Since that time, CDC has noted additional benefits of offering the influenza vaccine, such as reducing the overall number of individuals requiring health care, thus reducing pressure on health care resources and reducing the number of individuals who may need to be tested for COVID-19 due to the similarity of symptoms between influenza and COVID-19. Weighing the costs and benefits of an influenza vaccination program would also better inform CBP considerations of offering COVID-19 vaccines, if and when such a vaccine were to become available.

*Standards for Internal Control in the Federal Government* notes that documentation is a necessary part of an effective internal control system and that documentation provides a means to retain organizational knowledge and mitigate the risk of having that knowledge limited to a few personnel, as well as a means to communicate that knowledge as

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<sup>74</sup>The ICE Health Service Corps serves as ICE's medical authority for health issues of individuals in custody and oversees the administration and costs of medical care at all facilities. In addition, ICE Health Service Corps provides direct medical care in some ICE facilities.

<sup>75</sup>The daily population is the number of ICE detainees housed in a particular facility in a day. The annual average daily population is the sum of the daily population divided by the number of days in the year.

<sup>76</sup>For example, in the first two quarters of fiscal year 2019, Border Patrol released 164,100 individuals apprehended as members of a family (family units) into the interior of the United States with a notice to appear in immigration court. See GAO, *Southwest Border: Actions Needed to Improve DHS Processing of Families and Coordination between DHS and HHS*, [GAO-20-245](#) (Washington, D.C.: Feb. 19, 2020).



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needed to external parties, such as Congress and the public.<sup>77</sup> CDC guidance for public health decision-making include analyzing the costs and consequences of different public health interventions, particularly when resources are limited.<sup>78</sup> For example, a cost-effectiveness study can be used to compare the cost of a program to its health outcomes, such as illnesses and deaths averted. Similarly, a cost-benefit analysis can be used to compare monetary costs of a program to its expected monetary benefits, such as the cost of implementing the program as compared to savings expected to accrue from the program.

CBP officials stated that they continue to meet with the department on public health issues, including how to prevent the spread of influenza in its facilities, and will use this forum to continually reassess whether to offer influenza vaccines to individuals in its custody. Documenting what information it uses in reassessing this decision, including how the agency weighs costs and benefits associated with providing the influenza vaccine to individuals in its custody, would help provide CBP, Congress, and the public assurance that any reassessment has taken into account all relevant factors, such as the number of potential illnesses and deaths averted and related cost savings.

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### CBP Requires Officers and Agents to Monitor for Medical Distress in Children but Does Not Provide Relevant Training

CBP's policy documents require Border Patrol agents and CBP officers to identify potential medical issues in all individuals, including children, but CBP has not developed and implemented training for agents and officers on identifying medical distress in children—a more specific and nuanced area within overall responsibilities of CBP personnel for providing care for those in its custody. More specifically, CBP's updated medical directive requires Border Patrol agents and OFO officers to observe and identify potential medical issues for all individuals, including children, upon initial encounter, such as when agents apprehend adults or children in remote

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<sup>77</sup>[GAO-14-704G](#).

<sup>78</sup>Cost-effectiveness analyses and cost-benefit analyses are two economic evaluation approaches that can be used to identify, measure, value, and compare the costs of public health interventions. See Centers for Disease Control and Prevention, Office of the Associate Director for Policy and Strategy, *Economic Evaluation*, accessed May 20, 2020, <https://www.cdc.gov/policy/polaris/economics/index.html>.

field locations.<sup>79</sup> Additionally, CBP's standards for detaining individuals, TEDS, requires CBP officers and agents to conduct monitoring of detention areas on a regular and frequent basis and, as part of this activity, CBP officials stated that CBP officers and agents monitor for, among other things, physical and mental distress of individuals in custody, including children.<sup>80</sup> However, in its report, CDC noted that, based on its site visits and observations, Border Patrol agents did not appear to have sufficient training to triage or identify acutely ill individuals.

CBP officers and agents receive some medical-related training. For example, as part of initial training, all CBP officers and agents take two first aid courses. The Individual First Aid Kit is an 8-hour course with an emphasis on agent and officer self-care and combat medicine. The second course is the 4-hour American Red Cross Community First Aid and Safety Program, which provides an overview of how to identify and respond to various types of emergency situations that officers and agents may encounter in the field, such as how to perform cardiopulmonary resuscitation (CPR) on an individual experiencing a heart attack.

However, these courses do not include information specifically related to identifying medical distress in children, and CBP officials told us that the agency does not otherwise provide such training to all officers and agents. For example, our review of the instructor manuals and related instructional materials for the first aid courses that CBP officers and agents receive during initial training found that these courses provide information on how to identify and respond to certain types of emergencies—such as a heart attacks, choking, and seizures—but do not provide information on identifying more nuanced symptoms that children may have when becoming medically distressed. For example, these courses do not include information on changes to a child's skin tone and crying patterns that could alert officers and agents of the need to refer a child for medical care or how to elicit useful medical history information from parents and children taking into account cultural differences. Further, although CBP's training materials note that first aid and CPR knowledge and skills begin to decline within as little as 3 months after training, CBP

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<sup>79</sup>U.S. Customs and Border Protection, *CBP Directive No. 2210-004: Enhanced Medical Support Efforts* (Dec. 30, 2019).

<sup>80</sup>Officers and agents are required to monitor for distress in individuals regardless of whether there are contracted medical providers on site.

officers and agents are not required to take refresher first aid courses after their initial training.

Representatives from the AAP stated that recognizing medical distress in children is both challenging and time-sensitive. For example, AAP representatives stated that the signs and symptoms of children experiencing medical distress and illness may differ from those of adults, and children are less able to communicate about their illness. AAP representatives stated that these problems may be heightened in the context of CBP detention, where stress may weaken immune systems and cultural differences further inhibit communication. AAP representatives also noted that recognizing medical distress in children in a timely fashion is important because children can fall severely ill faster than adults. As previously mentioned, in 2019 CBP and AAP developed a training video on recognizing medical distress in children. CBP included the AAP-developed training on recognizing signs of medical distress in children as part of its training for the 1,185 emergency medical technicians and paramedics that work on the southwest border.<sup>81</sup> CBP officials told us that the agency has not provided the training video to all officers and agents because they believed this training was too technical to provide to all of the approximately 43,000 CBP officers and agents. CBP officials noted that the course was available as an optional continuing education course for all officers and agents but that they do not require or expect them to take the course.<sup>82</sup>

The need for all CBP officers and agents to be able to recognize medical distress in children has grown as the number of children CBP apprehends has increased in recent years. For example, the number of unaccompanied alien children and family units (parents or legal guardians arriving with children under age 18) increased from 37 percent of CBP apprehensions in fiscal year 2017 to 62 percent of CBP apprehensions in fiscal year 2019. Additionally, while fiscal year 2019 represented a particularly high number of apprehensions for CBP, the trend of an increasing number of children coming into the custody of CBP is not new. In October 2016, the former Secretary of Homeland Security noted that the demographics of unlawful migration on the southern border had

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<sup>81</sup>As of April 2020, CBP could not provide information on how many of its CBP emergency medical technicians and paramedics had taken this training.

<sup>82</sup>As of December 2019, a total of 383 Border Patrol and Office of Field Operations personnel across both components have completed this training, according to CBP's records.

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changed significantly over the previous 15 years—from mostly single adults to more family units and unaccompanied alien children.<sup>83</sup>

Both long-standing and recent CBP policies require CBP officers and agents to assess and monitor children for medical distress. Further, *Standards for Internal Control in the Federal Government* states that management should demonstrate a commitment to recruit, develop, and retain competent individuals.<sup>84</sup> The standards also note that competence is the qualification to carry out assigned responsibilities and requires relevant knowledge, skills, and abilities, which are gained largely from professional experience, training, and certifications. CBP officials stated that they have considered training on recognizing medical distress in children for all officers and agents who may come into contact with children in custody but have not begun to take steps to develop and implement such training. Without providing training on medical distress in children to all officers and agents who may come into contact with children in custody, CBP does not have assurance that CBP officers and agents are well-positioned to observe signs of medical distress in children during monitoring of detention areas or upon apprehension.

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### CBP Did Not Consistently Complete Annual Reviews of Its Agreement for Obtaining Onsite Medical Care

Since fiscal year 2015, CBP has used an agreement, known as a single-award blanket purchase agreement, to order contracted medical care for facilities along the southwest border but did not follow certain aspects of the Federal Acquisition Regulation (FAR), including conducting annual reviews of the blanket purchase agreement and requesting discounts as appropriate. Specifically, among other requirements, FAR requires contracting officers to review blanket purchase agreements and, as part of that review, to determine in writing whether estimated order quantities have been exceeded and additional discounts can be obtained.<sup>85</sup>

CBP contracting officials told us they did not conduct the required annual reviews of the agency's blanket purchase agreement for medical

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<sup>83</sup>Department of Homeland Security, *Statement by Secretary Johnson on Southwest Border Security* (Washington, D.C.: Oct. 18, 2016).

<sup>84</sup>[GAO-14-704G](#).

<sup>85</sup>See FAR § 8.405-3(e). Determination of whether estimated quantities have been exceeded can be made either annually or at option exercise.

providers in fiscal years 2016 through 2018. CBP officials conducted an annual review for fiscal year 2019; however, the review did not include all of the elements of an annual review required under FAR, as described above. Specifically, the review included the contracting officer's determination that the blanket purchase agreement still represented the best value but did not include whether the agency exceeded its estimated quantities of services under the agreement and whether additional discounts could be obtained.

