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May 6, 2020

RE: FOIA Request No. 20-0085

This is in response to your Freedom of Information Act (FOIA) request submitted March 22, 2020, and received in our Office the following day. We assigned your request tracking number 20-0085. Specifically you requested, *"A copy of each Management Advisory, Management Advisory Memorandum, and Management Advisory Report produced by the Peace Corps Office of Inspector General since January 1, 2017. A printout of the listing of Management Advisories, Management Advisory Memoranda, and Management Advisory Reports issued by the Peace Corps OIG since January 1, 2010."*

An online search for records located the following documents as responsive to your request. Enclosed, you will find five PDF documents, totaling 149 pages. This information is being released to you in full.

Your request is now closed in our office. If you are not satisfied with this response, you may contact me as the Peace Corps FOIA Public Liaison to discuss it at vburke@peacecorps.gov. Additionally, you may contact the Office of Government Information Services (OGIS) at the National Archives and Records Administration to inquire about the FOIA mediation services they offer if you are unable to resolve any initial disputes with this office. The contact information for OGIS is as follows: Office of Government Information Services, National Archives and Records Administration, 8601 Adelphi Road-OGIS, College Park, Maryland 20740-6001, e-mail at ogis@nara.gov; telephone at 202-741-5770; toll free at 1-877-684-6448; or facsimile at 202-741-5769.

You also have the right to submit an administrative appeal to the appellate authority within 90 business days of receipt of this letter. Please address the appeal to Clark Presnell, Associate Director – Management, Peace Corps, 1275 First Street NE,

Washington, DC 20526. Please submit any appeal by email to foia@peacecorps.gov during the Corona Virus Disease 2019 pandemic (COVID-19). The FOIA Office is not available to receive faxes or postal mail during the Peace Corps' Continuity of Operations status in response to COVID-19. Your appeal must include the FOIA request number in the body of your message, and a statement explaining the reason for your appeal. Clearly mark "FOIA Appeal" on the email subject line, along with the assigned FOIA case number.

If you have questions regarding this response, please contact Kimberly Battle, FOIA/PA Specialist, at foia@peacecorps.gov.

Sincerely,

Virginia E. Burke
FOIA/PA Officer

Enclosures

To: Jody Olsen, Director
Anne Hughes, Chief Compliance Officer

From: Kathy A. Buller, Inspector General

Subject: Management Advisory Report: Managing the Suspension of Peace Corps/Kenya: A Case Study (IG-18-02-SR)

Date: September 14, 2018

The purpose of this Management Advisory Report (MAR) is to alert you to how the agency managed aspects of the suspension of Peace Corps/Kenya and provide recommendations for improvement. This report outlines the steps that the Peace Corps took from July 2014 until July 2018 to manage the suspension of Peace Corps/Kenya. The agency's approach revealed some deficiencies in the process of managing suspended posts generally. As a result, we have made two recommendations to address those deficiencies.

The agency may provide a response to the two recommendations within 45 days of the issuance of the report. Should a response be provided, the report will be updated to include them in Appendix A.

Synopsis

The Peace Corps established a program in Kenya in 1964 and has since sent over 5,000 Volunteers to serve in Kenya. Peace Corps Kenya supported 123 Volunteers and Trainees in FY 2012 and 100 in FY 2013. Violence in Kenya raised concerns among agency officials about security risks for Volunteers, and the agency cancelled a new training group scheduled to arrive in 2014. In July 2014, the 55 Volunteers serving in Kenya at the time were evacuated due to escalating security concerns, and the program was suspended.[1] The 35 Peace Corps/Kenya staff were not dismissed from their employment following the departure of Volunteers, however, because the agency believed the suspension would be temporary. The agency assessed the security environment in Kenya in the spring of 2015 and briefly considered lifting the suspension, but subsequent violence in the country derailed these efforts. A year later, in April 2016, the Director approved a plan to return with a small number of Volunteers and a narrowly focused program, but the plan was not implemented. Peace Corps/Kenya's workforce was not reduced until June 2017. In late 2017, headquarters management began the process to close the office in Nairobi, three and a half years after Volunteers were evacuated.

[1] In September 2013, militants seized the Westgate shopping mall in Nairobi and killed more than 60 people. In June 2014, 48 people were killed when militants attacked hotels and a police station near the island resort of Lamu. Several smaller attacks targeted public transportation vehicles, which were a type of transportation commonly used by Volunteers.

Figure 1 shows a summary of key events from the July 2014 suspension through the implementation of closing the Peace Corps office in Kenya nearly four years later.

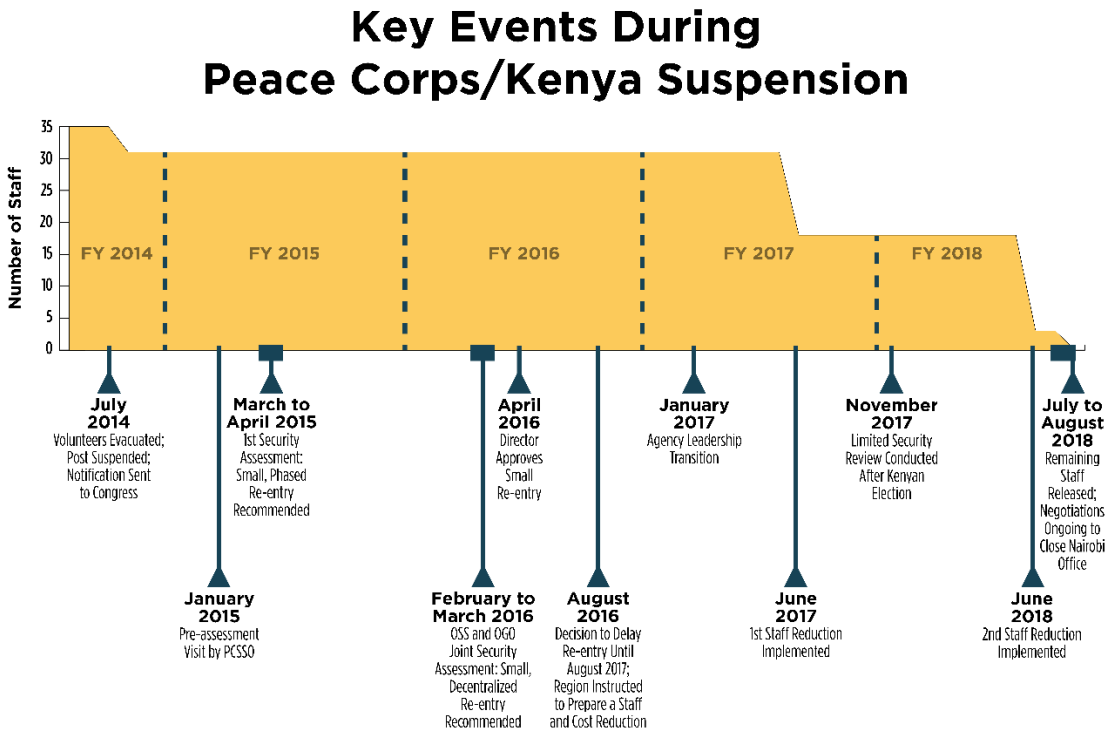

Figure 1: Timeline of the Suspension of Peace Corps/Kenya.

Results

The Africa Regional Director did not timely adjust Peace Corps/Kenya's staffing levels after deciding to significantly downsize the program.

Peace Corps managers reported to OIG that after Volunteers were evacuated from Peace Corps/Kenya in July 2014, the agency anticipated a short-term suspension and chose not to reduce staffing at the post's offices in Nairobi to facilitate re-entry. Managers said that removing staff and rehiring them later when the Volunteers returned would have been costlier than keeping them employed over a limited period. Managers reported, however, that the suspension was prolonged by ongoing safety and security concerns in Kenya.

A regional Safety and Security Officer conducted a pre-assessment visit to explore options for future operations in Kenya in January 2015. In March 2015, eight months after the suspension, the agency more comprehensively assessed prospects for lifting the suspension to return Volunteers to Kenya. The agency's safety and security staff who conducted a security assessment briefed managers that the program should not resume its former footprint and recommended that, should Volunteers return, the agency should plan for a phased re-entry in Kenya's western area to mitigate safety and security risks. The staff did not propose the size of the returning Volunteer group but recommended using reinstated Kenya Volunteers and Peace

Corps Response Volunteers before regular two-year Volunteers. Due to staff turnover and lack of documentation, OIG was unable to determine to what extent agency managers accepted this assessment or considered adjusting Kenya's staffing levels. In FY 2015 there were, on average, 31 staff including one US direct hire, administrative staff continuing day-to-day operations, and programming staff who continued to support the evacuated Volunteers' projects in the communities they served.

In February 2016, 19 months after the suspension, officials from the Office of Safety and Security (OSS) and Office of Global Operations (OGO) conducted another security assessment to evaluate the viability of re-entering with a small footprint of Volunteers in the western area of Kenya. The results of the assessment were not documented but the officials briefed agency leaders that the suspension could be lifted to reinstate a much smaller and decentralized program. Agency managers informed OIG that it would have taken many years to scale up the proposed program, which undercut the agency's initial rationale that the program would quickly return to its former size. Managers also reported that the proposed program would shift operations and staff out of Nairobi, but the agency did not identify which staff, if any, would have been willing to relocate to western Kenya to support the program. Several agency officials with whom we spoke maintained that only three or four Kenyan staff were in fact willing to relocate. For these reasons, the security assessment should have resulted in a workforce reduction in Kenya.

Figure 2: Approximate Area of Programming Interest for Peace Corps/Kenya's Proposed Re-entry.

Africa regional management developed a re-entry plan following the assessment, which the Director approved in April 2016, but it did not sufficiently address staffing adjustments for the much smaller, decentralized program. The plan aimed to place "about ten" Response Volunteers in western Kenya in late 2016, with 5 more the following year. The plan provided that "Over the course of the first year, the preponderance of staff will be relocated to the western regional office or be released if they are not able to relocate." As previously noted, agency officials we interviewed believed that only a few staff would relocate. Thus, the region could have begun planning for the release of most of the staff without delay. The region could have also planned the release of non-essential staff who would no longer have a role in the much smaller, narrowly focused program, yet the plan did not make provisions to assess the staffing footprint until after the arrival of Volunteers.

Managers reported to OIG that Africa regional management did not begin to consider downsizing staff until August 2016, and an actual reduction in staff was not executed until June 2017, with the release of 12 staff. Managers said that the post was reduced to 18 essential staff required to maintain operations, including some programming staff due to ongoing activities for which the post was still receiving PEPFAR funding. The Office of Safety and Security

conducted another limited review in the wake of Kenya's disputed presidential election held in August 2017. The review determined again that the only viable initial re-entry was a small program in the western area. For reasons related to the small size and limited growth potential of the recommended re-entry, Agency leadership decided to close the office in Nairobi and phase out the remaining staff. Most were released during a second reduction in staff in June 2018, and the last staff departed one month later in July 2018. Table 1 shows the length of time that staff were maintained without Volunteers at the post.

Table 1: Peace Corps/Kenya Staff, Volunteers, and Operation Costs by Fiscal Year

	FY 2012	FY 2013	FY 2014[2]	FY 2015	FY 2016[3]	FY 2017[4]	FY 2018
Volunteer Onboard Strength	123	100	0	0	0	0	0
Average Staff[5]	32	35	31.7	30	30	25.2	16.1
Funding Appropriated to Peace Corps	$2,316,457	$2,093,821	$2,158,690	$1,667,844	$1,401,043	$1,061,115	$802,416
PEPFAR Funding	$1,547,400	$1,549,806	$1,377,427	$1,004,150	$1,454,132	$1,044,987	$722,431
Total Planned Operating Costs	**$3,863,857**	**$3,643,627**	**$3,536,117**	**$2,671,994**	**$2,855,175**	**$2,106,102**	**$1,524,848**

Conclusion

Several factors contributed to the prolonged continuation of Kenya's pre-suspension staffing levels. The re-entry plan signed by the Director in April 2016 did not sufficiently address staffing needs under the new plan and generally did not provide a clear or complete picture of how the plan would affect staffing the new office. Changes in the agency's leadership also impacted re-entry planning. Headquarters staff we interviewed said that disruptions from the leadership transition in late 2016 and early 2017 resulted in less focus on the Kenya suspension and that managers in acting roles had been reluctant to make a major decision that could be questioned by their successors, like closing a high-profile post with a long, successful history. In addition, high-level managers did not adequately record key decisions and recommendations related to the Kenya suspension, and the incoming management team lacked important information to guide their decision-making. Such documentation could also be used to help better inform Congress of

[2] 55 Volunteers were evacuated in the fourth quarter of FY 2014.
[3] Proposed on-board strength of 10 Volunteers was approved in April 2016 but not implemented.
[4] Proposed on-board strength of 15 Volunteers was approved in April 2016 but not implemented.
[5] Staff numbers provided by the agency for FYs 2012-13 reflect operational plan projections. The remainder reflect average staff levels.

agency deliberations and actions when consultation and notification is required.[6] Lastly, we could not identify guidance or policy concerning the management of post suspensions that would direct senior staff to determine staffing levels of suspended posts. The agency executes post suspensions based on situational assessments, knowledge or experience with past suspensions, and input from relevant managers.

OIG concluded that the reduction in staff should have been implemented in April 2016, once the post was approved to reopen, or possibly even earlier, following the safety and security assessment in March 2015. Due to the unnecessary delay in staff reduction, the funds used to maintain non-essential staff in Peace Corps/Kenya could have been put to better use. The combined salaries of non-essential staff members released in June 2017 amounted to approximately $25,000 per month. Based on this approximation, over the 14-month period from the re-entry plan approval in 2016 to the reduction in staff in 2017, the agency could have put to better use approximately $350,000. If calculated from the time of the earlier safety and security assessment in 2015, this figure would reach approximately $675,000. Our assessment is based on our limited-scope review of the timeliness of the staffing reductions and may not contain the total amount resulting from maintaining staff at the post for multiple years. Approximating the total amount of funds that could have been put to better use would require a more comprehensive review, including an assessment of the appropriateness of core staff designations, the range of staff activities conducted during the suspension, and the nature of expenditures during the period in question.

We recommend:

1. **That the Director develop guidelines and a process for staff to periodically assess the suitability of staffing levels at suspended posts, and to make timely reduction in staff decisions. The process should include, at minimum, staff from the Director's office, Regional Operations Office, Office of Safety and Security, Office of Global Operations, Congressional Relations, General Counsel, Office of the Chief Financial Officer.**

2. **That the Director maintain adequate documentation of key decisions and recommendations related to opening, closing, and suspending any overseas office or country program.**

[6] Successive Peace Corps appropriation acts since 2009 have required "[t]hat any decision to open, close, significantly reduce, or suspend a domestic or overseas office or country program shall be subject to prior consultation with, and the regular notification procedures of, the Committees on Appropriations, except that prior consultation and regular notification procedures may be waived when there is a substantial security risk to volunteers or other Peace Corps personnel, pursuant to section 7015(e) of this Act…." In reviewing Peace Corps related correspondence, OIG notes that in July 2014 the Peace Corps notified the Committees on Appropriations of its decision to suspend the program in Kenya and informally communicated in May 2016 with appropriations staff regarding its intent to restart the Kenya program. However, the plan to restart the program was not implemented.

cc: Michelle Brooks, Chief of Staff
Carl Sosebee, Senior Advisor to the Director
Maura Fulton, Senior Advisor to the Director
Kathy Stroker, Deputy General Counsel
Patrick Young, Associate Director, Office of Global Operations
Johnathan Miller, Regional Director, Africa Region
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Shawn Bardwell, Associate Director, Office of Safety and Security
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Joel Frushone, Associate Director, Office of External Affairs
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Angela Kissel, Compliance Officer
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IG

APPENDIX A: AGENCY RESPONSE TO THE REPORT

MEMORANDUM

To: Kathy Buller, Inspector General

From: Anne Hughes, Chief Compliance Officer

Date: October 18, 2018

CC: Jody Olsen, Director
Michelle Brooks, Chief of Staff
Matthew McKinney, Deputy Chief of Staff/White House Liaison
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Johnathan Miller, Regional Director, Africa Region
Greg Huger, Regional Director, Inter-America and the Pacific Region
Doug Warnecke, Acting Regional Director, Europe, Mediterranean, and Asia Region
Nancy Herbolsheimer, Director, Office of Congressional Relations

Subject: Agency Response to the Management Advisory Report: Managing the Suspension of Peace Corps/Kenya: A Case Study (IG-18-02-SR)

The agency would like to thank the Office of Inspector General for their continued cooperation on this Management Advisory Report and the two accompanying recommendations, both of which the agency is in concurrence.

There is one point of clarification the agency wishes to make with regard to Table 1: Peace Corps/Kenya Staff, Volunteers, and Operations Costs by Fiscal Year. During this period of uncertainty, the agency strove to economize on expenditures, spending well below what was initially budgeted between FY 2014-2017. Table 1 lists the amounts of funding appropriated to Peace Corps and PEPFAR Funding from FY 2012-2018.

The table below represents the budgeted information presented in Table 1, along with actual expenditures for FY 2014-2017. During this time period, actual expenditures were $3,682,929, or 33%, under budget.

	FY 2014	FY 2015	FY 2016	FY 2017	Total Costs & Average Variance %
Funding Appropriated to Peace Corps	$2,158,690	$1,667,844	$1,401,043	$1,061,115	-
Actual Expenditure	***$1,812,284***	***$1,283,925***	***$1,055,557***	***$859,205***	-
PEPFAR Funding	$1,377,427	$1,004,150	$1,454,132	$1,044,987	-
Actual Expenditure	***$795,803***	***$519,141***	***$573,622***	***$586,922***	-
Total Planned Operating Costs	$3,536,117	$2,671,994	$2,855,175	$2,106,102	*$11,169,388*
Total Actual Operating Costs	***$2,608,087***	***$1,803,066***	***$1,629,179***	***$1,446,127***	***$7,486,459***
Variance	***$928,030***	***$868,928***	***$1,225,996***	***$659,975***	***$3,682,929***
	26%	***33%***	***43%***	***31%***	***33%***

Recommendation 1

That the Director develop guidelines and a process for staff to periodically assess the suitability of staffing levels at suspended posts, and to make timely reduction in staff decisions. The process should include, at minimum, staff from the Director's office, Regional Operations Office, Office of Safety and Security, Office of Global Operations, Congressional Relations, General Counsel, Office of the Chief Financial Officer.

Concur

Response: The agency recognizes the utility of outlining a process for periodically assessing the suitability of staffing levels at suspended posts. The Offices of the Director, Global Operations, Safety and Security, External Affairs, the General Counsel, the Chief Financial Officer and Human Resources will collaborate to update and revise MS 341 *Non-Emergency Post Closing*. In revising this policy, these offices will develop a process that outlines these types of periodic assessments, including guidance on which offices must be involved and what type of documentation must be produced.

Documents to be Submitted:

- Revised MS 341 *Non-Emergency Post Closing*

Status and Timeline for Completion:
April 2019

Recommendation 2
That the Director maintain adequate documentation of key decisions and recommendations related to opening, closing, and suspending any overseas office or country program.

Concur
Response: The agency will issue guidance to accompany MS 340 *Opening a Post* and MS 341 *Non-Emergency Post Closing* that details which types of documents must be maintained in relation to opening, closing, and suspending any overseas office or country program. This guidance will reference and correspond with the agency's records schedule.

Documents to be Submitted:

- Guidance for MS 340 *Opening a Post* and MS 341 *Non-Emergency Post Closing* regarding document retention as it relates to these two policies and the agency's records schedule

Status and Timeline for Completion:
April 2019

APPENDIX B: OIG COMMENTS

Management concurred with both recommendations. OIG will review and consider closing recommendations 1 and 2 when the documentation reflected in the agency's response is received. We wish to note that, in closing recommendations, we are not certifying that the agency has taken these actions or that we have reviewed their effect. Certifying compliance and verifying effectiveness are management's responsibilities. However, when we feel it is warranted, we may conduct a follow-up review to confirm that action has been taken and to evaluate the impact.

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To: Jody Olsen, Director
Anne Hughes, Chief Compliance Officer

From: Kathy A. Buller, Inspector General

Subject: Management Advisory Report: Purchase Card Review (IG-18-03-SR)

Date: September 27, 2018

The purpose of this report is to bring to your attention needed improvements the Office of Inspector General (OIG) identified while reviewing the Peace Corps' purchase card program. We found that inadequate controls resulted in non-compliance with agency policies and guidance from the Office of Management and Budget (OMB). In order to reduce the risk of fraudulent behavior and financial abuse, the agency needs to improve its policies and procedures, training, and oversight provided to the purchase card program, as outlined below.

This report makes six recommendations to help enhance controls over purchase card transactions. The agency has 45 days from the issuance of the report to provide its response to these recommendations. Once we receive the response, the report will be updated to include it in Appendix A.

Background

The General Services Administration (GSA) administers the Government purchase card program, which provides the Government's charge card services to Federal agencies. The purpose of the program is to streamline the payment process for small purchases, minimize paperwork, and generally simplify the administrative efforts associated with procuring goods and services under certain thresholds. Agencies are responsible for monitoring the actions of their cardholders as well as issuing agency-specific policies and procedures on the appropriate use of purchase cards.

OIG participated in a Federal Government-wide project with the Information Technology (IT) Committee of the Council of the Inspector General on Integrity and Efficiency (CIGIE) to analyze and review Government purchase card data and determine risks associated with purchase card transactions. This project required the data-mining of purchase card transactions for potential fraud indications and for compliance with Federal purchase card requirements.

Between October 1, 2016 and March 31, 2017, the Peace Corps processed about 5,200 purchase card transactions amounting to approximately $2,080,000. The CIGIE IT committee provided audit steps to be performed in analyzing data and in identifying high-risk transactions. The CIGIE methodology identified 2,238 high-risk Peace Corps purchase card transactions. We sampled from these transactions, with consideration toward the Peace Corps' operating environment as an agency operating 24/7 in overseas locations across the globe. We selected a

total of 205 transactions amounting to approximately $238,500 for testing. Of these transactions, 155 were from the high-risk category and 50 were random samples. (See Table 1.)

Table 1: Details of Sample Selected

Criteria	Transactions	Reviewed	Explanation
Transaction Amount greater than limit	43	12	Included 23 transactions where the account limit was zero, as the card was discontinued after the charges were incurred
Closed Account activity	2	2	Reviewed both transactions
Prohibited MCC Code	272	4	Peace Corps has additional authorized Merchant Category Codes (MCC), beyond those allowed for in the CIGIE methodology. We tested Citibank control over Peace Corps-approved MCC codes and determined to be low risk and selected a small sample for verification
Questionable MCC Code	429		
Unauthorized Third-Party Merchant transactions	967	55	The merchant in question was not considered an authorized third-party merchant under the CIGIE methodology. However, it is an authorized MCC for the Peace Corps. We selected a sample to verify compliance with purchase card policies
Potential split Transactions	77	77	As these were considered to be a higher-risk category of exception, we reviewed all transactions
Include sales tax transactions	1	0	We added this transaction with $0.01 tax amount to overcome an error message in executing the IDEA[1] program script CIGIE provided.
Weekend- Holiday	447	5	We noted online retailers use shipping date as transactions date and orders placed on weekdays may be shipped on weekend/holidays. We deemed this to be low risk and selected a small sample for testing.
Total IDEA Results	2,238	155	
Random Sample	50	50	Random sample per CIGIE guideline
	2,288	205	

What We Found

Rejection Reports and Auto-Close Purchase Card Statements

Peace Corps Manual Section (MS) 731 Peace Corps Purchase Card Program,[2] provides that the cardholder is responsible for reconciling and reallocating transactions on their monthly statement of account to ensure that the "transactions are accurate and funded appropriately." Approving officials are responsible for ensuring that the transactions comply with the purchase card procedures; and must review the purchase card log, statement, and supporting documentation to

[1] IDEA is an audit software used for data mining

[2] Peace Corps Manual Section 731 *Peace Corps Purchase Card Program,* Section 7.0 Reconciling and Reallocating the Monthly Statement of Account.

verify that all transactions were made in accordance with purchase card guidance before approving the monthly statement.[3]

MS 731 Attachment I, Reallocating Transactions, provides procedures that cardholders must follow in order to match individual purchase card charges to the appropriate obligation number(s) (reallocate). After the reallocation is complete, the cardholder can submit the statement to their approving official for review and approval. If their monthly statement of account is not electronically submitted within eight business days after the close of the monthly billing cycle, it is automatically closed (Auto-Closed) by the Citibank system.[4]

Rejection Reports

When the agency receives a purchase card statement from Citibank, it pays immediately. Per the current practice, this payment is logged as a pre-payment until individual transactions are recorded to appropriate expense accounts. The agency financial system later matches the monthly electronic file of purchases with obligations cardholders reallocated when they submitted their approved monthly statement. Any mismatched transactions are included in the Odyssey rejection (fall-out) report.

The Office of the Chief Financial Officer (OCFO) currently does not have a documented procedure for managing the transactions appearing in the rejection report. However, the Supervisory Financial Management Officer of Global Accounts Payable (GAP), provided information about the current practice for addressing various errors that cause transactions to be rejected during the matching process. Per the Agency Purchase Card Coordinator (APC), OCFO is preparing a formal process for addressing the rejection report transactions.

Currently, GAP reaches out to cardholders to complete appropriate corrections before recording the relevant expense account. Until the errors are corrected, the amount is retained as a prepayment in the financial system. For example, if the obligation entered in Citibank is incorrect, the holder will be required to create or provide a corrected obligation to GAP for manual correction (as noted in the issue below). The rejection report is a cumulative report, as the financial system tracks the "rejected" transactions until they are resolved.

We obtained the relevant rejection reports for the period under review. The rejection report for October 2016 included 738 purchase card transactions totaling approximately $322,000 USDE.[5] These transactions ranged from November 2015 to October 2016. After reviewing these transactions, we expanded our range to include rejection reports from October 2016 to April 2017. We summarized and analyzed these reports, identifying the dates when the errors were corrected, and the transactions were recorded as expense in the financial system. (See Table 2.)

[3] Peace Corps Manual Section 731 *Peace Corps Purchase Card Program,* Section 4.5.1-4.5.2 Review for Misuse and Abuse and Review of Cardholder Monthly Statement and Purchase Card Log.
[4] Peace Corps Manual Section 731 *Peace Corps Purchase Card Program,* Section 4.5.1 Review of Misuse and Abuse.
[5] US Dollar Equivalent

We noted the following:

- There were 1,406 unique purchase card transactions in the cumulative rejection report with total value of approximately $531,000.
- 119 purchase card transactions amounting to approximately $97,000 USDE pertained to the prior Fiscal Year.
- 20 purchase card transactions amounting to approximately $11,000 USDE were recorded as an expense more than one year after their Citibank invoice date.
- 114 of the 1,406 purchase card transactions amounting to approximately $48,500 USDE were also included in the auto-close report.
- $439,500 in unsupported questioned costs (see Table 3: Unsupported Questioned Costs)[6]

Table 2: Summary of Rejection Report Purchase Card Transactions, October 1, 2016 – April 30, 2017

Number of Days from Citibank Statement Date to Recording in Odyssey Date				
No of Days in Rejection Report	No. Of Records	% of Records	Transaction Amount	% of Amounts
0 to 30	312	22%	$ 105,131	20%
30 to 60	503	36%	$ 154,549	29%
60 to 90	133	9%	$ 52,763	10%
90 to 180	322	23%	$ 152,040	29%
180 to 360	116	8%	$ 55,872	11%
360 to 540	20	1%	$ 11,082	2%
Totals:	**1,406**	**100%**	**$ 531,437**	**100%**

Based on our discussion with the APC and GAP staff, we believe that the large number of rejected purchase card transactions represent a lack of adequate Peace Corps training for the cardholders and the approving officials about the agency policies and procedures. The delay in completing corrective actions represents a lack of adequate resources allocated to the process and lack of coordination between APC and GAP.

Auto-Close Statements

The cardholder statements are auto-closed when the monthly statements have not been approved by the approving official by the due date[7] (even if the re-allocation is correct and the transactions are not in the rejection report). An auto-closed statement indicates that the purchase card holder and/or the approving official did not fully comply with the purchase card policy requirements; i.e. the cardholder did not submit the reallocated statement for approval and/or the approving official did not perform reviews of the supporting documents in a timely manner in the Citibank system.

[6] $439,500 represents net of total of $531,000 less $43,500 administrative errors and $48,500 also reported in Auto-Close Report

[7] Peace Corps Manual Section 731 *Peace Corps Purchase Card Program,* Section 7.0 Reconciling and Reallocating the Monthly Statement of Account.

During the period under review, there were approximately 940 monthly statements for all the purchase card holders. Of these, 118, or approximately 13 percent, of the statements were auto-closed. Nine cardholders had three or more auto-close statements within this six-month period. We identified that these auto-closed statements represented over 400 transactions amounting to approximately $192,000 USDE and included this sum in Table 3: Unsupported Questioned Costs.

We noted that MS 731[8] authorized the APC to revoke the purchase card for repeat auto-close offenders. However, the agency does not require the APC to obtain the purchase card log and other documents to verify that the transactions appearing on the auto-closed statements were properly supported. As a result, it appears that the transactions on the auto-close statements were certified for payment without verifying if they were legal, proper and correct per federal certification requirements.

We could not obtain support to verify if the prior APC obtained and verified the supporting documents for the period under review. The current APC requests the purchase card log and obligating documents to verify proper support exists for transactions in the auto-closed statements.

Tracking of Auto-closed Statements

Per MS 731,[9] the APC is required to track auto-closed statements. If a cardholder's statement of account is auto-closed three times within the fiscal year, the APC has the authority to rescind the delegation of authority and revoke the purchase card.[10]

We noted that two cardholders' accounts were auto-closed continuously for 6 months and another cardholder statement was auto-closed continuously for 5 months. None of these cards were subsequently revoked. Additionally, during a recent post audit, the former APC failed to revoke the purchase card of a cashier with 14 consecutive auto-closures. When asked why the card was not revoked, the former APC explained that the online banking system does not send notification to the APC when the cardholder fails to enter the obligation codes, only when the codes are entered and not approved by the cardholder's supervisor. However, per the current APC, the banking system does notify the APC of all transactions that are not approved. It appears that the former APC neglected to thoroughly review the statements and monitor recurring auto-closures.

Based on the lack of actions for these auto-closures, it appears that the former APC did not exercise the authority to rescind the purchase cards. By not exercising the suspension authority granted in the purchase card policy, the former APC left the agency vulnerable to fraud and abuse of Government purchase cards. The current APC has followed up on auto-closures and is working to implement additional oversight procedures.

[8] See footnote 4.
[9] Peace Corps Manual Section 731 *Peace Corps Purchase Card Program,* Section 7.0 Reconciling and Reallocating the Monthly Statement of Account.
[10] See footnote 7

Split Purchases

Per OMB Circular A-123, Appendix B Section 4.6,[11] "any purchase that should not have been made, or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements", is an improper purchase. This includes purchases made on the same day from the same vendor totaling more than the single transaction limit (split purchase).

During our review of 77 potential split transactions, we identified one split purchase totaling approximately $3,500, which we included in Table 3: Unsupported Questioned Costs. The split purchase was made by one overseas post ordering different parts of a camera system. Per the purchase cardholder, the order was split due to the need to deliver various components to different addresses. Per the Director of Management and Operations (DMO), they considered the items separately, and unintentionally overlooked the requirement to obtain approval from the Office of Acquisition and Contact Management (OACM). As the estimated purchase exceeded the single purchase limit,[12] the current APC agreed that the cardholder needed to obtain approval from OACM before making the purchase.

MS 731[13] states that approving officials should verify that purchases have not been split to "circumvent the cardholder's single purchase limit or avoid competition." Neither the purchase card approving officials, nor the APC identified this split purchase. Further, discussions with the Office of the Chief Financial Officer and the APC indicated that the agency does not have procedures to identify and protect against split purchases. Without reviewing potential split purchases, the agency risks allowing cardholders to circumvent competition requirements.

Purchases Over the Micro-Purchase Limit

Per Overseas Financial Management Handbook Chapter 45, Purchase Card, an individual purchase should not exceed the single purchase limit for goods of $3,000. Each individual purchase may be comprised of multiple items, but the total, including shipping, freight, or administrative charges, cannot exceed the single purchase dollar limit of $3,000.[14]

During our review, we noted three instances where post cardholders made purchases over the micro-purchase limit set by policy. Hence, the cardholders did not follow the competition requirements set by the Office of the Chief Financial Officer/Acquisition and Contract Management for purchases over the micro-purchase limit. Purchasing over the micro-purchase threshold creates an unauthorized commitment. The total value of these three purchases was approximately $12,000, which we included in Table 3: Unsupported Questioned Costs.[15]

Per the cardholders, these transactions occurred due to misunderstanding or oversight of procedures, and not with the intention to circumvent the single purchase limit. Nevertheless, by

[11] Office of Management and Budget, *Improving the Management of Government Charge Card Programs*, Circular A-123, Appendix B Revised (Jan. 15, 2009).
[12] Overseas Financial Management Handbook 45.2 Spending Limit.
[13] See footnote 4
[14] See footnote 10
[15] Included $8,500 in Table 3: Unsupported Questioned Costs as $3,500 was also reported in Split Purchases

not following the micro-purchase process and guidelines, these transactions did circumvent the competition requirement.

