OFFICE OF INSPECTOR GENERAL

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Chairwoman Roybal-Allard, Ranking Member Fleischmann, and members of the Subcommittee, thank you for inviting me today to discuss the work of the Department of Homeland Security (DHS) Office of Inspector General (OIG). I am pleased to have the opportunity to share our office's recent oversight efforts into some of the Department's most high profile areas of work.

It is the OIG's mission to provide independent, objective oversight and promote excellence, integrity, and accountability within DHS. Through our work, we help the Department address challenges and fulfill its vital mission of protecting and securing our Nation. The work of the OIG is done by about 790 dedicated federal employees located both in Washington, D.C. and in 32 field offices across the United States.

One of OIG leadership's most persistent challenges is determining how best to leverage our relatively small staff to provide comprehensive oversight of the third-largest Cabinet department with over 240,000 federal employees and the most diverse mission set in the Federal government. We have recently created a new process internally to address this challenge, whereby leadership across all functions of our agency meet in a weekly discussion to set priorities regarding the DHS programs we will audit, inspect, review, and investigate. Through this approach, we are able to take into account our legislatively mandated reviews, congressional requests, referrals from other oversight agencies, and discretionary job proposals to create a balanced and comprehensive oversight portfolio. Our ultimate goal is to be a nimble organization poised to quickly respond to DHS' highest risk challenges with impactful oversight that provides value to the Department, the Congress, and the American taxpayer.

In fiscal year (FY) 2018 alone we released 89 audits, inspections, and other reviews containing 318 recommendations. During the same time period, the work of our office's criminal investigators resulted in 103 arrests, 132 indictments, 76 convictions and 31 personnel actions. Complaints from DHS employees and the public to our hotline continue to grow, with 40,657 complaints received in FY 2018 and 7,331 received to date in FY 2019. DHS OIG's return on investment averages $9.47 over the last 5 years, meaning that for every $1 invested in the OIG, we have identified $9.47 in potential savings.

My testimony today will focus on our recent work in the areas of: (1) family separation, (2) unannounced inspections of U.S. Immigration and Customs Enforcement (ICE) facilities, (3) the Department's efforts to hire and train border patrol agents and immigration officers, and (4) oversight of the Federal Emergency Management Agency (FEMA) disaster relief work.

Initial Observations Regarding Family Separation Issues Under the Zero Tolerance Policy

Last year, the Administration's Zero Tolerance Policy and the resulting family separations sparked intense public debate. In early May 2018, DHS determined that the Zero Tolerance Policy would cover alien adult arriving illegally in the United States with minor children, a change to its approach to immigration enforcement. Because the minor children cannot be held in criminal custody with an adult, alien adults who entered the United States illegally would have to be separated from any accompanying minor children when the adults were referred for criminal prosecution. The children, who DHS then deemed to be unaccompanied alien children (UAC) were held in DHS custody until they could be transferred to the U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR).

In response to significant congressional and public interest, DHS OIG deployed a multi-disciplinary team comprised of attorneys, inspectors, and criminal investigators to areas in and around El Paso and McAllen, Texas to conduct unannounced visits at Customs and Border Protection (CBP) and ICE facilities between June 26 and June 28, 2018. While our work did not evaluate the merits of the Zero Tolerance Policy, family separations or the Department's efforts to reunify separated families, we did report on our observations made in the field[1], including:

- DHS was not fully prepared to implement the Zero Tolerance Policy or to deal with certain effects of the policy following implementation.
- A lack of fully integrated Federal immigration information technology system made it difficult for DHS to reliably track separated parents and children.
- CBP regulated the number of asylum-seekers entering at the ports of entry, which may have resulted in additional illegal border crossings.
- CBP detained UACs for extended periods in facilities intended for short-term detention.
- Lack of access to reliable data poses an obstacle to accurate reporting on family separations.