CBP officials provided various reasons for not conducting annual reviews in fiscal years 2016 through 2018 and for not conducting a complete annual review in fiscal year 2019, as required by FAR. For example, CBP officials stated that they did not conduct annual reviews prior to fiscal year 2019 due to an oversight resulting from heavy workloads. They also said they did not document whether the blanket purchase agreement's estimated quantities were exceeded in fiscal year 2019 because they modified the agreement to increase the estimated quantities of services earlier in the year. CBP officials stated that they did not request a discount because they were operating with new estimated quantities, which they had not exceeded.<sup>86</sup> Further, CBP officials said they thought requesting a discount was unnecessary and would not be well received because they believed the contractor's prices were fair and they had not encountered problems with performance.<sup>87</sup> However, FAR requires the contracting officer to determine in writing whether the estimated order quantities have been exceeded and whether additional discounts can be obtained, which was not done.

Annual reviews present contracting officers with an opportunity to assess whether the blanket purchase agreement represents the best value and to request a discount if estimated quantities have been exceeded. Annual reviews also provide the agency with a means of ensuring that it is using its resources efficiently. While the blanket purchase agreement that CBP has used to order contracted medical services at its facilities expires on

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<sup>86</sup>At the same time, CBP increased the total amount it could spend for these services by increasing the ceiling of the blanket purchase agreement. Specifically, the blanket purchase agreement ceiling was raised in February 2019 from \$55 million to \$72.5 million.

<sup>87</sup>Prior GAO work found that although the ability to negotiate discounts by leveraging buying power through larger volume purchasing is one of the advantages of using blanket purchase agreements, many agencies—including DHS—did not maximize opportunities for savings under blanket purchase agreements. See GAO, *Contract Management: Agencies Are Not Maximizing Opportunities for Competition or Savings under Blanket Purchase Agreements despite Significant Increase in Usage*, [GAO-09-792](#) (Washington, D.C.: Sept. 9, 2009).

September 29, 2020, CBP plans to award a new blanket purchase agreement to continue those services. Without ensuring that annual reviews on its medical services agreement are performed and properly documented, as required by FAR, contracting officers may miss opportunities for additional savings and to ensure that the agreement continues to be the best option to fill the need for contracted medical services.

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## CBP Does Not Have Reliable Information on Deaths, Serious Injuries, and Suicide Attempts in Custody and Did Not Consistently Report Information on Deaths

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### CBP's Significant Incident Reporting System Does Not Have Reliable Information on Deaths, Serious Injuries, and Suicide Attempts

CBP's Significant Incident Reporting System is intended to inform DHS and CBP leadership about significant incidents—including the death, serious injury, or attempted suicide of an individual in CBP custody—in a timely manner.<sup>88</sup> When a significant incident occurs, field personnel are to call the Situation Room to provide an initial, verbal notification of the significant incident. Situation Room personnel then generate a blank significant incident report template in the web-based Significant Incident Reporting System and send this to personnel in the field. According to CBP policy, field personnel have 4 hours to complete this report, which includes classifying the type of significant incident that occurred.

In May 2018, CBP updated its directive on significant incident reporting. According to CBP officials, this update was intended to clarify requirements for reporting significant incidents. For example, CBP

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<sup>88</sup>According to a May 2018 CBP directive on Significant Incident Reporting, among other incidents, CBP components are to enter reports on the death, serious injury, or suicide attempt of an individual in custody, or that occurred during an encounter with CBP officers or agents, into the Significant Incident Reporting System within 4 hours of occurrence. See U.S. Customs and Border Protection, *CBP Directive No. 3340-025E: Reporting Significant Incidents to the Commissioner's Situation Room*. In addition, a preceding directive had similar reporting requirements; U.S. Customs and Border Protection, *CBP Directive No. 3340-025D: Reporting Significant Incidents to the Commissioner's Situation Room*.

officials stated that the prior directive, from 2010, did not provide a definition of serious injury, leaving field personnel to determine which injuries they considered serious for the purpose of reporting. Among other changes, the May 2018 directive defines a serious injury as any injury of an individual in custody that creates a substantial risk of death or causes serious disfigurement, serious impairment of health, serious loss or impairment of the function of any bodily organ or structure, or involves a serious concussive impact to the head.

However, according to CBP officials, despite the clarifications in the May 2018 directive, it is difficult to use data from the Significant Incident Reporting System on deaths, serious injuries, and suicide attempts in custody to reliably report on overall numbers of these events or analyze trends for three reasons:

- First, the May 2018 directive does not provide a definition for all types of incidents. Specifically, the May 2018 directive does not provide a definition of a suicide attempt, and CBP officials stated, as a result, field personnel have varying definitions of what they consider a suicide attempt for the purposes of reporting. For example, CBP officials stated that some field personnel classify an individual making a suicidal statement as a suicide attempt, whereas other field personnel will only report a suicide attempt when an individual takes physical action to attempt suicide.
- Second, field personnel who complete significant incident reports do not consistently classify incidents in accordance with this directive. For example, in our review of 50 Significant Incident Reports from fiscal year 2019, we identified two reports related to deaths of individuals that were incorrectly classified as injuries and illnesses.
- Third, the Significant Incident Reporting System does not have a category specific to either serious injuries or suicide attempts, although the May 2018 directive requires both types of incidents to be reported in the system. In particular, the directive states that field personnel are to use the Significant Incident Reporting System to report the death, serious injury, or attempted suicide of an individual occurring while in CBP custody or during an encounter with a CBP officer or agent. CBP officials stated that all serious injuries and suicide attempts are classified under the more general category of a “non-employee injury or illness” and would therefore be classified together with less serious incidents.

CBP officials stated it is feasible to modify the Significant Incident Reporting System to include additional categories but stated that these

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issues do not hinder CBP's operations because, according to those officials, as long as field personnel report all incidents to the Significant Incident Reporting System, DHS and CBP leadership will be notified of the incidents expeditiously, regardless of how the incidents are classified.

However, without appropriate classification of these incidents, CBP does not have complete and reliable information by incident type, making it difficult to identify changes or trends in, for example, the number or location of in-custody deaths, serious injuries, and suicide attempts. Such information could provide CBP with valuable insight into the extent to which its policies to ensure the health and safety of those in its custody are effective, and CBP officials told us that such trend analysis could be useful. Moreover, both Border Patrol's and OFO's implementation plans for its medical efforts identify the number of deaths in custody as a metric that those components plan to use to monitor compliance with the medical directive, but without appropriate classification of deaths in custody in the Significant Incident Reporting System, CBP is not well-positioned to use data from the system to inform this metric.

According to *Standards for Internal Control in the Federal Government*, management should process the data it collects into quality information that can be used to support the internal control system. These standards also call for management to develop procedures to monitor the performance of regular operations over time and to effectively communicate within and across agencies to help ensure that appropriate decisions are made.<sup>89</sup> Without providing additional guidance to field personnel to ensure that they classify Significant Incident Reports in accordance with CBP directive, and updating the Significant Incident Reporting System to include categories that align with the current directive, CBP will continue to lack reliable information on the number of deaths, serious injuries, and suicide attempts that occur in its custody; where they occur; and under what circumstances. In turn, reliable information would better enable the agency to analyze these data for trends—information that could help improve policies and procedures to help prevent or reduce the number of deaths, serious injuries, and suicide attempts that occur among individuals in CBP custody.

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<sup>89</sup>[GAO-14-704G](#).



## CBP Has Taken Steps to Clarify Responsibilities and Procedures for Reporting Deaths in Custody, but Reporting Gaps Remain

CBP has taken steps to revise its policies and procedures for reporting deaths in custody, but the agency has not consistently reported deaths in custody to Congress, as directed, or maintained documentation of such reporting. Additionally, CBP components have not consistently reported deaths in custody to appropriate entities in headquarters. From fiscal year 2015 through fiscal year 2019, congressional reports accompanying annual DHS appropriation acts directed CBP to report to Congress on deaths of individuals in CBP’s custody, including relevant circumstances of the fatality.<sup>90</sup> Additionally, in fiscal year 2014, DHS was directed to provide information on deaths in custody in summary statistics to Congress.<sup>91</sup> Specific reporting time frames varied each fiscal year, as shown in table 4.<sup>92</sup>

**Table 4: Time Frames for Reporting on Deaths in U.S. Customs and Border Protection (CBP) Custody Included in Congressional Reports Accompanying Annual Appropriations Acts for the Department of Homeland Security**

Fiscal Year	Time frame for reporting on deaths in custody to Congress		
	Annually	Within 2 weeks	Within 24 hours
2015	Yes	Yes	No
2016	Yes	No	Yes
2017	Yes	No	Yes
2018	No	No	Yes
2019	No	No	Yes

Source: GAO analysis of congressional reports. | GAO-20-536

<sup>90</sup>The committee report accompanying DHS’s fiscal year 2020 appropriations act continued requirements for reporting on deaths in custody within a 24-hour period. We did not review the extent to which CBP has or has not reported deaths in accordance with these directives for fiscal year 2020.

<sup>91</sup>See House Report No. 113-91 (2013).

<sup>92</sup>From fiscal years 2015 through 2019, the congressional reports described in Table 4 also directed DHS and CBP to provide information on deaths subsequent to a use of force by any CBP personnel. CBP officials told us that, to avoid double-counting, any incident where an individual in custody died as a result of a use of force was classified solely as a use-of-force death.

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Note: The congressional reports accompanying annual the Department of Homeland Security's appropriations act for fiscal years 2015, 2016, 2017, 2018, and 2019, respectively, are House Report No. 113-481 (2014); House Report No. 114-215 (2015); House Report No. 114-668 (2016); House Report No. 115-239 (2017); and House Report No. 116-9 (2019) (Conf. Rep.).