Purchases Without Obligation

Per Overseas Financial Management Handbook Chapter 32, Obligations, an obligation is a firm reservation of funds that creates a legal liability on the U.S. Government for the payment of goods and services ordered. The cardholder can use the purchase card only after checking that the obligation shows funding is available.[16]

We noted one purchase of approximately $750 USDE where the cardholder did not create an appropriate obligation in a timely manner. In response to our review, the cardholder provided an obligation number for the purchase made in September 2016. However, we noted that the obligation number provided was incorrect and was allotted to a different transaction. After further inquiry, the cardholder then provided the correct obligation number for this transaction. We noted that the post had created this obligation in January 2017, approximately 4 months after the transaction date. The cardholder did not provide a clear explanation as to why the post did not create the obligation in a timely manner, or for the delay in creating the new obligation.

Document Retention

We noted five transactions amounting to approximately $1,300 USDE where the post cardholder did not provide the required supporting documents (approved statement, purchase card log, obligating document, invoice, etc.) and included the sum in Table 3: Unsupported Questioned Costs. Per MS 731, Peace Corps Purchase Card Program, cardholders are required to retain supporting documents for 3 years.[17] However, per MS 892 Records Management, Attachment A (for HQ), and Attachment B (for Posts) the retention requirement for Common Office Records (including purchase card logs and supporting documents) is 6 years.[18] As this manual section prescribes Federally mandated records disposition requirements, the agency is not in compliance with its own records retention requirements and the General Records Schedule prescribed by NARA.[19]

It is important for cardholders to retain documents as they are the official records supporting the transactions in question. If the cardholder does not retain the support for credit card transactions, there is no audit trail to validate the purchases. Supporting documentation is necessary for management to appropriately review the purchase made and ensure compliance with Peace Corps policies. The cardholders we interviewed did not provide an explanation for their missing documents.

[16] Overseas Financial Management Handbook 45.4 Purchasing Procedures for Cardholders.
[17] Peace Corps Manual Section 731 *Peace Corps Purchase Card Program,* Section 4.5.2 Review of Cardholder Monthly Statement and Purchase Card Log.
[18] MS 892 Attachment A, Common Office Records, Financial Transaction Records
[19] National Archives and Records Administration, General Records Schedule 1.1.11, Financial Management and Reporting Records, Transmittal No. 28 July 2017.

Available Data Analytic Tools Not Used

The Peace Corps uses the GSA SmartPay program.[20] Visa and Citibank offer data analytics tools for government purchase card managers through the GSA SmartPay contract. For example, Visa IntelliLink allows program managers to implement centralized spending policies and identify areas where agencies can make better purchasing decisions; and the Citi Program Audit Tool (PAT) provides card managers with real-time access to key spending and transaction information through dashboards that systematically identify transactions that meet pre-defined business rules. Using these tools allows the agency to identify potential misuse and abuse.[21] The Peace Corps is currently not utilizing these reporting and analytical tools. However, per APC, the agency plans to implement several new analytical tools when they complete implementation of the purchase card modernization project.

Additionally, GSA and the purchase card–issuing banks made other monitoring and management tools available to agencies in the current SmartPay2 master contract that went into effect in November 2008.[22] GSA developed a data analytic system, called the SmartPay Data Warehouse, which is designed to assist agencies with monitoring and analyzing their purchase card spending. According to GSA, the Data Warehouse reached initial operating capability in early 2015. We noted that the agency is currently utilizing some of the SmartPay2 capabilities, however, it is not utilizing the Data Warehouse that provides data-visualization tools through an online dashboard that allows agencies to monitor related trends in their use of purchase cards.[23]

Conclusions and Recommendations

Based on our review of policy and procedure documents, as well as our analysis of testing results, we believe that by not maintaining sufficient controls to assure compliance with Peace Corps and Federal requirements, the Peace Corps put itself at risk for fraudulent behavior and financial abuse. We found several weaknesses caused by insufficient controls: inadequate policies and procedures, lack of required training, inadequate oversight, and inadequate use of the available data analytic tools.

---

[20] GSA SmartPay was established in 1998 and provides services to more than 560 Federal agencies, organizations, and Native American tribal governments. GSA SmartPay provides payment solutions that enable authorized government employees to make purchases on behalf of the Federal Government in support of their agency/organization's mission. Prior to using GSA SmartPay, the Federal Government used traditional paper-based payment processes such as purchase orders for small dollar purchases (under the micro-purchase threshold).

[21] https://smartpay.gsa.gov/sites/default/files/downloads/GSA008%20%20GSA%20SmartPay%20Forum_Analytics_CLP.pptx

[22] The current GSA SmartPay2 Master Contract expires on November 29, 2018. The future program, referred to as GSA SmartPay3, contains additional oversight and monitoring tools for agencies that we did not review. Citibank and U.S. Bank were awarded contracts for GSA SmartPay3.

[23] https://smartpay.gsa.gov/sites/default/files/downloads/GSA008%20%20GSA%20SmartPay%20Forum_Analytics_CLP.pptx

Policies and procedures were inadequate. During our review, we noted that Peace Corps Manual section 731 refers to "SOP 731 Peace Corps Purchase Card Program Procedures." Unfortunately, the electronic link to these procedures is not functional and they are not available in hard-copy form for cardholder use.

As noted previously, several items on the rejection report were cleared after 180 days. This indicates that the agency lacked formal procedures for addressing these transactions and did not provide oversight by monitoring delays in clearing items on the rejection report and initiating corrective action. Similarly, there was a lack of documented procedures for verification of transactions in the auto-close purchase card statements and a lack of monitoring and oversight to address repeat offenders (as the prior APC did not exercise the authority to suspend purchase cards of repeat offenders, in one instance for over 12 months).

Training was not provided as required. Per OMB Circular No. A-123, Appendix B 3.4[24] requires that all purchase card program participants (cardholders and supervisors) receive training prior to their appointment and that they must take refresher training, at a minimum, every 3 years. The Peace Corps provides the generic training from General Services Administration to new cardholders and approving officials but does not provide training targeted to agency policies and procedures and does not provide and track refresher training.

Not providing the required training has resulted in the significant weaknesses we have observed in purchase card oversight. Without adequate training, and access to the purchase card procedures document (as noted above), it is difficult for the cardholders and approving officials to comply with Peace Corps and OMB policies and procedures.

The purchase card program had inadequate oversight. As noted above, approximately 13 percent of statements during the review period were auto-closed because card holders and/or approving officials did not did not fully comply with the purchase card policy requirements. Further, Peace Corps does not have procedures to assure approving officials are aware of their role and oversight requirements. According to the current APC, the prior APC did not maintain a detailed follow-up process. Thus, there is no record of adequate oversight during the period under review. The current APC is putting an oversight process in place but has not yet formally established that process. To date, that process does not provide for any monitoring of potential split purchases.

As several items on the rejection reports were not cleared for many months, this indicates that there was a lack of oversight over the rejection report process for the period under review.

In addition, the Peace Corps has not made adequate use of the data analytic tools available through the SmartPay2 contract, Visa IntelliLink, and GSA SmartPay Data Warehouse.

The agency has recognized these weaknesses and has implemented a Government purchase card modernization project to address them.

[24] OMB, *Improving the Management of Government Charge Card Programs*, Circular A-123, Appendix B Revised (Jan. 15, 2009).

We recommend:

1. That the Office of the Chief Financial Officer develop agency-wide procedures to ensure purchase card controls are appropriate to the Peace Corps purchasing environment, and fully define the roles and responsibilities of Peace Corps purchase cardholders, approving officials, and the Agency Program Coordinator.

2. That the Office of the Chief Financial Officer develop, provide and track Peace Corps-specific training for all purchase card program participants including obligating, reallocating, and approving procedures. Further, ensure that this training complies with OMB guidelines for both initial and refresher training.

3. That the Office of the Chief Financial Officer ensure appropriate oversight over the purchase card program to include monitoring of transactions, the use of available data analytics tools and ensuring that follow-up processes receive sufficient staffing and oversight, in both ACM and GAP.

4. That the Office of the Chief Financial Officer:

    - develop controls to ensure the APC monitors, identifies, and follows-up potential split purchases.
    - ensure rejected transactions are monitored and resolved in a timely manner.
    - develop procedures for the APC to monitor auto-closed Citibank monthly statements and review transactions on auto-closed statements to verify for adequate support and authorization
    - remind cardholders and approving officials to comply with Peace Corps policy for retaining supporting documents for appropriate period.

5. That the Office of the Chief Financial Officer review purchases over the micro-purchase limit identified, including the split purchase identified, and take appropriate action, consistent with GSA and agency policy on misuse or abuse of the purchase card.[25] The agency should review each transaction

[25] Card holders and approving officials agree to abide by policies, procedures, and instructions used by the Peace Corps, GSA, and the cardholder bank with respect to their official functions.

and determine what action is appropriate (i.e. collection of funds or disciplinary action).

6. That the Office of the Chief Financial Officer correct the record retention requirements in MS 731 to be consistent with MS 892 and National Archives and Records Administration requirements.

Questioned Costs

We identified the following questioned costs during the review.

Table 3: Unsupported Questioned Costs

Recommendation	Description	Amount
4	Develop controls to ensure the APC monitors, identifies and follows-up potential split purchases.	$3,500
4	Ensure rejected transactions are monitored and resolved in a timely manner.	$439,500
4	Develop procedures for the APC to monitor auto-closed Citibank monthly statements and review transactions on auto-closed statements to verify for adequate support and authorization.	$192,000
4	Remind cardholders and approving officials to comply with Peace Corps policy for retaining supporting documents for appropriate period.	$1,300
5	The Office of Acquisition and Contract Management review the need to ratify the items purchased over micro-purchase limits.	$8,500

Consistent with the Inspector General Act of 1978, as amended, **questioned costs** are defined as follows:

"Questioned costs" are costs that are questioned because of an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement or document governing expenditure of funds; a finding that, at the time of the audit, such cost is not supported by adequate documentation; or a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable. The questioned costs in this table are unsupported.

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Karla Wesley, Director, Office of Staff Learning and Development
Traci DiMartini, Chief Human Capital Officer
IGChron
IG

Appendix A: Agency Response to the Report

MEMORANDUM

To: Kathy Buller, Inspector General

From: Anne Hughes, Chief Compliance Officer

Date: November 13, 2018

CC: Jody Olsen, Director
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Matt McKinney, Deputy Chief of Staff/White House Liaison
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Subject: Agency Response to the Management Advisory Report: Purchase Card Review (IG-18-03-SR)

The agency would like to thank the Office of Inspector General for their continued cooperation on this Management Advisory Report (MAR) and the six accompanying recommendations, all of which the agency is in concurrence. The agency's responses and planned corrective actions are outlined below.

Recommendation 1

That the Office of the Chief Financial Officer develop agency-wide procedures to ensure purchase card controls are appropriate to the Peace Corps purchasing environment, and fully define the roles and responsibilities of Peace Corps purchase cardholders, approving officials, and the Agency Program Coordinator.

Concur

Response: As mentioned in the report, the agency has been working to finalize its purchase card modernization project which includes revising purchase card procedures. The revised procedures will fully define the responsibilities of all purchase card program participants and document program controls. These procedures will be captured in both the Overseas Financial Management Handbook and the Domestic Financial Management Handbook.

Documents to be Submitted:

- Overseas Financial Management Handbook (OFMH) Chapter 67 "Purchase Card"
- Domestic Financial Management Handbook (DFMH) Chapter 25 "Purchase Card"

Status and Timeline for Completion: February 2019

Recommendation 2

That the Office of the Chief Financial Officer develop, provide and track Peace Corps-specific training for all purchase card program participants including obligating, reallocating, and approving procedures. Further, ensure that this training complies with OMB guidelines for both initial and refresher training.

Concur

Response: As part of the agency's purchase card modernization project, the agency will produce a Peace Corps specific training for program participants which complies with OMB guidelines. Additionally, the agency has been working to finalize revised procedures (referenced in response to Recommendation 1), which will fully define training responsibilities of all program participants and the training monitoring requirement of the Agency Program Coordinator.

Documents to be Submitted:

- Overseas Financial Management Handbook (OFMH) Chapter 67 "Purchase Card"
- Domestic Financial Management Handbook (DFMH) Chapter 24 "Purchase Card"
- LearningSpace Purchase Card Training Module
- Purchase Card Training Records

Status and Timeline for Completion: February 2019

Recommendation 3

That the Office of the Chief Financial Officer ensure appropriate oversight over the purchase card program to include monitoring of transactions, the use of available data analytics tools and ensuring that follow-up processes receive sufficient staffing and oversight, in both ACM and GAP.

Concur

Response: The General Services Administration (GSA) SmartPay3 contract includes the requirement of a data mining tool, IntelliLink. The Visa IntelliLink tool will be implemented by Citibank, Peace Corps' SmartPay3 vendor, beginning January 5, 2019. Additionally, the agency has been working to improve its procedures under the purchase card modernization project. These revised procedures define transaction oversight responsibilities and use of the aforementioned data mining tool within OCFO.

Documents to be Submitted:

- Sampling data from Visa IntelliLink and applicable follow up correspondence with program participants
- Domestic Financial Management Handbook (DFMH) Chapter 25 "Purchase Card Monitoring"
- Overseas Financial Management Handbook (OFMH) Chapter 68 "Purchase Card Monitoring"

Status and Timeline for Completion: February 2019

Recommendation 4

That the Office of the Chief Financial Officer:

•Develop controls to ensure the APC monitors, identifies, and follows-up potential split purchases.

•Ensure rejected transactions are monitored and resolved in a timely manner.

•Develop procedures for the APC to monitor auto-closed Citibank monthly statements and review transactions on auto-closed statements to verify for adequate support and authorization.

•Remind cardholders and approving officials to comply with Peace Corps policy for retaining supporting documents for appropriate period.

Concur

Response: The agency has been working to improve oversight of the purchase card program under its purchase card modernization project. The OCFO is actively managing rejected transactions and will provide the Inspector General the last three months of its 'Fall Out Report' and follow-up correspondence. Additionally, the agency is working on 1) revised procedures which fully define split purchases, monitoring requirements of OCFO, and documentation requirements of all program participants and 2) a desk reference for the Agency Program Coordinator role, which will serve as a day-to-day resource guide. The agency will also remind

program participants of record retention requirements at the start of the SmartPay3 contract, which is January 5, 2019.

Documents Submitted:

- Fall out report tracker from 07/2018 – 10/2018 and applicable follow up correspondence with program participants resolving issues surrounding rejected transactions

Documents to be Submitted:

- Overseas Financial Management Handbook (OFMH) Chapter 67 "Purchase Card"
- Overseas Financial Management Handbook (OFMH) Chapter 68 "Purchase Card Monitoring"
- Domestic Financial Management Handbook (DFMH) Chapter 24 "Purchase Card"
- Domestic Financial Management Handbook (DFMH) Chapter 25 "Purchase Card Monitoring"
- Purchase Card Agency Program Coordinator Desk Reference
- Sampling data from Visa IntelliLink and applicable follow-up correspondence with program participants resolving issues surrounding split purchases
- Email reminder to program participants regarding required documentation and record retention requirements

Status and Timeline for Completion: February 2019

Recommendation 5

That the Office of the Chief Financial Officer review purchases over the micro-purchase limit identified, including the split purchase identified, and take appropriate action, consistent with GSA and agency policy on misuse or abuse of the purchase card. The agency should review each transaction and determine what action is appropriate (i.e. collection of funds or disciplinary action).

Concur

Response: The OCFO will review the purchases identified by the Inspector General and take action consistent with agency policy.

Documents to be Submitted:

- Memorandum from OCFO analyzing transactions and identifying corrective action

Status and Timeline for Completion: December 2018

Recommendation 6

That the Office of the Chief Financial Officer correct the record retention requirements in MS 731 to be consistent with MS 892 and National Archives and Records Administration requirements.

Concur

Response: As mentioned in the report, the agency has been working to finalize its purchase card modernization project, which includes a revision to Manual Section (MS) 731. The revised MS 731 will be updated to reflect the record retention requirements specified in MS 892.

Documents to be Submitted:

- Revised MS 731

Status and Timeline for Completion: February 2019

Appendix B: OIG Comments

Management concurred with all six recommendations. All six recommendations remain open, and OIG will review and consider closing these recommendations when the documentation reflected in the agency's response is received. We wish to note that, in closing recommendations, we are not certifying that the agency has taken these actions or that we have reviewed their effect. Certifying compliance and verifying effectiveness are management's responsibilities. However, when we feel it is warranted, we may conduct a follow-up review to confirm that action has been taken and to evaluate the impact.

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To: Jody Olsen, Director
Anne Hughes, Chief Compliance Officer

From: Kathy A. Buller, Inspector General

Subject: Management Advisory Report: Volunteer Drug Use (IG-18-01-SR)

Date: August 7, 2018

The purpose of this Office of Inspector General (OIG) report is to bring to your attention our concern that the Peace Corps' efforts to address Volunteer drug use[1] have been insufficient, and that drug use continues to pose a serious risk to the integrity and reputation of the Peace Corps as well as the health and safety of Volunteers. In order to reduce these risks, the agency should take additional measures to support country directors in resolving drug use allegations at posts, gather accurate information on drug use among Volunteers, and place greater emphasis on educating Volunteers about the impacts of drug use on their safety and the effectiveness of their service.

This report includes six recommendations. The agency may provide a response to the six recommendations within 45 days of the issuance of the report. Should a response be provided, the report will be updated to include them in Appendix B.

Volunteer Drug Use and its Effect on Health, Safety, and Peace Corps Operations

Our 2016 'Recurring Issues' report[2] found that during the three-year period from 2012 to 2015, OIG had opened 25 cases relating to Volunteer drug use, nearly half of which occurred in 2015. We noted that a single case can often lead to administrative actions against multiple Volunteers, seriously affecting post operations. Since our 2016 report, drug use has remained a serious problem marked by further investigations, arrests, and lost years of Volunteer service.

From January 2015 to February 2018, at least 152 Peace Corps Volunteers separated[3] from service across 26 countries in connection with drug use.[4] As a result of these separations, students, counterpart agencies, host family members, and other community members lost

[1] For the purposes of this report, any reference to Volunteers is meant to be inclusive of trainees, unless otherwise specified. Additionally, any reference to drug use is intended to exclude the authorized use of pharmaceuticals for medical purposes.

[2] Final Report on Recurring Issues: Common Challenges Facing Peace Corps Posts, Fiscal Years 2012-2015 (IG-16- 04-SR), available at https://s3.amazonaws.com/files.peacecorps.gov/documents/inspector-general/Recurring_Issues_Report.pdf

[3] For the purposes of this report, 'separated' refers to instances where (1) the administrative separation process was initiated by the post after a finding of drug involvement, or (2) the Volunteer resigned after a credible allegation of drug involvement was made.

[4] For the purposes of this analysis we compared complementary Volunteer separation information contained in two agency databases—Database of Volunteer Experience (DOVE) and Odyssey—with investigative records in the OIG Investigation Case Management system.

117 potential years of service and support from the Peace Corps.[5] For context, this loss would be equivalent to the Volunteer service years lost if Peace Corps had decided to cease all operations at a small post such as Belize or Tonga over the same 3-year period.[6]

Beyond the impact to host country partners of removing a Volunteer, these lost years of service represent a substantial waste of agency resources. The Peace Corps domestic operations make significant investments of staff and resources in recruiting, screening, and placing Volunteers. At posts, the loss of a single Volunteer is further damaging because posts devote much of their resources to developing host country counterparts for Volunteers; identifying host families or other appropriate housing; making appropriate health, medical, and safety and security arrangements; and providing training on the local language, technical skills, and cultural issues. While it is difficult to express the worth of a Volunteer's service in dollar value, we have calculated that in training expenses alone, the premature separation of 152 Volunteers in connection with drug use totaled approximately $482,000 in taxpayer and host country partner resources wasted.[7] At posts found to have widespread drug use, large portions of the Volunteer population may be separated, resulting in an especially acute waste of resources.

Volunteers Separated from Posts

in connection with Office of Inspector General drug investigations

From January 2015 to February 2018

9 Volunteers in	West Africa	representing 8% of Volunteers in country
18 Volunteers in	West Africa	representing 17% of Volunteers in country
13 Volunteers in	East Africa	representing 10% of Volunteers in country
19 Volunteers in	North Africa	representing 25% of Volunteers in country
21 Volunteers in	East Africa	representing 19% of Volunteers in country
9 Volunteers in	West Africa	representing 3% of Volunteers in country
2 Volunteers in	West Africa	representing 1% of Volunteers in country
8 Volunteers in	The Pacific	representing 35% of Volunteers in country
22 Volunteers in	Southern Africa	representing 9% of Volunteers in country

Volunteers separated in connection with OIG investigations have often been concentrated within a programmatic sector.[8] In one such instance, 52 percent of one post's agricultural sector Volunteers were separated in connection with a single investigation. Another three investigations led to the separation of more than 30 percent of Volunteers in a single sector at other posts.

[5] Volunteer service-years lost are calculated by subtracting months served since Volunteers' dates of oath of service from the projected 24-month term of service. Third-year Volunteers are calculated at a 36-month term. A separated trainee is counted as 24 months of service lost. Peace Corps Response Volunteers are calculated by subtracting months served from a projected 6-month term of service.

[6] Calculated by using Peace Corps Volunteer/Trainee Years calculator in PCApps from January 1, 2015 to February 6, 2018.

[7] This number is based on the agency's calculation of "Training Costs per V/T year" within the 2014-2017 Country Portfolio Review Historical Dataset. These costs were averaged across the four years of available data to provide a value for each post. This value was then adjusted for the number of months of service lost for each of the 152 Volunteers we examined.

[8] OIG investigators note that 68% of Volunteers separated as a result of OIG investigations since 2015 were separated after a finding of marijuana use. Other cases include the use of cocaine, LSD, heroin, hashish, hallucinogenic mushrooms, valium, codeine, and other prescription drugs.

These large-scale removals have created serious disruptions to operations of affected posts and have the potential to harm the Peace Corps' partnerships with host country governments.

Any incident where a Volunteer is found to be using or in possession of drugs can have serious social, political, and legal ramifications for the Peace Corps.[9] This is especially true when drug use compromises Volunteer health and safety. Between January 2015 and February 2018, one Volunteer died as a result of drug use, and seven were arrested by foreign law enforcement. One Volunteer was sentenced to 6 months in prison for drug trafficking,[10] marking the second occasion in which a Volunteer was convicted of drug trafficking in the same country within the last five years.[11]

Agency Policy on Volunteer Drug Use

The agency facilitates the separation of Volunteers found to be using drugs, or otherwise suspected of using drugs, through a zero-tolerance policy. Peace Corps manual section (MS) 204 states:

> ***3.5.1 General Policy***
>
> *Except as described in section 3.5.2 below regarding Voluntary Self-Referral, a V/T found to be involved with drugs in a manner not authorized by the Peace Corps for medical purposes, in any way in any country, will be administratively separated immediately pursuant to section 3.5.4. The Peace Corps enforces this strict policy not only because the cultivation, manufacture, and traffic in and use of drugs, including marijuana, is illegal in most countries; but also because drug involvement by V/Ts in any country could seriously jeopardize the entire Peace Corps program, as well as the safety and health of the V/Ts. Individuals separated in connection with involvement with drugs (whether via administrative separation, resignation in*

[9] See MS 204 3.5.3
[10] The Volunteer was released from jail after 26 days.
[11] In 2013 another Volunteer in the same country was convicted of one count of trafficking in psychotropic substances and received a 12 month suspended sentence.

lieu of administrative separation, or medical separation) will not be considered for a transfer to another program or reinstatement regardless of the quality of their service.[12]

In addition to the strict consequences the agency has put in place for Volunteers found to be involved in drugs, the agency has recognized that Volunteer drug use seriously jeopardizes the entire Peace Corps program, as well as the safety and health of the Volunteer. As stated in MS 204:

> ***3.5.3 Notice to Director***
>
> *Because of the potentially serious social, political, and legal impact of such incidents, every case of V/T drug involvement shall be brought immediately to the personal attention of the Peace Corps Director and the appropriate Regional Director.*

The requirement to bring cases of Volunteer drug use to the immediate attention of the director of the agency is unique among Volunteer misconduct policies and highlights the seriousness of the issue to Peace Corps management. Despite this emphasis on reporting, agency policy does not require that anything be done with this data after it reaches the Director. There is no aggregate tally of instances of drug use about which the Director has been notified, nor is this information forwarded to another office for analysis.

In September 2017, the agency amended MS 204 to provide for a self-referral option that allows a Volunteer to request help from Peace Corps staff if their drug use is associated with an illness requiring treatment. Under this provision, the Volunteer will not be immediately administratively separated if they report drug use prior to the Peace Corps or OIG having an indication that they are using drugs. The Peace Corps Medical Officer and the Office of Health Services (OHS) then assess the self-referring Volunteer and may recommend the Volunteer for medical evacuation. Per MS 204:

> ***3.5.2 Voluntary Self-Referral***
>
> *A [Volunteer] who is medically evacuated will not return to service. If the [Volunteer] is not medically evacuated or medically separated, the [Volunteer] will be referred back to the Country Director for administrative separation in accordance with Manual Section 284. In addition, if a [Volunteer] for whom medical treatment is recommended subsequently does not comply with recommended treatment, the OHS will notify the Country Director, who will initiate administrative separation procedures.*

OIG requested information on Volunteer self-referrals from the Office of Health Services, but within the first 5 months the policy had been in place, that office was unable to identify any Volunteers who invoked the self-referral policy for drug use. However, our independent review identified one Volunteer who admitted marijuana use to a counselor, who then attempted to refer

[12] Peace Corps policy reflects a modification the agency made in December of 2017. In order to create immediate consequences should a Volunteer admit drug use to the Country Director or a member of OIG staff, the agency eliminated some requirements from the administrative separation process, including the Consideration of Administrative Separation memo, Volunteer response, Regional Director concurrence, and consultation with the Office of General Counsel. The new policy retained the opportunity for Volunteers to resign in lieu of administrative separation within 24 hours of being informed they are being administratively separated. Nearly every Volunteer in our analysis who was considered for administrative separation chose to resign in lieu. It is too early to evaluate whether this policy modification will be effective in streamlining administrative separations under MS 204, 3.5.1.

this Volunteer to the Peace Corps Counselling and Outreach Unit (COU) for treatment. After reviewing the Volunteer's case, COU determined that medical treatment was not appropriate, and the Volunteer was consequently referred to their post for administrative separation. Whether a self-referring Volunteer is successfully treated, refuses treatment, or is denied treatment, any self-referral will ultimately result in the termination of their Peace Corps service.

In short, agency policy recognizes the serious risks that Volunteer drug use poses to Volunteer safety and security as well as the integrity of Peace Corps operations. While the agency has made modifications to its policy on drug use – streamlining the administrative process when a Volunteer admits to drug use and providing a self-referral process – the current policy alone is insufficient to reduce the risks associated with Volunteer drug use.

Supporting Policy Enforcement

While the Peace Corps policy on Volunteer drug use is strict, OIG remains concerned that post management lacks sufficient guidance and tools to enforce MS 204, 3.5.1 consistently. In 2012, the agency changed its policy so that it was no longer mandatory for individual drug use by Volunteers to be reported to OIG for investigation. Instead, such misconduct is reported to post management so that it can be expeditiously addressed by the country director (CD), like some other aspects of Volunteer conduct are, as specified under MS 204, 3.3.[13] As such, OIG does not typically investigate allegations of individual drug use by Volunteers, but rather may investigate such cases at the request of post staff or in the wake of significant events. In the past, this has included instances where drug use is alleged to be widespread among Volunteers at a post, in response to Volunteer arrests, and in one case in the wake of a Volunteer death.

Despite this shift, our analysis of agency data and OIG investigative records suggest OIG has remained a primary actor in investigating Volunteer personal drug use. Of the 152 Volunteers OIG identified as separated in connection with drug use from January 2015 through February 2018, 121 were separated as a result of field-based OIG investigations at 9 posts. The remaining 31 Volunteers were removed by in-country staff from 20 posts.[14] Arrests by foreign law enforcement predicated 7 of these Volunteer separations. Given the documented impact of Volunteer involvement with drugs, and the potential harm articulated in the Peace Corps policy, OIG assesses that more can be done to support and encourage overseas posts to enforce the policy before a serious health and safety incident occurs, and before drug use becomes so widespread that OIG is asked to investigate.

When a policy requires further guidance in order to assure effective and consistent implementation across posts or units, the agency typically supplements it by issuing additional

[13] The agency retained the requirement under MS 861, 7.1 to report to OIG cases involving the sale, distribution, or smuggling of illegal drugs or prescription drugs. In accordance with this policy, while Peace Corps OIG reserves the right to investigate any misconduct, OIG prioritizes allegations of widespread drug use at a post, or allegations involving the sale, distribution, or smuggling of drugs.

[14] If OIG is contacted by country staff about possible Volunteer drug use, a record is created and tracked in the investigation case management system regardless of whether OIG takes an active role in investigating the claim.

procedures or guidance. In cases of drug involvement, CDs are expected, under agency policy, to consult with the Peace Corps Office of General Counsel (OGC), if feasible, when considering administratively separating a Volunteer. In these cases, OGC's role is to advise CDs on how to apply the policy, including the standard of proof necessary to administratively separate a Volunteer and how to provide accused Volunteers with a meaningful opportunity to reply to allegations.

OGC informed OIG that, since the 1970s, it has required that any finding of Volunteer involvement with drugs – which triggers the administrative separation process under MS 204 – be supported by 'clear and convincing' evidence.[15] OGC reported that the requirements to meet the 'clear and convincing' standard are discussed in individual consultations with CDs and during the legal session on Volunteer misconduct at Overseas Staff Trainings (OST), as well as at annual CD conferences. To better understand how CDs apply this standard, OIG reviewed the Consideration of Administrative Separation memorandums available in DOVE for the three-year time period which is the subject of this report. In cases where Volunteers did not admit drug use, OIG found that the associated memorandums reflected inconsistent application of OGC's requirements. A lack of uniform application suggests that not all CDs may be aware of these requirements, or that they may need additional support to consistently meet the 'clear and convincing' standard.

While Volunteer and Staff misconduct is generally decided by a 'preponderance of evidence',[16] the standard used for demonstrating "involvement with drugs" is 'clear and convincing', a standard that requires a higher level of certainty. Obtaining sufficient evidence can require interviewing reluctant or uncooperative Volunteers and weighing the truthfulness of conflicting statements, many times without physical evidence. Given the heightened evidentiary standard and the difficulty in developing sufficient evidence in drug use cases, CDs could benefit from the agency's provision of additional tools, such as reasonable suspicion drug testing, that would facilitate their decisions about disciplinary action.

Reasonable suspicion drug testing, also known as for-cause drug testing, could provide a mechanism for CDs to make more timely and better-informed decisions.[17] In situations where a Volunteer denies drug use, but credible evidence exists, a country director could ask or require a Volunteer to submit to a drug test. The test results could provide exculpatory information or evidence of drug use and help a country director in formulating a decision. While there is a wide range of other drug testing modalities (i.e. random drug testing and applicant screening) that both public and private organizations have commonly employed to deter drug use, reasonable

[15] Despite this policy interpretation, OIG notes that under the Peace Corps Act, Volunteers serve at the pleasure of the President. The authority of the President has been delegated through the Director of the Peace Corps to Country Directors.

[16] E.g., Under agency policy evidence supporting a finding of Sexual Misconduct is considered under a 'preponderance of the evidence' standard, a lower evidentiary standard than 'clear and convincing'. See Interim Policy Statement 1-12 Procedures Section 8.1 (last accessed: https://files.peacecorps.gov/documents/IPS-1-12-Interim-Procedures.pdf).

[17] OIG notes that in 2004 drug testing was contemplated by the agency to address what agency officials considered a significant problem among Volunteers, especially in countries where drugs are more readily available. Our review was unable to identify what, if any, decisions or actions came out of the discussion.

suspicion testing could provide CDs with evidence to support findings of drug use.[18] Regardless of the continued debate about the deterrent effect of drug testing, advances in testing technologies currently provide relatively reliable and objective indicators of recent use of most types of commonly used illicit drugs.[19]

CDs bear great responsibility in addressing allegations of Volunteer drug use because of the realized risk to health and safety of Volunteers and the impact Volunteer drug use has on the integrity of agency operations. In order to resolve allegations of drug use in a more independent and expeditious manner at posts, the agency should give CDs greater support and guidance for making decisions about corrective actions.