[1] *Special Review – Initial Observations Regarding Family Separation Issues Under the Zero Tolerance Policy* (OIG-18-84).

- Dissemination of inconsistent or inaccurate information resulted in confusion among alien parents about separation and reunification process.

Our observations indicate that DHS was not fully prepared to implement the Zero Tolerance Policy, or to deal with certain effects of the policy following implementation. For instance, while the Government encouraged all asylum-seekers to come to ports of entry to make their asylum claims, CBP managed the flow of people who could enter at those ports of entry through metering, which may have led to additional illegal border crossings. Additionally, CBP held alien children separated under the policy for long periods in facilities intended solely for short-term detention.[2] The OIG team also observed that a lack of a fully integrated Federal immigration information technology system made it difficult for DHS to reliably track separated parents and children, raising questions about the Government's ability to accurately report on separations and subsequent reunifications. Finally, inconsistencies in the information provided to alien parents resulted in some parents not understanding that their children would be separated from them, and made communicating with their children after separation difficult.

Next Steps

As we noted in our *Initial Observations* report, while Executive Order 13841 halted the practice of family separation, OIG multi-disciplinary family separation teams continue to work on the issues we identified during our initial observations.

We initiated a full-scale audit in October looking at the effectiveness of DHS' IT systems for tracking and supporting efforts to reunify unaccompanied alien children with separated families. Our audit will determine whether the IT systems and processes DHS relied upon were adequate to carry out specific border security operations, including tracking separated families, prior to and following the implementation of the Zero Tolerance Policy. We are also looking at whether DHS effectively tracked family reunification efforts following the federal judge's court order in late June 2018. Using our data analytics capabilities, we will assess data reliability and the accuracy of DHS's reported numbers for separated parents and children. We are currently in the fieldwork phase.

[2] Notwithstanding this observation, OIG observed that the DHS facilities it visited appeared to be operating in substantial compliance with applicable standards for holding children. The detailed results of OIG's unannounced inspections of these facilities are described in a separate OIG report titled *Results of Unannounced Inspections of Conditions for Unaccompanied Alien Children in CBP Custody* (OIG-18-87), discussed later in this testimony.

We have also opened a review into CBP's Processing of Asylum Seekers at Ports of Entry. The objective of this work is to determine whether CBP Office of Field Operations is turning away those who present themselves for asylum at ports of entry and separating family units that seek asylum and documenting separations appropriately. As part of its ongoing fieldwork, the team travelled to ports of entry in Texas, Arizona, and California, where it observed operations, gathered documents, and interviewed CBP officers, representatives of non-governmental organizations, and asylum seekers.

Finally, we will take a closer look at the removal of separated alien families. Our work will determine whether ICE removed any parents without first offering them the opportunity to bring their separated children with them. The review will identify why this may have happened and how many separated parents may have been removed without having that option.

Results of Unannounced Inspections of Conditions for Unaccompanied Alien Children in CBP Custody

As part of our initial observation work regarding the Zero Tolerance Policy and family separations, we reported on the conditions we observed in the Texas CBP facilities we visited on June 26-28, 2018.[3] We visited nine CBP facilities in McAllen and El Paso, Texas, including five Border Patrol stations and four CBP Office of Field Operations (OFO) ports of entry.

As you are aware, CBP facilities must provide safe and sanitary holding facilities as detailed in CBP's 2015 *National Standards on Transport, Escort, Detention and Search* (TEDS Standards). Generally, CBP must transfer UACs into the custody of ORR within 72 hours of identifying them as such. The TEDS Standards also outline protocols for CBP on how to treat vulnerable populations and specify requirements for general care and conditions for children in temporary custody.

The CBP facilities we visited appeared to be operating in compliance with the TEDS Standards. While there was one exception of inconsistent cleanliness of the hold rooms, we observed that UACs had access to hygiene items and clean bedding at all facilities we visited. We did not encounter issues with temperatures or ventilation, access to emergency medical care, inadequate supervision, or access to telephones. In all nine CBP facilities we visited, UACs had access to food and snacks; the children we spoke with did not complain of hunger and said they had enough food.