Our review of CBP's internal documentation and reports to Congress found that CBP did not consistently report deaths to Congress or maintain documentation to show that such reports occurred. In total, we identified 31 individuals who died in CBP custody along the southwest border from fiscal year 2014 through fiscal year 2019, and CBP provided documentation that it reported 20 to Congress.<sup>93</sup>

For example, neither DHS nor CBP reported information on deaths in CBP custody to Congress for fiscal year 2014—when DHS was directed to provide such information in summary statistics and when two deaths, including that of a child, occurred in CBP custody.<sup>94</sup> CBP officials stated they were unaware of the reporting directive for fiscal year 2014 to include information about deaths in CBP custody in an annual report of summary statistics.<sup>95</sup> Similarly, for fiscal year 2016, CBP did not have documentation that it reported any deaths in custody when the agency was directed to provide notifications to Congress on each death within 24 hours as well as an annual report on the status or results of ongoing investigations related to such deaths. Our analysis identified that three adults died in Border Patrol custody during that fiscal year. CBP officials told us that they believed CBP provided email notification to Congress for two of these deaths but were unable to provide documentation of those notifications.

Additionally, when CBP reported deaths to Congress, it did not always report them in a timely manner. For example, for fiscal years 2016

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<sup>93</sup>Our review did not include individuals who died in CBP custody along other borders, at airports, or at seaports. We took steps to determine the number of deaths that occurred in CBP custody along the southwest border. Specifically, we compared records maintained by CBP's Situation Room to those maintained by OPR. We then compared these records to reports that CBP provided to Congress and CBP public press releases. To corroborate our understanding of both of these sources, we interviewed officials from the CBP Situation Room and OPR on their offices' practices for collecting and storing this information. We determined that the steps we took resulted in sufficiently reliable information on the number of deaths that occurred in CBP custody along the southwest border from fiscal year 2014 through fiscal year 2019.

<sup>94</sup>In fiscal year 2014, one child died in OFO custody, and two adults died in Border Patrol custody. App. II provides more information about deaths in CBP custody from fiscal year 2014 through fiscal year 2019.

<sup>95</sup>See House Report No. 113-91 (2013).

through 2019, CBP was directed to report all deaths in custody within 24 hours. However, CBP was unable to substantiate that the 24-hour requirement was met for fiscal years 2016 and 2017. In particular, CBP did not provide us with documentation that it reported to Congress within 24 hours on deaths that occurred in those fiscal years. Further, in December 2018, CBP reported to Congress the death of a 7-year-old Guatemalan girl who died in Border Patrol custody 4 days after the 24-hour window for notification had passed.<sup>96</sup> Moreover, CBP was directed to provide annual information on deaths in custody for fiscal year 2017 but did not provide this information until March 2019.<sup>97</sup>

CBP officials attributed these reporting issues to a lack of defined responsibilities and procedures. In December 2018—recognizing the need for more consistent and timely reporting—the CBP Commissioner issued a memorandum outlining interim policy and procedures for notifications of a death in CBP custody.<sup>98</sup> The memorandum requires component personnel to directly notify OPR of deaths in custody. Prior to the issuance of this memorandum, OPR officials told us that their office was generally only informed of deaths involving a use of force or suspected CBP officer or agent misconduct. OPR officials stated that they believe the new policies and procedures have improved CBP’s ability to track and report deaths to Congress, as directed.

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<sup>96</sup>According to the DHS Office of Inspector General, on Thursday, December 6, 2018, a 7-year-old Guatemalan girl and her father were apprehended in Antelope Wells, New Mexico. During transport from Antelope Wells to another Border Patrol facility 90 miles away in Lordsburg, New Mexico, the child’s father reported that she was ill with a fever and vomiting. The child also started having seizures. When the child arrived at the Border Patrol station in Lordsburg, Border Patrol emergency medical technicians initiated medical care and flew the child to the hospital by commercial air ambulance. Border Patrol personnel drove the father to the hospital. The child was pronounced dead at the hospital on Saturday, December 8. The state medical examiner’s autopsy report found the child died of natural causes due to sequelae of streptococcal sepsis. Department of Homeland Security, Office of Inspector General, *The Office of the Inspector General Completes Investigation of the Death of Seven-Year-Old Guatemalan Child Who Died in U.S. Border Patrol Custody* (Washington, D.C.: Dec. 20, 2019). CBP notified Congress of her death on Thursday, December 13, 2018.

<sup>97</sup>In March 2019, CBP issued an annual report to Congress that provided information on the deaths in custody that occurred in fiscal year 2017 and fiscal year 2018, reporting a total of 10 deaths for those years.

<sup>98</sup>U.S. Customs and Border Protection, *CBP Interim Procedures on Notification of a Death in Custody*.

Since the issuance of the December 2018 memorandum, OPR officials have also identified continued areas for improvement in reporting on deaths in custody. For example, the memorandum defines “death in custody” as any death of an individual while detained, under arrest, or in the process of being arrested by CBP law enforcement (or en route to be incarcerated or detained) at a facility owned by, contracted with, or used by CBP. However, OPR officials stated that components have varying interpretations of this definition and, therefore, which deaths are governed by the interim procedures.<sup>99</sup> For example, OPR officials told us that OFO identified fewer deaths as occurring in custody as compared to Border Patrol, in part because OFO tended to identify fewer individuals as in custody as compared to Border Patrol. More specifically, OPR officials told us that OFO did not consider all deaths that occur during secondary inspection to be deaths in custody.<sup>100</sup> In contrast, OPR officials noted that Border Patrol personnel counted almost all deaths that occurred after an agent encountered an individual—regardless of whether the agent had detained the individual—as a death in custody. OPR officials stated that, since the issuance of the interim procedures, to ensure CBP has timely, reliable information for reporting to Congress, components are to send information on any death to OPR so that OPR can review the facts and circumstances of the death to determine if it occurred in custody and requires reporting. To simplify this process, in April 2019, OPR convened a working group to refine the definition of “death in custody” under the memorandum to ensure that it is implemented consistently across CBP components.

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<sup>99</sup>According to CBP’s *Interim Procedures on Notification of a Death in Custody*, a “death in custody” is any death of an individual while detained, under arrest, or in the process of being arrested by any CBP law enforcement personnel; en route to be incarcerated or detained, or is incarcerated or detained at any CBP facility; any facility pursuant to a contract with CBP; or any state or local government facility used by CBP. According to CBP officials, this definition was developed from the definition of “in custody” in the *Death in Custody Reporting Act of 2013*. See Pub. L. No. 113-242, 128 Stat. 2860 (codified as amended at 18 U.S.C. § 4001 note). This act requires federal law enforcement agencies—including CBP—to report to the Attorney General on the death of any individual in custody as well as the deceased’s name, gender, race, ethnicity, age, and a brief description of the circumstances surrounding the death. The full definition as provided in the *Death in Custody Reporting Act of 2013* can be found in app. II.

<sup>100</sup>A secondary inspection is when travelers, vehicles, or cargo undergo additional inspection at land ports of entry and OFO officers determine admissibility into the United States. A secondary inspection could include physical or canine searches and x-ray examinations, among other things. Not all individuals in secondary inspection are suspected of violating U.S. law or being inadmissible to the United States. However, CBP officials stated that individuals are not free to leave until a secondary inspection is completed.

However, we found that field personnel have not consistently followed the procedures for reporting deaths to OPR outlined in the December 2018 memorandum. For example, we identified four deaths during our review of Situation Room reports that occurred after the issuance of the December 2018 memorandum but were not reported to OPR to determine whether they represented deaths in custody. Of these, OPR determined one to be a death in custody, which CBP then reported to Congress after the 24-hour window for notification had passed. OPR officials attributed these issues to a lack of understanding of the new procedures among component staff. Specifically, officials stated that component staff may not be aware that the December 2018 memorandum requires them to report deaths both to the Situation Room—to provide immediate awareness to CBP leadership—and to OPR so that OPR can conduct a more thorough investigation and ensure that Congress is informed of deaths in CBP custody.

In addition, CBP was unable to provide documentation that two deaths that occurred in CBP custody after the issuance of the interim procedures had been reported to Congress: an 8-year-old Guatemalan boy who died in Border Patrol custody in December 2018 and a 40-year-old Mexican man who died in Border Patrol custody in El Paso. CBP officials stated they may have notified Congress by telephone.

CBP officials stated that they expected updated policy and procedures on notifications of a death in CBP custody to be finalized in September 2020, and acknowledged that additional guidance with more specifics to support implementation would be helpful.

Congressional reports call on CBP to provide timely and reliable information to Congress on deaths in custody, and CBP's own policies echo this directive and note that transparency with Congress, including providing timely and accurate information as directed, is a means of securing and maintaining trust in the agency. *Standards for Internal Control in the Federal Government* states that management should communicate quality information to enable personnel to perform key roles in achieving the agency's objectives.<sup>101</sup> Further, *Standards for Internal Control in the Federal Government* notes that documentation is a necessary part of an effective internal control system.<sup>102</sup> Such communication could take the form of additional guidance as CBP

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<sup>101</sup>[GAO-14-704G](#).

<sup>102</sup>[GAO-14-704G](#).

updates policies and procedures for notifications of a death in CBP custody. Additional guidance to components on procedures for reporting deaths in custody would help ensure that CBP has reliable, timely information on deaths in custody to report to Congress. Ensuring that this information is reported to Congress as directed, and documented appropriately, would help improve transparency with Congress and, in turn, help secure and maintain trust in the agency.

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## Conclusions

CBP is charged with providing care and ensuring the health and safety of each adult and child in its custody. CBP has taken steps to improve its care and custody of adults and children and requested emergency supplemental funds to support these operations along the southwest border. However, CBP did not provide sufficient guidance on how components could use these funds, and, as a result, made obligations in violation of appropriations law. Further, no entity within CBP took responsibility for providing full oversight of obligations made using “consumables and medical care” funds—including whether such obligations were consistent with the purpose of the funds. Absent greater oversight of obligations, CBP is not well-positioned to ensure funds are used consistent with their purpose and to take corrective actions—such as adjusting accounts—in a timely manner.