We recommend:

1. **That the Director of the Peace Corps provide country directors with additional support to resolve allegations of drug involvement under manual section 204, 3.5.1 and specifically consider the efficacy of reasonable suspicion drug testing as a means of doing so.**

2. **That the Office of General Counsel review the evidentiary standard required to administratively separate a Volunteer suspected of involvement with drugs to determine whether the standard, and its application, is consistent with promoting the integrity of the program and continues to serve the policy interest of the Peace Corps.**

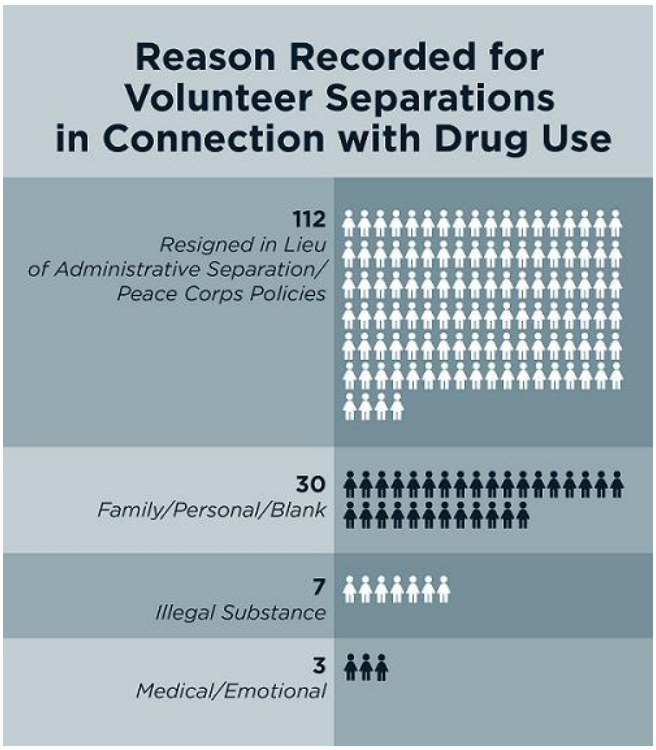
Incomplete Data Obscures the Scope of Drug Use

Our review concluded that there are substantial gaps in the data that the Peace Corps collects related to Volunteer resignations due to drug use. As a result, the agency is limited in its ability to identify basic information about Volunteer drug use. Such information should include how many Volunteers have separated within any given time period due to involvement with drugs, which regions or countries those Volunteers served in, and other common conditions of Volunteer service. Lack of such information obscures the scope of drug use among Volunteers and remains an obstacle to prioritizing and addressing the problem.

[18] Our review did not make a finding about the potential deterrent impact of drug testing Volunteers in the Peace Corps environment. While multiple studies suggest that in some circumstances drug testing could be an effective deterrent to drug use, others studies disagree. Moreover, literature reviews we examined have noted methodological gaps and weaknesses in some of the studies. OIG makes no comparison here about the efficacies of different modes of testing.

[19] See Pidd K, Roche AM. 2014. How effective is drug testing as a workplace safety strategy? A systematic review of the evidence. Accident Analysis and Prevention 71:163.

The Volunteer End of Service Information (VESI) application is the means by which all posts out-process their Volunteers, regardless of how the Volunteers end their service. In a requirement specific to Volunteer resignations, posts must fill out the *Volunteer/Trainee Resignation Form* as part of their VESI submission.[20] The form allows posts to choose one or two selections from a list of 39 pre-defined codes to explain the reasons behind Volunteer resignations. Among the 39 codes that can be assigned by post, one is 'illegal substance'. The information provided in VESI is then included in an Odyssey database, which produces the Terminated Volunteers Report we reference in this analysis.[21] Because information provided in VESI is the basis for aggregate statistics on how, when, and why Volunteers separate or leave service, it is important that the data input into it be accurate and complete.



In reviewing the Odyssey database, we found that resignations in connection with drug use were often not identified as such. Of the 152 Volunteers we identified as having been separated in connection with drug use from January 2015 to February 2018, only seven were coded as 'illegal substance'.

Our review revealed that overseas staff too often use non-descriptive codes to characterize resignations on the Volunteer/Trainee Resignation Form. Specifically, 'Resignation in Lieu of Administrative Separation' and 'Peace Corps Policies' frequently appear in Odyssey without a secondary reason to explain the nature of misconduct. Coded in this fashion, Volunteers who are found to have violated drug policy are indistinguishable from those who violated travel policies, committed sexual assault, or were simply found to be ill-suited for Peace Corps service. Even though there is a field in the Volunteer/Trainee Resignation Form providing an opportunity for staff to include a secondary reason for the resignation, it has only be used 9 percent of the time to explain the circumstances behind a 'Resignation in Lieu of Administrative Separation' or 'Peace Corps Policies' coding.[22] The agency has not provided comprehensive, authoritative guidance on

[20] Appended to this report as Appendix A.

[21] The Office of Strategic Information, Research, and Planning (OSIRP) uses the agency's Volunteer database, PCVDBMS, to aggregate statistics on early terminations. Resignation data in PCVDBMS mirrors what is available in Odyssey.

[22] Of the 309 resignations within our sample coded as either Resignation in Lieu of Administrative Separation or Peace Corps Policies, 28 supplied secondary codes to describe circumstances. An additional 17 supplied Resignation in Lieu of Administrative Separation or Peace Corps Policies as a secondary code, but were not counted in this total.

how to appropriately code Volunteer resignations, or who is responsible for ensuring that the data input into VESI is accurate, complete, and consistent across posts.

Distinct from VESI, Database of Volunteer Experience (DOVE) is the agency's official record of administrative separation documentation, including documentation related to resignations in lieu of administrative separation. DOVE is an essential tool for managing Volunteer applications and placement but is limited as an official record of misconduct because it does not provide a means of aggregating separation data across individual Volunteer profiles. Our limited review also found records in this system to be incomplete. Of the Volunteers we found to have been separated in connection with drug use, the agency recorded 100 as having resigned in lieu of administrative separation in their VESI submission, yet 25 of these individuals had no separation documentation in their DOVE profile at the time of our review. Three of these individuals had been arrested by foreign law enforcement.

The agency's current approach to Volunteer separation data leaves multiple opportunities for important information to be lost. Even with the benefit of investigative records to supplement our analysis of agency records, we found it difficult to determine how many Volunteers were separated due to a finding of drug involvement. The chart below compares the record of a single OIG investigation with the agency's resignation data, as found in Odyssey and in each Volunteer's DOVE profile.

Volunteer	OIG Record	Data in Odyssey		Data in DOVE
	Record from OIG case management system	Assignment Status	Primary Resignation Reason	Record of Separation
Volunteer A	Admitted- Marijuana Use	ET-Resignation	Illegal Substance	None
Volunteer B	Admitted- Marijuana Use	ET-Resignation	Other Personal/Family Related	None
Volunteer C	Admitted- Mushrooms Use	ET-Resignation	Other Personal/Family Related	None
Volunteer D	Admitted- Marijuana Use	ET-Resignation	Other Personal/Family Related	None
Volunteer E	Admitted- Marijuana Use	ET-Resignation	Other Personal/Family Related	None
Volunteer F	Admitted- Marijuana and mushrooms Use	ET-Resignation	Illegal Substance	None
Volunteer G	Admitted- Provided marijuana and mushrooms	ET-Resignation	Illegal Substance	None
Volunteer H*	Admitted- Marijuana Use	ET-Resignation	Other Personal/Family Related	None

* Volunteer H later reapplied and was accepted to another Peace Corps program.

In sum, gathering data on the reasons why Volunteers separate from service early provides important information that could guide policy decisions. This is especially important in instances of drug use, as agency policy states that each instance entails a "potentially serious social, political, and legal impact" to the Peace Corps.[23] If the agency's data on Volunteer separations is inaccurate, incomplete, or inconsistent, it will necessarily lack insight into the application of its policy, and thus risk making uninformed decisions about corrective action to address serious Volunteer misconduct issues like Volunteer drug use.

[23] MS 204 3.5.3

We recommend:

3. **That the Director of the Peace Corps make necessary changes to policies, procedures, and forms related to Volunteer resignations and administrative separations, so that Volunteer files and early termination statistics include accurate information regarding unauthorized drug use.**

4. **That the Director of the Peace Corps take effective steps to ensure ongoing compliance and consistency in implementation of the Volunteer separation recordation processes.**

Understanding the Volunteers' Drug Use Environment

In most matters concerning Volunteer health and safety, the agency has made an effort to understand the experiences of Volunteers by asking what challenges they face. The Annual Volunteer Survey (AVS) is a confidential global survey, and the primary means by which the agency collects Volunteer opinions on a variety of issues related to their service, including health and safety. Within the AVS, there are seven questions that assess a Volunteer's exposure to, and resiliency toward, different forms of harassment. Similarly, there are five questions that gauge a Volunteer's alcohol consumption and factors that contribute to potential alcohol abuse. The AVS is a significant tool in guiding the agency's improvements, yet it includes no questions that address drug use.

Information captured through the AVS on matters of harassment, sexual assault, and alcohol abuse is analyzed by the agency and guides the trainings it provides to Volunteers on how to reduce their risks and establish resilient behaviors. A similar process of gathering feedback about Volunteer experiences related to drugs, through the AVS or another data-gathering tool, could be used to better understand the problem and inform the agency's actions to mitigate Volunteer drug use. While it would be challenging to elicit honest responses from Volunteers about personal drug use, the agency could ask questions about the influences and pressures Volunteers face while serving.[24]

Without asking Volunteers about their experiences, the agency is limited in its understanding of the circumstances surrounding drug use in the field. Establishing baselines for the influences and

[24] Questions could include whether they have observed drug use during service, how they perceive the availability of drugs in their community, how well their training has prepared them to navigate these influences and pressures, or how they perceive the agency's policy itself. Additionally, the agency could consider asking recently returned Volunteers, or those closing service, more direct questions about their personal experiences in order to understand the efficacy of the agency's current policies and practices.

pressures factoring into Volunteer drug use would give the agency insight into where the challenges may exist currently, and may later lead to more innovative, post-specific trainings or other interventions.

We recommend:

5. **That the Director of the Peace Corps gather and analyze continuous information on the prevalence of, and factors contributing to, unauthorized drug use in the context of Volunteer service, through the Annual Volunteer Survey or another data gathering tool.**

Opportunities to Develop and Enhance Training

The training the agency provides Volunteers on drugs is limited to a focus on compliance with policy. At multiple points through the application and training processes, the agency makes applicants and Volunteers aware of the Peace Corps' drug policy and asks them to acknowledge that they understand it. The training process includes a mandatory session on Peace Corps policies during pre-service training with a group discussion about a hypothetical situation in which a Volunteer finds other Volunteers smoking marijuana at a party. In this situation, Volunteers are instructed to report the use of marijuana to their country director for administrative action. This hypothetical scenario exercise is optional, and a small aspect of a broader training on Peace Corps policy.

The agency also provides Volunteers with a series of resiliency training sessions from pre-service to mid-service, aimed at designing safe and healthy coping strategies and avoiding high-risk behaviors. Drug use is identified in the resiliency sessions as a high-risk behavior, along with excessive alcohol consumption, unprotected sex, leaving site unannounced, and general isolation, but this discussion is limited to identifying these behaviors as outcomes of ineffective resiliency practices.

The agency has devoted considerable resources to developing training in response to other serious threats to Volunteer health and safety. During pre-service training (PST), trainees attend sessions on personal security and risk reduction, unwanted attention, transportation safety, sexual assault awareness, and bystander intervention – complemented by in-service trainings on sexual assault reporting and response, and a follow-up collaborative training on shared experiences.

Additionally, the agency has mandated that all trainees attend a session on alcohol awareness, in which they identify the effects of alcohol use, the ways that alcohol puts them at risk, and strategies to manage consumption; and then they develop personal plans to manage their consumption during service.

While the agency provides information to Volunteers on its strict drug policy during PST and acknowledges Volunteers might use drugs as an unhealthy coping behavior, the agency has not

developed a training program proportionate to the importance it has assigned to the Volunteer drug use problem. Promoting resiliency among Volunteers throughout the service lifecycle is important, but more can be done. Through effective messaging and dedicated training, Volunteers could be made more aware of the risk that drug use poses to their safety, the effectiveness of their service, and the operations of their post. Training sessions with this focus could be structured to share the anonymous experiences of current and former Volunteers. Part of the discussion could connect drug use with the impact on a community or on a post when a Volunteer is abruptly separated, including how even the rumors of drug use could affect a Volunteer's and the Peace Corps' reputation.

We recommend:

6. **That the Director of the Peace Corps provide training to Volunteers that raises awareness of the risks that drug use poses to their health and safety, the effectiveness of their service, and the operations of the post itself.**

Conclusion

Drug use among Peace Corps Volunteers risks damaging host-country relations and has led to foreign incarceration, loss of life, and the premature departure from service of many Volunteers. The Peace Corps' policy has placed a unique level of urgency on Volunteer drug use by requiring that every case of drug involvement be brought to the attention of the Peace Corps Director, yet the agency's action has not been proportional to the urgency placed on the problem. The agency needs to re-examine its strategy by first assessing ways it can more effectively support CDs in resolving allegations of drug use at their posts. Further, the agency should gather accurate information on drug use among Volunteers and the extent to which its policy is enforced. Through this information, the agency can further develop and enhance Volunteer training and communication that treats drug use as a serious threat to Volunteer health and safety, as well as post operations.

List of Recommendations

We recommend:

1. That the Director of the Peace Corps provide country directors with additional support to resolve allegations of drug involvement under manual section 204, 3.5.1 and specifically consider the efficacy of reasonable suspicion drug testing as a means of doing so.

2. That the Office of General Counsel review the evidentiary standard required to administratively separate a Volunteer suspected of involvement with drugs to determine whether the standard, and its application, is consistent with promoting the integrity of the program and continues to serve the policy interest of the Peace Corps.

3. That the Director of the Peace Corps make necessary changes to policies, procedures, and forms related to Volunteer resignations and administrative separations, so that Volunteer files and early termination statistics include accurate information regarding unauthorized drug use.

4. That the Director of the Peace Corps take effective steps to ensure ongoing compliance and consistency in implementation of the Volunteer separation recordation processes.

5. That the Director of the Peace Corps gather and analyze continuous information on the prevalence of, and factors contributing to, unauthorized drug use in the context of Volunteer service, through the Annual Volunteer Survey or another data gathering tool.

6. That the Director of the Peace Corps provide training to Volunteers that raises awareness of the risks that drug use poses to their health and safety, the effectiveness of their service, and the operations of the post itself.

cc: Michelle Brooks, Chief of Staff
Carl Sosebee, Senior Advisor to the Director
Kathy Stroker, Deputy Chief Executive Officer
Matthew McKinney, Deputy Chief of Staff/White House Liaison
Shawn Bardwell, Associate Director, Office of Safety and Security
Jill Carty, Acting Associate Director, Office of Health Services
Richard Swarttz, Chief Financial Officer
Stephanie Rust, Director, Office of Overseas Programming and Training Support
Steve Dillingham, Director, Office of Strategic Information, Research, and Planning
Tina Williams, Acting Associate Director, Office of Volunteer Recruitment and Selection
Robert Shanks, General Counsel
Patrick Young, Associate Director, Office of Global Operations
Tim Hartman, Acting Regional Director, Africa Region
Kris Besch, Acting Regional Director, Europe, Mediterranean, and Asia Region
Greg Huger, Regional Director, Inter-America and the Pacific Region
IGChron
IG

APPENDIX A: VOLUNTEER/TRAINEE RESIGNATION FORM

Peace Corps

Resignation Form
Staff Copy

The Peace Corps works to define the reasons that Volunteers and trainees decide to end their service early. Your feedback can help to improve the Peace Corps' programs and policies. Per the Peace Corps Manual, MS 284, you are required to complete this form for resignations. Complete this form ONLY for resignations.

Resignation Date: _____ Post:_____ Volunteer Name:_____

What is the primary reason for resigning? Please review the list of reasons and write the code in the box below:

Primary Reason ☐

Peace Corps Support
110 technical support
111 medical support
112 administrative support
113 Peace Corps policies
114 Peace Corps staff in country
115 other Peace Corps support

Peace Corps Program/Work Assignment
210 technical skills
211 language skills
212 host country counterpart/support
213 matching skills with work assignment
214 amount of work
215 project/site development
216 political/civil unrest
217 other program/work assignment

Personal Health
310 physical health
311 emotional/mental health
312 illegal substance
313 alcohol

Country Assignment/Adaptation
410 host country culture
411 host community/host family
412 living arrangements/housing
413 site location
414 preferred another country/region
415 other country assignment/adaptation

Personal Safety
510 crime and personal safety
511 physical assault/harassment
512 sexual assault/harassment
513 road safety/traveling
514 other personal safety

Personal/Family-Related
610 romantic interest
611 further education
612 other career opportunity
613 financial
614 spousal responsibility
615 friend(s) or other family responsibility
616 other personal/family related

Other
710 resignation in lieu of administrative separation
711 other volunteers/trainees
712 unrealistic expectations

If the volunteer had a secondary reason, please indicate it here: ☐

Please use the space below and the back of this form to tell us why the Volunteer resigned.

"PRIVACY ACT NOTICE: This notice is provided under the Privacy Act of 1974, as amended (5 U.S.C. §552a). The information requested is collected under the authority of the Peace Corps Act, 22 U.S.C. §2501 et seq., for Peace Corps to study reasons for volunteer and trainee resignation. The information may also be used for the routine uses listed in the System of Records Notice PC-7, Peace Corps Volunteers: Reasons for Resignation, available in our electronic reading room at http://www.peacecorps.gov. Providing the material herein is completely voluntary. Failure to provide sufficient information will result in the information not being processed by Peace Corps."

PC-284 D Rev. 4/2008

APPENDIX B: AGENCY RESPONSE TO THE REPORT

MEMORANDUM

To: Kathy Buller, Inspector General

From: Anne Hughes, Chief Compliance Officer

Date: September 6, 2018

CC: Jody Olsen, Director
Michelle Brooks, Chief of Staff
Matthew McKinney, Deputy Chief of Staff/White House Liaison
Carl Sosebee, Senior Advisor to the Director
Robert Shanks, General Counsel
Shawn Bardwell, Associate Director, Office of Safety and Security
Jill Carty, Acting Associate Director, Office of Health Services
Tina Williams, Acting Associate Director, Office of Volunteer Recruitment and Selection
Patrick Young, Associate Director, Office of Global Operations
Richard Swarttz, Chief Financial Officer
Steve Dillingham, Director, Office of Strategic Information, Research, and Planning
Johnathan Miller, Regional Director, Africa Region
Kris Besch, Acting Regional Director, Europe, Mediterranean, and Asia Region
Greg Huger, Regional Director, Inter-America and the Pacific Region

Subject: Agency Response to the Management Advisory Report: Volunteer Drug Use (IG-18-01-SR)

As the OIG's Management Advisory Report (MAR) recognizes, the Peace Corps has long had a strict "zero tolerance" policy regarding drug use by Volunteers. The Peace Corps' General Policy on Drug Use, in Peace Corps Manual Section (MS) 204 *Volunteer Conduct*, paragraph 3.5.1, provides for mandatory separation of Volunteers found to be involved with drugs. Historically, the agency referred all cases of Volunteer drug use to the OIG for investigation. In 2012, agency policy and practice changed based on an agreement with the OIG, whereby only cases of drug sale, distribution, smuggling, or widespread drug use by Volunteers would be referred to OIG on the basis that these situations constitute violations of Peace Corps policy that may have a serious impact on the integrity of Peace Corps programs or operations. Until this year, the OIG has the exclusive authority to investigate cases of alleged widespread drug use, leaving cases of alleged individual use to country directors (CDs), under guidance. Most early separations have been the result of major OIG investigations of alleged widespread drug use in relatively few countries.

With respect to guidance to CDs on individual drug use cases, the agency has regularly provided oral and written guidance to CDs on each case of suspected drug use, including dissemination of a memorandum on the topic from the Office of the General Counsel, as well as an information sheet for CDs on "OIG Investigation of Volunteer Drug Use at Your Post." Furthermore, the agency provides guidance and training to incoming CDs during Overseas Staff Training on cases involving Volunteer drug use.

To understand the problem that the Peace Corps policy addresses, it is worth noting that drug use is not only a Peace Corps problem, it is a national problem in the United States. For example, according to the Substance Abuse and Mental Health Services Administration, in 2016 one in four young adults aged 18-25 in the United States used an illicit drug within the past 30 days. The National Institute on Drug Abuse states that "[i]n 2013, an estimated 24.6 million Americans aged 12 or older – 9.4 percent of the population – had used an illicit drug in the past month." The number of Volunteers separated (152) for drug involvement during the roughly three-year period cited in the MAR, from January 2015 to February 2018, represents about 1.5 percent of the approximately 10,000 Volunteers who served during that same period.[1] While the number of early separations is concerning, it is not remarkable when viewed in the broader context of drug use by young people in the United States. Also, while the figures for drug-related early separations only represent those who were caught or who admitted to involvement with drugs, there is no basis for concluding that drug use among Peace Corps Volunteers is higher than, or even as pervasive as within the general U.S. population.

While the number of early separations highlighted in the MAR from 2015-2017 is higher than that for the previous three-year period, it is not possible to conclude from these numbers alone that drug use increased during the relevant period. For instance, the numbers could also indicate heightened awareness of this issue, leading to increased reporting of drug use, and heightened enforcement efforts. The data is equally consistent with the conclusion that the Peace Corps' strict drug policy is working to find and remove individuals who are in violation of our "zero tolerance" policy.

The agency recognizes that drug use is a pervasive societal problem across the world, and, despite aggressive criminal laws, enforcement, and treatment options, no country or institution has yet identified a means to eliminate drug use completely. Nevertheless, as confirmed by the agency's "zero tolerance" policy, the Peace Corps does not tolerate drug use by Volunteers.

While we are not persuaded that drug use among Peace Corps Volunteers is any more pervasive than that among the general US population, we do agree with the OIG that drug use by a subset of Volunteers poses a serious risk to the integrity and reputation of the Peace Corps, as well as to the health and safety of our Volunteers, which are our highest priorities. We have devoted considerable efforts to developing and enforcing our strict policy against drug use, and to

[1] The MAR asserts that 152 Volunteers were separated from service from January 2015 to February 2018 "in connection with drug use" but notes that, of these, the agency recorded only 112 as administrative separations or resignations in lieu of a separation. Therefore, a significant number of the Volunteers counted by the OIG as having been separated in connection with drug use actually resigned without any formal agency determination as to whether they were actually involved with drugs and may have had reasons for their resignations that are independent of any pending allegations of drug use. Pursuant to the Peace Corps Act, a Volunteer may resign at any time, for any reason.

supporting our CDs in their efforts to enforce this policy in our posts around the world, as well as ensuring that all allegations of widespread use or trafficking are promptly reported to the OIG for investigation. However we recognize that we can always adapt and find ways to make our policies and procedures more effective and to provide additional tools to CDs to help resolve allegations of Volunteer drug use. Therefore, we appreciate the OIG's efforts in this report and are giving very serious consideration to the recommendations.

Recommendation 1

That the Director of the Peace Corps provide country directors with additional support to resolve allegations of drug involvement under manual section 204, 3.5.1 and specifically consider the efficacy of reasonable suspicion drug testing as a means of doing so.

Concur

Response: While the agency has in the past regularly provided CDs with support to resolve allegations of drug involvement, the Offices of Global Operations, Health Services, Safety and Security, and the General Counsel will collaborate to develop additional guidance to ensure CDs are properly prepared to resolve such allegations in line with agency policy. In addition, while drug testing of Volunteers is not a new topic and has previously been considered, the agency will reassess its validity and will complete its consideration in the coming months.

Documents to be Submitted:

- Documentation of additional guidance for CDs on resolution of allegations of drug involvement.
- Documentation of the outcome of renewed consideration of reasonable suspicion drug testing

Status and Timeline for Completion:

February 28, 2019

Recommendation 2

That the Office of General Counsel review the evidentiary standard required to administratively separate a Volunteer suspected of involvement with drugs to determine whether the standard, and its application, is consistent with promoting the integrity of the program and continues to serve the policy interest of the Peace Corps.

Concur

Response: The agency has for many years required "clear and convincing" evidence of involvement of drugs before a Volunteer could be administratively separated. This strict evidentiary standard was developed in connection with the "zero tolerance" policy and in recognition of the fact that administrative separation is mandatory in all cases of drug involvement and that this penalty has significant adverse consequences for the separated Volunteer. The Office of the General Counsel will review the evidentiary standard as recommended.

Documents to be Submitted:

- Documentation of Office of the General Counsel review of the evidentiary standard

Status and Timeline for Completion:
February 28, 2019

Recommendation 3
That the Director of the Peace Corps make necessary changes to policies, procedures, and forms related to Volunteer resignations and administrative separations, so that Volunteer files and early termination statistics include accurate information regarding unauthorized drug use.

Concur
Response: The agency has already taken steps to revise policy to ensure more consistent recordation of drug-related allegations against Volunteers. In particular, since the issuance of the MAR, the agency has implemented a new policy and system to track allegations of serious misconduct, including drug involvement, that are pending when Volunteers leave service (MS 284 *Early Termination of Service,* Section 6, and Attachment J). The agency will review whether additional changes are needed to policies, procedures, and forms.

Documents Submitted:

- Updated MS 284 and Attachment J

Documents to be Submitted:

- Any necessary revised policies, procedures, and forms related to Volunteer resignations and administrative separations

Status and Timeline for Completion:
February 28, 2019

Recommendation 4
That the Director of the Peace Corps take effective steps to ensure ongoing compliance and consistency in implementation of the Volunteer separation recordation processes.

Concur
Response: The agency has several existing procedures designed to record information surrounding Volunteer separations, such as those described in MS 284 *Early Termination of Service,* Attachments D (Resignation Form), H (Notification to VRS of Administrative Separations and Process for Capturing Documentation (Records)) in DOVE, and J (Volunteers/Trainees Who Early Terminate Pending Investigation or Inquiry). In addition, the Office of Volunteer Recruitment and Selection regularly audits its database to ensure that documentation of administrative separations and resignations in lieu of administrative separation is appropriately recorded. The agency is analyzing its processes on recording reasons for Volunteer separation and will take necessary steps to ensure ongoing compliance and consistency. After a thorough review of current procedures, any needed changes will be

identified and implemented to improve compliance and consistency in recording reasons for Volunteer separations.

Documents to be Submitted:

- Updated procedural documents

Status and Timeline for Completion:
May 31, 2019

Recommendation 5
That the Director of the Peace Corps gather and analyze continuous information on the prevalence of, and factors contributing to, unauthorized drug use in the context of Volunteer service, through the Annual Volunteer Survey or another data gathering tool.

Partially Concur
Response: The Peace Corps agrees that a better understanding of Volunteers' experiences related to the prevalence of, and contribution to, unauthorized drug use will be useful to inform the agency's actions taken to mitigate Volunteer drug use. Thus, the Peace Corps will explore the feasibility and utility of several options, including the Annual Volunteer Survey, for gathering information on the prevalence of, and factors contributing to, unauthorized drug use in the context of Volunteer service.

Additionally, the agency plans to analyze its external alternatives for data gathering to determine the best option for collecting drug use information, providing final results and options to senior leadership. The agency will consider the external alternatives based on budget availability combined with the potential usefulness and credibility of the data it hopes to acquire.

Documents to be Submitted:

- Documentation of the agency's determinations on feasibility of internal agency data gathering tool options and outputs, if acquired, of any survey administered on this topic
- Results of analysis of external data gathering options

Status and Timeline for Completion:
December 2018

Recommendation 6
That the Director of the Peace Corps provide training to Volunteers that raises awareness of the risks that drug use poses to their health and safety, the effectiveness of their service, and the operations of the post itself.

Concur
Response: The responsibility of Volunteers to not use illicit drugs is already covered in the Medical Policies and Procedures session at Pre-Service Training, as well as by Peace Corps Medical Officers and through other training material that individual posts may add on this topic

locally (see, for example, *Pre Service Training (PST) sessions "Medical Policies and Procedures"* and Peace Corps Medical Technical Guideline 520, Alcohol Misuse and Abuse Section 3, Prevention). The agency is developing a core training module for all Volunteers that addresses fundamental drug-related issues relevant in all posts, such as basic health and safety risks, risk to the effectiveness of their service, risk of arrest and imprisonment, and risk to the reputation and efficacy of the Peace Corps. This module will be required for all Volunteers. The agency will also issue guidance to posts on the required development of a post-specific component of the training to provide local contextual information.

Documents to be Submitted:

- Standard Agency-Wide Required Pre-Service Training module

Status and Timeline for Completion:

May 31, 2019

APPENDIX C: OIG COMMENTS

Management concurred with five recommendations, and partially concurred with one.

In its response, management recognized opportunities to adapt policies and procedures and better support Country Directors in resolving allegations of Volunteer drug use. While this is a positive step, OIG is concerned that the agency confused the problem and its associated risks when it stated that the number of Volunteers separated "is not remarkable when viewed in the broader context of drug use by young people in the United States."

OIG makes no assertion that the problem of drug use among Volunteers is better or worse than the U.S average, nor do we agree that a comparison between the number of Volunteers disciplined by the agency and the number of young adults believed to be using drugs in the United States is a productive means of measuring the risk presented to Peace Corps and its Volunteers. As Volunteers serve abroad, agency policy is focused not on behavioral norms in the United States, but on the conditions of service and the laws in the countries where Volunteers serve. Agency policy highlights the potentially serious social, political, and legal impacts of Volunteer drug use and describes how it can seriously jeopardize the entire Peace Corps program, as well as the safety and health of the Volunteers. It is because of this risk that Peace Corps policy requires that every case of Volunteer drug involvement must be brought immediately to the personal attention of the Peace Corps Director.

In our report, we discuss the agency's limitations in understanding the scope of the drug problem. This problem is underscored in the agency's response. The agency reasons that a "significant number" (40) of the 152 Volunteers counted in OIG's analysis may have had reasons for resignation that were independent of any allegation of drug use. The number cited comes from the agency's own records in Odyssey. Of the Volunteers who appear in Odyssey to have resigned without a formal agency determination, 25 admitted drug use during an interview with OIG investigators or senior post officials, or were otherwise recorded by the agency as having resigned due to illegal substances. Another 15 Volunteers resigned shortly after they were made aware of a credible allegation of drug involvement against them. Although OIG examined the details of every one of the 152 cases outlined in our report, we found multiple instances where Volunteer involvement with drugs was not captured by Peace Corps systems. Agency records should be viewed only as a starting point to discuss this issue.

Finally, with respect to OIG involvement in investigating cases of widespread drug use, while OIG has encouraged staff to report such cases, and has made itself available to management to address such incidents, it is important to clarify that agency policy has not given OIG the "…exclusive authority to investigate…" these cases.

All six recommendations remain open pending acceptance of documentation listed in the agency's response. We wish to note that, in closing recommendations, we are not certifying that the agency has taken these actions or that we have reviewed their effect. Certifying compliance and verifying effectiveness are management's responsibilities. However, when we feel it is warranted, we may conduct a follow-up review to confirm that action has been taken and to evaluate the impact.

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To: Jody Olsen, Director
Anne Hughes, Chief Compliance Officer

From: Kathy A. Buller, Inspector General

Date: April 9, 2019

Subject: Management Advisory Report: Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/Comoros (IG-19-04-SR)

Please find attached the Management Advisory Report: Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/Comoros (IG-19-04-SR) for your review and response. This report makes seven recommendations. We request the agency's response to these recommendations by **Friday, May 24, 2019**. Once we receive the response, the report will be updated to include it in Appendix G.

Please provide us with an electronic copy of your signed cover memo and response. The response should provide your concurrence or non-concurrence with each recommendation. In addition, please use TeamCentral to document corrective action and upload documentation supporting any actions planned or implemented to address the recommendations.

cc: Michelle Brooks, Chief of Staff
Robert Shanks, General Counsel
Karen Becker, Associate Director, Office of Health Services
Patrick Young, Associate Director, Office of Global Operations
Johnathan Miller, Regional Director, Africa Region
Tim Hartman, Chief of Operations, Africa Region
Shawn Bardwell, Associate Director, Office of Safety and Security
Carl Sosebee, Senior Advisor to the Director
Maura Fulton, Senior Advisor to the Director
Angela Kissel, Compliance Officer
Randa Wilkinson, Country Director, Comoros

PEACE CORPS
Office of
INSPECTOR GENERAL

Map Sources: UNCS, ESRI, The Times Atlas of the World.
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Map created in Sep 2013.

Management Advisory Report

Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/Comoros

IG-19-04-SR

April 2019

EXECUTIVE SUMMARY

This report provides the results of our review of the circumstances surrounding the death of Peace Corps Volunteer Bernice Heiderman (PCV Heiderman) on January 9, 2018, in Comoros. PCV Heiderman died from undiagnosed malaria, specifically cerebral malaria caused by the species *Plasmodium falciparum (P. falciparum).* This is the deadliest species of malaria when left untreated, and the dominant species in Comoros. Because of the risk of infection from malaria in Comoros, the Peace Corps requires all Volunteers to take antimalaria medication. The Peace Corps' medical technical guidelines for malaria diagnosis and treatment directs its medical officers to assume that all Volunteers serving in malaria endemic areas could become infected with malaria, and to always consider a diagnosis of malaria in any Volunteer with a fever. Rapid malaria tests and malaria treatment medication (Coartem) are provided to Peace Corps Volunteers and maintained in medical units in order to initiate treatment for malaria when necessary.

Our review found the Peace Corps medical officer (PCMO) in Comoros, PCMO Nizar Ahamada Said, did not consider a diagnosis of malaria at any point from January 2, 2018, until PCV Heiderman's death on the morning of January 9, 2018. Malaria test kits and treatment medication were available in Comoros to assist in diagnosing and treating PCV Heiderman throughout her illness, but were not used. Our review found that if PCV Heiderman had been diagnosed with malaria when her initial symptoms indicated a possible malaria infection (headache, nausea, diarrhea, lower abdominal pain, vomiting, dizziness, sweats, chills and a temperature of 37.9°C, or 100.2°F) and had she received timely treatment, she could have made a rapid, full recovery.