[3] *Results of Unannounced Inspections of Conditions for Unaccompanied Alien Children in CBP Custody* (OIG-18-87).

We also observed that OFO ports of entry had offices and storage spaces redesigned into holding rooms to be able to hold more UACs, family units, and other border crossers referred for processing. For example, at the Gateway International Bridge in Brownsville, one hold room with a bathroom and sink was only used as a bathroom so that temporary hold rooms that did not have bathroom facilities could have access to them. The OFO ports of entry we visited have very limited number of holding cells for short-term custody. We observed in these situations when a UAC was required to be held separately from unrelated adults, there was limited ability to hold other people.

Our observations are limited to the times and locations of the team's visits and cannot be generalized to other times or locations. We are certainly aware of the deaths late last year of two minor children who died while in DHS custody and we have open investigations into the facts and circumstances of both children's deaths. We are also investigating the death of a third child who died shortly after being released from DHS custody. We will report out publicly on these investigations once complete. Additionally, several of our reports have identified significant issues with ICE facilities.

Unannounced Inspections of ICE Facilities

In response to requirements set forth by this Committee and concerns raised by immigrant rights groups and complaints to the OIG Hotline, the OIG conducts unannounced inspections of detention facilities to evaluate compliance with ICE detention standards. We generally limit the scope of our inspections to the ICE *Performance-Based National Detention Standards* (ICE Standards) for health, safety, medical and mental health care records, grievances, classification and searches, use of segregation, use of force, language access, and staff detainee communication. Our inspections focus on elements of the ICE Standards that can be observed and evaluated by OIG employees who do not have specialized training in medicine, mental health, or corrections.

In 2017, our inspection of five detention facilities raised significant concerns about the treatment and care at four of the facilities visited.[4] At these four facilities we observed potentially unsafe and unhealthy detention conditions. Further, in violation of ICE Standards, all detainees entering one facility were strip-searched. In our two most recent unannounced inspections of Essex County Correctional Facility in Newark, New Jersey[5] and Adelanto ICE

[4] *Concerns about ICE Detainee Treatment and Care at Detention Facilities* (OIG-18-32).
[5] *Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey* (OIG-19-20).

Processing Center in Adelanto, California[6], we found significant health and safety risks in violation of ICE Standards. Specifically, we found the following issues of concern:

- Unreported Security Incidents
- Food Safety Issues
- Facility Conditions
- Nooses in Detainee Cells
- Improper and Overly Restrictive Segregation
- Untimely and Inadequate Detainee Medical Care

Unreported Security Incidents

According to the ICE Standards, Essex County Correctional Facility must report to ICE any incidents involving detainees. However, the facility failed to do so following a detainee's discovery and reporting of a guard's loaded handgun left in a facility staff bathroom that the detainee was cleaning. This marks the fourth time in less than a year that the facility failed to notify ICE of incidents involving detainees and raises serious concerns about the facility's ability to handle security issues.

Interviews with detainees and facility management revealed facility leadership completed a review of the incident, but did not interview the detainee who found the weapon. Rather, facility leadership reported to us that they told the detainee not to discuss the matter with anyone else. The review documented by the facility does not mention that the detainee found and reported the loaded weapon.

Facility records also do not indicate that ICE was notified of the incident, as required by ICE Standards. ICE confirmed it was never notified, despite previously citing the facility for failure to report issues involving detainees, including detainee fights and hospitalization for mental illness.

During our site visit, we notified ICE of the incident and, in August 2018, ICE issued a Contract Discrepancy Report. The report outlined this incident as the fourth time in less than a year that the Essex Facility had failed to notify ICE of detainee-related incidents. The penalty for this discrepancy report can be a fine up to a 5 percent reduction of invoiced amounts. The penalty is pending final review and issuance by ICE.