CBP identified a need to improve its processes and procedures for providing medical care to individuals in its facilities. Increasing contracted medical provider support, issuing new health screening policies, and engaging with the CDC and others were positive steps in making these changes. However, further action is needed to ensure the consistent implementation of CBP’s efforts. While CBP issued implementation plans for medical efforts, the agency has not fully developed and implemented oversight mechanisms to include documentation of expected practices, metrics and corresponding performance targets, and roles and responsibilities for taking corrective action. As a result, CBP does not have assurance that its efforts to enhance medical care are being implemented as intended and may not be achieving its goal of mitigating risk to, and improving medical care for, individuals in its custody.

Further, CBP did not document what factors it weighed in deciding not to implement the CDC’s recommendation to offer influenza vaccines and, as a result, is not well-positioned to provide assurance that the agency has fully weighed all costs and benefits in an appropriate manner. As part of

its new health screening policies, CBP places increased importance on the role of officers and agents in observing individuals for medical distress, including children. By developing and implementing training for these officers and agents, CBP would have better assurance that its officers and agents are well-equipped to recognize signs of medical distress in children. CBP plans to award a new blanket purchase agreement for medical services but did not perform annual reviews on its previous agreement for multiple years. Performing annual reviews and properly documenting them would help ensure that CBP has exhausted opportunities for additional savings and that its medical services agreement continues to be the best option to provide such services.

Through updated directives and memorandums, CBP has taken steps to improve the internal reporting of deaths, serious injuries, and suicide attempts in custody as well as the external reporting of deaths in custody. Providing additional guidance to the field on classifying and reporting significant incidents and updating the Significant Incident Reporting System to include categories that align with the current directive would position CBP to provide more reliable information to senior CBP and DHS leadership as well as to analyze this information for trends to potentially improve policies and procedures. CBP's December 2018 memorandum on notification procedures for a death in custody states that transparency, including reporting to Congress on deaths in custody, is a means of securing and maintaining the public's trust in the agency. Additional guidance for components on procedures for reporting deaths in custody to OPR, reporting timely and reliable information on deaths in custody to Congress, and documenting that reporting would help CBP meet congressional directives and improve transparency.

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## Recommendations for Executive Action

We are making the following 10 recommendations to CBP:

The Commissioner of CBP should develop and implement additional guidance for ensuring funds appropriated for specific purposes are obligated consistent with the purpose of the funds. (Recommendation 1)

The Commissioner of CBP should establish and document oversight roles and responsibilities to ensure funds appropriated for specific purposes are obligated consistent with the purpose of the funds. (Recommendation 2)

The Commissioner of CBP should develop and implement oversight mechanisms for CBP's implementation of policies and procedures relating to medical care for individuals in its custody to include documentation of expected practices, metrics and corresponding performance targets, and roles and responsibilities for taking corrective action. (Recommendation 3)

The Commissioner of CBP should document what information it is using to assess whether to offer the influenza vaccine to individuals in custody, including how it weighs costs and benefits. (Recommendation 4)

The Commissioner of CBP should develop and implement training on recognizing medical distress in children for all CBP officers and Border Patrol agents who may come into contact with children in custody. (Recommendation 5)

The Commissioner of CBP should ensure that contracting officers for its medical services blanket purchase agreement perform and properly document annual reviews, as required by FAR. (Recommendation 6)

The Commissioner of CBP should provide additional guidance to field personnel to ensure they classify significant incident reports on deaths, serious injuries, and suicide attempts, in accordance with CBP policy. (Recommendation 7)

The Commissioner of CBP should update the Significant Incident Reporting System to include categories that align with CBP's directive on the reporting of significant incidents. (Recommendation 8)

The Commissioner of CBP should provide additional guidance to components on the procedures for reporting deaths in custody to OPR and other entities within CBP. (Recommendation 9)

The Commissioner of CBP should ensure that timely, reliable information on deaths in custody is reported to Congress, as directed, and maintain documentation on those reports. (Recommendation 10)

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## Agency Comments and Our Evaluation

We provided a draft of this report to DHS and HHS for review and comment. DHS provided formal, written comments, which are reproduced



in appendix III, and technical comments, which we incorporated as appropriate. HHS told us they had no comments on the draft report.

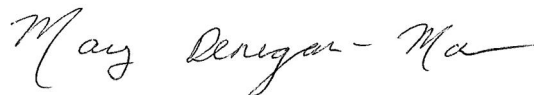
DHS concurred with our 10 recommendations and described actions planned or underway to address them. Regarding our recommendation that CBP ensure that contracting officers for its medical services blanket purchase agreement perform and properly document annual reviews, as required by FAR, DHS stated that officials from the Acquisition Procurement Directorate reviewed the requirements in the FAR with CBP staff. DHS requested that we consider the recommendation implemented. Once DHS provides documentation supporting these steps, we will assess the extent to which CBP's actions fully address the recommendation.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until one day from the report date. At that time, we will send copies to the appropriate congressional committees, the acting Secretary of Homeland Security, and the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at <https://gao.gov>.

If you or your staff have any questions about this report, please contact us at (202) 512-8777 or [gablerr@gao.gov](mailto:gablerr@gao.gov), or (202) 512-7114 or [deniganmacauleym@gao.gov](mailto:deniganmacauleym@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs are listed on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



Rebecca Gambler  
Director, Homeland Security and Justice



Mary Denigan-Macauley  
Director, Health Care

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*List of Requesters*

The Honorable Dianne Feinstein  
Ranking Member  
Committee on the Judiciary  
United States Senate

The Honorable Bennie Thompson  
Chairman  
Committee on Homeland Security  
House of Representatives

The Honorable Tammy Baldwin  
United States Senate

The Honorable Michael F. Bennet  
United States Senate

The Honorable Richard Blumenthal  
United States Senate

The Honorable Cory A. Booker  
United States Senate

The Honorable Sherrod Brown  
United States Senate

The Honorable Robert P. Casey, Jr.  
United States Senate

The Honorable Catherine Cortez Masto  
United States Senate

The Honorable Tammy Duckworth  
United States Senate

The Honorable Kirsten Gillibrand  
United States Senate

The Honorable Kamala D. Harris  
United States Senate

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The Honorable Mazie Hirono  
United States Senate

The Honorable Amy Klobuchar  
United States Senate

The Honorable Edward J. Markey  
United States Senate

The Honorable Robert Menendez  
United States Senate

The Honorable Jeffrey A. Merkley  
United States Senate

The Honorable Jack Reed  
United States Senate

The Honorable Bernard Sanders  
United States Senate

The Honorable Tina Smith  
United States Senate

The Honorable Tom Udall  
United States Senate

The Honorable Elizabeth Warren  
United States Senate

The Honorable Ron Wyden  
United States Senate

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# Appendix I: U.S. Customs and Border Protection—Obligations of Amounts Appropriated in the 2019 Emergency Supplemental, B-331888, June 11, 2020



441 G St. N.W.  
Washington, DC 20548

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## Decision

### Matter of: U.S. Customs and Border Protection—Obligations of Amounts Appropriated in the 2019 Emergency Supplemental

File: B-331888

Date: June 11, 2020

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## DIGEST

Supplemental appropriations enacted in fiscal year 2019 for U.S. Customs and Border Protection (CBP), U.S. Department of Homeland Security included line item appropriations for “consumables and medical care” and “establishing and operating migrant care and processing facilities.” CBP obligated these line item appropriations for goods and services for which the line items were not available. Accordingly, we conclude that CBP violated the purpose statute. CBP should adjust its accounts to obligate the account available for the appropriate purpose. If CBP lacks sufficient budget authority to make the adjustments, then it should report a violation of the Antideficiency Act as required by law.

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## DECISION

Pursuant to a congressional request, GAO is conducting an audit of U.S. Customs and Border Protection (CBP), U.S. Department of Homeland Security’s (DHS) care and custody of adults and children.<sup>103</sup> During the course of our work, we obtained documentation from CBP about its obligation of amounts appropriated in the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019 (2019 Emergency Supplemental). At issue is whether the obligations were consistent with the purpose statute.

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<sup>103</sup> The ongoing audit engagement includes an objective on the extent to which CBP obligated and conducted oversight of funds from the consumables and medical care line item appropriation from the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019. For a list of congressional requesters for the audit engagement, see pages 10 and 11.

As discussed below, we conclude that CBP violated the purpose statute when it obligated the line item appropriations in the 2019 Emergency Supplemental for goods and services that were not within the purpose availability of such line items. CBP has advised that it plans to adjust its accounts for several of these obligations. CBP should also adjust its accounts for any additional purpose violations by obligating the account available for the appropriate purpose. If CBP lacks sufficient budget authority to make the adjustments, then it should report a violation of the Antideficiency Act as required by law.<sup>104</sup>

In accordance with our regular practice, we contacted DHS for its legal views and factual information on this matter. GAO, *Procedures and Practices for Legal Decisions and Opinions*, GAO-06-1064SP (Washington, D.C.: Sept. 2006), available at <http://www.gao.gov/products/GAO-06-1064SP>; Letter from Managing Associate General Counsel, GAO, to Acting General Counsel, DHS (Feb. 26, 2020). CBP responded with factual information and its legal views. Letter from Chief Counsel, CBP, to Managing Associate General Counsel, GAO (Mar. 30, 2020) (Response Letter). We subsequently requested, and CBP provided, additional information.

E-mail from Senior Attorney, GAO, to, Acting Deputy Associate General Counsel for General Law, DHS, and Attorneys, CBP, *Subject: Follow-up Question about “migrant care and processing facilities”* (Apr. 10, 2020); Letter from Attorney, CBP, to Senior Attorney, GAO (Apr. 14, 2020) (Supplemental Response Letter).

#### BACKGROUND

CBP is responsible for enforcing and administering immigration laws in coordination with other DHS components, including processing persons who seek to enter or depart and short-term detention of persons unlawfully entering, or who recently unlawfully entered, the United States. 6 U.S.C. § 211(c)(8). As part of these responsibilities, CBP maintains both permanent and temporary facilities to process individuals apprehended at or between ports of entry and to provide short-term detention of these individuals pending transfer to another agency or removal from the United States. See 6 U.S.C. § 211(c), (m); Supplemental Response Letter, at 2.