Our review also found that PCV Heiderman had not been adhering to her required malaria suppression medication regime for several months prior to her death from malaria. The Peace Corps medical unit in Comoros was unaware of this fact and assumed that PCV Heiderman was taking her antimalarial pills.

Our review identified several vulnerabilities associated with the Peace Corps' failure to provide an early diagnosis and prompt treatment for PCV Heiderman's malaria. The agency had staffed the medical unit in Comoros with one medical officer who had limited training in infectious diseases and limited clinical experience caring for non-immune travelers to Comoros, who are at greater risk of dying from untreated *P. falciparum* malaria. Unlike most Peace Corps overseas medical units which are staffed by at least two qualified medical officers, no other PCMO was available in Comoros to observe PCV Heiderman and discuss with PCMO Nizar possible diagnoses and causes of her illness.

In addition, PCMO Nizar had a clinical proclivity to associate a diagnosis of malaria with the presence of a high fever, based on his two years of experience treating patients at the local public hospital in Comoros. However, since PCMO Nizar detected only a mild fever in PCV

Heiderman, he never suspected malaria as a possible diagnosis. PCMO Nizar remained 'anchored' to his original diagnosis of a suspected headache disorder and a gastrointestinal disorder, and believed that his treatment for PCV Heiderman was effective, including up until the evening before her death. After reviewing PCMO Nizar's consult note about PCV Heiderman on January 8, 2018, the Director of the Office of Medical Services, Dr. Colantino, called PCMO Nizar to discuss PCV Heiderman's case and advised him to keep PCV Heiderman on IV fluid, monitor her vital signs and urine output, and to do lab work first thing in the morning of January 9. The recommended lab work included conducting a basic metabolic panel, including creatinine and electroylytes, and a complete blood count. Dr. Colantino did not ask Dr. Nizar if he had considered a diagnosis of malaria.

We found that the agency's medical technical guidelines for the diagnosis and treatment of malaria were outdated and out of alignment in key respects with prevailing malaria diagnosis guidelines from the World Health Organization (WHO, 2015), which instructs doctors to suspect malaria in any sick patient with a mild fever of 37.5°C (99.5° F) and recommends using a rapid diagnostic test to confirm the presence of malaria parasites. The Peace Corps' medical technical guidelines for malaria from 2006 were less clear than 2015 WHO Guidelines about the definition of "febrile" in terms of a temperature, and did not instruct medical officers to suspect and test for malaria using a rapid diagnostic test, although the agency does provide the tests to Volunteers and medical officers. PCMO Nizar in fact had rapid diagnostic test kits in the sick bay where PCV Heiderman died from undiagnosed, untreated *P. falciparum* malaria, but did not use any of them because he did not recognize PCV Heiderman's symptoms as being consistent with a malaria infection.

PCMO Nizar, as well as other agency officials, expressed the viewpoint that it was more challenging to arrive at a diagnosis of malaria in PCV Heiderman because she did not have a high fever. We found that this viewpoint was inconsistent with clinical diagnosis guidelines that stress that patients with malaria typically present initially with non-specific symptoms, and that early diagnosis and prompt treatment for malaria, especially *P.falciparum* malaria in a non-immune patient, is key to patient survival.

While treating PCV Heiderman from January 2 through January 9, PCMO Nizar also did not follow the agency's medical technical guidelines for clinical documentation. Specifically, PCMO Nizar did not record PCV Heiderman's vital signs or document his clinical assessments of her condition for each of his encounters with her from January 2 through January 9. By not taking her vital signs, completing patient encounter forms, or documenting the basis for his assessment that PCV Heiderman's condition was improving, Dr. Nizar made diagnostic and treatment decisions for PCV Heiderman based on insufficient clinical evidence. The lack of clinical data also made it challenging to review the provision of care for PCV Heiderman and difficult to create an accurate timeline of the circumstances surrounding her death.

PCMO Nizar did not follow the agency's clinical escalation policy related to medical emergencies or follow instructions he received from the Director of the Office of Medical Services on January 8, 2018. Specifically, on January 8, PCMO Nizar did not recognize that PCV Heiderman's vital signs had met the threshold for a medical emergency, and so did not initiate a clinical escalation properly. Had he recognized this, PCMO Nizar should have escalated the matter by placing a phone call to the Office of Health Services. Instead, PCMO Nizar submitted a written consult note through the agency's electronic medical records system with no specific request for guidance. When he was contacted late in the evening on January 8 by the Director of the Office of Medical Services about this consult note, PCMO Nizar maintained that PCV Heiderman was getting better and was not in crisis. PCMO Nizar then failed to follow the instructions he received on that call from the Director of OMS to call her back should PCV Heiderman's condition change in any way in the night of January 8. PCV Heiderman died in the early morning on January 9 before PCMO Nizar could perform the diagnostic tests that he had been instructed to do that morning.

Finally, we found that the agency's patient safety event review focused on the clinical decision-making of PCMO Nizar and that the agency had not yet assessed its systems or processes to identify ways to decrease the likelihood of another Volunteer death from undiagnosed malaria. OIG has four outstanding recommendations to the Peace Corps to improve its sentinel event review process in order to identify and address systemic or institutional vulnerabilities that contribute to serious adverse events.

This report also summarizes the investigative steps OIG took to respond to allegations that PCV Heiderman's death may have been a homicide.

This report makes 7 recommendations to the Peace Corps to address the vulnerabilities we identified and make it more likely that medical officers will provide timely diagnosis and prompt, effective treatment for malaria so that future Volunteer deaths from the disease can be prevented.

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BACKGROUND

Ms. Bernice Heiderman was a 24-year-old Peace Corps Volunteer in Comoros who died on the morning of January 9, 2018 in the capital of Moroni on the island of Grande Comore. PCV Heiderman had served as an English teacher at a middle school in Salimani-Itsandra, close to Moroni, since August 18, 2016. At the time of her death, PCV Heiderman had been under the care of the Peace Corps/Comoros medical officer, Dr. Nizar Ahamada Said, since January 2, 2018. From January 4 until her death on January 9, PCV Heiderman was staying in a hotel room that served as the post's sick bay[1] for sick or injured Volunteers on medical hold[2] status. The sick bay was close to the Peace Corps office and to PCMO Nizar's home. When she was put on medical hold, PCV Heiderman's symptoms included headache, dizziness, nausea, vomiting, diarrhea, dehydration, fatigue, lower abdominal pain, fever, sweats, and chills. PCMO Nizar provided treatment for PCV Heiderman's symptoms, but did not suspect or test PCV Heiderman for malaria or attempt to identify other potential infections.

[1] The Peace Corps did not use the local public hospital (El Marrouf hospital) in Moroni to provide routine or non-urgent medical care for Volunteers due to concerns about sub-standard conditions at the hospital, including the lack of a radiologist, infectious disease specialist, a pathologist, and other factors. Because the hospital had an intensive care unit, the agency had determined to only use it to stabilize a critically sick or injured Volunteer in preparation for an emergency medical evacuation to South Africa.

[2] Peace Corps *Technical Guideline 380 Medical Evacuation* provides that "A Volunteer may be placed on Medical Hold if an illness or injury precludes his/her return to site or country of service. This may occur while being evaluated at the post Health Unit, at COS or when out of the country on leave."

CAUSE OF DEATH

According to the May 2018 final autopsy report prepared by the Office of the Armed Forces Medical Examiner (AFME), PCV Heiderman died from malaria, specifically cerebral malaria caused by the species *P. falciparum*:

> *Findings confirm and support the clinical diagnosis of cerebral malaria with immunohistochemical evidence of Plasmodium falciparum in the brain, lungs, and liver.*

The autopsy report lists the cause of death as "malaria", and the manner of death as "natural".

OIG HOMICIDE INVESTIGATION AND DEATH REVIEW

Following PCV Heiderman's death, the Peace Corps Office of Inspector General (OIG) undertook two activities to establish the facts and circumstances surrounding her death. In January 2018, before the cause of death had been established by the autopsy, OIG conducted an investigation in Comoros to determine if PCV Heiderman's death had been a homicide. This investigation was related to concerns that PCV Heiderman had expressed through text messages to her family and friends stating that she thought she was being poisoned. OIG investigators reviewed the text messages in question as well as collected and examined a variety of other evidence. OIG interviewed various witnesses and consulted with government pathologists from AFME and the Centers for Disease Control and Prevention's (CDC) Infectious Diseases Pathology Branch to ascertain the cause of death. A pathologist conducted an autopsy toxicology test that did not uncover the type of poison (Chloralose, a rodenticide) that had been initially considered as part of the homicide investigation, or other poisons.

After the May 2018 final autopsy report established malaria as the cause of PCV Heiderman's death, OIG undertook a review of the medical care she had received from the Peace Corps. The purpose of this review was to understand the circumstances surrounding PCV Heiderman's death and, in particular, why PCMO Nizar did not diagnose PCV Heiderman with malaria and treat her for it. Through the review, we developed a more complete understanding of the actions taken by PCMO Nizar to care for PCV Heiderman from January 2 through January 9, 2018, and of the actions that PCMO Nizar should have taken but did not.

OBJECTIVE, SCOPE AND METHODOLOGY OF OIG DEATH REVIEW

To help establish the facts and circumstances surrounding PCV Heiderman's death from malaria, OIG obtained and reviewed all the available medical records pertaining to PCV Heiderman's care. We obtained an independent medical expert opinion about the care PCV Heiderman received from the Peace Corps from January 2 until January 9, 2018 (See Appendix E). We also consulted with the Office of Healthcare Inspections within the Department of Veterans Affairs' Office of Inspector General for technical assistance that informed our assessment of the medical care received by PCV Heiderman.

The medical doctors who assisted us each reviewed available records of PCMO Nizar's encounters with PCV Heiderman, and pertinent medical technical guidelines that the Peace Corps expects its medical officers to follow when treating a Volunteer for malaria or when dealing with a medical emergency. In July 2018, OIG interviewed PCMO Nizar and the post's medical assistant, Ms. Anturia Mihidjai (MA Mihidjai) about the steps they took from January 2 to January 9 to provide medical care for PCV Heiderman. We also interviewed the Peace Corps' Director of the Office of Medical Services, Dr. Alison Colantino, regarding her communication with PCMO Nizar about PCV Heiderman's care. In September 2018, we received the agency's report (prepared by an external medical doctor) that reviewed the quality of care PCV Heiderman had received by PCMO Nizar. We also reviewed a report of the agency's assessments in July and August 2018 of the available medical facilities throughout Comoros. We conducted a complete evaluation of Peace Corps/Comoros operations in January 2019, which included gathering information about Volunteer awareness of the risks of malaria transmission and the agency's ability to meet Volunteer healthcare needs in the country. We interviewed other agency officials about the agency's ability to respond to medical emergencies in remote parts of the world with limited transportation options and sub-standard medical infrastructure, like Comoros. We also reviewed other medical and administrative records related to PCV Heiderman, as well as to the Peace Corps program in Comoros.

INFORMATION ABOUT COMOROS

The Union of the Comoros includes four main islands in the Mozambique Channel between the northwest coast of Madagascar and the east coast of Mozambique. Peace Corps Volunteers serve on the islands of Grande Comore, Anjouan, and Moheli; the island of Mayotte remains under French administration. Comoros' population in 2015 was estimated at 788,000. Its human development index rank of 159 out of 188 countries places it in the lowest quartile of countries in human development. Comoros has limited health care infrastructure and chronic dysfunction, such as low attendance by doctors and nurses at health clinics, poor distribution of medical personnel throughout the country, and lack of funding for its healthcare system. The Peace Corps assessed the country's health facilities in July and August of 2018 (as part of the agency's response to the death of PCV Heiderman) and concluded that there were "facilities, clinicians, and diagnostic centers able to provide basic medical care and acute stabilization" of Volunteers. This special site assessment report conveyed more than 30 recommendations to improve the Peace Corps/Comoros medical unit's functioning and its ability to refer Volunteers to local medical providers on each island.

INFORMATION ABOUT MALARIA IN COMOROS

The CDC provides information on the presence of endemic infectious diseases for each country. The CDC reports that malaria is present in all areas of Comoros, and that the primary species of malaria in the country is *P. falciparum*. The Peace Corps website provides information to anyone considering service in Comoros about the health risks Volunteers will face in the country, including malaria, and the agency stresses its requirement that all Volunteers in Comoros take antimalarial medication:

> Malaria, HIV/AIDS, gastrointestinal infections, typhoid fever, and hepatitis are all common illnesses, most of which are entirely preventable with appropriate knowledge and interventions. Because malaria is endemic in Comoros, taking anti-malaria pills is required of all Volunteers.

According to the World Health Organization's (WHO) 2018 country brief on Comoros, there was a sharp decline in malaria cases in Comoros after 2013, from over 53,000 cases in 2013 to just 1,066 cases in 2016. However, in 2017 there was a significant increase in malaria cases to 3,230 including 3 deaths. The WHO also reports that the dominant species (100%) of malaria in Comoros is *Plasmodium falciparum.*

PEACE CORPS MALARIA PREVENTION PROGRAM

According to Peace Corps *Technical Guideline 840 (TG 840) on the Prevention of Malaria (December 2014)*, which provides guidance to PCMOs on preventing malaria among Volunteers:

> *P. falciparum* is the most dangerous species…and poses the greatest risk of death to non-immune persons and is the species most likely to develop resistance to anti-malarial drugs.

TG 840 sets the expectation that the agency's medical officers and Volunteers will act vigilantly to reduce Volunteers' risk of contracting malaria:

> Malaria is a mosquito-borne parasitic disease endemic to many areas of the world served by Peace Corps Volunteers. It is a serious and sometimes fatal disease. As such, the Office of Medical Services (OMS) employs a comprehensive prevention program to prevent malaria in Volunteers. Medical officers and Volunteers are required to rigorously adhere to the components of the program.

TG 840 describes four main components of this comprehensive malaria prevention program: (1) providing Volunteers with screens and insect repellent to reduce their exposure to mosquito bites; (2) providing Volunteers with antimalarial medication; (3) educating PCMOs and Volunteers on malaria prevention measures; and (4) requiring that all Volunteers "rigorously adhere to malaria prevention measures." A Volunteer's failure or refusal to take required antimalarial medication constitutes grounds for administratively separating the Volunteer from service.

GUIDELINES FOR CLINICAL CONSIDERATION AND DIAGNOSIS OF MALARIA

The Peace Corps' 2006 medical technical guidelines for malaria diagnosis and treatment (TG 845), and guidelines from the World Health Organization (WHO) and the CDC all emphasize that the early symptoms of malaria are **nonspecific** and look like a minor illness. WHO Guidelines emphasize that an individual with malaria may initially appear to have a minor viral illness:

> The first symptoms of malaria are nonspecific and similar to those of a minor systemic viral illness. They comprise headache, lassitude, fatigue, abdominal discomfort and muscle and joint aches, usually followed by fever, chills, perspiration, anorexia, vomiting and worsening malaise...

Peace Corps TG 845 alerts the agency's medical officers that a Volunteer with malaria may present with nonspecific respiratory or gastrointestinal disorder symptoms:

> In practice, presenting symptoms are variable. The disease may present with nonspecific respiratory or gastrointestinal symptoms.

WHO 2015 Guidelines specify the circumstances in which a doctor should always suspect and test for the presence of malaria in a sick patient:

> In malaria-endemic areas, malaria should be suspected in any patient presenting with a history[3] of fever or temperature ≥ 37.5° C and no other obvious cause...All cases of suspected malaria should have a parasitological test (microscopy or Rapid diagnostic test (RDT)) to confirm the diagnosis.

The CDC's 2013 malaria treatment guidelines for clinicians also stress that the symptoms of malaria are nonspecific and that doctors should consider a diagnosis of malaria in any sick patient with a fever and evaluate the patient "urgently":

> Symptoms of malaria are generally non-specific and most commonly consist of fever, malaise, weakness, gastrointestinal complaints (nausea, vomiting, diarrhea), neurologic complaints (dizziness, confusion, disorientation, coma), headache, back pain, myalgia, chills, and/or cough. The diagnosis of malaria should also be considered in any person with fever of unknown origin regardless of travel history…Patients suspected of having malaria infection should be urgently evaluated.

Peace Corps TG 845 instructs PCMOs caring for Volunteers in malaria areas to suspect that any Volunteer with a fever may have malaria:

[3] "History" of fever in this context means that the patient reports having had a fever when describing his or her symptoms to a medical provider.

> …assume that all Volunteers are infected with the malaria parasite and that any Volunteer may develop the clinical signs and symptoms of malaria infection…. PCMOs should always consider the diagnosis of malaria in any febrile Volunteer who has been in a malarial area for more than one week…

TG 845, written in 2006 to follow CDC guidelines, does not define febrile, though it does mention that a patient's temperature may range from normal to 40.6° C, or 105° F. However, WHO Guidelines issued in 2015 clearly define the fever for the purpose of suspecting a diagnosis of malaria as a temperature of ≥ 37.5° C. This difference and its significance will be discussed further later in the report. For a comparison of WHO and Peace Corps malaria guidelines, see Appendix B.

THE IMPORTANCE OF EARLY DIAGNOSIS AND PROMPT TREATMENT OF MALARIA

The World Health Organization's 2015 Guidelines for the Treatment of Malaria, 3rd edition, emphasizes as its first core principle that doctors must diagnose malaria early and treat it promptly to reduce the patient's risk of death from the disease:

> Uncomplicated falciparum malaria can progress rapidly to severe forms of the disease, especially in people with no or low immunity, and ***severe falciparum malaria is almost always fatal without treatment*** [emphasis added]. Therefore, programmes should ensure access to early diagnosis and prompt, effective treatment within 24-48 hours of the onset of malaria symptoms.

WHO Guidelines state that early diagnosis and treatment is especially important for patients with no previous exposure to the disease (such as Peace Corps Volunteers) who are more at risk (as compared to residents of the country with prior exposure to malaria who may have partial immunity to the disease) of dying from untreated *P. falciparum* malaria:

> Correct diagnosis in malaria-endemic areas is particularly important for the most vulnerable population groups, such as…***non-immune populations, in whom falciparum malaria can be rapidly fatal*** [emphasis added].

According to the WHO, a patient whose malaria is diagnosed early and treated promptly with effective antimalarial medication is expected to make a rapid, full recovery. Conversely, a patient with undiagnosed *P.falciparum* malaria may develop severe malaria which, if left untreated, is usually fatal.

TIMELINE OF CARE OF PCV HEIDERMAN

Below is a description of the medical care the Peace Corps provided PCV Heiderman each day from January 2 through January 9, based on the available medical records of PCMO Nizar's encounters with PCV Heiderman; and on OIG's interviews of PCMO Nizar, MA Mihidjai, and Dr. Colantino. The Peace Corps medical technical guideline (TG 113) for clinical documentation standards states: "Vital Signs including blood pressure must be taken at every encounter."[4] One of the challenges our review encountered in assessing the clinical care PCMO Nizar provided to PCV Heiderman was the general lack of sufficient clinical documentation of his encounters with her from January 2 through January 9, 2018.

The reader can also find a timeline constructed separately by an independent infectious disease specialist who reviewed the available medical records and who provided an opinion to inform this report. See Appendix E.

Tuesday, January 2, 2018

PCV Heiderman visited PCMO Nizar for the first encounter[5] with the Peace Corps concerning her complaint of headache and dizziness. PCV Heiderman explained that she started feeling sick three days before (which would have been on December 30, 2017) and had vomited and lost her appetite. She said she had a runny nose and was congested. She did not report having had a fever, diarrhea, or abdominal pain. PCMO Nizar checked her vital signs during this visit. Her heart rate was 119 beats per minute, and her blood pressure was 100/60. She had a mild fever of 37.5°C (99.5°F).

PCMO Nizar's medical record of his encounter with PCV Heiderman on January 2 indicated his observations that her general appearance was weak and fatigued; her mental state was alert, oriented and logical; she had minor dehydration; and she was in a lot of pain (her pain level was noted as 8 out of 10). PCMO Nizar's diagnosis was a suspected headache disorder. He gave her medicine for nausea (Phenergan), antacid, acetaminophen for her headache, a decongestant (Phenylephrine), and told her to drink more water and rest. He noted his intention to follow-up soon with her.

[4] According to TG 113, "The purpose of this guideline is to establish clinical documentation standards which assure accuracy, timeliness, and quality in the recording of clinical data and the provision of care. These standards assist in establishing criteria for review of clinical documentation, identification of provider educational needs, and support the performance evaluation process."

[5] An encounter is the term Peace Corps uses to describe an interaction between a Volunteer and a Peace Corps medical officer regarding a health condition.

Wednesday, January 3, 2018

There was not an encounter between PCV Heiderman and PCMO Nizar, and no medical record for January 3.

Thursday, January 4, 2018

PCV Heiderman saw PCMO Nizar for the first time since January 2. According to our interview with PCMO Nizar we believe that PCV Heiderman called him on the morning of January 4 saying she was tired, and that he sent the Peace Corps driver and car to her house (a short distance from the Peace Corps office in Moroni) to bring her to the office so he could do a follow-up exam.

The medical record of PCMO Nizar's encounter with PCV Heiderman on January 4 indicates that she had a range of symptoms, including: diarrhea, lower abdominal pain, vomiting, nausea, dizziness, sweats, and chills. PCMO Nizar noted his observation that PCV Heiderman was fatigued and had moderate dehydration, as well as PCV Heiderman's vital signs which included a fever of 37.9℃, or 100.2°F. PCMO Nizar's diagnosis of PCV Heiderman on January 4 broadened his January 2 diagnosis of suspected headache disorder to include diarrhea and vomiting.

The medical record for January 4 notes that PCMO Nizar continued treating PCV Heiderman with the same medication for her headache, and that he put PCV Heiderman on an intravenous (IV) drip for hydration that included Phenergan to control her nausea and vomiting. According to our interview with MA Anturia Mihidjai, MA Mihidjai put the IV in PCV Heiderman on January 4. PCMO Nizar placed PCV Heiderman on a "medhold" status starting January 4 in a hotel near the Peace Corps office.

According to PCMO Nizar, PCV Heiderman required monitoring while on medhold at the hotel, so he stayed at the same hotel the night of January 4 in another room.

Friday, January 5, 2018

The medical record of his encounter with PCV Heiderman on January 5 contains PCMO Nizar's note that PCV Heiderman complained of a bad headache and dizziness, nausea and abdominal pain. He also noted that PCV Heiderman said she did not think she had a fever, her vomiting had improved, and she had no other complaints.

The medical record notes that her general appearance was fatigued and that her health history included diarrhea, vomiting, and a headache disorder. He described her mental status as "alert, oriented and logical," and noted minor abdominal tenderness. The medical record does not include PCMO Nizar's observations about PCV Heiderman's dehydration or indicate whether PCMO Nizar continued the IV drip for PCV Heiderman.

During our interview with PCMO Nizar he indicated that he stopped the IV drip on Friday after talking to PCV Heiderman, who, according to PCMO Nizar, was improving and told him "I'm doing much better." PCMO Nizar said he left the IV catheter in her arm to make it easier to re-start the drip later if she needed it. As he had done the night before, PCMO Nizar stayed overnight in another room at the hotel on January 5.

PCMO Nizar did not take PCV Heiderman's vital signs during his encounter with her on January 5.

Saturday, January 6, 2018

There is no medical record of PCMO Nizar's encounter with PCV Heiderman on January 6.

In his interview, PCMO Nizar told us that he visited PCV Heiderman the morning of January 6 but did not check her vital signs. PCMO Nizar told us he thought PCV Heiderman's condition was improving. He decided that he did not need to stay at the hotel any longer, but that PCV Heiderman should remain there over the weekend. If her condition continued to improve, PCMO Nizar planned to release her from medhold on Monday January 8.

Sunday, January 7, 2018

There is no medical record of PCMO Nizar's encounter with PCV Heiderman on January 7.

According to PCMO Nizar, PCV Heiderman remained at the hotel and received at least one visit from a friend. PCMO Nizar said he visited PCV Heiderman Sunday morning. Though he was planning to release PCV Heiderman from the hotel sick bay on Monday morning, PCMO Nizar wanted PCV Heiderman to stay at the hotel Sunday: "it's better for her to stay close to…me because I was staying just…five minutes away." PCMO Nizar did not check PCV Heiderman's vital signs on January 7.

It was unclear how many times PCMO Nizar visited PCV Heiderman on January 7. MA Mihidjai indicated that after PCMO Nizar left PCV Heiderman's room, at some point during the night of January 7, the IV needle that was in PCV Heiderman's arm to facilitate putting her back on an IV drip, must have come out.

Monday, January 8, 2018

There are several medical records from January 8 and reconstructing the timeline of events was challenging due to problems with the way the agency's electronic medical records system fails to maintain accurate time zone information on the records. The following summary draws from several sources: medical records completed by PCMO Nizar of his encounters with PCV Heiderman; a separate note that PCMO Nizar entered into the agency's medical records system; a subsequent note Dr. Colantino entered about her guidance to PCMO Nizar; our interviews with

PCMO Nizar, MA Mihidjai, and Dr. Colantino; and the medical doctors whom we consulted for our review.

Between approximately 8:00 am to 10:00 am

PCV Heiderman called PCMO Nizar early that morning to say that she was vomiting frequently. PCMO Nizar then called MA Mihidjai to meet him at the Peace Corps office at 7:30 am and accompany him to PCV Heiderman's hotel room. PCMO Nizar went to the Peace Corps office to tell the staff that he and MA Mihidjai had to go to the hotel to attend to PCV Heiderman. The medical record of PCMO Nizar's encounter with PCV Heiderman on Monday morning indicates that PCV Heiderman stated "I do still vomit a lot. My headache is fine now, no diarrhea and dizziness improved. No fever and no other concerns. I do feel my chest pain probably related to the vomit."

MA Mihidjai and PCMO Nizar told us that they saw that PCV Heiderman's IV needle was no longer in place when they visited her the morning of Monday January 8. To rehydrate PCV Heiderman, PCMO Nizar and MA Mihidjai attempted several times to place an IV but were unsuccessful. MA Mihidjai stated to us that it was "very hard" to find a vein for the IV needle due to PCV Heiderman's severe dehydration. PCMO Nizar noted PCV Heiderman's mental status as "alert, oriented, and logical thought" and that she had minor tenderness in the upper abdomen. Antiemetics[6] and Cimetidine[7] were prescribed.

After this morning encounter with PCV Heiderman, MA Mihidjai remained with PCV Heiderman until 10:00 am, then left PCV Heiderman to rest. PCMO Nizar told PCV Heiderman to try and drink to aid her rehydration, and that they would return after a few hours to try to place the IV again.

PCMO Nizar did not take PCV Heiderman's vital signs during his encounter with her on the morning of January 8.

Approximately 2:00 pm

According to MA Mihidjai, as well as to PCMO Nizar's medical record summarizing actions taken on January 8 before PCV Heiderman's death, PCMO Nizar and MA Mihidjai returned to PCV Heiderman's room at 2:00 pm in order to try again to place an IV. They were still unable to place the IV in PCV Heiderman.

PCMO Nizar did not create a Patient Encounter Form or record PCV Heiderman's vital signs during his encounter with her at 2:00 pm on January 8.

[6] Antiemetics counteract vomiting.
[7] Cimetidine is a H2 blocker usually prescribed for gastrointestinal conditions.

Approximately 4:30 pm to 5:00 pm

In the late afternoon of January 8 PCMO Nizar returned to PCV Heiderman's hotel room with his wife, a pediatric nurse, who succeeded in placing an IV in PCV Heiderman at 5pm. The IV contained Vogalene, an anti-nausea medication, and Cimetidine.

PCMO Nizar took PCV Heiderman's vital signs during this late afternoon encounter on January 8. PCV Heiderman's heart rate was 124 beats per minute and her blood pressure was 80/60 mmHg. Her temperature was 37.5℃ (99.49°F). PCV Heiderman complained of nausea, vomiting, dizziness, fatigue, and a burning pain in her chest. PCMO Nizar described PCV Heiderman's mental state as "Agitated before the IV was placed but calm and could sleep after the IV is placed." PCMO Nizar noted that PCV Heiderman's skin showed signs of severe dehydration.

According to the medical record in which PCMO Nizar summarized his actions and PCV Heiderman's condition on January 8, and as PCMO Nizar said to us when interviewed July 18 in Comoros, PCV Heiderman's vomiting and nausea stopped after the IV was placed at 5:00 pm.

Between approximately 7:30 pm to 11:00 pm

PCMO Nizar returned to the office, and MA Mihidjai remained in the room with PCV Heiderman. PCMO Nizar submitted to the Office of Health Services a note through the agency's electronic medical record system called a "consult case message." According to PCMO Nizar, the reason he submitted this consult note the evening of January 8 was because he recognized that he did not understand what was happening to PCV Heiderman, and he wanted to inform the Office of Health Services about the case:

> "…it's because for me it's…becoming strange. Like, I don't understand...the symptoms disappear for 48 hours…the symptoms that she [PCV Heiderman] has, disappearing for 48 hours. And then suddenly it's come...to other symptom. That's why [he submitted the consult note]. For me, it was something that make me [think]…something wrong is going on."

PCMO Nizar's consult note, which he labelled "Dehydration due to severe vomiting" summarized PCV Heiderman's condition as of 8:00 pm on January 8, but did not make a specific request for support:

> PCV is medhold since January 4th for headache, dizziness, diarrhea and nausea…earlier January 8th we tried to place an IV again hard to find til 5pm, we were able to place a IV fluid. Vital were (P 123; T 37.5; BP 80/60 and So2 97). Vogalene was used and after 2h observation, no vomit, no diarrhea and PCV is sleeping now. The MA assistant is staying with PCV now til tomorrow.

PCMO Nizar then returned to PCV Heiderman's hotel room after 8:00 pm and observed that PCV Heiderman was not vomiting, had no dizziness or fever or other complaints.

According to PCMO Nizar's medical record of PCV Heiderman's condition the evening of January 8, PCV Heiderman had received 2.5 liters of IV fluid that evening. MA Mihidjai remained in the hotel room with PCV Heiderman and PCMO Nizar went home.

At 10:40 pm (2:40 pm EST) Dr. Alison Colantino, the Director of the Office of Medical Services for the Peace Corps, called PCMO Nizar after reviewing the consult note he had submitted a few hours earlier. Dr. Colantino explained to us that she called PCMO Nizar because she was concerned by PCV Heiderman's low blood pressure and dehydration as indicated in PCMO Nizar's consult note. Dr. Colantino discussed PCV Heiderman's case with PCMO Nizar and advised him to keep PCV Heiderman on IV fluid, monitor her vital signs and urine output, and to do lab work first thing in the morning of January 9. The recommended lab work included conducting a basic metabolic panel, including creatinine and electroylytes, and a complete blood count. Dr. Colantino did not ask PCMO Nizar if he had considered a diagnosis of malaria, or discuss testing PCV Heiderman for malaria.

At 10:45 pm on January 8, after speaking to Dr. Colantino, PCMO Nizar requested that MA Mihidjai, who PCMO Nizar had directed to stay with PCV Heiderman throughout the night, take the vitals of PCV Heiderman. MA Mihidjai reported to PCMO Nizar that PCV Heiderman's temperature was 37.5°C, her pulse was 110 beats per minute and her blood pressure was 100/60 mmHg.

At 10:50 pm Dr. Colantino called PCMO to get the update on PCV Heiderman's vital signs. Dr. Colantino informed us that she instructed PCMO Nizar on the phone to call either the agency's Regional Medical Officer in South Africa or herself if PCV Heiderman developed a fever, if her heartrate increased, if there were continued low blood pressure, or if there were other changes in her condition. According to Dr. Colantino, PCMO Nizar relayed to her on the phone that in his judgment PCV Heiderman was dehydrated, needed more fluids, but overall was doing better.

Tuesday January 9, 2018 from 1:00 am until time of death at approximately 6:00 am

Based on the medical record PCMO Nizar wrote following the death of PCV Heiderman, summarizing his actions on January 9:

At 1:00 am on January 9 MA Mihidjai called PCMO Nizar to report that PCV Heiderman had been sleeping but awoke and complained of stomach pain and hiccups. PCMO Nizar did not call Dr. Colantino or a Regional Medical Officer.

At 3:30 am PCMO Nizar instructed MA Mihidjai via a cellphone text message to administer cimetidine through PCV Heiderman's IV drip.

At 4:44 am MA Mihidjai texted PCMO Nizar that PCV Heiderman was in pain, had

heartburn, and felt hot, but was not sweating. PCMO Nizar did not call Dr. Colantino or a Regional Medical Officer.

At 5:18 am PCMO Nizar instructed MA Mihidjai via text message to take PCV Heiderman's vitals. PCV Heiderman's blood pressure was 100/60 mmHg; her pulse was 130 beats per minute, and no temperature was taken. MA Mihidjai informed OIG during our interview that there were no more single-use thermometers in the hotel room, and so she was unable to take PCV Heiderman's temperature at that moment.

At 5:20 am PCMO Nizar asked MA Mihidjai if PCV Heiderman was able to urinate.

At 5:28 am MA Mihidjai replied to PCMO Nizar that PCV Heiderman wanted to urinate but felt too nauseous to go to the bathroom so remained in bed.