[6] *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG-18-86).

Health and safety concerns at Essex County and Adelanto ICE Processing Center

At Essex County Correctional, we also observed extreme mishandling of meats, which of course can spread salmonella, listeria, and E. coli, leading to serious foodborne illnesses. We observed facility staff serving potentially spoiled meat to detainees. Over a seven month period in 2018, detainees filed approximately 200 kitchen-related grievances (about 12 percent of all grievances filed) with comments such as:

- "For dinner, we were served meatballs that smell like fecal matter. The food was rotten."
- "The food that we received has been complete garbage, it's becoming impossible to eat it. It gets worse every day. It literally looks like it came from the garbage dumpster; I have a stomach infection because of it and the nurse herself told me it was caused by the food."[7]

The facility at Essex also presents a risk to detainee health and safety. ICE Standards require the facility to conduct preventive maintenance and regular inspections to ensure timely repairs. Despite these standards, we observed conditions that pose serious health and safety risks for detainees, including leaking ceilings in detainee living areas, showers laced with mold and peeling paint, and dilapidated beds. These facility conditions revealed serious concerns about basic maintenance and upkeep.

We observed violations of the ICE Standards at the Adelanto ICE Processing Center in Adelanto, California that were equally concerning. As detailed in our *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California*[8], we observed braided bedsheets, referred to as nooses by center staff and detainees, hanging from vents in 15 of the 20 cells we visited within 4 housing units. Interviews with detainees provided a variety of reasons for braiding and hanging bedsheets, with one detainee noting "I've seen a few attempted suicides using the braided sheets by the vents and then the guards laugh at them and call them 'suicide failures' once they are back from medical."

In March 2017, a 32-year old male died at an area hospital after being found hanging from his bedsheets in an Adelanto cell. In the months after this suicide, ICE compliance reports documented at least three suicide attempts by hanging at Adelanto, two of which specifically used bedsheets. Media reports based on 911 call logs indicate at least four other suicide attempts at the

[7] *Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey* (OIG-19-20).
[8] *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG-18-86).

center from December 2016 to July 2017.[9] In total, these reports represent at least seven suicide attempts at the Adelanto Center from December 2016 to October 2017. Nationwide, self-inflicted strangulation accounts for 4 of the 20 detainee deaths reported between October 2016 to July 2018, according to ICE news releases.

ICE has not taken seriously the recurring problem of detainees hanging bedsheet nooses at the Adelanto Center and according to a senior ICE official, ICE management at Adelanto does not believe it is necessary or a priority to address the braided sheets issue. It must be noted that all ICE detainees are held in civil, not criminal, custody. ICE detention is administrative in nature, aimed to process and prepare detainees for removal. ICE must ensure the Adelanto Center and all ICE facilities comply with detention standards to establish an environment that protects the safety, rights, and health of detainees. Although this form of civil custody should be non-punitive, some of the center conditions and detainee treatment we identified during our visits and outlined in the Management Alert are similar to those one may see in criminal custody.

ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements

In addition to our own inspections of conditions, we also are concerned by the findings of our review of the adequacy of ICE's own oversight of immigration facilities. Our report found deficiencies in both ICE's immigration detention inspection and post-inspection follow-up processes.[10]

ICE uses two inspection types to examine detention conditions in more than 200 detention facilities. ICE contracts with a private company, Nakamoto Group, Inc., and relies on its Office of Detention Oversight (ODO) for inspections. ICE also uses an onsite monitoring program. Yet, neither the inspections nor the onsite monitoring ensure consistent compliance with detention standards, nor do they promote comprehensive deficiency corrections.