Congress typically appropriates an annual lump-sum to CBP for “Operations and Support” to provide for CBP’s necessary expenses.<sup>105</sup> See, e.g., Consolidated

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<sup>104</sup> If an agency violates the Antideficiency Act, the head of the agency must report all relevant facts and a statement of actions taken to the President and Congress and must transmit a copy of the report to the Comptroller General. 31 U.S.C. § 1351.

<sup>105</sup> Congress also appropriates an annual lump-sum to CBP for “Procurement, Construction, and Improvements.” See, e.g., Consolidated Appropriations Act, 2019, Pub. L. No. 116-6, div. A, title II, 133 Stat. 13, 18 (Feb. 15, 2019). A lump-sum appropriation is generally available to cover the necessary expenses of a wide array of programs, projects, or items. See B-329373, July 26, 2018, at 3 n.17; B-327003, Sept. 29, 2015, at 4 n.2

Appropriations Act, 2019, Pub. L. No. 116-6, div. A, title II, 133 Stat. 13, 17 (Feb. 15, 2019). In fiscal year 2019, Congress appropriated additional amounts to CBP under this heading for “necessary expenses to respond to the significant rise in aliens at the southwest border and related activities.” 2019 Emergency Supplemental, Pub.

L. No. 116-26, title III, 133 Stat. 1018, 1019 (July 1, 2019). Within these supplemental amounts, Congress provided several line item appropriations, including about \$112 million specifically for “consumables and medical care” and

\$708 million specifically for “establishing and operating migrant care and processing facilities.”<sup>106</sup> *Id.*, 133 Stat. at 1020.

As relevant here, CBP obligated the consumables and medical care line item appropriation for CBP’s canine program; the CBP-wide vaccine program for CBP personnel; computer network upgrades; transportation-related items such as boats, all-terrain vehicles (ATVs), and dirt bikes; and building equipment and services such as HVAC upgrades, sewer system upgrades, and janitorial services. Response Letter, at 1–2, 12–15. In addition, CBP obligated both the consumables and medical care and the establishing and operating migrant care and processing facilities line item appropriations for certain goods and services. *Id.* at 15.

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## DISCUSSION

Under the purpose statute, appropriations are available only for the purpose for which Congress has provided them and for obligations that are reasonably necessary to the accomplishment of that purpose. 31 U.S.C. § 1301(a); B-306424, Mar. 24, 2006. To interpret the purpose of an appropriation, we turn to the statutory text. See B-329373, July 26, 2018, at 3.

In analyzing statutory language, we assume that each word has meaning and that Congress was aware of such meaning when it included each term in the legislation. B-329603, Apr. 16, 2018, at 5, and cases cited therein. Further, we interpret terms that are not otherwise defined in accordance with their common meaning. *Sebelius v. Cloer*, 569 U.S. 369, 376 (2013); B-330776, Sept. 5, 2019, at 6. Here, Congress appropriated amounts for CBP in the 2019 Emergency Supplemental for Operations and Support for “necessary expenses to respond to the significant rise in aliens at the southwest border and related activities.” Pub. L. No. 116-26, 133 Stat. at 1019. Under that heading, Congress included amounts specifically for “consumables and

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<sup>106</sup> The 2019 Emergency Supplemental also included line item appropriations under the Operations and Support heading for “transportation,” “temporary duty and overtime costs,” and “mission support data systems and analysis.” Pub. L. No. 116-26, 133 Stat. at 1020. In contrast to a broadly available lump-sum appropriation, a line item appropriation is available only for the specific object described. See B-330862, Sept. 5, 2019, at 10 n.9; see also note 3, *supra*.

medical care.” Pub. L. No. 116-26, 133 Stat. at 1020. Neither the term “consumables” nor the phrase “medical care” is expressly defined in the

2019 Emergency Supplemental, its limited legislative history, or any legislation authorizing CBP’s activities. As is our usual practice when determining the ordinary meaning of terms that are not defined in the enacted legislation itself, we refer to dictionary definitions. B-329603, Apr. 16, 2018, at 4, 5.

The ordinary meaning of the noun “consumable” is “[a] consumable good or service.” *American Heritage Dictionary of the English Language* 395 (5th ed. 2018) (definition of “consumable”). In turn, the adjective “consumable” refers to items “[c]apable of being depleted or worn out by use.” *Id.* In accordance with these definitions, in the context of CBP’s appropriation the term “consumable” refers to goods that are exhausted by use.

The ordinary meaning of the term “medical” is “[o]f or relating to the study or practice of medicine.” *Id.*, at 1092 (definition of “medical”). “Medicine,” in turn, is defined as “[t]he science and art of diagnosing and treating disease or injury and maintaining health.” *Id.* (definition of “medicine”). Lastly, the ordinary meaning of the noun “care” is “[a]ttentive assistance or treatment to those in need.” *Id.*, at 281 (definition of “care”). In light of these definitions, the phrase “medical care” includes goods and services used to provide assistance related to the diagnosis and treatment of disease or injury and maintaining health.

Some of CBP’s obligations of the consumables and medical care line item—such as obligations for hygiene products, food, clothing, and baby supplies—are goods worn out by use and fall squarely within the ordinary meaning of “consumable.” Other obligations—including obligations for medical supplies such as defibrillators, masks, ointment, and gloves—relate to the treatment of disease or injury and fall squarely within the plain meaning of “medical care.” For such obligations, we can readily conclude that CBP properly obligated the consumables and medical care line item.

Other obligations, however, do not clearly fall within the definition of either term. For those obligations, we apply the “necessary expense” rule and consider whether the good or service bears a reasonable and logical relationship to the purpose of the consumables and medical care line item appropriation.<sup>107</sup> B-329373, July 26, 2018, at 4. We generally look to the agency’s justification to determine whether an obligation is reasonably related to accomplishing the purposes of the appropriation charged, but such relationship must not be “so attenuated as to take it beyond th[e]

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<sup>107</sup> The purpose analysis involves three steps: (1) the obligation must bear a reasonable, logical relationship to the appropriation; (2) the obligation must not be prohibited by other law; and (3) the obligation must not be otherwise provided for. See, e.g., B-330776, Sept. 5, 2019; B-303170, Apr. 22, 2005. With regard to step 2, we are not aware of any statute that specifically prohibits the use of amounts appropriated to CBP for the goods and services at issue.



range” of legitimate discretion. B-329373, July 26, 2018; B-223608, Dec. 19, 1988; see 65 Comp. Gen. 797 (1986); 63 Comp. Gen. 110 (1983).

Such obligations include supplies and services for CBP’s canine program; items in support of the annual CBP-wide vaccine program for CBP personnel; computer network upgrades to analyze factual information in support of CBP’s border operations; and items used for processing individuals apprehended by CBP such as printers, security camera systems, and speakers. CBP did not—nor did it attempt to—make any connection between these obligations and the consumables and medical care line item appropriation. See Response Letter, at 13–15. Because CBP did not show, and we do not otherwise see, a reasonable nexus between these obligations and the consumables and medical care line item appropriation, we conclude that CBP violated the purpose statute and should adjust its accounts.<sup>108</sup>

CBP also obligated the consumables and medical care line item appropriation for transportation-related items, including vehicles such as ATVs, motorcycles, dirt bikes, boats, passenger vans, and small utility vehicles.<sup>109</sup> Response Letter at 3, 12. According to CBP, certain modes of conveyance such as ATVs, boats, and motorcycles are needed to carry out CBP’s border enforcement activities; some modes of conveyance, such as passenger vans, are needed to transport individuals between courtrooms, CBP facilities, and other locations; and other modes of

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<sup>108</sup> For the canine program, CBP-wide vaccine program, and network upgrades for analyzing factual information in support of CBP’s border operations, CBP advised that it plans to adjust its accounts. Response Letter, at 1, 13, 14–15. For example, CBP stated that obligations for the Incident Driven Video Recording System, a network upgrade that is used to provide additional information regarding law enforcement encounters with members of the public, would be properly chargeable to the mission support data systems and analysis line item. *Id.*, at 13. We agree with CBP’s position. For other items, such as shelving, CBP is reviewing the obligations to determine whether the intended use of the item is consistent with the purpose of the consumables and medical care line item appropriation. *Id.*, at 14. For example, CBP maintains—and we agree—that shelving acquired to store consumables and medical supplies bears a reasonable relationship to the consumables and medical care line item, whereas shelving procured for general storage does not. *Id.*

<sup>109</sup> Other transportation-related items included carports, trailers, maintenance items, tools, and commercial driver’s license certifications with passenger endorsement. See Response Letter, at 3.

conveyance, such as vehicles characterized as emergency medical service (EMS) vehicles, are needed specifically for providing medical care.<sup>110</sup> *Id.*, at 12–13.

CBP explained, and we agree, that vehicles with a primary purpose of providing medical care would be properly chargeable to the consumables and medical care line item appropriation. *See id.*, at 13. However, for the transportation-related items CBP uses to perform its border enforcement duties and to transport individuals as part of CBP’s operations, we find no nexus to consumables or medical care.

Further, CBP did not provide any explanation as to how these items relate to the consumables and medical care line item appropriation. Therefore, we conclude that CBP violated the purpose statute when it obligated the consumables and medical care line item appropriation for these purposes and should adjust its accounts.<sup>111</sup>

In addition, CBP obligated the consumables and medical care line item appropriation for facility services such as HVAC upgrades, sewer system upgrades, and janitorial services. Response Letter, at 3, 14. According to CBP, the relationship between maintenance services for facilities (in which CBP included HVAC upgrades and septic and plumbing repairs) and the consumables and medical care line item appropriation “may be too attenuated to charge to that line item” because these activities “involve the maintenance, repair, and improvements to permanent CBP facilities.” *Id.*, at 3. CBP nevertheless justified its obligation of the consumables and medical care line item appropriation for HVAC upgrades, sewer system upgrades, and janitorial services by explaining that the upgrades were necessary to provide clean, sanitary, and humane conditions for individuals in detention. *Id.*, at 14.