In Washington, DC

At 9:33 pm in Washington DC on the evening of January 8, which was 5:33 am the morning of January 9 in Comoros, after her phone calls with PCMO Nizar, Dr. Colantino sent an email to Dr. Maxwell Mahari, a Regional Medical Officer for the Office of Health Services, based in Pretoria, South Africa. Dr. Colantino had not been updated by PCMO Nizar about PCV Heiderman's condition since speaking to PCMO Nizar by phone about 7 hours earlier. In her correspondence to Dr. Mahari, Dr. Colantino asked him to call Dr. Nizar about PCV Heiderman's condition and coach Dr. Nizar to pursue more aggressive care for PCV Heiderman if her condition had not improved. Dr. Colantino copied the agency's international health coordinator on her message to Dr. Mahari to signal the possible consideration of an emergency medevac of PCV Heiderman.

In Comoros

At about 5:40 am PCV Heiderman got out of bed with assistance from MA Mihidjai, sat on the toilet and collapsed while urinating. MA Mihidjai called PCMO Nizar to come to the hotel, stating that PCV Heiderman had collapsed in the bathroom. MA Mihidjai told PCMO Nizar that PCV Heiderman had a pulse.

At 5:51 am MA Mihidjai notified PCMO Nizar that she could no longer find PCV Heiderman's pulse and was starting cardiopulmonary resuscitation (CPR).

At 5:55 am PCMO Nizar arrived at the hotel room and continued efforts to resuscitate PCV Heiderman through CPR. PCMO Nizar continued CPR for approximately 4 more minutes.

PCV Heiderman died at approximately 6:00 am on January 9, 2018.

SUMMARY OF MEDICAL EXPERT OPINION REGARDING CARE OF PCV HEIDERMAN

The full text of the report by an independent medical expert who reviewed the medical records related to PCMO Nizar's care for PCV Heiderman from January 2 to January 9 can be found in Appendix E to this report.

Excerpts from opinion of medical expert consulted for OIG review

> *Throughout her course this woman had signs and symptoms that are well characterized as indicators of malaria. These included chills, sweats, headaches, nausea and vomiting. While not specific for malaria, such abnormalities should trigger its consideration as a possible cause of illness. It is expected that a physician tasked with caring for patients previously living in the US and now visiting a malaria endemic region be aware of this. Diagnosis and initiation of treatment for malaria at an earlier stage would likely have proven lifesaving.*
>
> *US travelers to malaria endemic regions are at particular risk for severe complications. Unlike the local population, travelers from non-malaria endemic countries (such as the US) typically lack immunity to the infection. Infections in people such as this volunteer can quickly progress with potentially devastating consequences. Malaria in US travelers to the Comoros is a medical emergency and should be treated accordingly. Delay in diagnosis and treatment can lead to severe complications including death. It is expected that a clinician caring for US travelers to a malaria endemic region be aware of the differences in immunity and potential outcomes of malaria between the local population and such travelers. Failure to consider the potential devastating complication of malaria in this US traveler to The Comoros was a major contributor to her death.*
>
> *An additional important point of this case is the failure to proactively attempt to identify a potentially treatable underlying infection for her symptoms. While her infection was ultimately proven to be malaria, a patient with similar presentation could have had other potentially treatable infections that require specific therapies. These include typhoid fever, bacterial sepsis and meningitis.*
>
> *In summary this case represented multiple failures that conspired to lead to the death of this woman. These included a failure to consider the diagnosis of malaria in a timely fashion, failure to obtain laboratory testing that would have assisted in establishing the correct diagnosis, failure to initiate prompt treatment for malaria and failure to recognize the limitation of what is medically feasible in the Comoros. Hence a mechanism for transfer to a locale with more advanced medical facilities was not activated in a timely fashion. An additional area of concern is lack of a process for systematically evaluating a patient whose symptoms should raise the alarm for a range of treatable infections.*

In short, PCV Heiderman's recorded symptoms from January 2 through the 9 were consistent with malaria and should have led PCMO Nizar to consider and test for malaria.

Although as noted below there is a lack of clinical documentation in this case, the medical records that do exist show that PCV Heiderman's symptoms were "well characterized as indicators of malaria." Specifically, on January 4 PCV Heiderman's symptoms should have led PCMO Nizar to consider and test for the disease. Had he recognized the need to do so, it is more likely than not that he could have confirmed the presence of malaria in PCV Heiderman and initiated prompt treatment with Coartem. The 2015 WHO Guidelines indicate that patients who are diagnosed in the early stage of malaria and receive timely therapy are expected to make a rapid, full recovery.

The next section of this report provides our assessment of the reasons why PCMO Nizar did not suspect that PCV Heiderman's symptoms were consistent with malaria. We also offer our analysis of the systemic or institutional vulnerabilities we identified that the Peace Corps should address in order to mitigate the risk that similar clinical errors by other medical officers will lead to similar results for other sick Volunteers in malaria-endemic areas.

OIG ASSESSMENT OF PCV HEIDERMAN'S CARE AND RELATED VULNERABILITIES

As our timeline of events indicates, at no point from January 2 until her death on January 9 did PCMO Nizar consider that PCV Heiderman may have had malaria or another life-threatening illness. Rapid malaria test kits to detect the presence of the malaria parasite and medication (Coartem) to treat malaria were available throughout the time PCV Heiderman was on medical hold but they were not used because PCMO Nizar failed to consider malaria as a possible cause of PCV Heiderman's illness. As already noted, the agency's medical technical guidelines for the diagnosis and treatment of malaria (TG845) instructs medical officers caring for Volunteers to assume that Volunteers in malaria-endemic areas have been infected with malaria and to always consider a diagnosis of malaria in any febrile Volunteer. TG 845 also cautions medical officers that the initial symptoms of malaria are variable, nonspecific and appear similar to a respiratory or gastrointestinal illness.

During OIG's interview with PCMO Nizar he said "I didn't think of it" when answering our questions about whether he ever suspected a diagnosis of malaria. Below we present our understanding of the factors that explain why PCMO Nizar did not consider that PCV Heiderman's symptoms may have been caused by malaria.

PCMO Nizar, acting by himself, was convinced that PCV Heiderman had a gastrointestinal disorder and was responding to his treatment.

PCMO Nizar thought that PCV Heiderman had a gastrointestinal disorder and did not reconsider this diagnosis because he observed that PCV Heiderman's symptoms had improved as a result of the medication he gave her to stop her vomiting and nausea. PCMO Nizar acknowledged that this caused him to fail to consider other possible causes of PCV Heiderman's illness:

> "I went straight to the…symptom that I had for somebody with…her vomiting…I went to gastro[interitis]. Because you will see like, most of the procedure that I did were focused on only that…So that's where I mi- why probably I missed the - thinking of …"

When asked to explain why he did not consider the possibility that PCV Heiderman may have had malaria, PCMO Nizar said that he observed PCV Heiderman's symptoms improve in response to the medication he was using to treat her vomiting and nausea:

> "After giving the Vogalene and her symptom disappear….That's…keeping me in the wrong…direction."

PCMO Nizar believed that PCV Heiderman's symptoms were due to a gastrointestinal disorder, and that she was responding positively to the treatment he had been providing her. However, in the late afternoon of January 8, PCMO Nizar began to suspect that something else was wrong

with PCV Heiderman. That evening he submitted the consult note to the Office of Health Services.

Our review identified that PCMO Nizar's conviction that PCV Heiderman had a headache and gastrointestinal disorder exposed a vulnerability related to the manner in which the Peace Corps had staffed the medical unit in Comoros. Specifically, PCMO Nizar had limited experience as a clinician treating non-immune visitors to Comoros and had no qualified colleague on site with whom he could discuss patient care. Further, no other medical officer was available to directly observe PCV Heiderman in this case.

PCMO Nizar said that in hindsight it would have been very helpful to have another Peace Corps medical officer on site to observe PCV Heiderman and consider alternatives to his diagnosis of gastroenteritis. Had another doctor been with him, PCMO Nizar said, he could have discussed PCV Heiderman's case and become 'unanchored' to his incorrect diagnosis:

> "I think…it's possible. It's possible. Uh, because one man thinking, it's never be the same…as two-man thinking."

The fact that PCV Heiderman was not improving should have been evident by her worsening state of dehydration--she progressed from mild dehydration on January 2 to moderate dehydration on January 4 to severe dehydration by January 8. PCV Heiderman had a persistent high heart rate and other unstable vital signs, including low systolic blood pressure on January 8, which PCMO Nizar observed before reassuring Dr. Colantino by phone that he believed PCV Heiderman was doing better.

Based on our discussion with PCMO Nizar, our review of the medical records (despite their being incomplete) and our discussions with other Office of Health Service doctors about this case, we concluded that the presence of another qualified medical officer in Comoros would have increased the likelihood that other possible causes of PCV Heiderman's symptoms would have been considered and a timely diagnosis of malaria could have been made.

Among 62 countries, Peace Corps/Comoros was one of just five where the Peace Corps had a sole medical officer. Other posts have at least two medical officers. Office of Health Service doctors and other medical staff expressed discomfort about having only one PCMO in a vulnerable environment like Comoros. Comoros has limited medical resources, few doctors, no suitable hospitals the Peace Corps is willing to use, and is difficult to access in an emergency due to its remoteness and the infrequency of flights to and from the country. OHS officials we interviewed expressed the viewpoint that the agency should have at least two qualified medical officials at every Peace Corps post, no matter how small, and consider this the cost of doing business anywhere. The agency's report (*Comoros Special Site Assessment*) in July and August 2018 assessing the healthcare facilities in Comoros includes a recommendation that the Peace Corps/Comoros be staffed with an additional medical officer:

> *Peace Corps Comoros must be staffed with two full-time PCMOs credentialed for independent practice (Nurse Practitioner, Medical Doctor or equivalent) and one Medical Assistant (ideal) or Medical Secretary to assist in the administrative aspects of the Peace Corps health unit management.*

A March 2019 article in the Journal of the American Medical Association (JAMA) summarized results from a study that found that a collaborative or team-based approach to patient diagnosis achieved a significantly higher degree of diagnostic accuracy compared to a model of diagnosis characterized by a single medical practitioner assessing a patient and arriving at a diagnosis on his or her own[8]. There is arguably a stronger case to be made in isolated environments such as Comoros where acceptable medical facilities and access to other qualified medical professionals are limited.

We recommend:

1. **That the Director deploy at least two qualified medical officers to Comoros and assess the need to have a minimum of two qualified medical officers at posts with an active Volunteer population, prioritizing in the short term those posts with just one medical officer and additional vulnerabilities or factors (e.g. a medical officer with limited clinical experience, a remote archipelago with inadequate local medical facilities) that complicate the agency's ability to meet Volunteers health care needs.**

PCMO Nizar had limited training and experience diagnosing malaria in non-immune patients with the early nonspecific symptoms of malaria.

Our review also found that PCMO Nizar did not suspect malaria in PCV Heiderman because his experience and training did not prepare him well enough to recognize the early signs and symptoms of malaria in a non-immune patient. PCMO Nizar's clinical experience with malaria had been mostly limited to observing or treating partially immune patients at the local public hospital in Comoros during two years of practice prior to being hired by the Peace Corps in 2015. PCMO Nizar had limited training in tropical medicine from his years of medical schooling in China. Reflecting on this training, PCMO Nizar recalled only one non-immune patient coming to the hospital with malaria—a Chinese individual who had returned from a trip to Africa. PCMO Nizar did not have other exposure in medical school to malaria or tropical medicine.

PMCO Nizar's relevant clinical experience after medical school came in Comoros from 2013 to 2015. During this time he diagnosed and treated malaria at the local public hospital in Moroni

[8] "Comparative Accuracy of Diagnosis by Collective Intelligence of Multiple Physicians vs Individual Physicians." Barnett, Michael, MD, MS; Boddupalli, Dhruv, MD, MBA; Nundy, Shantanu, MD, MBA; Bates, David W., MD, MSc. JAMA Network Open. March 1, 2019.

where most patients had contracted malaria multiple times. At that hospital PCMO Nizar estimated he saw, over a two-year period, on average seven Comorian patients with malaria per week, or approximately 700 patients in total. PCMO Nizar said that most local patients would come to the hospital late, when their malaria had already progressed to an advanced stage, some in a coma and near death. Therefore, PCMO Nizar did not have experience or medical training that would have helped him diagnose a non-immune sick patient with the sort of non-specific initial symptoms of uncomplicated malaria that PCV Heiderman exhibited on January 2 and January 4.

Our review found that while the Peace Corps had determined that PCMO Nizar was sufficiently qualified to be hired as its medical officer for Comoros, he had minimal training in infectious disease or tropical medicine. PCMO Nizar's medical experience in Comoros treating partially-immune patients may have compromised his ability to diagnose the non-immune American patients he was hired to treat.

The malaria prevention training that the Peace Corps provided PCMO Nizar during the continuing medical education sessions he attended in 2016 and 2017 focused on updates to the agency's medical technical guidelines related to its malaria prevention program, TG 840. The Peace Corps continuing medical education sessions did not address malaria diagnosis and treatment (TG 845), or when and how to suspect a diagnosis of malaria in a non-immune patient with non-specific symptoms. PCMO Nizar did not have relevant training or experience in this area and would have benefitted from continuing medical education training that focused on diagnosing malaria, especially in a non-immune sick patient with non-specific symptoms.

We reviewed documents pertaining to PCMO Nizar's qualifications and the agency's efforts to provide guidance and feedback to him, as a newly hired medical officer, on the quality of his clinical documentation (chart review). We also reviewed documents related to the Office of Health Services efforts to mentor PCMO Nizar during his first months of work as a new medical officer (mentor report). It was not possible to ascertain from documents provided to PCMO Nizar during this chart review process or from his mentor's reports if the Peace Corps Office of Health Services had assessed PCMO Nizar's ability to suspect malaria in a sick Volunteer at an early stage. The agency's template for assessing the clinical skills of new doctors (the "PCMO mentoring checklist") did not specify an assessment of a clinician's knowledge of TG 845, the proper threshold for suspecting malaria, or of the clinician's management of sick patients with non-specific symptoms.

We recommend:

2. **That the associate director for the office of health services establish during hiring, chart review, mentoring, continuing medical education events or other clinical oversight and support processes, improved training for medical officers on diagnosing and treating sick patients in malaria areas that incorporates critical diagnostic considerations found in WHO Guidelines, including the importance of early consideration of a malaria diagnosis based on initial non-specific symptoms, particularly for non-immune patients such as Peace Corps Volunteers.**

PCMO Nizar and Dr. Colantino did not follow the agency's medical technical guidelines to always consider a diagnosis of malaria in a febrile Volunteer.

Peace Corps TG 845 instructs PCMOs caring for Volunteers in malaria areas to suspect that any Volunteer with a fever may have malaria:

> …assume that all Volunteers are infected with the malaria parasite and that any Volunteer may develop the clinical signs and symptoms of malaria infection…. PCMOs should always consider the diagnosis of malaria in any febrile Volunteer who has been in a malarial area for more than one week…

TG 845 also states that a Volunteer with malaria may have a temperature that ranges from normal to very high. However, as seen in the timeline above, neither PCMO Nizar nor Dr. Colantino considered a diagnosis of malaria. The specific symptom that PCMO Nizar understood to be a cardinal sign of malaria was a high fever, based on his experience and his understanding of medical guidance:

> "Well, for me…having the volunteer for four days without any high fever, for me it was…not the indicator that would show me."

> "…when we read the literature, you would say okay, high fever, chills."

PCMO Nizar was not the only medical professional who reviewed PCV Heiderman's medical records from January 2 to 9 and expressed that PCV Heiderman's fever was not consistent with their understanding of malaria. When we asked Dr. Colantino if PCMO Nizar should have suspected that PCV Heiderman may have had malaria, Dr. Colantino also asserted that she had reviewed PCV Heiderman's vital signs in the agency's electronic medical records system and maintained that she didn't have a fever:

> "You have to keep in mind though the definition of fevers. When you say that there were some fevers, the definition of fever…a clinical definition of fever is…and it depends where you go—but 100.3°F or

> higher...when you go through what's documented…she doesn't meet the clinical definition of fever."

In addition, the September 2018 report prepared by an external medical doctor consulted by the Peace Corps to review PCV Heiderman's care also observed that the lack of a "high fever" in PCV Heiderman had made it more difficult for PCMO Nizar to suspect malaria:

> Falciparum malaria was a more challenging diagnosis in this case, which represented an atypical presentation in this nonimmune PCV…She did not have the more typical symptoms of high fevers, rigors and severe malaise which would be usual in a non-immune individual.

The WHO Guidelines from 2015 for malaria diagnosis instruct clinicians to base a suspicion of malaria in a sick patient on a fever of 37.5°C (99.5°F); and do not use the words 'high fever' in its diagnostic guidance. Peace Corps medical technical guidelines for malaria diagnosis are from 2006 and do not define the temperature threshold for suspicion of malaria. When we asked PCMO Nizar if he was familiar with TG 845, he said that he was. He noted that "febrile" as written in TG 845 was not helpful. PCMO Nizar expressed that instead, TG 845 should more clearly state that PCMOs treating Volunteers in malaria areas should always keep malaria in their differential diagnosis in order to rule out malaria as a matter of routine for all sick patients.

On January 4, PCV Heiderman's symptoms included a fever of 37.9°C (100.2°F) along with a range of other symptoms and met the threshold identified in WHO's guidelines for suspecting and testing for malaria.

In contrast to the WHO's 2015 guidelines, TG 845 does not include a defined fever threshold but instead uses the term "febrile:

> assume that all Volunteers are infected with the malaria parasite and that any Volunteer may develop the clinical signs and symptoms of malaria infection…. PCMOs should always consider the diagnosis of malaria in any febrile Volunteer who has been in a malarial area for more than one week…

By not defining 'febrile', TG 845 allows for ambiguity regarding when to suspect malaria, and leaves it to the discretion of its medical officers to interpret what 'febrile' means based on their training and experience. PCMO Nizar told us that he did not consider malaria in PCV Heiderman because she did not have a "high" fever. Dr. Colantino also stated that PCV Heiderman's recorded temperature had not met the clinical definition of a fever.

TG 845 contains language regarding the typical presentation of malaria that has the potential to reinforce a medical officer's proclivity to delay consideration of a diagnosis of malaria until the patient develops a high fever instead of suspecting malaria at an earlier stage of disease progression. Specifically, although TG 845 states that an individual with malaria may have a temperature that ranges from normal to very high (105˚F, 40.5°C), it also notes:

> Most Volunteers will have a temperature of 102˚F [38.9°C] or higher at some time in their illness.

The degree of fever included as guidance in TG 845 is 2.5˚F higher than the 99.5˚F defined in the 2015 WHO Guidelines.

In our interview with him, PCMO Nizar did not express an understanding of the urgency of an early diagnosis and treatment for malaria in a non-immune patient, or what the early symptoms of malaria can look like. The World Health Organization's (WHO) 2015 *Guidelines for the Treatment of Malaria* (3rd edition)— provide that when a non-immune person in a malaria endemic area (such as Peace Corps Volunteers in Comoros or other places where malaria is endemic) contracts malaria, the disease can progress very rapidly from non-specific symptoms to severe malaria, and if left untreated, severe malaria is almost always fatal. Compared to 2015 WHO Guidelines, the Peace Corps TG 845 does not convey the same sense of urgency or provide useful guidance to medical officers on this topic.

OIG also notes its concern related to the agency's maintenance of two discrete medical technical guidelines for malaria, one focused on prevention (TG 840) and another on diagnosis and treatment (TG 845). By maintaining its own medical technical guidelines for malaria prevention and for malaria diagnosis the agency elevates the risk that its guidelines will become outdated, out of alignment with one another, or that one will be out of alignment with prevailing authoritative guidance on malaria, as has happened. Our review identified that the agency's malaria diagnosis guidelines were out of date and that a review and revision of the Peace Corps' TG 845 to include updated resources is warranted. In Appendix B we compare TG 845 to the 2015 WHO Guidelines and highlight some areas that should be considered for update[9].

To improve the likelihood that other medical officers--especially recently hired doctors from malaria endemic areas whose experience is based on treating patients with partial immunity--will suspect malaria at an early stage, we recommend:

We recommend:

3. **That the associate director for the office of health services update the agency's medical technical guidelines for the diagnosis and treatment of malaria, and specify in them when the agency expects medical officers to suspect malaria, consistent with the most recent WHO Malaria Guidelines.**

[9] TG 845 has not been updated since 2006 and does not reflect current agency practice. For example, TG 845 states that rapid diagnostic tests to confirm malaria diagnosis are not available for widespread clinical use. However, Peace Corps does use RDTs widely, and in this case was available to both PCMO Nizar and the Volunteer. While not a factor in this case because the PCMO did not suspect malaria, this outdated guidance could cause confusion.

4. **That the associate director for the office of health services, taking into consideration prevailing malaria diagnosis and treatment guidelines, develop guidance for the treatment of sick patients (or make modifications to TG 113) that addresses when Peace Corps medical officers should consider and document in their assessment a suspected diagnosis of malaria as a matter of routine.**

PCMO Nizar did not follow the agency's clinical documentation standards and made diagnostic and treatment decisions without sufficient clinical data.

The agency's clinical documentation standards, TG 113 (Appendix C), are in place in to "…assure accuracy, timeliness, and quality in the recording of clinical data and the provision of care. These standards assist in establishing criteria for review of clinical documentation, identification of provider educational needs, and support the performance evaluation process."

As noted in the timeline above, PCMO Nizar had several encounters with PCV Heiderman from January 2 until January 9 which were poorly documented, and which failed to comply with the documentation standards. This lack of documentation included failure to take vital signs for some of his encounters with PCV Heiderman on January 5, 6, 7 and 8, and a failure to document some encounters.

As already noted PCMO Nizar did not consider malaria or other possible causes of PCV Heiderman's symptoms, so his 'Assessment' on each of the Patient Encounter Forms simply notes his observations of her symptoms (headache, nausea, vomiting, diarrhea) rather than an attempt to assess the underlying cause of her symptoms. PCMO Nizar did not undertake a more systematic differential diagnosis to rule out the range of possible causes of PCV Heiderman's symptoms which would have logically included malaria given her symptoms and the presence of malaria throughout Comoros. The lack of documentation in this case reflected the medical officer's failure to make clinical care decisions for PCV Heiderman based on sufficient clinical observations, including of PCV Heiderman's vital signs, and on sufficient assessments of potential underlying causes of her observed symptoms. The poor clinical documentation created gaps in the understanding of PCV Heiderman's condition while under the medical officer's care.

We recommend:

5. **That the associate director for the office of health services specify in technical guidance such as TG 113 the degree of documentation required to reflect the medical officer's assessment of possible underlying causes of the patient's symptoms.**

PCMO Nizar did not follow the agency's clinical escalation policy or respond to Dr. Colantino's instructions on January 8 regarding communicating PCV Heiderman's condition.

In addition to the main clinical error of failing to consider malaria as a possible cause of PCV Heiderman's illness, PCMO Nizar did not properly inform the Office of Health Services about PCV Heiderman's condition.

The agency's clinical escalation policy (TG 212) requires Peace Corps Medical Officers to notify the Office of Health Services (OHS) or their regional medical officer (RMO) if a Volunteer "is experiencing a significant illness or has sustained a significant injury" as soon as possible. TG 212 (see Appendix D) lists the types of situations in which the PCMO must notify either OHS or his or her RMO. Among the serious health situations listed in TG 212 were four that applied to PCV Heiderman's condition, namely:

- Any condition likely to require emergency surgery or hospitalization.
- Any condition accompanied by unstable vital signs, including significant tachycardia (>130 bpm) or bradycardia (< 45 bpm), symptomatic cardiac dysrhythmias, hypotension (< 90 mmHg systolic), hypertension (>200mmHg systolic), tachypnea (>26 breaths/min), hypoxia (< 92% at sea level), or temperature greater than 39.5°C.
- Any condition likely to require transfer to a higher-level facility in-country or an emergency medical evacuation.
- When clinical presentation of uncertain etiology may represent a serious underlying condition, e.g., chest pain, syncope, shortness of breath, altered mental state.

PCV Heiderman required an IV drip on January 8 which was very difficult for MA Mihidjai and PCMO Nizar to place due to her degree of dehydration. Had an acceptable hospital been available in Comoros, it is likely that PCMO Nizar would have taken PCV Heiderman to it the morning or afternoon of January 8 when efforts to get PCV Heiderman on an IV drip were unsuccessful. The policy does not explicitly address situations such as Comoros where hospitalization or transfers to high level facilities are generally not approved or available.

Also, on January 8, PCV Heiderman's hypotensive systolic blood pressure reading in the afternoon (80 mmHg systolic) met the threshold for a clinical escalation.

PCMO Nizar was provided, and said that he was familiar with, the agency's clinical escalation policy. However, when asked about it, he expressed an erroneous understanding of the policy. PCMO Nizar told OIG he thought that he was supposed to place a phone call to the office of health services during the weekend, and that during other normal business hours he could submit a consult note through the agency's medical records system. He said he thought that whether or

not to follow the escalation policy by placing a phone call was a case by case consideration. This was incorrect.

PCV Heiderman's vital signs and condition had met the threshold on January 8 for the clinical escalation policy, and PCMO Nizar should have immediately called the Office of Health Services or the Regional Medical Officer in Pretoria. However, OIG assesses that PCMO Nizar did not recognize PCV Heiderman's condition to be an emergency, and therefore did not follow the clinical escalation policy as designed. Instead, as described above in the timeline of care, PCMO Nizar entered a note into the agency's electronic medical records system. His note did not convey a sense of urgency or a request for assistance. Dr. Colantino read and responded to PCMO Nizar's consult note about two hours later only because she happened to be reviewing all the consult notes on Monday afternoon, January 8, to prepare in advance for a standing triage meeting the next morning, January 9. Had Dr. Colantino not been preparing in advance for the Tuesday morning meeting, PCMO Nizar's consult note about PCV Heiderman would not have been read by an Office of Health Services official until after PCV Heiderman's death. Dr. Colantino, as noted in the timeline above, directed PCMO Nizar on January 8 to call her or the RMO should PCV Heiderman's condition change during the night of January 8, and PCMO Nizar also failed to do that.

We recommend:

6. **That the associate director for the office of health services examine the threshold for clinical escalation and adjust or clarify the threshold as appropriate to take into account that the agency's ability to respond to a medical emergency may be complicated by factors such as the lack of suitable local medical facilities, the lack of flights to the country, or other complexities.**

Peace Corps/Comoros Took a Passive and Ineffective Approach to Implementing a Main Component of the Agency's Malaria Prevention Program

We identified vulnerabilities in the approach Peace Corps/Comoros took to implementing the agency's malaria prevention program. Three of the four components of Peace Corps malaria prevention program were completed. Specifically, the Peace Corps provided PCV Heiderman with a bed net, training about malaria and how to reduce her exposure to the risk of contracting the disease, information about the agency's malaria prevention policy and program, and a box of treatment pills (Coartem) to treat the disease if directed by her Peace Corps medical officer. PCV Heiderman, like all Volunteers serving in malaria endemic areas, signed a form acknowledging her understanding of the agency's requirement that she take her antimalarial medication, and she completed a personal health plan in which she noted her intention to adhere to her malaria

prophylaxis. The Peace Corps also provided training to PCMO Nizar in 2016 and 2017 on malaria prevention measures, including updates to the agency's malaria prevention program (TG 840) regarding the different malaria chemoprophylaxis options for Volunteers.

With respect to one key component of the agency's malaria prevention program--providing Volunteers with antimalarial medication--TG 840 sets the expectation that the agency's medical officers will provide malaria medication to Volunteers. The manner by which posts provide the medication to Volunteers varies, and posts have discretion to manage the distribution of the medication. The agency promotes as a best practice--but does not require--that its medical officers track each Volunteer's medication regime(s) to know when the Volunteer will need a prescription re-fill, including antimalarial medication.

In Comoros, the post's health unit distributed malaria medication depending on Volunteers' requests for additional medication. The post would send periodic reminders to all Volunteers about the importance of taking their antimalarial medication, and expected Volunteers to request more medicine when they needed it. Volunteers who lived close to the medical office, like PCV Heiderman, would visit the office to pick up their antimalarial medication. Volunteers would then sign the medication log book at the office with their signature and ID number. However, health unit staff did not consult the medication log book to identify Volunteers who had fallen out of compliance with their malaria chemoprophylaxis adherence, nor did they maintain a separate tracking system to anticipate when each Volunteer would require more medicine.

The post's medication log book showed that PCV Heiderman only obtained 120 Doxycycline pills between August 2016 and January 2018: she obtained 60 pills of Doxycycline on August 3, 2016 which would have lasted her until October 2, 2016; she obtained 60 more pills on January 27, 2017. After January 27, 2017 post's medication log book had no record of additional Doxycycline being dispensed to PCV Heiderman. If PCV Heiderman had taken all of those pills (we do not know if she did or did not take the 120 pills the Peace Corps provided her) she would have experienced two major gaps in her malaria suppression medication during her service in Comoros: a gap of approximately 4 months between October 2016 and January 2017, and a longer gap of approximately 9 months from late March 2017 until her death from malaria in early January 2018.

PCMO Nizar thought that PCV Heiderman had been taking her Doxycycline when he treated her in January 2018 and was not aware that it had been almost a year since PCV Heiderman last obtained Doxycycline from the health unit. According to PCMO Nizar, PCV Heiderman asked him during one of his initial encounters (January 2 or 4) if she should be taking her Doxycycline along with the other medicine he was using to treat her symptoms. He indicated to us that he had told PCV Heiderman to keep taking her Doxycycline and assumed her question meant that she had been taking it. The doctor acknowledged that he did not verify with her that she had the pills

and did not see her take them. He said that in hindsight this assumption on his part may have contributed to his failure to consider malaria as a possible cause of her illness.

Had the medical staff in Comoros established a process in 2016 or 2017 to track the provision of malaria medication to Volunteers, staff may have become aware that PCV Heiderman had not obtained sufficient antimalarial medication. Staff could have used that information to counsel PCV Heiderman (as well as other Volunteers) about the importance of rigorously adhering to the antimalarial medication schedule and could have provided her with the medication she needed, or administratively separated her if she expressed an unwillingness to take antimalarial medication. Had that process been in place before January 2018, it is possible that PCMO Nizar would have known that PCV Heiderman's malaria protection had been compromised, and thus been more likely to suspect malaria as a cause of her illness.

Based on evaluation fieldwork in Comoros in January 2019 we became aware that PC/Comoros had taken, since PCV Heiderman's death, a more active approach to tracking Volunteer requests for refills of their antimalarial medication and to communicating with Volunteers about their prophylaxis schedules. We also became aware that some Volunteers did not believe malaria remained a risk in Comoros and were not taking their antimalarial medication.

For this reason, we concluded that the medical unit in Comoros should take a more active approach to monitoring Volunteers' malaria suppression medication schedules and administratively separating Volunteers who do not consistently adhere to the requirement to take antimalarial drugs.

We recommend:

7. **That the Peace Corps medical officer(s) in Comoros institute a process to track and provide Volunteers with malaria chemoprophylaxis on a schedule that makes it possible for Volunteers to rigorously adhere to their antimalarial medication requirement, and administratively separate Volunteers who fail to adhere to their malaria prophylaxis schedules.**

PEACE CORPS PATIENT SAFETY EVENT REVIEW

The Peace Corps patient safety event policy (TG 167) requires the agency to undertake a root cause analysis of the systemic factors that contributed to serious negative health outcomes including Volunteer deaths. The Peace Corps consulted an external medical doctor to review PCV Heiderman's care and provide a summary report (see Appendix F). This September 2018 report was provided to OIG as the agency's root cause analysis report regarding the death of PCV Heiderman. The report focused on PCMO Nizar's clinical decisions and observed that PCMO Nizar had failed to "…consider a possible underlying etiology for her persistent severe symptoms. PCMO [Nizar] needed to have performed basic labs when she had persistent symptoms…" The reviewer also noted that since the medical infrastructure in Comoros was poorly equipped to handle a patient with a severe illness, PCV Heiderman should have been medically evacuated when it was clear that she was severely dehydrated and the IV access was "tenuous." The review further noted that PCMO Nizar had failed to follow the clinical escalation policy in a timely manner.

However the reviewer's report includes a timeline with several errors, and draws some conclusions that are inconsistent with the results of OIG's review. For example, its timeline for Sunday January 7 includes information for Monday, January 8. This timeline error was likely due to how the agency's electronic medical records system failed to maintain accurate original timestamp information on Patient Encounter Forms that had been created in one time zone (Comoros) and then reviewed in another time zone (Washington, DC). The reviewer's report incorrectly states that PCMO Nizar notified a Regional Medical Officer on January 8, but that notification did not occur. And the reviewer's report concludes that:

> Falciparum malaria was a more challenging diagnosis in this case, which represented an atypical presentation in this nonimmune PCV. It was more difficult to make a diagnosis of malaria in country [sic] where transmission was widely considered to have been interrupted...She did not have the more typical symptoms of high fevers, rigors and severe malaise which would be usual in a non-immune individual.

As demonstrated above, PCV Heiderman's range of symptoms were in fact consistent with well-established indicators of malaria, including chills, abdominal pain, sweats, headaches, nausea and vomiting, and fever. Also, PCMO Nizar understood that malaria remained a risk to Volunteers in Comoros. It is correct that PCV Heiderman's fever was not "high"; however, it is also true that each time her vitals were taken she had a fever that met the clinical threshold for suspecting malaria as defined by the 2015 WHO Guidelines. The WHO Guidelines do not state that a high fever is a typical symptom of a patient with malaria. The fact that PCMO Nizar had a clinical proclivity to consider a diagnosis of malaria only when treating a patient with a high fever was one of the main vulnerabilities that led to the failure to properly diagnose PCV Heiderman.