Neither type of inspection ICE uses to examine detention facilities ensures consistent compliance with detention standards or comprehensive correction of identified deficiencies. Specifically, because the Nakamoto inspection scope is too broad, ICE's guidance on procedures is unclear, and Nakamoto's inspection

[9] Paloma Esquivel, *'We don't feel OK here': Detainee deaths, suicide attempts and hunger strikes plague California immigration facility*, LOS ANGELES TIMES (Aug. 8, 2017), http://www.latimes.com/local/lanow/la-me-ln-adelanto-detention-20170808-story.html.
[10] *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (OIG-18-67).

practices are not consistently thorough, its inspections do not fully examine actual conditions or identify all compliance deficiencies. In contrast, ODO uses effective methods and processes to thoroughly inspect facilities and identify deficiencies, but the inspections are too infrequent to ensure the facilities implement all corrections.

Moreover, ICE does not adequately follow up on identified deficiencies or systematically hold facilities accountable for correcting deficiencies, which further diminishes the usefulness of both Nakamoto and ODO inspections. In addition, ICE Enforcement and Removal Operations (ERO) field offices' engagement with onsite monitoring program Detention Service Managers (DSM) is inconsistent, which hinders implementation of needed changes. Although ICE's inspections, follow-up processes, and DSMs' monitoring of facilities help correct some deficiencies, they do not ensure adequate oversight or systemic improvements in detention conditions. As a result, certain deficiencies remain unaddressed for years.

ICE needs to comprehensively examine and assess its inspections process, improve its follow-up procedures for corrective actions, and ensure ERO field offices more consistently engage in overseeing detention operations. Taking such actions will help limit and correct persistent deficiencies, as well as effect long-lasting changes and systemic improvements in ICE detention facilities.

ICE concurred with all seven of our recommendations from our Adelanto Center, Essex County Correctional, and ICE's Inspections and Monitoring of Detention Facilities reports, committing to corrective action to ensure the Adelanto Center meets ICE Standards, and undertaking steps to update processes and guidance to improve oversight over detention facilities.

ICE Contracting Issues

Another way in which ICE could hold detention facilities to applicable detention standards is through contracting tools. We reviewed[11] how ICE manages and oversees detention contracts, as ICE contracts with 106 detention facilities to detain removable aliens. In FY 2017, these 106 facilities held an average daily population of more than 25,000 detainees. Since the beginning of FY 2016, ICE has paid more than $3 billion to the contractors operating these 106 facilities. We found that ICE is failing to use quality assurance tools and impose consequences for contract noncompliance such as failure to meet performance standards. Additionally, the use of waivers may circumvent detention standards specified in contracts. Instead of holding facilities accountable through financial penalties, ICE frequently issued waivers to facilities with

[11] *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards* (OIG-19-18).

deficient conditions, seeking to exempt them from having to comply with certain detention standards.

In fact, ICE is not imposing financial penalties, even for serious deficiencies such as those we found in the Discrepancy Reports. In addition to the issues flagged by these Discrepancy Reports, from October 2015 to June 2018 various inspections and DSMs found 14,003 deficiencies at the 106 contract facilities we focused on for our review. Deficiencies including those that jeopardize the safety and rights of detainees, such as failing to notify ICE about sexual assaults and failing to forward allegations regarding misconduct of facility staff to ICE ERO. Despite these identified deficiencies, ICE only imposed financial penalties twice.[12]

ICE also has no formal policies and procedures to govern the waiver process, thereby allowing officials without clear authority to grant waivers, and failing to ensure key stakeholders have access to approved waivers. In some cases, officials may violate Federal Acquisition Regulation (FAR) requirements because they seek to effectuate unauthorized changes to contract terms. Key officials admitted there are no policies, procedures, guidance documents, or instructions to explain how to review waiver requests. Further, contract facilities may be exempt from compliance with otherwise applicable detention standards indefinitely, as waivers generally do not have an end date and the Custody Management Division within ERO does not reassess or review waivers after it approves them. In our sample of 65 approved waiver requests, only three had identified expiration dates; the 62 others had no end date.