We do not find CBP’s justification adequate to support a finding of a reasonable relationship between these obligations and the consumables and medical care line item appropriation. To begin, these types of services typically involve the maintenance or repair of facilities where CBP processes and detains individuals, though CBP also provides certain types of medical care there.<sup>112</sup> In addition,

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<sup>110</sup> 8 CBP is reviewing whether any of the modes of conveyance may be properly categorized as EMS vehicles. Response Letter, at 13.

<sup>111</sup> For several of the obligations for transportation-related items, CBP advised that it plans to adjust its accounts. Response Letter, at 1, 12–13. For example, CBP provided that costs for the procurement, operation, and maintenance of modes of conveyance that are intended to be used to carry out CBP duties, to include border enforcement and the transportation of individuals between CBP facilities, may be properly charged to the “transportation” line item. *Id.* We agree with CBP’s position.

<sup>112</sup> According to CBP, CBP provides medical support to and addresses medical concerns of individuals by providing “first aid,” “triage,” “some secondary medical evaluation,” and “low acuity treatment.” CBP, Fiscal Year 2020 Congressional Justification, at CBP–OS–32, available at [https://www.dhs.gov/sites/default/files/publications/19\\_0318\\_MGMT\\_CBJ-Customs- Border-Protection\\_0.pdf](https://www.dhs.gov/sites/default/files/publications/19_0318_MGMT_CBJ-Customs- Border-Protection_0.pdf) (last accessed May 28, 2020); see also *id.*, at CBP–OS–113; Response Letter, at 3, 5.

although we agree that these building services may result in clean facilities and, as such, may incidentally protect the health of individuals processed and detained there, the primary purpose of these types of services is to ensure the functioning and operation of the facility itself. To find that it is within CBP's discretion to obligate the consumables and medical care line item for any obligation that may result in a clean facility or in humane conditions would render meaningless Congress's carefully tailored line item appropriations in the 2019 Emergency Supplemental. See

2A Sutherland, *Statutes and Statutory Construction* § 46:6 (7th ed.), Westlaw (database updated Oct. 2019) ("Courts assume that every word, phrase, and clause in a legislative enactment is intended and has some meaning and that none was inserted accidentally."). Therefore, we conclude that CBP violated the purpose statute when it obligated the consumables and medical care line item for these purposes and should adjust its accounts.

Finally, for other items and services, CBP obligated both the consumables and medical care and the establishing and operating migrant care and processing facilities line item appropriations.<sup>113</sup> For example, CBP obligated both appropriations for items such as hygiene products, food, clothing, and baby supplies that are clearly "consumable" and for medical supplies such as defibrillators, masks, ointment, and gloves that clearly relate to "medical care." CBP may obligate both appropriations for these purposes only if Congress has specifically authorized it to do so. See

B-330984, May 27, 2020, at 5; B-272191, Nov. 4, 1997. Because we are unaware of any such authorization here, CBP must obligate the appropriation properly chargeable and specifically available for each purpose to the exclusion of the other line item appropriations in the 2019 Emergency Supplemental.<sup>114</sup> See, e.g., B-289209, May 31, 2002.

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<sup>113</sup> CBP obligated both appropriations for hygiene products, food, clothing, baby supplies, defibrillators, masks, ointment, gloves, custodial services, caregiver services, ice machines, oscillating fans, pallet jacks, refrigerators, and recreational goods. Response Letter, at 15.

<sup>114</sup> We note that Congress used specific statutory language to make the line item appropriations in the 2019 Emergency Supplemental available in addition to amounts already appropriated in CBP's annual lump-sum Operations and Support appropriation. Pub. L. No. 116-26, 133 Stat. at 1019; see B-322062, Dec. 5, 2011. Thus, although CBP must obligate the line item appropriation that is specifically available for a particular good or service if CBP obligates the 2019 Emergency Supplemental, CBP may also obligate its annual lump-sum Operations and Support appropriation for such purposes.

By its express terms, the consumables and medical care line item appropriation is available for goods and services related to consumables and medical care. Thus, for the goods and services listed above that clearly fall within the definitions of those terms, the consumables and medical care line item appropriation was the only line item in the 2019 Emergency Supplemental that was available. Accordingly, we conclude that CBP violated the purpose statute when it obligated the establishing and operating migrant care and processing facilities appropriation for such items.

The reverse is also true for obligations that are properly chargeable to the establishing and operating migrant care and processing facilities line item and for which that line item is specifically available. In that case, CBP must obligate the establishing and operating migrant care and processing facilities line item for that purpose, and any obligation of the consumables and medical care line item appropriation would violate the purpose statute. CBP should review the obligations it charged to both appropriations and adjust its accounts as necessary to ensure its obligations are consistent with the purpose statute.

#### Antideficiency Act

An agency violates the Antideficiency Act if it incurs an obligation in excess of legally available amounts. 31 U.S.C. § 1341(a). Here, we conclude that CBP violated the purpose statute when it obligated amounts expressly appropriated for consumables and medical care and establishing and operating migrant care and processing facilities for other purposes. CBP should correct its purpose violations by adjusting its accounts to obligate the account available for the appropriate purpose—either the annual lump-sum Operations and Support appropriation or, if applicable, the appropriate line item in the supplemental appropriation.<sup>115</sup> See B-322062, Dec. 5,

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<sup>115</sup> For several of the obligations discussed in this decision, CBP advised that it plans to adjust its accounts. Response Letter, at 1, 13, 14; see notes 6, 9, *supra*. In addition to the obligations for which we sought CBP's legal views, however, in its response to our letter CBP identified other obligations for which CBP plans to take additional action. For example, CBP obligated the consumables and medical care line item appropriation for tactical gear and law enforcement equipment, such as riot helmets, and temporary portable structures. Response Letter, at 4. For such items, CBP advised that it plans to adjust its accounts. *Id.* In addition, CBP obligated the consumables and medical care line item appropriation for detention guard services. *Id.* CBP provided its view that obligations for this purpose may be too attenuated to the consumables and medical care line item and informed us that it would review such obligations. *Id.* Lastly, CBP explained its view that some other obligations of the consumables and medical care line item appropriation may not be an authorized use of appropriated funds. *Id.* CBP advised us that it will take additional actions as appropriate after reviewing these obligations. *Id.* CBP should ensure that such actions are consistent with the findings in this decision.


2011. If CBP lacks sufficient budget authority to make the adjustments, then it should report a violation of the Antideficiency Act as required by law.<sup>116</sup> 31 U.S.C.

§§ 1341, 1351; see B-328323, Feb. 28, 2017.

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## CONCLUSION

We conclude that CBP violated the purpose statute when it obligated the line item appropriations in the 2019 Emergency Supplemental for goods and services that were not within the purpose availability of such line items. CBP plans to adjust its accounts for several of these obligations and should do so for any additional purpose violations by obligating the account available for the appropriate purpose. If CBP lacks sufficient budget authority to make the adjustments, then it should report a violation of the Antideficiency Act as required by law.



Thomas H. Armstrong  
General Counsel

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<sup>116</sup> If an agency violates the Antideficiency Act, the head of the agency must report all relevant facts and a statement of actions taken to the President and Congress and must transmit a copy of the report to the Comptroller General. 31 U.S.C. § 1351.

*List of Requesters*

The Honorable Dianne Feinstein  
Ranking Member

Judiciary Committee  
United States Senate

The Honorable Bennie G. Thompson  
Chairman

Committee on Homeland Security  
House of Representatives

The Honorable Tammy Baldwin  
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The Honorable Tom Udall  
United States Senate

The Honorable Elizabeth Warren  
United States Senate

The Honorable Ron Wyden  
United States Senate

## Appendix II: Deaths in U.S Customs and Border Protection (CBP) Custody Along the Southwest Border

CBP defines “death in custody” as any death of an individual while detained, under arrest, or in the process of being arrested by CBP law enforcement (or en route to be incarcerated or detained) at a facility owned by, contracted with, or used by CBP.<sup>1</sup> We took a number of steps to determine the number of deaths that occurred in CBP custody along the southwest border. Specifically, we compared records maintained by CBP’s Situation Room to those maintained by CBP’s Office of Professional Responsibility (OPR). We then compared these records to reports CBP provided to Congress and CBP public press releases. To corroborate our understanding of both of these sources, we interviewed officials from the CBP Situation Room and OPR on their offices’ practices for collecting and storing this information. We determined that the steps we took resulted in sufficiently reliable information on the number of deaths that occurred in CBP custody along the southwest border from fiscal year 2014 through fiscal year 2019.

We determined that 31 individuals died in CBP custody from fiscal year 2014 through fiscal year 2019 along the southwest border.<sup>2</sup> This number included 30 individuals in the custody of U.S. Border Patrol (Border Patrol) and one in the custody of the Office of Field Operations (OFO) at

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<sup>1</sup>According to CBP officials, this definition was developed from the definition of “in custody” in Death in Custody Reporting Act of 2013. See Pub. L. No. 113-242, 128 Stat. 2860 (codified as amended at 18 U.S.C. § 4001 note). The act defines a death in custody as any death of an individual who is detained, under arrest, or is in the process of being arrested by any officer of such federal law enforcement agency, (or by any state or local law enforcement officer while participating in and for purposes of a federal law enforcement operation, task force, or any other federal law enforcement capacity carried out by such federal law enforcement agency); or en route to be incarcerated or detained, or is incarcerated or detained at any facility (including any immigration or juvenile facility) pursuant to a contract with such federal law enforcement agency; any state or local government facility used by such federal law enforcement agency; or any federal correctional facility or federal pretrial detention facility located within the United States.

<sup>2</sup>We only reviewed deaths in custody along the U.S. southwest land border and did not include deaths at airports, at seaports, or along other land borders.