The reviewer's report also concludes that:

> The primary significant errors in medical decision-making made by the PCMO included the failure to obtain any laboratory investigations when the PCV had persistent and severe illness and the failure to adequately monitor PCV's volume status. In particular performing a CBC may have lead [sic] to consideration of malaria and a basic metabolic panel would have led to consideration of more serious electrolyte imbalances. The PCMO also did not follow the chain of notification in a timely manner.

As provided above, our review identified that the main clinical error PCMO Nizar committed was a failure to consider malaria in PCV Heiderman based on her initial symptoms. Our review determined that PCV Heiderman's chance of surviving malaria would have been significantly enhanced provided PCMO Nizar had undertaken an earlier diagnosis based on her non-specific symptoms.

Although the agency's root cause analysis report did identity failures of the PCMO to investigate the causes of PCV Heiderman's illness and to follow the agency's clinical escalation policy, it did not assess the agency's systems or processes to identify potential improvements that would decrease the likelihood of a similar negative health outcome (i.e. a Volunteer death from undiagnosed malaria). For that reason, we concluded that the agency has not yet adhered to its policy on patient safety events (sentinel events). The OIG has several recommendations to the Peace Corps regarding its sentinel event review process, four of which remain open[10]:

> 6. That the associate director of the Office of Health Services implement a screening process for root cause analyses that considers severity and frequency of negative health outcomes.
>
> 7. That the associate director of the Office of Health Services ensure staffing is sufficient to adequately implement a more effective sentinel event reporting system and that staff involved in root cause analyses have not had direct involvement in the case.
>
> 8. That the associate director of the Office of Health Services perform all root cause analyses in a manner that includes key components (system focus, cause/effect, action plan and measures).
>
> 9. That the associate director of the Office of Health Services improve staff understanding of best practices for selecting sentinel events for review and for carrying out root cause analyses.

The recently enacted Sam Farr and Nick Castle Peace Corps Reform Act of 2018 mandates that the Director implement the aforementioned recommendations[11]. Because OIG has these open recommendations we are not making another recommendation, however we urge the agency to undertake a robust root cause analysis to identify potential vulnerabilities in its systems and processes related to malaria protection and early diagnosis.

[10] Final Program Evaluation Report: OIG Follow-Up Evaluation of Issues Identified in the 2010 Peace Corps/Morocco Assessment of Medical Care [IG-16-01-E]. March 2016 (recommendations 6,7,8 and 9)
[11] The law establishes timeframes for the Peace Corps to report to Congress on its progress in implementing the recommendations.

CONCLUSION

Our review identified numerous instances where PCMO Nizar departed from the standard of care as well as vulnerabilities associated with PCMO Nizar's inability to effectively manage PCV Heiderman's illness. These vulnerabilities were related to the doctor's training and experience, as well as the support and guidance the Peace Corps made available to him, and together they help explain why the doctor did not suspect that PCV Heiderman had malaria.

The doctor worked by himself, without the support of another medical officer at Peace Corps/Comoros with whom he could discuss PCV Heiderman's condition and treatment. PCMO Nizar did not escalate the case to the Regional Medical Officer in South Africa or to OHS as required by policy. Had another medical officer been on site to observe PCV Heiderman and discuss her care with PCMO Nizar, such consult would have increased the likelihood that PCV Heiderman's blood would have been tested for malaria and that effective treatment could have been initiated.

Further, the agency's clinical oversight processes did not appear to include sufficient opportunity for medical professionals in the Office of Health Services to identify and address observable risks related to PCMO Nizar's approach to diagnosing patients presenting with non-specific symptoms consistent with possible malaria.

TG 845 was 12 years old and poorly aligned with more current, authoritative guidance on malaria diagnosis and treatment, specifically the 2015 guidelines from the World Health Organization. WHO guidelines on malaria diagnosis and treatment include specific instructions to doctors about when to suspect and test for malaria based on a sick patient's initial, non-specific symptoms. WHO guidelines direct doctors to always suspect and test for malaria in any sick patient with a history of fever of at least 37.5°C (99.5°F) and no other known causes. This specific guidance for when to suspect and test for malaria is lacking in TG 845. PCMO Nizar did not suspect PCV Heiderman had malaria because she did not have the high fever that he associated with malaria. In her consultation with him on January 8, Dr. Colantino did not ask PCMO Nizar if he had considered a diagnosis of malaria. Dr. Colantino stated that PCV Heiderman's temperature had not met the clinical definition of a fever. The highest temperature PCMO Nizar recorded for PCV Heiderman between January 2 and January 9 was 37.9°C, or 100.2°F on January 4. Her other recorded symptoms on that day included: diarrhea, abdominal pain, vomiting, nausea, dizziness, and sweats and chills, all of which were consistent with possible malaria and should have led the doctor to test her blood for malaria.

At critical times, PCMO Nizar failed to document and check for vitals. The lack of clinical documentation in this case reflected the medical officer's failure to make clinical care decisions for PCV Heiderman based on sufficient observations, including of PCV Heiderman's vital signs, and on sufficient assessments of the potential underlying causes of her observed symptoms. The

poor clinical documentation created gaps in the understanding of PCV Heiderman's condition while under the medical officer's care. Not only did this hamper our review, but it made it more difficult to perform effective clinical oversight.

PCMO Nizar also erroneously thought that PCV Heiderman had been adhering to her antimalarial medication. This false presumption, combined with the way PCV Heiderman's symptoms did not conform to his experience treating Comorian patients, also contributed to the doctor's failure to suspect malaria. PCV Heiderman had asked the doctor while under his care from January 2 if she should take her malaria pills along with the medication he was providing her for her nausea, headache and other symptoms. As a result of this communication the doctor assumed that PCV Heiderman was taking her daily antimalarial pills. In fact, as the post's medication log book indicated, PCV Heiderman had not obtained the malaria suppression medication she required for almost a year before her fatal illness, and had likely experienced more than one gap of several months in her malaria suppression medication since October of 2016. The doctor was unaware of these lapses in PCV Heiderman's malaria suppression medication. The post took a passive approach to the distribution and tracking of required malaria chemoprophylaxis, trusting that Volunteers would request and obtain refills for the medication. The doctor did not know PCV Heiderman had not obtained the quantity of doxycycline she required for protection from malaria.

Our report makes seven recommendations to the Peace Corps to address these vulnerabilities.

LIST OF RECOMMENDATIONS

1. That the Director deploy at least two qualified medical officers to Comoros and assess the need to have a minimum of two qualified medical officer at posts with an active Volunteer population, prioritizing in the short term those posts with just one medical officer and additional vulnerabilities or factors (e.g. a medical officer with limited clinical experience, a remote archipelago with inadequate local medical facilities) that complicate the agency's ability to meet Volunteers health care needs.
2. That the associate director for the office of health services establish during hiring, chart review, mentoring, continuing medical education events or other clinical oversight and support processes, improved training for medical officers on diagnosing and treating sick patients in malaria areas that incorporates critical diagnostic considerations found in WHO Guidelines, including the importance of early consideration of a malaria diagnosis based on initial non-specific symptoms, particularly for non-immune patients such as Peace Corps Volunteers.
3. That the associate director for the office of health services update the agency's medical technical guidelines for the prevention and treatment of malaria, and specify in them when the agency expects medical officers to suspect malaria, consistent with the most recent WHO Malaria Guidelines.
4. That the associate director for the office of health services, taking into consideration prevailing malaria diagnosis and treatment guidelines, develop guidance for the treatment of sick patients (or make modifications to TG 113) that addresses when Peace Corps medical officers should consider and document in their assessment a suspected diagnosis of malaria as a matter of routine.
5. That the associate director for the office of health services specify in technical guidance such as TG 113 the degree of documentation required to reflect the medical officer's assessment of possible underlying causes of the patient's symptoms.
6. That the associate director for the office of health services examine the threshold for clinical escalation and adjust or clarify the threshold as appropriate to take into account that the agency's ability to respond to a medical emergency may be complicated by factors such as the lack of suitable local medical facilities, the lack of flights to the country, or other complexities.
7. That the Peace Corps medical officer(s) in Comoros institute a process to track and provide Volunteers with malaria chemoprophylaxis on a schedule that makes it possible for Volunteers to rigorously adhere to their antimalarial medication requirement, and administratively separate Volunteers who fail to adhere to their malaria prophylaxis schedules.

APPENDIX A: QUALIFICATIONS AND TRAINING OF PEACE CORPS/COMOROS MEDICAL UNIT STAFF

Qualifications and Training of Peace Corps Medical Officer, PCMO Nizar.

PCMO Nizar completed his medical education at China's Shanghai Jiao Tong University. He received a Bachelor of Medicine, Bachelor of Surgery (MBBS) degree in 2010 (a five-year program), followed by a Master of Surgery degree in June, 2013. After completing his degree in surgery, PCMO Nizar returned to Comoros and worked at hospitals there for approximately two years from September 2013 until being selected by the Peace Corps in the fall of 2015 to be its Peace Corps medical officer for Volunteers in Comoros. In July 2015 the Peace Corps determined that PCMO Nizar had met its eligibility requirements for core privileges, which allowed PCMO Nizar to treat conditions that fall within the typical scope of a Doctor of Medicine or a Doctor or Osteopathy.

Peace Corps policy requires that to be eligible for core privileges, applicants for PCMO positions should have Doctor of Medicine degrees, or an equivalent degree from a foreign medical school, and a valid clinical license to practice medicine. According to OHS officials we spoke to, PCMO Nizar's medical degrees (an MBBS degree and a Master of Surgery degree) qualified him for the PMCO position, and the Peace Corps employs other medical officers with medical training and experience similar to PCMO Nizar's.

Qualifications and Training of Peace Corps Medical Assistant, Anturia Mihidjai

Ms. Mihidjai holds a bachelor's degree in nursing and had experience as a nurse, dental and pharmaceutical technician prior to being selected in February 2015 to be the medical assistant for Peace Corps/Comoros. Ms. Mihidjai was required to work under the direct clinical supervision of PCMO Nizar. The Peace Corps had not granted her clinical privileges that would have allowed her to provide independent medical treatment for any conditions. Her scope of work included providing administrative support for the operation of the health unit, such as maintaining an inventory of medical supplies, corresponding with pharmacists and laboratories, sterilizing equipment, accompanying Volunteers to medical appointments, and other support functions.

OIG determined that Ms. Mihidjai consistently acted under the direct supervision of PCMO Nizar from January 2 through January 9, and did not make her own independent clinical care decisions at any point during PCV Heiderman's illness.

APPENDIX B: COMPARISON OF THE WORLD HEALTH ORGANIZATION AND PEACE CORPS MALARIA GUIDELINES

Area of Comparison	WHO Guidelines (2015)	Peace Corps TG 845 (2006) and TG 840 (2014)
Do Guidelines Reflect Current Standards of Care?	Yes. 3rd edition of WHO Guidelines, published in 2015, is the most recent and cited by medical doctors we consulted as setting standards of care internationally.	No. TG 845 was last updated in November of 2006 and based its recommendations on guidance from the CDC. TG 845 is 12 years old and does not contain current information about rapid diagnostic tests (see below). TG 845 also does not sufficiently emphasize several points about malaria we noted in WHO Guidelines, specifically: the risk of death from *P. falciparum* malaria is under-stated on p.1 and on p.8 of TG 845 (see below comparison of how guidelines discuss fatality rate). TG845 does not define 'febrile' on p.2 so fails to provide useful guidance to PCMOs on when to suspect (and hence to test for) malaria. By contrast WHO Guidelines recommend suspecting malaria if a fever is at or above 37.5° Celsius. TG845 provides information about the sort of temperature (102°F, 38.9°C) that "most Volunteers will have" that could cause PCMOs to disregard lower level fevers as being irrelevant to a consideration of malaria, as PCMO Nizar did.
What do guidelines say about using Rapid Diagnostic Tests (RDTs)?	*Since 2012 the WHO has recommended that RDTs should be selected in accordance with the following criteria, based on the results of the assessments of the WHO Malaria RDT Product Testing programme…For detection of P. falciparum in all transmission settings…* *The tests have many potential advantages, including: rapid provision of results and extension of diagnostic services to the lowest-level health facilities and communities…*	TG 845 states: *This test, a rapid and simply accomplished dipstick antigen capture assay, appears promising for field diagnosis; however, it is currently not available for widespread clinical use.*

What do guidelines say about the fatality rate of malaria, and the importance of early diagnosis and treatment?	*…severe falciparum malaria is **almost always fatal** without treatment. Therefore, programmes should ensure access to early diagnosis and prompt, effective treatment within 24-48 h of the onset of malaria symptoms.*	TG 845 states: *Infection with the species P. falciparum can be life threatening…In the absence of medical treatment, parasitemia of more than 5% is often fatal.* TG 845 under *"Treatment of Uncomplicated Malaria"* on page 7 lists a key principle of malaria management: *"Recognize early infection due to P. falciparum."* *It is imperative that PCMOs maintain a high index of suspicion and a willingness to presumptively treat Volunteers in malaria endemic areas who exhibit signs and symptoms of malaria infection. Medical Officers should not delay treatment for an ill Volunteer with presumed malaria. Delaying treatment worsens the prognosis and may result in significant disease complications and treatment complications secondary to the use of potentially toxic intravenous drugs. The mortality rate for P. falciparum malaria, if not adequately and promptly treated, can be as high as 25%.*
What do the guidelines say about how malaria affects a non-immune person?	*Travelers who acquire malaria are often non-immune people living in cities in endemic countries with little or no transmission or are visitors from non-endemic countries travelling to areas with malaria transmission. Both are at higher risk for severe malaria.* *Correct diagnosis in malaria-endemic areas is particularly important for the most vulnerable population groups, such as young children and non-immune populations, in whom falciparum malaria can be rapidly fatal.*	TG 845 offers no direct guidance for PCMOs on this topic. It states: *Signs and symptoms also depend on the malaria species, the Volunteer's degree of immunity, and whether the Volunteer has regularly taken chemoprophylaxis.* TG 840 on malaria prevention states: *P. falciparum malaria is the most dangerous species among the five. It poses the greatest risk of death to non-immune persons.*
What do the guidelines say are the signs and symptoms of malaria, and how it progresses?	*The first symptoms of malaria are nonspecific and similar to those of a minor systemic viral illness. They comprise headache, lassitude, fatigue, abdominal discomfort and muscle and joint aches, usually followed by fever, chills, perspiration, anorexia, vomiting and worsening malaise…At this early stage of disease progression…a rapid, full recovery is expected, provided prompt, effective antimalarial treatment is given. If ineffective or poor-quality medicines are given or if treatment is delayed, particularly in P. falciparum malaria, the parasite burden often continues to increase and the patient may develop*	TG 845 states: *Malaria classically presents with nonspecific and irregular fever, chills, headache, and malaise…Often there is a…phase…that is similar to a non-specific viral illness. Initial symptoms may progress over 1-2 days to include any of the following:* *Malaise, myalgia, backache* *Mild or severe headache, dizziness, fatigue* *Anorexia, nausea, vomiting, diarrhea* *Slight fever with chills*

	potentially lethal severe malaria. Disease progression to severe malaria may take days but can occur within a few hours.	*Dry cough, shortness of breath* *In practice, presenting symptoms are variable. The disease may present with nonspecific respiratory or gastrointestinal symptoms.* *A cyclical or periodic fever pattern may or may not be present.* *Most physical signs are nonspecific. The Volunteer may seem only slightly ill…there may be sweating, anxiety, and distress.* *Temperature may range from normal to 105°F (40.6°C).* *Most Volunteers will have a temperature of 102°F [38.9°C] or higher at some time in their illness.*
When do guidelines say doctors should suspect and test for malaria in a sick patient in a malaria endemic area?	*The signs and symptoms of malaria are non-specific. Malaria is suspected clinically primarily on the basis of fever or a history of fever. There is no combination of signs or symptoms that reliably distinguishes malaria from other causes of fever; diagnosis based only on clinical features has very low specificity and results in overtreatment. Other possible causes of fever and whether alternative or additional treatment is required must always be carefully considered. The focus of malaria diagnosis should be to identify patients who truly have malaria, to guide rational use of antimalarial medicines.* *In malaria-endemic areas, malaria should be suspected in any patient presenting with a history of fever or temperature $\geq$ 37.5° C and no other obvious cause.* *All cases of suspected malaria should have a parasitological test (microscopy or Rapid diagnostic test (RDT)) to confirm the diagnosis. Both microscopy and RDTs should be supported by a quality assurance programme.*	TG 845 states: *PCMOs should assume that all Volunteers are infected with the malaria parasite and that any Volunteer may develop the clinical signs and symptoms of malaria infection…. PCMOs should always consider the diagnosis of malaria in any febrile Volunteer who has been in a malarial area for more than one week…* TG 845 does not define "febrile" for purposes of establishing a temperature threshold for the clinical suspicion of malaria.

APPENDIX C: PEACE CORPS CLINICAL DOCUMENTATION STANDARDS

Peace Corps
Technical Guideline 113
Clinical Documentation Standards

1. PURPOSE

The purpose of this guideline is to establish clinical documentation standards which assure accuracy, timeliness, and quality in the recording of clinical data and the provision of care. These standards assist in establishing criteria for review of clinical documentation, identification of provider educational needs, and support the performance evaluation process.

2. BACKGROUND

Clinical documentation ensures that a complete, accurate, clear, consistent, and secure record of health care is created. It substantiates decisions and management plans; supports continuity of care; facilitates proactive and reactive risk management strategies, and provides useful information for quality improvement and data gathering for research purposes. Medical records are viewed as foundations of professional healthcare which makes crucial the evaluation processes.

3. PROCESS

PCMEDICS is the Peace Corps electronic medical record. Most of the necessary documentation forms/tools are located within PCMEDICS. The forms assist the provider to meet documentation standards and provide a standardized template to facilitate the clinical management of the patient.

To ensure standard documentation practices and support appropriate care, the following standards are implemented:

A. ROUTINE ENCOUNTER DOCUMENTATION TOOLS

1) **Summary Page** is the screen or "page" that opens when a Volunteer's name is selected and his/her PCMEDICS record is opened. The page contains numerous informational data fields. The PCMO is required to review medications, allergies, and active medical problems with each Volunteer during every encounter and document updates to the corresponding fields as necessary.
2) **New Encounter Form** is located in PCMEDICS in the Encounter History dropdown box in the Volunteer name banner. This form is used to document the Consultation/Brief Description/Reason for Visit, Visit Category, Record Sensitivity, Facility, Date of Service, and Issues (Injuries/Medical/Allergies). Completing/Saving this form is required in order to open the PEF and document an encounter.
3) **Vital Signs Form** is located in the Clinical Tab. Vital Signs including blood pressure must be taken at every encounter.
    a. LMP must be documented for all female Volunteers in the appropriate field.

    b. If the PCMO is not seeing the Volunteer face to face, temperature

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should be taken by the Volunteer, conveyed to the PCMO and documented by the PCMO.

4) **Patient Encounter Form (PEF)** is the primary documentation form for the majority of patient encounters. It is located in PCMEDICS under the Clinical Tab. The PEF is used to document the following Visit Categories: Office Visit, Telephone Consult, E-mail/Text/Portal Communication, Supply Refill, Immunization Only, Lab/Diagnostics Only, Local Consultant Visit, Training Event Consultation, Mental Consultation (HQ), Hospitalization, Medical Accompaniment, Health Unit Observation, Initial Clinical Intake Interview, Interim Health Evaluation, 72 Hour COS Checkout. The PEF should also be used for Sexual Assault Follow-Up visits in conjunction with the Sexual Assault Follow Up form. The PEF should not be used to document other Sexual Assault Visit Categories.

B. SEXUAL ASSAULT DOCUMENTATION TOOLS

In addition to the Summary Page, New Encounter Form, and Vital Signs Form specialized forms are used to document Sexual Assault Encounters. These forms are located under the Sensitive Tab in PCMEDICS.

1) **Volunteer Reporting Preference Statement** (VRPS), also known as the Volunteer Preference Statement (VPS) is located in MS 243 "Procedures for Responding to Sexual Assault", Annex II. A prior version is also located within PCMEDICS, however, because Volunteers are not always available to sign the document at the time it is explained to them, complete the paper form of the document, obtain Volunteer signature, and then scan the document into the SA Folder in PCMEDICS. This form must be completed for all Volunteers who are Sexually Assaulted.
2) **Sexual Assault Clinical Exam Authorization** is found in PCMEDICS, however, at this time, use the paper form located in TG540, Attachment C, obtain the Volunteer signature, and then scan the document into the SA Folder in PCMEDICS. This form must be filled out for all Volunteers who require or desire a physical exam.
3) **Female and Male Sexual Assault Exam Forms** are found in PCMEDICS under the Sensitive Tab. This form must be used to document the Initial Evaluation for ALL Sexually Assaulted Volunteers. It may also be used if the Initial Evaluation is split between two separate encounters. Some Volunteers may want to have the physical exam done during one visit and the history taken during a second encounter. Use one form for the first encounter and open a second form for the second encounter, annotating on the form in the VS Notes box that it is a continuation of the Initial Evaluation. Ensure all unused blanks are filled out or populated with N/A if not applicable.
    a. Tabs A-F must be completed to the fullest extent possible as appropriate for the history of the assault.
    b. Sections E and F must be completed on all Volunteers who have been Sexually Assaulted.
    c. The Summary Note at the end of Section I must be completed on all Initial Evaluation encounters.
    d. If the Volunteer chooses a Restricted Report, the Assessment in the Summary Note is not selected via SNOMED but is

documented.

e. If the Volunteer chooses a Standard Report the Assessment in the Summary Note is selected via SNOMED and is therefore automatically placed on the Problem List located on the Summary Page.

4) **Sexual Assault Standing Orders and Treatment Plan and Sexual Assault Discharge Instructions Forms** are located within PCMEDICS under the Sensitive Tab. Both of these forms are completed during the Initial Evaluation. Orders are automatically populated onto the Discharge Instructions. Ensure all unused blanks are filled out or populated with N/A if not applicable. The Volunteer must sign the Discharge Instructions and is to be given a copy of the form so that he/she can reference it for information and the follow-up appointment schedule. The signed Discharge Instruction form is then scanned into the SA Folder in PCMEDICS.

5) **Sexual Assault Follow-Up Form** is located at the Sensitive Tab in PCMEDICS. This form is used at every Sexual Assault Follow-Up appointment or telephone call. The form is a Mental Health Evaluation and STD/ASD Screening, identical to Section E and F of the Sexual Assault Exam Form. In addition to using the Sexual Assault Follow-Up Form for follow-up appointments or contacts, the PCMO must also open a PEF and use it to complete the encounter including other pertinent history elements, a physical exam as necessary, and required elements of assessment, medications, labs, and patient education.

C. CLINICAL DOCUMENTATION STANDARDS— ROUTINE ENCOUNTERS

All Routine Patient Encounters must include the following elements:

1) A problem list is in use, completed appropriately and current
2) Medications are reconciled/updated
3) Allergies, including reactions (Document NKA or list Allergy and reaction)
4) Chief complaint is identified
5) (S) Encounter contains problem-focused medical history (HPI)
6) (S) Volunteer safety is documented
7) (O) Complete vital signs for each visit (including LMP)
   Note: Phone consult must have temperature and/or assess fever
8) (O) Problem focused physical exam
9) (A) Assessments are consistent with findings
10) (P) Plans of action/treatment are consistent with assessment; see following:
    9A. Appropriate consultation with OHS/RMO/In- Country Consultants
    9B. Diagnostic and Lab testing is appropriate to assessment
    9C. Patient Education documented
    9D. Medications are appropriate to assessment and prescribed correctly
    9E. Patient follow-up documented and appropriate
11) Unresolved problems from previous visits are addressed
12) Three patient identifiers on each scanned page (name, DOB, gender or SSN/ID)
13) Consultant reports and/or diagnostic testing results are reviewed, translated, initialed, dated and scanned into PCMEDICS

14) Continuity and coordination of care between PCMO and consultants
15) Care is medically appropriate
16) Provider signature and date within 72 hours

D. CLINICAL DOCUMENTATION STANDARDS—SEXUAL ASSAULT

ALL Sexual Assault, Aggravated Sexual Assault, and Rape patient encounters must include the following elements:

1) The problem list is complete and updated appropriately per Volunteer Preference Statement
2) Medications are reconciled/updated
3) Allergies, including reactions (Document NKA or list Allergy and reaction)
4) Sexual Assault Encounter Form (SAEF) is used for documentation of the encounter & signed by PCMO
5) (S) Sexual Assault history (HPI) is completed (SAEF, Section C, boxes 1-3 and others completed as indicated)
6) (S) PCV safety is documented
7) (O) Vital Signs obtained and LMP documented (SAEF Section B, box 1)
8) (O) Mental Health Status is documented (Sections E & F completed)
9) (O) Problem focused physical exam documented (Sections G-I as appropriate)
10) (A) Assessments are consistent with findings (Section L Summary note)
11) (P) Sexual Assault Standing Orders & Treatment Plan are initiated (button @ top right of form) & signed by PCMO
    10A. Appropriate consultation and follow-up with OHS/RMO/In-Country Consultants
    10B. Diagnostic and Lab testing is appropriate for the assessment (Standing Orders)
    10C. Sexual Assault Discharge Information /Instructions are implemented, signed by Volunteer & PCMO and scanned into PCMEDICS
    10D. Medications are appropriate for the assessment and prescribed correctly (Standing Orders)
12) Three patient identifiers on each scanned page (name, DOB, gender or SSN/ID)
13) Consultant reports & test results are reviewed, translated, initialed, dated and scanned into PCMEDICS
14) Volunteer Preference Statement is signed by Volunteer & PCMO and scanned into PCMEDICS
15) Sexual Assault Clinical Exam Authorization is completed and signed by Volunteer & PCMO and scanned into PCMEDICS
16) Care is medically appropriate
17) Sexual Assault Forensic Exam (SAFE) if performed is documented on medical forms in Sexual Assault Kit (SAK) per TG 542

E. DOCUMENTATION REVIEW

1) Routine Encounters
    a. During each quarter of the fiscal year, the Quality Improvement Unit will review the PCMEDICS documentation of 10 Volunteer encounters completed by each PCMO.
    b. Quality Improvement Nurses will select encounters for review from

the PCMO list of completed encounters during the specified scheduled review quarter.

c. Selected encounters will represent and reflect clinical management. Encounters documenting medication pick-up, COS physical forms, IST or mid-service evaluations or immunization updates will not be selected for review.

d. If available within the review period, at least one encounter documenting each the following types of illness will be reviewed:
Gastrointestinal
Respiratory
Mental Health
Sexual Assault

e. Chart reviews are an important element in PCMO annual performance review and scores will be utilized in this process.

2) Aggravated Sexual Assault and Rape Encounters

a. SNOMED Codes are not used to document the Assessment/Diagnosis on Restricted Report Sexual Assaults; therefore, for **all Aggravated Assault and Rape encounters** PCMOs must send the Volunteer's name and DOB to the **Quality Improvement Unit via SFTP e-mail with the subject line: "SA (country) for Review".**

b. The Quality Improvement SARRRP Nurse will review the encounter(s) as they are reported by the PCMO.

F. SCORING STANDARD

95-100%: Excellent **(E)**

90-94%: Meets Standards **(MS)**

Less than 90% does not meet standards: Needs Improvement **(NI)**

G. SCORING GUIDELINES AND INTERVENTIONS

1) Charts will be reviewed by clinicians who are knowledgeable in Peace Corps documentation standards and current clinical practice standards.
2) PCMOs will receive appropriate and timely feedback.
3) PCMOs who consistently score 95% and above for a period of one year (four submissions) will be assigned a two times per year submission schedule (this rule does not pertain to Aggravated Sexual Assault and/or Rape Charts).
4) All Aggravated Assault and Rape charts must be reviewed. PCMOs will notify Quality Improvement Unit via SFTP e-mail message when Aggravated Sexual Assault and/or Rape charts are ready for review.
5) If at any time the PCMO review scores fall below 90%, OHS reserves the right to place PCMO on remediation
6) Reviewer must notify OHS Clinical Director when a PCMO is placed on remediation.

H. MONITORING, EVALUATION, AND REPORTING

1) The Quality Improvement Unit will present QI quarterly and annual reports to the Quality Council regarding the status of clinical oversight/chart reviews and interventions; these reports will include a separate section on the results of the aggravated sexual assault and rape cases.
2) The Quality Improvement Unit will submit the results of the clinical oversight/chart reviews and interventions regarding aggravated sexual assault and rape cases to the Sexual Assault Risk Reduction and Response Program (SARRRP) on a quarterly and annual schedule.

APPENDIX D: PEACE CORPS CLINICAL ESCALATION POLICY

Peace Corps
Technical Guideline 212

CLINICAL ESCALATION POLICY

1. PURPOSE

The purpose of this policy is to provide guidance regarding Peace Corps Medical Officer (PCMO) reporting of hospitalizations, critical injuries and illnesses to the Office of Health Services (OHS).

2. BACKGROUND

It is the responsibility of PCMOs to report by phone, the status of Peace Corps Volunteers (PCV) or Peace Corps Trainees (PCT) to the Office of Health Services when a significant illness, injury, or hospitalization occurs.

3. ESCALATION PROCESS

The PCMO should notify OHS/RMO if a PCV/T is experiencing a significant illness or has sustained a significant injury as soon as possible. Notification should never delay care in a life threatening situation. Situations in which OHS/RMO *must* be notified include, but are not limited to:

- Life threatening or potentially life threatening conditions.
- Any condition likely to require emergency surgery or hospitalization.
- Any condition accompanied by unstable vital signs, including significant tachycardia (>130 bpm) or bradycardia (< 45 bpm), symptomatic cardiac dysrhythmias, hypotension (< 90 mmHg systolic), hypertension (>200mmHg systolic), tachypnea (>26 breaths/min), hypoxia (< 92% at sea level), or temperature greater than 39.5 °C.
- Any condition likely to require transfer to a higher level facility in-country or an emergency medical evacuation.
- Trainee or Volunteer with an acute psychiatric problem who is a threat to the PCV/T or others.
- Any Volunteer involved in a motor vehicle accident, motorcycle accident or pedestrian accident involving a motorized vehicle.
- Prior to any surgical procedure requiring anesthesia.
- Prior to any blood or blood product transfusion.
- Loss of consciousness.
- When clinical presentation of uncertain etiology may represent a serious underlying condition, e.g., chest pain, syncope, shortness of breath, altered mental state.
- When a condition or diagnosis carries a possible prognosis of long term disability or morbidity, e.g., traumatic injury with possible of loss of function.
- When a condition may lead to significant cosmetic deformity, e.g., large facial lacerations, facial leishmaniosis.
- When a condition or diagnosis is associated with a significant radiographic abnormality.
- After a physical or sexual assault where there is significant trauma or psychological issues.

When reporting to OHS/RMO, the PCMO should have as much of the following information available as possible:

- Recent and past medical history
- Mechanism of traumatic injury and status of anyone else involved in the trauma
- Working diagnosis
- Vital signs and any available laboratory or imaging studies
- Initial plan of care
- Location of PCV including the capabilities of the healthcare facilities
- Safety of PCV
- Potential need to move PCV and plan of action should this become necessary
- PCMO follow-up plan
- Determine if permission given to speak to family members

APPENDIX E: EXPERT OPINION OF DR. SHMUEL SHOHAM

JOHNS HOPKINS
MEDICINE

I have been asked to comment on the events leading up to the death of a volunteer who had been working in The Comoros as part of a Peace Corps assignment. In this letter I will address her clinical presentation, medical management and ultimate death due to severe malaria. I will specifically address the following points:

- How unusual was the patient's presentation of malaria in this case?
- How should a doctor with clinical experience diagnosing malaria have responded to these symptoms?

Medical qualifications

I am an Associate Professor of Medicine at Johns Hopkins University School of Medicine. I am certified by the American Board of Internal Medicine in the subspecialty of Infectious Diseases and am licensed to practice medicine in the State of Maryland and the District of Columbia. I have over 17 years of experience in management of patients with invasive infections including illnesses such as malaria. I am the author or co-author of over 100 original articles, book chapters and topic reviews. I serve as a reviewer and expert consultant to multiple journals, professional societies and government agencies in the US and abroad and am a member of professional guideline committees for the American Society of Transplantation (AST), the European Organization for Research and Treatment of Cancer/Invasive Fungal Infections Cooperative Group and Infectious Diseases Mycoses Study Group (EORTC/MSG) and the National Comprehensive Cancer Network (NCCN). In 2015 the Washington, DC Chapter of the American College of Physicians honored my commitment to excellence in medical care and service to the College with their highest award, the John F. Maher Memorial Laureate Award. In 2017, I completed specialized training in reducing patient harm and graduated from the Armstrong Institute Patient Safety and Quality Improvement Leadership Academy, Johns Hopkins Medicine.