ICE officials concurred with all our report recommendations, including the recommendation that ICE develop protocols to ensure that all existing and future waivers are (1) approved by ICE officials with appropriate authority; distributed to key stakeholders; consistent with contracting terms; and compliant with FAR requirements, as applicable. ICE also agreed to review all current waivers to determine continuing applicability, and, if appropriate, cancel any waivers that are no longer needed. ICE anticipates completing these actions by April 30, 2019.

Border Security: Hiring and Training DHS Law Enforcement Officials

The Department, CBP, and ICE continue to face significant challenges in identifying, recruiting, hiring, and fielding the number of law enforcement

[12] ICE deducted funds from one facility as a result of a pattern of repeat deficiencies over a 3-year period, primarily related to health care and mental health standards. The other deduction was made due to a U.S. Department of Labor order against the contractor for underpayment of wages and was not related to any identified deficiency.

officers as mandated by two January 2017 Executive Orders.[13] In response to multiple OIG Hotline complaints related to the performance and management of a CBP Accenture Contract, we audited the hiring contract and found serious performance issues.

CBP Needs to Address Serious Performance Issues on the Accenture Hiring Contract

In November 2017, CBP awarded Accenture a $297 million contract to help meet the demands of recruiting and hiring agents and officers under the President's January 25, 2017 Executive Order, *Border Security and Immigration Enforcement Improvements*.[14] The contract includes 1 base year, with 4 option years, to hire 7,500 fully qualified applicants, including Customs and Border Protection Officers, Border Patrol Agents, and Air and Marine Interdiction Agents.

In July 2018, we initiated an audit to determine whether CBP awarded and is managing its $297 million hiring contract with Accenture in a fiscally responsible manner according to Federal, departmental, and component requirements. Our review determined that Accenture has not provided the promised hiring process or results, yet CBP has paid Accenture approximately $13.6 million for startup costs, security requirements, recruiting, and applicant support. In return, Accenture has processed two accepted job offers.

Recognizing Accenture could not fulfill the contract's requirements without significant delays, CBP agreed to modify the contract to accommodate Accenture.[15] Under the modification, CBP staff carried out a significant portion of the hiring operations. During this period, since Accenture could not determine which applicants it recruited, CBP agreed to give credit and temporarily pay Accenture for a percentage of all applicants regardless of whether CBP or Accenture processed the applicants. As of October 1, 2018, CBP had processed 14 applicants on behalf of Accenture. All 14 applicants accepted job offers and 7 of the 14 entered on duty, which translated to payment of approximately $500,000 to Accenture for work CBP had completed.

In its first year, CBP's contract with Accenture has already taken longer to deploy and delivered less capability than promised. Accenture is nowhere near satisfying its 7,500-person hiring goal over the next 5 years. Further, CBP has

[13] Executive Order 13767- *Border Security and Immigration Enforcement Improvements*, January 25, 2017; and Executive Order 13768- *Enhancing Public Safety in the Interior of the United States*, January 25, 2017.
[14] *Management Alert — CBP Needs to Address Serious Performance Issues on the Accenture Hiring Contract* (OIG-19-13).
[15] As of October 1, 2018, CBP has modified the contract four times, changing the scope of work and raising the cost ceiling by about $8 million.

used significant staffing and resources to help Accenture do the job for which it was contracted. As such, we are concerned that CBP may have paid Accenture for services and tools not provided. CBP risks wasting millions of taxpayer dollars on a hastily approved contract that is not meeting its proposed performance expectations. CBP must hold the contractor accountable, mitigate risk, and devise a strategy to ensure results without additional costs to the Government.

Funding Limitations Impact Training

Between July 2017 and March 2018, we also reviewed and analyzed the January 2017 Executive Orders, DHS's implementation memorandums concerning the January 2017 Executive Orders, and respective agency hiring plans and training strategies.[16] While the Federal Law Enforcement Training Centers (FLETC), U.S. Border Patrol (USBP) and ICE have each developed hiring surge training plans and strategies, funding limitations has delayed implementation. As a result, the Department pushed FY 2017 and 2018 hiring and training projections to FY 2019 and beyond. Funding limitations will also delay efforts to improve and construct necessary training venues and facilities.