**Appendix II: Deaths in U.S Customs and  
Border Protection (CBP) Custody Along the  
Southwest Border**

ports of entry. During this period, five of the 31 deaths in CBP custody were children. This number includes individuals who died while in CBP's custody but does not include those who were killed by a use of force while in custody, as CBP reports those separately as use-of-force deaths to avoid double-counting. Table 5 below provides more information on the individuals who died in CBP custody.

**Table 5: U.S. Customs and Border Protection (CBP) Deaths in Custody Along the Southwest Border for Fiscal Years 2014 through 2019**

<b>Fiscal year</b>	<b>Component</b>	<b>Location</b>	<b>Nationality</b>	<b>Gender</b>	<b>Age</b>
2019	U.S. Border Patrol (Border Patrol)	Lordsburg, NM	Salvadoran	Male	32 <sup>a</sup>
2019	Border Patrol	Tucson, AZ	Nicaraguan	Male	52 <sup>a</sup>
2019	Border Patrol	Nogales, AZ	Mexican	Male	47 <sup>a</sup>
2019	Border Patrol	McAllen, TX	Salvadoran	Male	43 <sup>a</sup>
2019	Border Patrol	Eagle Pass, TX	Honduran	Female	40 <sup>a</sup>
2019	Border Patrol	Roma, TX	Salvadoran	Male	33 <sup>a</sup>
2019	Border Patrol	Weslaco, TX	Guatemalan	Male	16 <sup>a</sup>
2019	Border Patrol	McAllen, TX	Mexican	Male	45 <sup>a</sup>
2019	Border Patrol	El Paso, TX	Mexican	Male	40
2019	Border Patrol	Alamogordo, NM	Guatemalan	Male	8
2019	Border Patrol	Lordsburg, NM	Guatemalan	Female	7 <sup>a</sup>
2018	Border Patrol	McAllen, TX	Salvadoran	Male	34 <sup>a</sup>
2018	Border Patrol	Eagle Pass, TX	Honduran	Female	33 <sup>a</sup>
2018	Border Patrol	Santa Teresa, NM	Mexican	Male	40 <sup>a</sup>
2018	Border Patrol	Casa Grande, AZ	Peruvian	Female	47 <sup>a</sup>
2018	Border Patrol	Rio Grande City, TX	Honduran	Male	39 <sup>a</sup>
2018	Border Patrol	Ajo, AZ	Mexican	Male	18 <sup>a</sup>
2017	Border Patrol	La Joya, TX	Romanian	Male	43 <sup>a</sup>
2017	Border Patrol	La Joya, TX	Salvadoran	Male	37 <sup>a</sup>
2017	Border Patrol	McAllen, TX	Salvadoran	Female	45 <sup>a</sup>
2017	Border Patrol	Weslaco, TX	Brazilian	Male	34 <sup>a</sup>
2016	Border Patrol	Roma, TX	Salvadoran	Male	25
2016	Border Patrol	Harlingen, TX	Mexican	Male	30
2016	Border Patrol	Laredo, TX	Mexican	Male	33
2015	Border Patrol	El Paso, TX	U.S. citizen	Male	36 <sup>a</sup>
2015	Border Patrol	Marfa, TX	Mexican	Male	45
2015	Border Patrol	Sunland Park, NM	Mexican	Male	31
2015	Border Patrol	Granjeno, TX	Salvadoran	Male	11

**Appendix II: Deaths in U.S Customs and Border Protection (CBP) Custody Along the Southwest Border**

Fiscal year	Component	Location	Nationality	Gender	Age
2014	Border Patrol	McAllen, TX	Unknown <sup>b</sup>	Male	54
2014	U.S. Office of Field Operations (OFO)	San Diego, CA	Mexican	Male	16
2014	Border Patrol	Campo, CA	U.S. citizen	Man	58

Source: GAO analysis of CBP information. | GAO-20-536

<sup>a</sup>Indicates CBP documented reporting the death to Congress.

<sup>b</sup>Indicates CBP was unable to provide this information.

In addition, CBP officials stated that from fiscal year 2014 through fiscal year 2019, there were 30 individuals who died after CBP personnel found them but who were technically not in custody at the time of their death. Specifically, CBP policy requires internal reporting when Border Patrol agents come across an individual dying in the field and take steps to save that person’s life—such as, for example, performing cardiopulmonary resuscitation (CPR) on the individual, calling for an ambulance, or transporting that individual in a CBP vehicle solely for the purposes of bringing the individual to a hospital for medical attention. For instance, Border Patrol agents may encounter an unconscious individual, perform CPR, and transport the individual to a hospital, but the individual later dies. OPR officials stated that although it has reported on these types of deaths in certain fiscal years, generally speaking, the agency would not consider these deaths as occurring in CBP custody. Table 6 below provides more information on the individuals who died in medical distress.

**Table 6: U.S. Customs and Border Protection (CBP) Deaths in Medical Distress Along the Southwest Border for Fiscal Years 2014 through 2019**

Fiscal year	Component	Location	Nationality	Gender	Age
2019	Office of Field Operations (OFO)	Nogales, AZ	Mexican	Male	67
2019	U.S. Border Patrol (Border Patrol)	Hachita, NM	Brazilian	Male	34
2019	Border Patrol	San Diego, CA	Mexican	Male	19
2019	Border Patrol	Falfurrias, TX	Mexican	Male	28
2019	Border Patrol	Penitas, TX	Mexican	Male	32
2019	Border Patrol	Laredo, TX	Guatemalan	Male	33
2019	Border Patrol	Roma, TX	Honduran	Male	44
2018	Border Patrol	Yuma, AZ	Mexican	Male	42 <sup>a</sup>
2018	Border Patrol	El Centro, CA	Mexican	Male	39 <sup>a</sup>
2018	Border Patrol	Three Points, AZ	Mexican	Male	20 <sup>a</sup>
2018	Border Patrol	Laredo, TX	Mexican	Male	43 <sup>a</sup>

**Appendix II: Deaths in U.S Customs and  
Border Protection (CBP) Custody Along the  
Southwest Border**

<b>Fiscal year</b>	<b>Component</b>	<b>Location</b>	<b>Nationality</b>	<b>Gender</b>	<b>Age</b>
2018	Border Patrol	McAllen, TX	Mexican	Male	39 <sup>a</sup>
2018	Border Patrol	Laredo, TX	Mexican	Male	24 <sup>a</sup>
2018	Border Patrol	Brownsville, TX	Mexican	Male	30 <sup>a</sup>
2018	Border Patrol	Laredo, TX	Mexican	Male	38 <sup>a</sup>
2018	Border Patrol	Falfurrias, TX	Honduran	Male	22 <sup>a</sup>
2018	Border Patrol	Carrizo Springs, TX	Mexican	Male	49 <sup>a</sup>
2018	OFO	San Luis, AZ	Mexican	Female	54
2018	Border Patrol	Laredo, TX	Mexican	Male	27 <sup>a</sup>
2018	Border Patrol	Hebbronville, TX	Honduran	Male	42
2018	Border Patrol	Laredo, TX	Guatemalan	Male	~10-17
2018	Border Patrol	Laredo, TX	Unknown <sup>b</sup>	Male	~10-17
2018	Border Patrol	Freer, TX	Guatemalan	Female	21
2018	Border Patrol	Freer, TX	Guatemalan	Female	23
2018	Border Patrol	Laredo, TX	Unknown <sup>b</sup>	Unknown <sup>b</sup>	Unknown <sup>b</sup>
2018	Border Patrol	Laredo, TX	Unknown <sup>b</sup>	Unknown <sup>b</sup>	Unknown <sup>b</sup>
2018	Border Patrol	Laredo, TX	Unknown <sup>b</sup>	Unknown <sup>b</sup>	Unknown <sup>b</sup>
2018	Border Patrol	Kingsville, TX	Guatemalan	Male	35 <sup>a</sup>
2016	Border Patrol	Abram, TX	Honduran	Male	25
2014	Border Patrol	Havana, TX	Mexican	Male	35

Source: GAO analysis of CBP information. | GAO-20-536

<sup>a</sup>Indicates CBP documented reporting the death to Congress.

<sup>b</sup>Indicates CBP was unable to provide this information.

## Appendix III: Comments from the Department of Homeland Security

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



**Homeland  
Security**

July 6, 2020

Rebecca Gambler  
Director, Homeland Security and Justice  
U.S. Government Accountability Office  
441G Street, NW  
Washington, DC 20548

Mary Denigan-Macauley  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Re: Management Response to Draft Report GAO-20-536, "SOUTHWEST BORDER:  
CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of  
Deaths"

Dear Ms. Gambler and Ms. Denigan-Macauley:

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

In October 2018, CBP faced unprecedented numbers of migrants attempting to cross into the United States. During the first three weeks in October, each day, on average, CBP encountered a combination of nearly 1,900 persons crossing the border illegally or presenting without documents at ports of entry. More than half of these arrivals were made up of family units and unaccompanied children, many of whom placed themselves in the hands of violent human smugglers. The inability to transfer custody of individuals to other agencies resulted in substantially overcrowded and difficult humanitarian conditions in CBP short-term processing and holding facilities.

CBP takes its role in providing care and ensuring the health, safety, security, and welfare of each adult and child in its custody very seriously. CBP is committed to improving its care and custody of adults and children and requested emergency supplemental funds to

**Appendix III: Comments from the Department  
of Homeland Security**

support these operations along the southwest border in order to do so. In addition, CBP is committed to ensuring that: 1) officers and agents are trained to recognize medical distress of individuals in CBP custody; 2) field personnel understand and execute their reporting obligations accurately and diligently; 3) contracting officers and their representatives hold and document the required contract reviews; and 4) there is robust medical oversight.

Although the GAO states that CBP obligated some appropriated funds for purposes other than consumables and medical care, it is important to note that 1) all obligations were for lawfully authorized consumable goods and services, such as food and hygiene products, as well as medical care goods and services including defibrillators, masks, and gloves needed to accomplish CBP's mission and agency operations in the midst of an unprecedented humanitarian crisis, and 2) only a very small percentage of these obligations were inaccurately categorized.