Facts of the case:

At the time of her death on January 9, 2018 the volunteer was a 24-year-old woman who was in overall good health. Over an approximately 10 day period she progressed from being asymptomatic to succumbing to severe malaria, which by then had involved multiple organs including her brain. The timeline of her clinical presentation and course are as follows:

- January 2: She reported a 3-day history of headaches with dizziness when getting out of bed. She reported to adhering with the prescribed anti-malaria treatment (doxycycline). At that time she had nasal congestion and physical exam findings of temperature 99.49F, heart rate of 119/min and blood pressure of 100/60. She was diagnosed with a new headache disorder

and given symptomatic treatment with promethazine, an antacid, acetaminophen, and phenylephrine.

- January 4: She reported no improvement in her original symptoms. She also had additional symptoms of diarrhea, vomiting, sweats, chills and lower abdominal pain at that time. Examination showed temperature of 100.2F, heart rate of 100/min and blood pressure of 100/60. She was treated with IV fluids and promethazine.

- January 5: She reported ongoing headache described and associated dizziness. While the diarrhea and nausea were reported as improving, her exam showed lower abdominal tenderness. The vital signs were not checked. She was treated symptomatically with acetaminophen with codeine.

- January 8-9: She was noted to vomiting and reported chest pain. The diarrhea and dizziness had improved on that day. Her examination showed temperature of 99.4F, heart rate of 124/min and blood pressure 80/60. She was treated symptomatically with acetaminophen, cimetadine, promethazine and metopimazine. Treatment with IV fluids was given, but this was not consistently successful due to poor venous access. She ultimately received 2.5 liters of isotonic IV fluids with transient improvement in hemodynamic status. Early in AM of January 9 she developed hemodynamic instability with more tachycardia (heart rate 130/min), felt hot and collapsed. Shortly after that she died of severe malaria with multiorgan involvement.

- Autopsy showed *Plasmodium falciparum* in lung, liver brain as confirmed by immunohistochemical studies. Plasmodium species antigen was present in post-mortem blood.

Analysis

This volunteer died of severe malaria. She was at risk for acquiring this infection and for developing severe disease once infected. Had she received timely therapy it is more likely than not that her death would have been prevented.

1. As a traveler to the Comoros she was at risk for this infection. The United States Centers for Disease Control and Prevention (CDC) identifies all areas of the Comoros as having malaria (primarily due to *Plasmodium falciparum*). Longer durations of stay in a malaria-endemic area, as in this case, may also increase the chance of infection. Doxycyline, which she reported to be taking, is a recommended method of prevention. However, no chemoprophylactic regimen is completely effective, and failure of prophylaxis for malaria is a well-known phenomenon. A clinician knowledgeable in malaria is expected to recognize that infection can be acquired and can progress despite a patient's report of taking doxycycline.

2. Throughout her course this woman had signs and symptoms that are well characterized as indicators of malaria. These included chills, sweats, headaches, nausea and vomiting. While not specific for malaria, such abnormalities should trigger its consideration as a possible cause of illness. It is expected that a physician tasked with caring for patients previously

living in the US and now visiting a malaria endemic region be aware of this. Diagnosis and initiation of treatment for malaria at an earlier stage would likely have proven lifesaving.

3. US travelers to malaria endemic regions are at particular risk for severe complications. Unlike the local population, travelers from non-malaria endemic countries (such as the US) typically lack immunity to the infection. Infections in people such as this volunteer can quickly progress with potentially devastating consequences. Malaria in US travelers to the Comoros is a medical emergency and should be treated accordingly. Delay in diagnosis and treatment can lead to severe complications including death. It is expected that a clinician caring for US travelers to a malaria endemic region be aware of the differences in immunity and potential outcomes of malaria between the local population and such travelers. Failure to consider the potential devastating complication of malaria in this US traveler to The Comoros was a major contributor to her death.

4. An additional important point of this case is the failure to proactively attempt to identify a potentially treatable underlying infection for her symptoms. While her infection was ultimately proven to be malaria, a patient with similar presentation could have had other potentially treatable infections that require specific therapies. These include typhoid fever, bacterial sepsis and meningitis.

In summary this case represented multiple failures that conspired to lead to the death of this woman. These included a failure to consider the diagnosis of malaria in a timely fashion, failure to obtain laboratory testing that would have assisted in establishing the correct diagnosis, failure to initiate prompt treatment for malaria and failure to recognize the limitation of what is medically feasible in the Comoros. Hence a mechanism for transfer to a locale with more advanced medical facilities was not activated in a timely fashion. An additional area of concern is lack of a process for systematically evaluating a patient whose symptoms should raise the alarm for a range of treatable infections.

Respectfully submitted, July 4, 2018

Shmuel Shoham, MD

Associate Professor of Medicine
Johns Hopkins University School of Medicine
Baltimore, MD 21205

APPENDIX F: PATIENT SAFETY EVENT REVIEW--LETTER FROM DR. PRINCY KUMAR

Georgetown University Hospital
MedStar Health

Princy N. Kumar, MD
Professor of Medicine and Microbiology
Division Chief

Department of Medicine
Divison of Infectious Diseases
and Travel Medicine

Thomas M. Wilkinson, M.D.
Medical Officer and Clinical Supervisor
Chief, Health Informatics Unit
Office of Health Services, United States Peace Corps
1111 20th St NW, Room 5136
Washington, DC 20526

September 5, 2018

Dear Dr. Wilkinson,

Please find below my review regarding Ms. Bernice Heiderman's death following a brief illness during her Peace Corps service in Comoros.

Sincerely,

Princy N. Kumar, MD, FIDSA, MACP
Professor of Medicine and Microbiology
Chief, Division of Infectious Diseases and Travel Medicine
Senior Associate Dean of Students
Georgetown University School of Medicine
[redacted]

[redacted]

Georgetown University Hospital
MedStar Health

Princy N. Kumar, MD
Professor of Medicine and Microbiology
Division Chief

Department of Medicine
Divison of Infectious Diseases
and Travel Medicine

Summary of BH

BH was a 24 year old female PCV in Comoros who presented for care on January 2nd 2018 with a 3 day history of non-specific symptoms consisting of headache, dizziness, vomiting, and coryza without self-reported fever. Her exam revealed a temperature of 37.5 and a pulse of 119, blood pressure 110/60. She appeared fatigued and weak but alert and oriented.

On January 3rd 2018 (day 4 of illness), she reported acute diarrhea, worsening non-bloody emesis, worsening orthostatic dizziness, intermittent hand numbness, sweats and chills with a borderline temperature of 37.9 (while taking Tylenol 650 mg TID). Her vital signs were stable (BP 100/60, HR 100). She was noted to have moderate dehydration and mild upper abdominal pain. She received IV fluids, antiemetics, and ongoing Tylenol.

On January 4th 2018 (day 5 of illness) she had persistent headache, orthostatic dizziness and stomach pain, but her vomiting and diarrhea had both improved and only mild abdominal pain on palpation. She had no self-reported fever, but vitals were not assessed at that visit as she was assessed at the hotel. She received Tylenol with codeine and ongoing supportive care.

Not assessed by health care provider January 5th or 6th (Friday and Saturday). Reports of other PCV's visiting

On January 7th 2018 (day 8 of illness) she again reported significant vomiting, but resolution of headache and improvement in dizziness, and chest pain that she attributed to vomiting. She was noted to have minor tenderness to the upper abdomen. She had no self-reported fever, but vitals were not assessed at that visit as she was assessed at the hotel. She was reassessed the same day as vomiting had

1

[redacted]

become persistent, noted to be agitated, hypotensive 80/60, tachycardic p 124, T 37.5 with difficulty placing an intravenous, but ultimately received 2.5-3L of IV fluid along with supportive care. She was admitted to the hotel overnight with a diagnosis of severe dehydration, with the medical assistant sleeping next door.

January 8th 2018 (day 9 illness) ongoing emesis with multiple failed attempts at IV placement (ultimately successful at 5 pm), although after IV fluids she appeared to improve without vomiting or dizziness, and vitals had stabilized (afebrile, T-37.5, heart rate 110, BP 100/60). PCMO spoke with CD. OMS/HQ are consulted. Following the request for consultation Dr. Colantino calls PCMO directly and is told that she is doing better, though IV is tenuous. Dr Colantino recommends repeating vital signs and to obtain a basic metabolic panel and a complete blood count. She then emails RMO (Mahari) that she is worried and requests that PCMO is coached on more aggressive care if she does not improve

January 9th 2018 (day 10 illness) from 1-4 am she described non-specific symptoms including stomach pain, hiccoughs, heart burn. Blood pressure was stable but tachycardia to 130. She went to the toilet to urinate with MA assistance, and collapsed while urinating, and was pulseless. CPR was performed unsuccessfully.

Autopsy Report:

The autopsy report conclusively confirms the diagnosis of malaria, based on the combined findings of P. falciparum antigen (Binax Now) present in blood, and immunohistochemical evidence of plasmodium falciparum in brain, lung, and liver, and splenomegaly. There was noted to be abundant intravascular and intraerythrocytic malarial parasites and intrahistiocytic malarial pigment. The findings were confirmed by the Center for Disease Control and Prevention, infectious disease pathology branch.

Assessment:

Medical decision making and clinical performance:

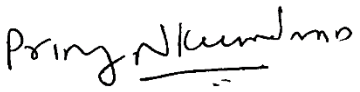
- Received attentive daily in person assessment, but there was no consistency in performing vital signs or appropriately assessing fluid balance/response to resuscitation
- Up until January 7th 2018 her clinical symptoms were not severe and were generally non-specific, and appeared to improve and might have been reasonably mistaken for any number of bacterial or viral syndromes, and she was showing signs of intermittent clinical improvement with supportive care. However on January 7th she showed signs of significant volume depletion and had persistent vomiting for over 1 week. At minimum a basis CBC, CMP and electrolytes should have been performed with close clinical monitoring of fluid balance (not done), and PCMO fails to perform any work-up or consider a possible underlying etiology for her persistent severe symptoms
- PCMO needed to have performed basic labs when she had persistent symptoms, particularly when they became severe.

- Infrastructure in Comoros not equipped to handle any patient with severe illness (ICU modern equipment, but from description non-functional), hence she needed to be medically evacuated when it becomes clear that she is significantly volume depleted and that IV access is tenuous.
- It appears that the PCMO did not follow the chain of notification in a timely manner. The RMO was notified only on January 8th 2018, 9 days into the illness and Peace Corps headquarters also received notification only on January 8th, 2018.
- Once Peace Corps headquarters was notified they took immediate action with Dr Allison Colantino placing a phone call directly to the PCMO and providing recommendations. Dr Colantino also then follows up by sending an email to RMO, Maxwell Mahari so that recommendations could be instituted in a more timely manner, given time difference. However by the time Peace Corp has been notified, it is essentially too late.

Conclusion:

The autopsy report is conclusive for cerebral malaria. Falciparum malaria was a more challenging diagnosis in this case, which represented an atypical presentation in this nonimmune PCV. It was more difficult to make diagnosis of malaria in country where transmission was widely considered to have been interrupted. The PCV also presented with GI-predominate symptoms, and a fluctuating course which seemed to improve at times, both of which are less common. She did not have the more typical symptoms of high fevers, rigors and severe malaise which would be usual in a non-immune individual, and in most case series of imported malaria over 95% of non-immune travelers have fever. However she did have low grade temperatures of 37.5-37.9, and malaria is a diagnosis that should be considered in any ill PCV within a potentially malaria-endemic zone whether or not fever is present. The primary significant errors in medical decision-making made by the PCMO included the failure to obtain any laboratory investigations when the PCV had persistent and severe illness and the failure to adequately monitor the PCV's volume status. In particular performing a CBC may have lead to consideration of malaria and a basic metabolic panel would have led to consideration of more serious electrolyte imbalances. The PCMO also did not follow the chain of notification in a timely manner.

Respectfully submitted,



Princy N. Kumar, MD, FIDSA, MACP
Professor of Medicine and Microbiology
Chief, Division of Infectious Diseases and Travel Medicine

WHO report – Comoros in 2015 ~1500 presumed and confirmed cases of malaria, only 1 death from malaria in 2015.

http://www.who.int/malaria/publications/world-malaria-report-2016/WMR-2016-annexes.pdf

APPENDIX G: AGENCY RESPONSE TO THE REPORT

MEMORANDUM

To: Kathy Buller, Inspector General

From: Jody K. Olsen, Director
Anne Hughes, Chief Compliance Officer

Date: May 24, 2019

CC: Michelle K. Brooks, Chief of Staff
Carl Sosebee, Senior Advisor to the Director
Robert Shanks, General Counsel
Shawn Bardwell, Associate Director, Office of Safety and Security
Karen Becker, Associate Director, Office of Health Services
Patrick Young, Associate Director, Office of Global Operations
Johnathan Miller, Regional Director, Africa Region
Tim Hartman, Chief of Operations, Africa Region
Randa Wilkinson, Country Director, Comoros

Subject: Agency Response to the Management Advisory Report: Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/Comoros (IG-19-04-SR)

Thank you for the opportunity to respond to the Management Advisory Report: *Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/Comoros* (MAR). The Peace Corps continues to mourn the tragic loss of Peace Corps Volunteer Bernice Heiderman (PCV Heiderman). The agency has undertaken a rigorous internal review of this case and is implementing numerous changes in response to this event.

The agency responds below to the specific recommendations outlined in the MAR. However, there are a number of statements and conclusions in the MAR that should be addressed. In the following three sections, the agency addresses three areas of the MAR: PCV Heiderman's non-adherence to Peace Corps' malaria prevention program, clinically relevant errors in the interpretation of the medical information, and the implication that Peace Corps headquarters staff

were not sufficiently proactive in addressing PCV Heiderman's case and did not follow the agency's Technical Guideline.

I. PCV Heiderman did not adhere to malaria prevention steps and prophylaxis requirements, or fully disclose her prophylaxis non-compliance, which affected the diagnosis.

The MAR states:

> *…the Peace Corps provided PCV Heiderman with a bed net, training about malaria and how to reduce her exposure to the risk of contracting the disease, information about the agency's malaria prevention policy and program, and a box of treatment pills (Coartem) to treat the disease if directed by her Peace Corps medical Officer. PCV Heiderman, like all Volunteers serving in malaria endemic areas, signed a form acknowledging her understanding of the agency's requirement that she take her antimalarial medication, and she completed a personal health plan in which she noted her intention to adhere to her malaria prophylaxis.*[12]

PCV Heiderman did not properly use the prevention strategies available to her as required by Peace Corps policy. As the MAR points out, "TG 840 sets the expectation that the agency's medical officers *and Volunteers* will act vigilantly to reduce Volunteers' risk of contracting malaria"[13] (emphasis added). The agency's TG 845 *Diagnosis and Treatment of Malaria* states, "Volunteers should not stop any chemoprophylactic regimen without consulting the Peace Corps Medical Officer (PCMO). Improper self-discontinuation of prophylaxis places a Volunteer at risk for malaria."

The MAR states that PCV Heiderman had not been adhering to her required malaria suppression medication for several months prior to falling ill at the end of December 2017 and did not notify the PCMO of this fact. Instead, as stated in the MAR, "PCV Heiderman asked him during one of his initial encounters (January 2 or 4) if she should be taking her Doxycycline along with the other medicine he was using to treat her symptoms. He…told PCV Heiderman to keep taking her Doxycycline and assumed her question meant that she had been taking it."[14] The Patient Encounter Forms (PEF) document Doxycycline on PCV Heiderman's active medication list, reflecting the PCMO's belief that his patient had been taking her antimalarial medications. This inaccurate assumption about malaria chemoprophylaxis, the atypical presentation of the disease, and the PCMO's incomplete documentation made diagnosis of malaria far more difficult than the MAR concludes.

[12] Management Advisory Report: Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/Comoros (IG-19-04-SR) (MAR) at 29.
[13] MAR at 7.
[14] MAR at 30.

PCV Heiderman's decision not to disclose her non-adherence with malaria prevention medication to the PCMO conveyed a very different risk profile, which contributed to the PCMO's assessment of potential diagnoses.

II. The MAR contains clinically relevant errors in the interpretation of the medical information and the complexity of the case.

a. The MAR relies on WHO recommendations to the exclusion of other authorities, including the Centers for Disease Control and Prevention and the Peace Corps' guidelines, and does not consider the challenges in medical diagnosis and decision-making.

The MAR refers to the 2015 WHO 'Guidelines for the Treatment of Malaria'[15] (WHO Guidelines) and relies upon them for establishing clinical standards in the care of malaria to the exclusion of all other authorities including the Centers for Disease Control and Prevention (CDC) and the Peace Corps' Technical Guidelines (TGs) effective at the time of this case.

The Peace Corps has historically aligned its malaria policy, specifically TG 845 *Diagnosis and Treatment of Malaria,* with recommendations from the CDC, a primary, authoritative external resource for the Peace Corps. Subsequent to PCV Heiderman's death, the 2018 Farr-Castle Peace Corps Reform Act requires Peace Corps to follow CDC guidance[16]. The PCMO and the Director of Medical Services' actions should be evaluated against the Technical Guidelines that medical staff were expected to use. It is not reasonable to expect Peace Corps clinicians to have used external, retrospectively identified guidelines in their clinical determinations in January 2018. The evaluation should have included a more detailed discussion of the medical literature, including the discrepancies and areas where guidance and guidelines vary in their descriptions of patients' symptoms (e.g., a description of temperature ranges) to better assess clinical decision-making in this case.

b. The MAR contends that PCV Heiderman had a fever, concluding that the PCMO and the Director of Medical Services should have made a definitive diagnosis of malaria.

Throughout the MAR, the words "temperature" and "fever" are used interchangeably.[17] In medical literature they are distinct and should not be used interchangeably.[18] This conflation of

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[15] https://apps.who.int/iris/bitstream/handle/10665/162441/9789241549127_eng.pdf;jsessionid=93AC020106E14B98FE8A51E3ECD8CD37?sequence=1

[16] 22 U.S.C. §2504(f), a(e)

[17] MAR at i; ii; 1; 9; 11; 12; 24; 25; 32; 34; 38.

[18] The word "temperature" refers to an objective data point – a quantifiable number. The word "fever" is a qualitative term used to classify temperature ranges and add clinical significance to a range of quantitative temperature recordings. For accuracy of an impartial assessment of a medical case, it is imperative that any reviewer

terms results in the conclusory statements that PCV Heiderman had a fever. However, there is no uniform description or criterion of "fever" in malaria related medical literature. PCV Heiderman's recorded temperatures did not rise to the level of a fever according to many clinical definitions of fever, including definitions from CDC[19] and the Infectious Disease Society of America[20].

The OIG's medical expert appropriately uses the word temperature in his timeline. He does not define the temperature as fevers or say that PCV Heiderman had fevers, in patterns either typical or atypical to malaria. The MAR quotes its medical expert's conclusion by adding the term 'fever', however, this is not what the OIG's medical expert stated.

The Director of Medical Services explained to the OIG staff in an interview that PCV Heiderman's temperature did not meet the threshold for a fever, based on the documentation maintained in the medical record by the PCMO.[21] The agency's TG 845 states that when diagnosing malaria a Volunteer's temperature, "may range from normal to 105ºF (40.6ºC). Most Volunteers will have a temperature of 102ºF or higher at some time in their illness." The Peace Corps' expert, Dr. Princy Kumar, Chief of the Division of Infectious Diseases and Travel Medicine at Georgetown University, and an expert in malaria, reported that "(Heiderman) did not have the more typical symptoms of high fevers, rigors and severe malaise which would be usual in a non-immune individual."[22]

c. The MAR oversimplifies diagnostic decision-making and does not consider, discuss, or analyze the complexities that would have been expected with a dynamic, 10-day course of illness.

The MAR oversimplifies the complexities of the case, because by the time OIG and the expert consultants were writing the MAR they were fully aware that malaria was the ultimate cause of death. The oversimplification occurs when the MAR applies early symptoms of malaria as typical throughout the clinical course of the disease and does not consider what severe malaria at a late stage presentation would typically look like. A patient within 7.5 hours of death from malaria, as was the case when the Director of Medical Services first reviewed the PCMO consult note in the agency's electronic medical record system, would not typically be described as improving (see Section III). A person with cerebral malaria, as PCV Heiderman was later found

understand the medical differences in these terms and also recognize that there is no uniform agreement in the medical literature of the precise range of quantified temperatures that should be classified as a clinical fever.

[19] https://www.cdc.gov/quarantine/maritime/definitions-signs-symptoms-conditions-ill-travelers.html

[20] https://www.idsociety.org/globalassets/idsa/practice-guidelines/2008-newfever-in-critically-ill.pdf

[21] MAR at 24-25.

[22] MAR at 55.

to have had, is usually obtunded, stuporous, or comatose.[23] They are typically ICU-level patients and they appear critically ill.[24]

Given that PCV Heiderman first reported symptoms on December 30, the information that the patient was feeling better would be atypical for a non-immune individual sick with malaria for at least 10 days. By omitting this important contextual information, the MAR does not consider or include all material facts that informed the clinical decision-making at the time of the evolving case.

d. The MAR failed to correct erroneous factual information and inaccurately questioned the accuracy of the agency expert's report.

An error in the MAR lists PCV Heiderman's hypotensive systolic blood pressure reading on the afternoon of January 8 as 60 mmHG systolic. The medical record documents her blood pressure reading as 80 mmHg systolic. This is a medically significant difference and would be readily noted by a medical professional. A blood pressure of 60 mmHG systolic would constitute shock, and would present with pale cold extremities and altered mental status.

The MAR also states that the report submitted by the Peace Corps' external consultant, Dr. Princy Kumar, Chief of the Division of Infectious Diseases and Travel Medicine at Georgetown University, included a timeline with several errors. The version attached as Appendix F to the MAR does not contain the errors reported by the OIG. The Peace Corps notified OIG of this matter prior to publication.

III. The MAR conveys an inaccurate impression that Peace Corps headquarters staff were not proactive in addressing the Volunteer's case and that the Director of Medical Services did not follow the agency's medical technical guidelines.

Typically, the agency is provided with an exposure draft of a MAR and given an informal opportunity to correct any inaccuracies in the draft or clarify issues that may have been overlooked. This case was unusual in that two exposure drafts of the MAR were issued. The second exposure draft contained six additions, which were not present in the first exposure draft, regarding the actions of the Washington, D.C. based Director of Medical Services. It is understood that the text was added to the second exposure draft after the first exposure draft was

[23] *Obtundation* is a state similar to lethargy in which the patient has a lessened interest in the environment, slowed responses to stimulation, and tends to sleep more than normal with drowsiness in between sleep states. *Stupor* means that only vigorous and repeated stimuli will arouse the individual, and when left undisturbed, the patient will immediately lapse back to the unresponsive state. *Coma* is a state of unarousable unresponsiveness. https://www.ncbi.nlm.nih.gov/books/NBK380/.

[24] Storm J, Craig AG Pathogenesis of cerebral malaria—inflammation and cytoadherence Front Cell Infect Microbiol. 2014 Jul 29;4:100

shared and discussed with PCV Heiderman's family, but without the addition of any new factual information supporting the additional changes.

Consistent with the agency's TG 370 *Field Consultation and Communication*, the Office of Medical Services provides consultation to overseas medical personnel. As part of a first consult, the Director of Medical Services is expected to review the available information and recommend a plan of management. When the Director of Medical Services was reviewing notes in the medical record system, she saw the recorded blood pressure of 80/60, and recognized that this was low and met the criteria per TG 212 *Clinical Escalation* for the PCMO to contact headquarters. The Director of Medical Services immediately called the PCMO directly. The PCMO provided an update on vital signs over the phone. PCV Heiderman's blood pressure had improved to 100/60, which is considered near the low range of normal for women and a value near her known baseline during service.

Further, at the time of the Director of Medical Services' call to the PCMO, the Patient Encounter Form (PEF) did not document a fever and included documentation that PCV Heiderman herself said she did not feel feverish. Likewise, PCV Heiderman's recorded temperature that day was 37.5°C (99.5ºF), which is not typically considered a fever according to the Peace Corps' malaria diagnosis guideline, TG 845 (see Section II. b.). During the call with the PCMO, who had firsthand, in-person knowledge of PCV Heiderman's situation, he indicated: PCV Heiderman was getting better; that he felt that the situation was under control; that antibiotics were not necessary; and that he did not believe hospitalization was necessary.

The revisions to the second exposure draft reference the fact that the Director of Medical Services did not discuss a possible malaria diagnosis with the PCMO. The clear implication is that failure to do so was improper. The agency maintains that the Director of Medical Services responded reasonably and thoroughly given the information she was provided at the time she worked to determine a cause and treatment for PCV Heiderman's symptoms. She immediately recommended additional tests and worked to ensure that resources were in place to activate a medical evacuation, if necessary.

The MAR implies that someone in the Director of Medical Services' position would arrive at a precise final diagnosis in less than an hour based on the incomplete information provided. The PCMO's anchoring on the diagnosis of gastrointestinal illness, the inclusion of Doxycycline anti-malarial medication on all PEF notes, the incomplete documentation and nonspecific clinical findings, the patient's and physician's assurances that she was feeling better, and the atypical temperature in a non-immune individual would not lead to an immediate diagnosis of malaria. The Director of Medical Service's actions were appropriate and reasonable given the context, circumstances, and timing.

The death of Bernice Heiderman in Comoros was a tragic event. It is important that the agency learns from this tragedy to better ensure that a case like this is not repeated.

Recommendation 1

That the Director deploy at least two qualified medical officers to Comoros and assess the need to have a minimum of two qualified medical officers at posts with an active Volunteer population, prioritizing in the short term those posts with just one medical officer and additional vulnerabilities or factors (e.g. a medical officer with limited clinical experience, a remote archipelago with inadequate local medical facilities) that complicate the agency's ability to meet Volunteers health care needs.

Concur

Response: The Office of Health Services (OHS) and the Office of Global Operations will recruit and add another PCMO in Comoros. The agency is currently assessing the need to have a minimum of two qualified medical officers at all other single PCMO posts.

Documents to be Submitted:

- *RMO Report*
- *Site assessment reports for single PCMO posts*
- *TG 204, Attachment J-Assessment of Air Ambulance Services*

Status and Timeline for Completion:

September 2019

Recommendation 2

That the associate director for the office of health services establish during hiring, chart review, mentoring, continuing medical education events or other clinical oversight and support processes, improved training for medical officers on diagnosing and treating sick patients in malaria areas that incorporates critical diagnostic considerations found in WHO Guidelines, including the importance of early consideration of a malaria diagnosis based on initial non-specific symptoms, particularly for non-immune patients such as Peace Corps Volunteers.

Partially Concur

Response: The Office of Medical Services (OMS) bases its recommendations for the prevention, diagnosis and treatment of malaria on the most recent guidance from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), current literature, expert consensus opinion, and evidence-based guidelines where they exist. The agency partially concurs with this recommendation because it does not solely rely on WHO Malaria Guidelines.

All PCMO candidates are asked an interview question, "What infectious and/or tropical diseases do you have experience treating?" as part of the hiring process. OHS' epidemiology unit has established improved training as referenced, including circulating to all posts a reminder email and review of malaria symptoms, testing, management and follow-up with links to current

review articles and resources on the epidemiology SharePoint site. In March 2019 a "Malaria Toolkit" was released on SharePoint with resources for post administration, PCMOs, and Volunteers, this was announced in the March OHS newsletter.

Malaria educational sessions were conducted during 2018 Continuing Medical Education (CME) cycle and will be during the 2019 CMEs. Malaria policy lectures were conducted during all OSTs in February 2018, October 2018 and February 2019. Both TG 840 *Prevention of Malaria* and TG 845 *Malaria Diagnosis and Treatment* are in the final process of external review.

Documents to be Submitted:

- Email to all posts about WHO temperature cutoff and need to test for Malaria in any illness in endemic countries
- TG 840 and 845 (See response #3)
- 2018 sample CME lecture on Malaria best practices
- 2019 sample OST lecture on Malaria policy
- 2018 sample CME agenda including lecture schedule
- 2019 planning documents for CME agenda
- OHS March Newsletter announcing malaria toolkit resource

Status and Timeline for Completion:

August/September 2019 (CME cycle)

Recommendation 3

That the associate director for the office of health services update the agency's medical technical guidelines for the prevention and treatment of malaria, and specify in them when the agency expects medical officers to suspect malaria, consistent with the most recent WHO Malaria Guidelines.

Partially Concur

Response: As noted in Recommendation 2, OMS bases its recommendations for the prevention, diagnosis and treatment of malaria on the most recent guidance from the CDC and WHO, current literature, expert consensus opinion, and evidence-based guidelines where they exist. The agency partially concurs with this recommendation because it does not solely rely on WHO Malaria Guidelines.

TGs 840 *Prevention of Malaria* and 845 *Malaria Diagnosis and Treatment* have both been updated and urge all PCMOs and Volunteers and Trainees working and living in malaria endemic areas to test for malaria when ill, whether with classic signs or non-specific illness. These updated TGs are with the CDC for peer review. The Domestic Malaria Chief in the CDC's Division of Malaria and Parasitic Diseases is our first peer reviewer has completed the review. After this review is complete, the agency will have a State Department Infectious Disease expert

review as well as outside experts in the neuropsychiatric side effects of antimalarial medication. These TGs and attachments are set to be complete prior to the PCMO CME this summer.

Documents to be Submitted:

- Updated TG *840 Prevention of Malaria and relevant attachments*
- Updated TG *845 Malaria Diagnosis and Treatment and relevant attachments*

Status and Timeline for Completion:

August 2019

Recommendation 4

That the associate director for the office of health services, taking into consideration prevailing malaria diagnosis and treatment guidelines, develop guidance for the treatment of sick patients (or make modifications to TG 113) that addresses when Peace Corps medical officers should consider and document in their assessment a suspected diagnosis of malaria as a matter of routine.

Concur

Response: TG 845 *Malaria Diagnosis and Treatment* has been updated to incorporate guidance on malaria evaluation and diagnosis.

In addition, there is extensive information in TG 845 on differential diagnosis, signs and symptoms, fever periodicity, laboratory diagnosis, and treatment. OHS also requires a consultation entered into PCMEDICS for all cases of presumed and confirmed malaria.

The escalation policy, TG 212 *Clinical Escalation Policy*, has been updated and circulated. It provides guidance regarding Peace Corps Medical Officer (PCMO) reporting of hospitalizations, critical injuries and illness to OHS.

TG 113 *Clinical Documentation Review* will be updated to incorporate documentation standards for presumed and confirmed malaria cases and documentation requirements.

Documents to be Submitted:

- *TG 845 Malaria Diagnosis and Treatment*
- *TG 212 Clinical Escalation Policy*
- *TG 113 Clinical Documentation Review*

Status and Timeline for Completion:

August 2019

Recommendation 5

That the associate director for the office of health services specify in technical guidance such as TG 113 the degree of documentation required to reflect the medical officer's assessment of possible underlying causes of the patient's symptoms.

Concur

Response: The updated TG 845 *Diagnosis and Treatment of Malaria* will contain guidance on malaria evaluation and diagnosis. PCMOs are instructed to suspect malaria until proven otherwise. There is also a section on writing required OHS consults for all cases of presumed and confirmed malaria cases.

In addition, TG 113 *Clinical Documentation Review* will be updated to integrate the requirements outlined in TG 845 and strengthen the requirements for clinical documentation.

Documents to be Submitted:

- *TG 845 Diagnosis and Treatment of Malaria*
- *TG 113 Clinical Documentation Review*

Status and Timeline for Completion:

August 2019

Recommendation 6

That the associate director for the office of health services examine the threshold for clinical escalation and adjust or clarify the threshold as appropriate to take into account that the agency's ability to respond to a medical emergency may be complicated by factors such as the lack of suitable local medical facilities, the lack of flights to the country, or other complexities.

Concur

Response: The Associate Director of OHS has examined the threshold for clinical escalation, and a revised clinical escalation policy, *TG 212 Clinical Escalation Policy*, has been completed and circulated to PCMOs and OHS staff. It will provide guidance regarding the PCMO reporting of hospitalizations, critical injuries and illnesses to OHS.

Documents to be Submitted:

- *TG 212 Clinical Escalation Policy*

Status and Timeline for Completion:

May 2019

Recommendation 7

That the Peace Corps Medical Officer(s) in Comoros institute a process to track and provide Volunteers with malaria chemoprophylaxis on a schedule that makes it possible for Volunteers to rigorously adhere to their antimalarial medication requirement, and administratively separate Volunteers who fail to adhere to their malaria prophylaxis schedules.

Concur

Response: The Comoros PCMO instituted a process to track malaria prophylaxis distribution for each PCV beginning in January 2019. The tracking is being done by the PCMO with assistance by the Medical Assistant (MA) for follow-up.

In addition, the PCV Comoros Health Manual is being updated with more detailed information about malaria and malaria prevention. The final update will be completed by June 1, 2019.

Concurrently, the PCMO will discuss compliance during site visits and use the document TG 204 to record her/his findings. Program staff will also include a conversation about health and taking malaria prophylaxis during their more frequent site visits. If Volunteers are found to be non-compliant with taking their malaria prophylaxis, staff will inform the PCMO, and the PCMO will inform the Country Director. Peace Corps Manual Section 262 *Peace Corps Medical Services Program* provides that "V/Ts who refuse to take required immunizations/vaccinations and medical prophylaxes will be administratively separated, as set out in MS 284 Early Termination of Service." If the Country Director determines that a V/T is refusing to take malaria prophylaxis, s/he will begin the administrative separation process as described in MS 284.