The existing training venues are in need of improvement. Consider how USBP revised its training curriculum based on current research and identified areas to enhance training, emphasizing performance based scenarios. However, because of lack of funding, CBP has not been able to construct most of the required venues to incorporate curriculum revisions. USBP Academy instructors are conducting trainings using "workarounds" that lack performance-based realistic settings. According to a senior USBP Academy Official "the workarounds were intended as a short term fix, and are not meant to be a permanent part of the training program."[17] Without necessary improvements, the quality of instruction will remain below intended levels and not include exposure to authentic environments. This presents a significant safety risk to the officers and anyone within their enforcement authority.

FEMA Oversight

DHS OIG has traditionally dedicated significant attention and resources to providing oversight to FEMA specifically. For many years, Congress funded OIG's oversight of FEMA's Disaster Relief Fund (DRF) spending through a transfer of funds from the DRF to OIG. Initially a $16 million transfer, that number increased to $24 million in recent years. While the FEMA Disaster

[16] *DHS Training Needs for Hiring 15,000 Border Patrol Agents and Immigration Officers* (OIG-19-07).
[17] *Id.*

Relief Fund transfer itself was discontinued in the FY 2017 appropriation, the appropriations committees directed OIG to continue to dedicate a minimum of almost $21 million in FY 2017 and $17 million in FY 2018 to disaster-related investigations and audits and we have done so. After the historic and devastating hurricane season of 2017, Congress also appropriated $35 million total in a combination of no-year and three-year supplemental funding to OIG for disaster-related oversight.

Hurricanes Harvey, Irma, and Maria made landfall in a four-week time period during August and September 2017. These storms now rank as three of the five most expensive in U.S. history, according to the National Oceanic and Atmospheric Administration (NOAA).[18] This makes the 2017 hurricane season the costliest in U.S. history, topping even the 2005 season, which included Katrina, Rita, and Wilma. For our office, the first order of business in response to the unprecedented disasters was to deploy auditors and investigators to FEMA's Joint Field Offices (JFOs) in Texas, Florida, and Puerto Rico. We quickly deployed staff from our local field offices as well as other auditors, analysts, and criminal investigators from around the country. Having OIG staff on the ground serves multiple purposes: we serve as an independent unit for oversight of disaster response and recovery activities, to detect and alert FEMA of systemic problems, and to help ensure accountability over Federal funds. Our deployment activities are focused on identifying potential risks and vulnerabilities and providing our stakeholders with timely, useful information to address emerging challenges and ongoing operations. Based on auditors' observations and analysis, we identified several areas where additional, more comprehensive traditional audit work was needed.

One of the chief challenges in a post-disaster environment is the vulnerability for fraud and abuse. Unfortunately, there are those that wish to profit from disasters, turning survivors into victims. Thus, OIG's criminal investigators play a very active and essential role during the post-disaster period. Our office works closely with the National Center for Disaster Fraud Hotline as we receive and process complaints. We also team with state and local law enforcement, federal partners, and U.S. Attorney's Offices in the affected jurisdictions to create local disaster fraud task forces. Currently, investigations related to FEMA fraud—from both 2017 and earlier disasters—represent 29.7 percent of OIG's currently open criminal investigative caseload.

In addition to the situational challenges facing FEMA during the 2017 hurricane season, other challenges to FEMA's programs and operations tend to be more persistent and systemic vulnerabilities:

[18] Damages from Harvey are estimated at $125 billion; Maria's damages are estimated at $90 billion; and Irma's at $50 billion.