Specifically, in response to GAO's legal opinion, CBP counsel and others carefully reviewed all obligations and determined that the majority – including the vehicle purchases discussed in the opinion – were, in fact, properly charged. In addition, a CBP Office of Finance (OF) analysis determined that these obligations only represented 0.35 percent of the \$1.1B supplemental bill, and \$3.9M (or 3.48 percent) of the total \$112M consumables and medical care line item. CBP is in the process of remedying the categorization of the transactions by making the appropriate accounting adjustments and has already taken steps to see that the remaining 2019 emergency supplemental appropriations act expenditures are charged appropriately in the first instance. CBP takes the need to safeguard taxpayer dollars appropriated by Congress very seriously and is committed to accurately recording all of its obligations.

The draft report contained 10 recommendations, with which the Department concurs. Attached find our detailed response to each recommendation. DHS previously submitted technical comments under a separate cover for GAO's consideration.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions. We look forward to working with you again in the future.

Sincerely,

JIM H

CRUMPACKER

JIM H. CRUMPACKER, CIA, CFE

Director

Departmental GAO-OIG Liaison Office

Digitally signed by JIM H  
CRUMPACKER  
Date: 2020.07.06 12:03:17 -0400

Attachment

2

**Attachment: Management Response to Recommendations  
Contained in GAO-20-536**

GAO recommended that the Commissioner of CBP:

**Recommendation 1:** Develop and implement additional guidance for ensuring funds appropriated for specific purposes are obligated consistent with the purpose of the funds.

**Response:** Concur. CBP OF will issue additional guidance for ensuring unobligated supplemental funds are obligated consistently with their purposes. This guidance will be modeled after the May 8, 2020, “Coronavirus Aid Relief, and Economic Security Act Funding for Medical care and Related Expenses” instructions to program offices on the authorized use of funds transferred to CBP in response to the current COVID-19 pandemic. This guidance, together with a new chapter that OF will add to the Monthly Obligations Analysis Standard Operating Procedure on special funds, will ensure unobligated supplemental funds are obligated consistently with their purposes. Estimated Completion Date (ECD): September 30, 2020.

**Recommendation 2:** Establish and document oversight roles and responsibilities to ensure funds appropriated for specific purposes are obligated consistent with the purpose of the funds.

**Response:** Concur. In addition to existing controls over budget execution, CBP’s OF will add a new chapter to the Monthly Obligations Analysis Standard Operating Procedure on special funds (e.g., supplemental). This chapter will establish clear oversight roles and responsibilities to assess and validate that program offices are executing funds consistent with congressional purposes. The new chapter will also establish a more targeted review process that improves the oversight of special funds. Results and findings from this review process will be formalized by producing a certificate of proper execution of funds or a corrective action plan if adjustments to expenditures and/or obligations is required. ECD: December 31, 2020.

**Recommendation 3:** Develop and implement oversight mechanisms for CBP’s implementation of policies and procedures relating to medical care for individuals in its custody to include documentation of expected practices, metrics and corresponding performance targets, and roles and responsibilities for taking corrective action.

**Response:** Concur. CBP Operations Support (OS) will continue to refine, enhance, develop, and implement oversight mechanisms for its evolving medical support efforts for persons in custody as called for, and in alignment with the recent Enhanced Medical Support Efforts Directive, dated December 30, 2019, and Implementation Plans, approved on March 27, 2020. Specifically, CBP will continue to utilize a robust, multi-

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**Appendix III: Comments from the Department  
of Homeland Security**

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layered approach to medical support oversight, such as: 1) medical quality management efforts; 2) contract oversight mechanisms; 3) operational engagement; 4) Office of Accountability Juvenile Coordinator efforts; and 5) enhanced Management Inspections compliance monitoring and inspections. As part of these efforts, CBP OS will further detail, clarify, and monitor performance metrics, targets, and corrective actions. ECD: February 26, 2021.

**Recommendation 4:** Document what information it is using to assess whether to offer the influenza vaccine to individuals in custody, including how it weighs costs and benefits.

**Response:** Concur. CBP OS will consider how best to document its consideration of these issues. ECD: February 26, 2021.

**Recommendation 5:** Develop and implement training on recognizing medical distress in children for all CBP officers and Border Patrol agents who may come into contact with children in custody.

**Response:** Concur. CBP OS in collaboration with the Office of Training and Development will continue to review and enhance its training efforts related to persons in custody. This enhancement will include developing and implementing training on recognizing medical distress in children for CBP personnel who may come into contact with children in custody. ECD: February 26, 2021.

**Recommendation 6:** Ensure contracting officers for its medical services blanket purchase agreement perform and properly document annual reviews as required by [Federal Acquisition Regulation] FAR.

**Response:** Concur. CBP Office of Acquisition Procurement Directorate (PD) administers the current medical services Blanket Purchase Agreement (BPA) discussed in the draft report. Procurement managers have reviewed the requirements set forth in the FAR with the current and previous administering contracting officers (CO) for CBP's medical services BPA. The COs are trained and aware of the requirement to annually review the BPA and include a written determination in the contract file. Specifically, between November 12, 2019 and June 17, 2020, procurement managers reviewed the requirements set forth in FAR 8.405-3(e) with several staff in the Border Enforcement Contracting Division (BECD) Central and Eastern Branches. In addition, the requirements of FAR 8.405-3(e) will be discussed at the division-wide (to include all branches) meeting scheduled for July 29 and 30, 2020.

We request that GAO consider this recommendation resolved and closed, as implemented.

**Recommendation 7:** Provide additional guidance to field personnel to ensure they classify significant incident reports on deaths, serious injuries, and suicide attempts in accordance with CBP policy.

**Response:** Concur. CBP OS is reviewing and updating its procedures for developing and submitting Significant Incident Reports. OS will include additional guidance regarding reporting on deaths, serious injuries, and suicide attempts as part of this effort. ECD: February 26, 2021.

**Recommendation 8:** Update the Significant Incident Reporting System to include categories that align with CBP’s directive on the reporting of significant incidents.

**Response:** Concur. CBP OS is reviewing and updating its procedures for developing and submitting Significant Incident Reports. As part of this, OS will include categories that align with CBP guidance regarding the reporting of significant incidents. ECD: February 26, 2021.

**Recommendation 9:** Provide additional guidance to components on the procedures for reporting deaths in custody to OPR and other entities within CBP.

**Response:** Concur. CBP Office of Professional Responsibility (OPR) established and chairs a Death in Custody Working Group from April 2019 through present to collaboratively improve procedures for reporting deaths in custody to OPR, as well as provide a clear cross-component definition of “custody” and delineation of circumstances that do not represent custodial deaths. These results will be included in CBP’s “Procedures on Notification of a Death in Custody.” The updated procedures will make OPR’s Investigative Operations Division responsible for ensuring deaths in custody are accurately categorized and will further provide updated guidance regarding DHS Office of Inspector General notification and OPR response. Once finalized, the procedures will be disseminated CBP-wide. ECD: September 30, 2020.

**Recommendation 10:** Ensure timely, reliable information on deaths in custody is reported to Congress as directed and maintain documentation on those reports.

**Response:** Concur. Pursuant to CBP’s December 17, 2018, “Death in Custody Notifications Memorandum,” CBP’s Office of Congressional Affairs (OCA) is already required to notify the following Congressional Committees and Members of Congress of a death-in-custody within 24 hours: 1) House and Senate Judiciary Committees; 2) House and Senate Homeland Security Committees; 3) House and Senate Appropriations Committees; and 4) individual House and Senate Members who represent the district and state where the death occurred. To ensure these notifications occur in all cases, and within the required 24-hour period, CBP’s OCA will develop its own internal reporting procedures to augment CBP’s “Death in Custody Notifications Memorandum.” These



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**Appendix III: Comments from the Department  
of Homeland Security**

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## Text of Appendix III: Comments from the Department of Homeland Security

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Page 1

July 6, 2020

Rebecca Gambler

Director, Homeland Security and Justice

U.S. Government Accountability Office 441G Street, NW

Washington, DC 20548

Mary Denigan-Macauley Director, Heath Care

U.S. Government Accountability Office 441 G Street, NW

Washington, DC 20548

U.S. Department of Homeland Security

Washington, DC 20528

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## Appendix IV: GAO Contact and Staff Acknowledgments

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### GAO Contacts

Rebecca Gambler, (202) 512-8777 or [gablerr@gao.gov](mailto:gablerr@gao.gov)

Mary Denigan-Macauley, (202) 512-7114 or

[deniganmacauleym@gao.gov](mailto:deniganmacauleym@gao.gov)

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### Staff Acknowledgments

In addition to the contacts named above, Lori Achman (Assistant Director), Ashley Davis (Assistant Director), Kathleen Donovan (Analyst-in-Charge), Kathryn Bernet, Kelsey Hawley, Brandon Nakawaki, and Heidi Nielson made key contributions to this report. Also contributing to the report were Dominick Dale, Helen Desaulniers, Timothy DiNapoli, Michele Fejfar, Eric Hauswirth, Diona Martyn, Janet McKelvey, Jan Montgomery, and Meghan Perez.



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Orice Williams Brown, Managing Director, [WilliamsO@gao.gov](mailto:WilliamsO@gao.gov), (202) 512-4400,  
U.S. Government Accountability Office, 441 G Street NW, Room 7125,  
Washington, DC 20548

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Chuck Young, Managing Director, [youngc1@gao.gov](mailto:youngc1@gao.gov), (202) 512-4800  
U.S. Government Accountability Office, 441 G Street NW, Room 7149  
Washington, DC 20548

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## Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, [spel@gao.gov](mailto:spel@gao.gov), (202) 512-4707  
U.S. Government Accountability Office, 441 G Street NW, Room 7814,  
Washington, DC 20548