- Improper procurement practices;
- Duplication of benefits;
- Mismanagement of disaster costs;
- Privacy vulnerabilities;
- Limitations in the ability to quickly protect survivors' homes and property from further damage;
- Obstacles with accurate and timely home inspections;
- Incomplete controls when providing Federal funds to high-risk entities; and
- Inconsistent contract oversight.

Unmitigated, these challenges could delay survivors' recovery and put billions of dollars of Federal funds at risk.

For almost a decade, OIG has been reporting on some of these persistent and systemic challenges in annual "capping" reports.[19] These reports consolidate all of OIG's FEMA-related findings and recommendations for the year and are designed to inform FEMA headquarters officials about significant and systemic issues of noncompliance and program inefficiencies that warrant FEMA's attention. As reported in our most recent capping report—consolidating our FY 2017 audit work—between FY 2009 and FY 2017, OIG audited FEMA grant funds totaling $13.75 billion and reported potential monetary benefits of $6.55 billion.

Collectively, our FY 2017 work shows that FEMA continues to face systemic problems and operational challenges, and fails to manage disaster relief grants and funds adequately. Furthermore, FEMA remains ineffective at holding grant recipients accountable for properly managing disaster relief funds and providing adequate monitoring of or technical assistance to subgrantees. We continue to identify problems such as improper contracting activities, and ineligible and unsupported expenditures.

Of particular concern to the OIG, the challenges identified in our annual capping reports tend to repeat year after year. For example, our FYs 2016, 2015, and 2014 summary reports also found that FEMA did not manage disaster relief grants and funds adequately and did not hold grant recipients accountable for properly managing disaster relief funds.[20] Moreover, since FY 2010, we have consistently reported that states, which are required to provide oversight of grant funds and subgrantee activities, are not doing an adequate job of educating subgrantees and enforcing Federal regulations through

[19] *Summary and Key Findings of Fiscal Year 2017 FEMA Disaster Grant and Program Audits* (OIG-18-75) was the ninth annual capping report issued by our office.
[20] *Summary and Key Findings of Fiscal Year 2016 FEMA Disaster Grant and Program Audits* (OIG-18-06)

effective and vigilant monitoring. We encourage FEMA to continue to take action on its commitment to strengthen grants management, including creating a plan that will identify root causes and identify solutions that are specific, viable, and can be implemented and managed to help prevent recurring problems similar to those that we have identified over the years.

Ongoing and Future Disaster Work

The OIG has a number of ongoing and planned audits related to disasters. Currently, we have audits underway regarding FEMA's Transitional Shelter Assistance Program, Individual Auto Assistance, as well as debris procurement issues. The majority of these reviews will be reported between spring and winter 2019. We are also initiating work to address mandates in the Disaster Recovery Reform Act of 2018, including reviews of state and tribal housing strategies and the lease and repair of rental units for temporary housing. We also have a number of planned and on-going audits in response to congressional requests and discretionary work, including reviews of FEMA's Sheltering and Temporary Emergency Power programs across different states and in Puerto Rico and more narrow reviews of FEMA contract management and debris removal efforts.

Ongoing projects also include reviews of:

- FEMA's Public Assistance (PA) grant awards to Puerto Rico Electric Power Authority (PREPA) and PREPA's contracts with Whitefish Energy Holdings LCC and Cobra;

- Supply chain issues related to FEMA's response to Hurricanes Irma and Maria in Puerto Rico;

- FEMA's advance contract strategy for Puerto Rico;

- Capacity Audits of various municipalities that received Public Assistance Grant Program funds. These audits, which are contracted to Independent Public Accountants, assess whether grant fund recipients and subrecipients have established and implemented policies, procedures, and practices to help ensure that funds are accounted for and expended in accordance with Federal regulations and FEMA guidance.

Finally, we will continue to conduct reviews of FEMA's oversight of state public assistance grant management and have initiated a broad review of FEMA's recovery of questioned state grant costs.

Madame Chairwoman, this concludes my testimony.

I am pleased to answer your questions, as well as those of the other Members.

Thank you.