During Pre-Service Training (PST) all the Peace Corps Trainees (PCTs) received a session on malaria presented by a Peace Corps Medical Officer. This session provides background information on malaria, including transmission, symptoms, prevention and treatment. It stresses the importance of taking malaria prophylaxis and contacting the PCMO if malaria is suspected. It also outlines the potential consequences of not taking the prescribed prophylaxis. In addition, the Peace Corps/Department of State video KNOW Malaria was viewed by the PCTs. All Volunteers at Post have received a two-day Malaria Training by Health the APCD from PC Senegal. The training covers aspects of malaria infection and prevention, as well as activities useful in schools and at the community level.

Documents to be Submitted:

- *Tracking of Malaria Prophylaxis for current and future Volunteers*
- *Updated chapter on malaria for the PCV Comoros Health Manual*
- *TG 204, Attachment A PCMO Site Visit Checklist*
- *TG 204, Attachment B Non-PCMO Site Visit Checklist*
- *Updated PCV Comoros Handbook 2019-2020 (pages 64 and 113)*
- *PST Malaria Training Session Outline*
- *PST Malaria PowerPoint presentation*

Status and Timeline for Completion:

June 2019

APPENDIX H: OIG COMMENTS

OIG Comments Concerning the Agency's Responses to the Review's Recommendations

Management concurred with recommendations 1,4,5,6 and 7, and partially concurred with recommendations 2 and 3. In its response, management described actions it is taking or intends to take to address the issues that prompted each of our recommendations. We wish to note that in closing recommendations, we are not certifying that the agency has taken these actions or that we have reviewed their effect. Certifying compliance and verifying effectiveness are management's responsibilities. However, when we feel it is warranted, we may conduct a follow-up review to confirm that action has been taken and to evaluate the impact.

OIG will review and consider closing recommendations 1,3,4,5,6 and 7 when the documentation reflected in the agency's response to the preliminary report is received. For recommendation 2 additional documentation is required. This recommendation remains open pending confirmation from the chief compliance officer that the documentation reflected in our analysis below is received.

OIG commends the agency for its responses to the MAR's recommendations, which are generally thorough and responsive. The actions the agency has undertaken thus far appear well crafted to address the vulnerabilities identified in the MAR.

However, after providing our analysis of the agency's response to the MAR's recommendations, we address some of the statements the agency made in its response to other information in the MAR (see below).

Recommendation 2

That the associate director for the office of health services establish during hiring, chart review, mentoring, continuing medical education events or other clinical oversight and support processes, improved training for medical officers on diagnosing and treating sick patients in malaria areas that incorporates critical diagnostic considerations found in WHO Guidelines, including the importance of early consideration of a malaria diagnosis based on initial non-specific symptoms, particularly for non-immune patients such as Peace Corps Volunteers.

Partially Concur

Response: The Office of Medical Services (OMS) bases its recommendations for the prevention, diagnosis and treatment of malaria on the most recent guidance from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), current literature, expert consensus opinion, and evidence-based guidelines where they exist. The agency partially concurs with this recommendation because it does not solely rely on WHO Malaria Guidelines.

All PCMO candidates are asked an interview question, "What infectious and/or tropical diseases do you have experience treating?" as part of the hiring process. OHS' epidemiology unit has established improved training as referenced, including circulating to all posts a reminder email and review of malaria symptoms, testing, management and follow-up with links to current review articles and resources on the epidemiology SharePoint site. In March 2019 a "Malaria Toolkit" was released on SharePoint with resources for post administration, PCMOs, and Volunteers, this was announced in the March OHS newsletter.

Malaria educational sessions were conducted during 2018 Continuing Medical Education (CME) cycle and will be during the 2019 CMEs. Malaria policy lectures were conducted during all OSTs in February 2018, October 2018 and February 2019. Both TG 840 *Prevention of Malaria* and TG 845 *Malaria Diagnosis and Treatment* are in the final process of external review.

Documents to be Submitted:

- Email to all posts about WHO temperature cutoff and need to test for Malaria in any illness in endemic countries
- TG 840 and 845 (See response #3)
- 2018 Sample CME lecture on Malaria best practices
- 2019 Sample OST lecture on Malaria policy
- 2018 sample CME agenda including lecture schedule
- 2019 planning documents for CME agenda
- OHS March Newsletter announcing malaria toolkit resource

Status and Timeline for Completion:

August/September 2019 (CME cycle)

OIG Analysis: In addition to the documents listed above, OIG requests that the agency provide documentation of its actions to establish improved guidance or training on malaria diagnosis for medical officers during *mentoring* and *chart review* processes. Please refer to the paragraph in the report that precedes recommendation 2; the paragraph presents the results of our review of agency processes to provide guidance and feedback to new medical officers, including through chart reviews and mentoring, on their clinical documentation and management of sick patients.

OIG notes that the agency has partially concurred with the recommendation on the basis that it does not rely solely on WHO Guidelines. OIG understands that the agency does not rely solely on WHO Guidelines. The recommendation does not contain language that requires the agency to rely solely on WHO Guidelines.

OIG will review the documents to be submitted for evidence that the agency has incorporated in them information about the importance of an early consideration of a

malaria diagnosis based on initial non-specific symptoms, particularly for non-immune patients.

OIG Comments Concerning Other Statements in the Agency's Response to the Review

The agency's response to the MAR includes some statements that we address below.

I. PCV Heiderman did not adhere to malaria prevention steps and prophylaxis requirements, or fully disclose her prophylaxis non-compliance, which affected the diagnosis.

On the second page of the agency's response, the agency correctly states that "The Patient Encounter Forms (PEF) document Doxycycline on PCV Heiderman's active medication list…" The agency then asserts that the Doxycycline noted on these PEFs reflected PCMO Nizar's "belief" that PCV Heiderman had been taking her antimalarial medication. Based on our interview of PCMO Nizar, and as noted on page 30 of the MAR, he did not verify during his encounters with PCV Heiderman that she had been taking her doxycycline every day. Doxycycline was noted next to 'Current Medications' on the PEFs because the agency's electronic medical record system *automatically populated* PCV Heiderman's PEF with this information by pulling it from the previous PEF that PCMO Nizar had created for PCV Heiderman. Its presence on the PEF was therefore not reliable evidence of PCMO Nizar's belief that PCV Heiderman was taking this medication.

The agency's response further states on the second page that the presentation of malaria in this case was "atypical" without support for this characterization. The MAR presents extensive evidence that PCV Heiderman's recorded signs and symptoms were well characterized as indicators of malaria, especially the early signs and symptoms documented in the PEFs for January 2, 4, and 5. The medical technical guidelines we reviewed, including TG845, and information about malaria signs and symptoms from the CDC and the World Health Organization described the range of signs and symptoms noted on the PEFs for PCV Heiderman. This is significant because one of the principle vulnerabilities the MAR documented was that PCMO Nizar did not consider a diagnosis of malaria in PCV Heiderman because he did not recognize her non-specific symptoms as being consistent with a possible malaria infection. As noted in the MAR, PCMO Nizar had a clinical proclivity to consider a diagnosis of malaria based on the specific symptom of a high fever.

More importantly, as noted in the MAR, the agency's malaria technical guidelines instruct medical officers to assume that Volunteers serving in malaria areas have become infected with malaria and may develop the signs and symptoms of a malaria infection. The agency's medical guidelines require PCMOs to consider a diagnosis of malaria in any Volunteer regardless of the extent to which Volunteers may disclose or fail to disclose their adherence to their required malaria prophylaxis schedule. PCMO Nizar understood this requirement yet did not consider a

diagnosis of malaria because he did not observe the specific symptom of a *high* fever in PCV Heiderman that he believed signaled a malaria infection.

There is not a reasonable basis for the agency to state that the diagnosis of malaria in this case was more difficult to make as a result of PCV Heiderman's undisclosed non-adherence to malaria medication, or because her symptoms were atypical.

II. The MAR contains clinically relevant errors in the interpretation of the medical information and the complexity of the case.

The agency's response indicates its perception that OIG relies on World Health Organization guidelines "to the exclusion of other authorities." However, our MAR made broad use of Peace Corps medical technical guidelines and referenced other authorities including the CDC and WHO Guidelines. The MAR's recommendations were not written to preclude Peace Corps from referring to or incorporating malaria diagnostic guidance from other authoritative sources.

The MAR included 2 recommendations that Peace Corps incorporate diagnostic guidelines and considerations found in the WHO's 2015 malaria guidelines because: 1) Peace Corps medical technical guideline 845 was out of date and 2) the incorporation and consideration of these more recent and authoritative WHO guidelines would have made it more likely that PCMO Nizar would have tested PCV Heiderman for a possible malaria infection. The PEFs for each of the documented encounters PCMO Nizar had with PCV Heiderman included the signs and symptoms that the WHO Guidelines indicate should prompt a suspicion of malaria. This was less clear when we compared the PEFs to the more ambiguous ("febrile") and outdated malaria diagnostic guidance found in TG 845. The 2015 WHO Guidelines appeared specifically written to provide unambiguous guidance to clinicians designed to increase the likelihood of identifying a malaria infection before it progresses to serious or complicated malaria, especially in developing countries where the risk of malaria infection is high, and the availability of advanced medical care is limited.

On the third page of the agency's response to the MAR, the agency says that "Subsequent to PCV Heiderman's death, the 2018 Farr-Castle Peace Corps Reform Act requires Peace Corps to follow CDC guidance." While under 22 U.S.C. §2504(f) the Peace Corps is required to follow Centers of Disease Control and Prevention guidance "regarding the prescription of medications" to volunteers, the act does not require or suggest that the Peace Corps limit its medical technical guidance for malaria diagnosis and treatment to the CDC, or prevent the agency from considering and incorporating diagnostic guidance found in other authoritative sources such as the WHO Guidelines.

On the third page of the agency's response, the agency incorrectly states that our MAR presents a conclusion that PCMO Nizar and the Director of the Office of Medical Services "should have made a definitive diagnosis of malaria." This overstates what the MAR says. As noted in the MAR, TG 845 directs medical officers to "always consider the diagnosis of malaria in any

febrile Volunteer who has been in a malaria area for more than one week." The MAR states that the PCMO and the Director of OMS did not consider a diagnosis of malaria. The MAR provides an assessment of why malaria was not considered in order to identify the underlying vulnerabilities the agency should address to reduce the risk that other medical officers would fail to consider a diagnosis of malaria when treating a patient with similar symptoms.

On the fifth page of the agency's response, it states that the MAR includes a systolic blood pressure reading on the afternoon of January 8 as 60 mmHG systolic. The timeline in the MAR on page 15 correctly states the blood pressure as 80/60 mmHg on the afternoon of January 8. However, the agency is correct that the MAR includes on page 28 the wrong hypotensive systolic blood pressure number "(60 mmHg systolic)", which should read "(80 mmHg systolic)." In our analysis we utilized the reading to discuss the threshold for clinical escalation. The reading of 80 mmHg systolic was below the agency's threshold for a clinical escalation. The error did not impact our finding and conclusion, but OIG will make the necessary correction on page 28 of the report.

On the fifth page of the agency's response, it states that the appended report by the external consultant does not contain the errors the MAR reported. The agency provided OIG with two versions of the consultant's report. Both reports contained timeline errors. As the MAR states, the information in the consultant's report related to January 7th includes information for January 8th, not January 7th.

III. The MAR conveys an inaccurate impression that Peace Corps headquarters staff were not proactive in addressing the Volunteer's case and that the Director of Medical Services did not follow the agency's medical technical guidelines.

The agency notes that without any new factual information supporting additional changes, OIG added text to the report after the first exposure draft was shared with the agency and PCV Heiderman's family. Our final report does include edits we made during our final review of the report, based in part on input we received from the agency and PCV Heiderman's family. This final review was part of our quality assurance process. As a part of that process both the Agency and the personal representative for PCV Heiderman were provided exposure drafts of this report in order to identify any perceived errors or inaccuracies in it.[25] We then made edits to the MAR that we determined were reasonable, important, and supportable based on the evidence we had collected.

With respect to the particular finding that PCMO Nizar and Dr. Colantino had not followed relevant medical diagnostic guidelines for malaria, OIG updated the finding to more clearly present criteria that was in the exposure draft but had not been directly cited in the finding

[25] OIG notes that the personal representative for PCV Heiderman was provided an exposure draft because the family served as an important source of information to understand the facts and circumstances surrounding her death.

statement: that neither physician had followed the agency's guidelines in TG 845 to "always consider" a diagnosis of malaria. The finding statement in the final MAR references the physicians' non-adherence to TG 845 in order to focus the rest of the finding on the underlying reasons why the agency's guidelines were not followed in this case.

OIG disagrees that the MAR conveys inaccurate impressions. The MAR accurately describes the actions of Dr. Colatino on January 8th, specifically as of 2:40 pm EST when she called PCMO Nizar after having reviewed the consult note he had entered a few hours earlier. The MAR summarizes Dr. Colantino's discussions with PCMO Nizar and other actions she took. The MAR includes a finding that PCMO Nizar did not follow the agency's clinical escalation properly or the instructions he had received from Dr. Colantino by phone on January 8th.

Help Promote the Integrity, Efficiency, and Effectiveness of the Peace Corps

Anyone knowing of wasteful practices, abuse, mismanagement, fraud, or unlawful activity involving Peace Corps programs or personnel should contact the Office of Inspector General. Reports or complaints can also be made anonymously.

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To: Jody Olsen, Director
Anne Hughes, Chief Compliance Officer

From: Kathy A. Buller, Inspector General

Subject: Management Advisory Report: Seed Global Health Services (IG-19-01-SR)

Date: October 25, 2018

The purpose of this management advisory report is to bring to the Peace Corps' attention concerns the Office of Inspector General (OIG) identified as a result of a series of media claims regarding favoritism and improper conduct involving Peace Corps officials and a nonprofit operated by the daughter of then-Secretary of State and former Chair of the Senate Foreign Relations Committee, John Kerry. Starting September 12, 2016, the series of press articles cited that more than $9 million of Department of State funding was funneled through the Peace Corps to Seed Global Health (formerly named Global Health Service Corps and hereinafter referred to as "Seed") without competition.[1] OIG was not made aware of this claim prior to the publication of these articles. However, we subsequently initiated this review to assess the Peace Corps' actions in relation to the claims identified in the articles.[2]

In September 2012, the Peace Corps entered into a cooperative agreement with Seed. The objective of our review was to determine if the cooperative agreement was awarded in accordance with applicable laws and policies. As such, the scope of our review was limited to the actions of the Peace Corps.[3]

Our review found that the Peace Corps did not fully comply with applicable Federal requirements relating to cooperative agreements and lacked internal controls in making the award to Seed. Specifically, the Peace Corps did not have sufficient documentation to justify awarding the cooperative agreement without competition. The Peace Corps made itself vulnerable to the perception of favoritism by obligating a total of approximately $7.5 million in Department of State funding to Seed through the award, modifications, and extensions of the agreement without proper controls. There was no segregation of duties for a senior agency official involved in the development, evaluation, awards, and oversight of the agreement with Seed. The Peace Corps lacked key policies governing cooperative agreements and, even after developing draft guidance, failed to properly implement it. Additionally, we identified other weaknesses in the cooperative agreement process including poor file management and lack of

[1] THE DAILY CALLER, *Exclusive: John Kerry's State Department Funneled Millions to His Daughter's Nonprofit*, September 12, 2016, available at: http://dailycaller.com/2016/09/12/exclusive-john-kerrys-state-department-funneled-millions-to-his-daughters-nonprofit/ (last accessed August 21, 2018).
[2] Our review does not address the programmatic merits and success of the cooperative agreement, as such determination would be outside of the scope of this review.
[3] Within the scope of our review, we did not identify any action taken by Secretary of State Kerry in relation to the awarding and funding of the cooperative agreement with Seed.

compliance with Federal laws and regulations. For example, the Peace Corps failed to obtain the necessary anti-lobbying certifications from Seed.

This report makes six recommendations to improve the agency's cooperative agreement process. The agency has 45 days from the issuance of the report to provide its response to these recommendations. Once we receive the response, the report will be updated to include it in Appendix A.

Background

The Department of State's Office of the U.S. Global AIDS Coordinator (OGAC) oversees and coordinates the U.S. global response to HIV/AIDS and reports directly to the Secretary of State. The Peace Corps has a memorandum of agreement (MOA) with OGAC to allocate U.S. President's Emergency Plan for AIDS Relief (PEPFAR) [4] funds each fiscal year. The MOA is amended for all subsequent increases of the allocation of funds within that fiscal year. The Peace Corps uses those funds to support its efforts to meet the HIV/AIDS prevention, care, and treatment goals set forth in PEPFAR. According to the MOA, the Peace Corps is responsible for keeping full and complete records and for exercising due diligence in the use of funds provided under the MOA.

The Peace Corps, using the funds allocated under the MOA, established the Global Health Service Partnership (GHSP) by entering into a cooperative agreement[5] with Seed in 2012. Seed is a non-profit organization established in 2011 with a mission to create sustainable solutions to strengthen health systems abroad by helping to address the vast shortages of health professionals in many resource-poor settings. The goal of the GHSP was to build stronger health sectors in developing countries. Through the cooperative agreement, GHSP placed U.S. health professionals alongside local medical and nursing faculty counterparts to meet the teaching needs identified at each partner institution. As of FY 2017, the program has placed a total of approximately 234 GHSP clinical educators in 5 countries.

The Office of Global Health and HIV (OGHH) provides agency-level guidance and overall leadership for the GHSP.[6] The agreement officer representative (AOR) for the GHSP cooperative agreement works in OGHH and is designated in writing by the agreement officer (AO)[7] to "assist in technical monitoring and administering certain aspects of the agreement." The Peace Corps' cooperative agreement with Seed requires the AOR to have substantial

[4] PEPFAR is the U.S. Government initiative to help save the lives of those suffering from HIV/AIDS around the world. GHSP funding is passed from OGAC to the Peace Corps through the Headquarters Operational Plan as part of Technical Leadership and Support. The Headquarters Operational Plan captures costs associated with staff at agency headquarters working specifically on PEPFAR and activities implemented by headquarters in support of field programs. The primary role of agency headquarters operations is to support field staff and country-level efforts towards PEPFAR goals.

[5] In OMB Uniform Guidance Section 200.24, the Office of Management and Budget (OMB) defines a cooperative agreement as a legal instrument of financial assistance between a Federal awarding agency or pass-through entity and a non-Federal entity. A cooperative agreement provides for substantial involvement between the Federal awarding agency or pass-through entity and the non-Federal entity.

[6] This role was initially provided by OGHH, then transitioned to the Office of Global Operations in 2013, to the Africa Region in 2014, and then finally back to OGHH in 2016.

[7] The AO has legal responsibility for this agreement and takes action on behalf of Peace Corps. The AO is located in the Office of Chief Financial Officer/Acquisition and Contract Management (OCFO/ACM).

involvement in assisting Seed achieve its agreement objectives to help support the Peace Corps in the GHSP.

The funding for the GHSP cooperative agreement is substantial relative to most of the Peace Corps' procurements, including contracts, and the only other large grant or cooperative agreement.[8] For example throughout the implementation period, Seed ranked among the top five agency awards. From the program's establishment to November 2017, the Peace Corps obligated over $7.5 million in funding under the cooperative agreement for Seed.

Table 1: GHSP funding summary as of June 2018. ***Source: The Peace Corps' budget office.***

Description	Amount (USD)	% of Transfers
Funding Obligated to Seed to implement GHSP	$7,525,000	36%
Funding Allotted to Peace Corps to support GHSP[9]	$13,509,698	64%
Total GHSP funding transferred from OGAC to Peace	**$21,034,698**	**100%**

As of April 2018, Peace Corps had disbursed $6,305,329 to Seed under the cooperative agreement.[10] Additionally, the Peace Corps allocated more than $13.5 million in PEPFAR funds to support GHSP activities.

Table 2: A Summary of the Peace Corps' Cooperative Agreement and Modifications with Seed, Associated Obligated Amounts, and the Reason for the Agreement or Modification. ***Source: OCFO/ACM Cooperative Agreement File.***

Agreement Type	Agreement Date	Period of Performance		Action Obligation	Reason for Agreement or Modification
Base	9/10/2012	9/10/2012	9/9/2015	$500,000	1st year obligation $500,000; 2nd year $650,000; and 3rd year $850,000
Mod 1	6/12/2013	9/10/2012	9/9/2015	$0.00	Change name from Global Health Service Corps to Seed Global Health
Mod 2	8/21/2013	9/10/2012	9/9/2015	$150,000	1st year obligation $650,000; 2nd year $1,109,268 and 3rd year $1,100,540
Mod 3	1/13/2014	9/10/2012	9/9/2015	$1,109,268	Obligated 2nd year agreement funds and included 1st year amount total $1,759,268.
Mod 4	11/19/2014	9/10/2012	9/9/2015	$140,732	3rd year total obligation of $1,900,000
Mod 5	2/27/2015	9/10/2012	9/9/2015	$959,808	3rd year total obligation of $2,859,808
Mod 6	9/9/2015	9/16/2012	9/30/2015	$0.00	Extend the end date to 9/30/2015
Mod 7	9/22/2015	9/30/2015	9/30/2019	$400,000	Extend agreement 4 additional years and obligate $400,000 for 10/1/2015-12/31/2015
Mod 8	3/1/2016	3/1/2016	9/30/2017	$2,870,000	Fully fund 4th and 5th year with a total of $2,780,000

[8] OIG was able to identify one other cooperative agreement over $500,000 - Grassroot Soccer, Inc., awarded on May 2, 2016 for an obligated amount of $548,552 for 3 years.

[9] This funding was spent on direct volunteer costs for GHSP volunteers in five posts (Tanzania, Uganda, Malawi, Liberia, and Swaziland) as well as support costs, including staff, supplies and equipment, and travel, etc. at all five posts and HQ.

[10] Prior to entering into the cooperative agreement with Seed, Peace Corps also paid $36,664 in travel related expenses for Seed employees or associates.

Mod 9	8/28/2017	3/1/2016	9/30/2017	$0	De-obligate $400,000 from FY16-FY17 funding and obligate $400,000 to replace the de-obligated funds
Mod 10	9/27/2017	3/1/2016	9/30/2018	$0	Revised the period of performance to end on Sept. 30, 2018
Mod 11	11/30/2017	10/1/2017	9/30/2018	$1,395,192	De-obligate $184,808, de-obligate $300,000, obligate $1,808,000
Mod 12	12/7/2017	10/1/2017	9/30/2018	$0	Correct typo in mod 11 to de-obligate 184,808 to reduce the amount to 775,000
Mod 13	9/7/2018	10/1/2017	9/30/2018 [sic]	$0	Perform a no cost period of performance extension until 12/31/2018

Peace Corps decided in February 2018 to discontinue GHSP, citing changes in PEPFAR funding for centrally managed activities. Accordingly, the agency reported that GHSP Volunteer activities ceased as of September 30, 2018, and Seed is currently conducting close out activities.

Issues

There was a lack of segregation of duties for the former AOR/Director of OGHH during the cooperative agreement's initial awarding process.

In 2011, the former Peace Corps Director (2009-2012) discussed an initiative to deploy medical professionals around the world with the founder of Seed. Subsequently, he asked the former Director of OGHH to become involved in developing a pilot program and to seek funding for it. The former Director of OGHH had been representing the Peace Corps at weekly OGAC meetings concerning the use of PEPFAR funding. One of the goals of PEPFAR was to train 140,000 health care workers. The Seed pilot program proposal was seen as a natural fit—to recruit doctors and nurses to serve as educators and to work side-by-side with host country national counterparts to increase the quality and capacity of their practice. After meeting with the former Peace Corps Director, the former Director of OGHH suggested there might be an intersection of interests between the proposed pilot program and the goals of PEPFAR. He knew the former Ambassador of OGAC from previous employment and discussed the idea and funding with the Ambassador. In addition to the agency's role in securing funding, a review of Peace Corps documents demonstrates that agency officials, including the former Director of OGHH, were involved in helping formulate the Seed pilot project proposal.

Despite his involvement in developing the pilot program proposal and working to obtain the funding source, in March 2012, the former Director of OGHH was designated the chairperson for the Technical Evaluation Committee (TEC). The TEC typically evaluates multiple proposals to carry out an agreement during the award process, but, in this case, was involved in the vetting process of Seed as the sole source. As chairperson of TEC, he was responsible for the committee's evaluation of the technical proposal submitted by Seed.[11] Essentially, the former Director of OGHH was evaluating a proposal that he had been involved in developing.

In September 2012, the cooperative agreement was signed designating the former Director of OGHH as the AOR. In the role of AOR, he was substantially involved in the management of

[11] According to the appointment memorandum, "The potential for conflict of interest for employees involved in the evaluation of proposals is a serious matter that at any time could call into question the entirety of the evaluation process. Even the appearance of a conflict of interest during the process may invite protests or litigation."

Seed's agreement. Because of the active involvement in the development and implementation of Seed's agreement, we concluded this designation to manage the agreement created a lack of segregation of duties and a perception of favoritism.

The Government Accountability Office standards state that segregation of duties helps prevent fraud, waste, and abuse in the internal control system.[12] We determined that the former Director of OGHH should have recused himself from the TEC chairperson role and, under the circumstances, the AOR role to avoid the appearance of bias and favoritism.

Moreover, in 2012, the former Director of OGHH left the Peace Corps and began working for Seed in 2015.[13] A criminal conflict of interest law permanently prohibited him from making an appearance before or communicating to Peace Corps regarding the cooperative agreement on behalf of Seed because of his personal and substantial involvement with the agreement.[14] He was later criminally charged[15] and entered into a deferred prosecution agreement with the U.S. Attorney's Office for the District of Columbia, which included paying a $10,000 penalty.[16]

We concluded that there have not been any segregation of duties issues with the present AOR who was not involved in the commencement of this cooperative agreement. We found that the AOR consistently monitors the activity of the program and reports directly to the present Director of OGHH.

Agency policy on cooperative agreements was lacking and procedural guidance was untimely and insufficient.

At the time of the initial award, the agency lacked comprehensive policy regarding cooperative agreements. Further, for much of the period of performance the agency used a draft, unvetted guidance to govern the provision of funding to Seed through the cooperative agreement without competition. The draft document was initially drafted by the contracting specialist in May 2013, 8 months after the initial Seed agreement was awarded. The former Chief Acquisition Officer (CAO),[17] who replaced the initial agreement officer, and the former contract specialist assigned to the cooperative agreement confirmed that the Peace Corps did not have a cooperative agreement policy at the time of the initial award.

[12] The Government Accountability Office's "Standards for Internal Control in the Federal Government" (GAO-14-704G) (Sept. 2014), Section 10.13. Section 3.08 further provides, "As part of delegating authority, management evaluates the delegation for proper segregation of duties within the unit and in the organizational structure. Segregation of duties helps prevent fraud, waste, and abuse in the entity by considering the need to separate authority, custody, and accounting in the organizational structure."

[13] The former Director of OGHH was hired as the Director of Operations for Seed, tasked with overseeing and managing relationships, including contracts and agreements, Peace Corps and PEPFAR, as well as representing SEED in negotiations.

[14] Title 18, United States Code Sections 207(a)(1).

[15] United States of America v. Warren W. Buckingham, U.S. District Court for the District of Columbia, Criminal no. 18-CR-21 (RMC) (2018).

[16] See Press Release, Peace Corps referral results in successful criminal prosecution, February 16, 2018.

[17] The CAO from the Peace Corps Office of the Chief of Financial Officer/Acquisition and Contract Management (OCFO/ACM) is responsible for awarding and administering the agency's contracts and agreements. Throughout the cooperative agreement process Peace Corps had two CAOs (2011 - 2013 and 2014 - 2016) and 3 acting CAOs.

The Government Accountability Office guidance states that management should implement control activities through policies.[18] The Peace Corps did not have a comprehensive policy on cooperative agreement awards. This likely contributed to the Peace Corps' failure to maximize competition when considering this agreement and to maintain sufficient documentation to support the noncompetition of the agreement, as detailed later in this report.

After the agreement was awarded, the former contract specialist stated that a draft policy was quickly developed when he recognized the need to have a policy in place. According to the contract policy specialist, USAID grant and cooperative agreement policy was used to model this draft guidance. Other documents reviewed by OIG confirm that, in the absence of an agency policy, the agency relied on the USAID grant and cooperative agreement policy as a best practice during the extension of the cooperative agreement.

Other Peace Corps officials acknowledged the timing of the issuance of the draft policy and confirmed it was never properly issued in final and, therefore, was not vetted by the Director or Senior Policy Committee as a procedure or a policy. Yet the former CAO (2014 – 2016) and staff stated Peace Corps OCFO/ACM has used the draft policy as a procedural guide for cooperative agreements since 2013.

Although the draft policy had not been made official agency policy, the former agreement officer referenced the draft policy in a 2015 official document justifying the Peace Corps' decision to extend the cooperative agreement for four additional years and to provide additional funding to Seed without competition. The Justification for Exception to Competition (JEC) memo stated, "This extension is requested under the Peace Corps draft Manual Section 735 exception to competition X.b.6 'Follow-on Awards and Extensions'." However, the Peace Corps Manual did not contain a section 735 and the draft language in question had not even been submitted to the Senior Policy Committee for consideration. The Senior Policy Committee did not vet and issue the draft policy as required under the Peace Corps Manual. This contributed to the agency's failure to implement adequate controls to identify weaknesses or gaps and ensure compliance with relevant regulations. Without a formal, transparent policy in place that governs how the Peace Corps engaged in cooperative agreements and disbursed multimillion dollar funding, the agency was made susceptible to perception of favoritism and bias.

Both the former CAO and the contracting staff indicated that the process of finalizing the draft policy document was not a priority in comparison to other duties since only two cooperative agreements had been issued. Immediately prior to the December 2016 departure of the former CAO, the former CAO issued a memorandum making the draft policy a procedure within ACM.

Moreover, this is not the first time OIG reported the need for the Peace Corps to develop policies and procedures for awarding cooperative agreements. In our 2012 audit of the Peace Corps' 50th Anniversary Program OIG recommended that the then Office of Acquisitions and Contract Management develop policies and procedures for awarding cooperative agreements, including appropriate uses, competition, and required documentation. OIG closed the recommendation in 2017 with the expectation that the guidance would be promptly issued as an agency policy and

[18] The Government Accountability Office's "Standards for Internal Control in the Federal Government" (GAO-14-704G) (Sept. 2014), Section 12.01.

procedure. However, to date the agency has not issued a policy and procedure on cooperative agreements.

Lack of competition and unsupported sole source justification put the agency at risk.

The Federal Grant and Cooperative Agreement Act of 1977 encourages competition, where deemed appropriate, in awarding cooperative agreements.[19] However, the Peace Corps did not compete the cooperative agreement. Instead, the former CAO (2011 - 2013), supported by the former contracting specialist, made a sole-source award based on an explicit, unsupported justification. The September 10, 2012 negotiation memorandum stated:

> This requirement was not publicly competed because the Office of the Global AIDS Coordinator (OGAC) required that PEPFAR funding be solely awarded to Global Health Service Corps for the GHSP. Please see attached document for further details.

The "attached document" was an announcement stating the launch of a partnership between the Peace Corps and Seed that did not include any details about OGAC requiring the Peace Corps to sole-source the award. Further, the announcement of the partnership was dated March 13, 2012, almost 6 months in advance of when the cooperative agreement was awarded.[20] When instructed by the former CAO[21] to prepare the agreement, the former contracting specialist received only the announcement as support for the justification to not compete the cooperative agreement.

OIG reviewed the relevant agreement files, agency documents, and media reports, as well as conducted interviews of current and former agency officials directly involved in negotiating and executing the cooperative agreement. Current and former agency officials could neither identify the source, nor confirm the details, of the OGAC requirement that the PEPFAR funding be solely awarded to Seed. After being shown the negotiation memorandum, the former Director of OGHH[22] stated that no one at OGAC had issued such an explicit direction. He told OIG that the justification for not publicly competing the cooperative agreement - that OGAC required Peace Corps to solely award the cooperative agreement to Seed - was not accurately stated. Rather, the former Director of OGHH confirmed he approached OGAC with the request for funding. Essentially, OIG found no supporting evidence for the justification statement in the 2012 negotiation memorandum.

Additionally, key agency officials may have mistakenly believed that there was another basis for sole-sourcing the agreement and extensions. Agencies may generally award sole-source cooperative agreements, grants, or contracts pursuant to receiving an unsolicited proposal. For example, the USAID policy, which the agency relied on as a best practice, closely mirrors what eventually became Peace Corps guidance:

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[19] Pub. L. 95-224, 92 Stat. 3, (Feb. 3, 1978), as amended by Pub. L.97-258, 96 Stat 1004 (Sept. 13, 1982), codified in relevant part at 31 U.S.C. Chapter 63 "Using Procurement Contracts and Grant and Cooperative Agreements."

[20] Although the announcement referred to the creation of a Public Private Partnership, a review of agency records of GHSP indicate that the engagement was treated as a type of non-contract procurement rather than a strategic partnership under MS 103.

[21] Peace Corps OIG contacted the former CAO, since retired, to discuss the Seed cooperative agreement. The former CAO did not make herself available for an interview.

[22] As previously mentioned, the former Director of OGHH signed a deferred prosecution agreement to truthfully cooperate with Peace Corps OIG.

Unsolicited applications

Unsolicited applications are those submitted to USAID for an award by an applicant solely on their initiative, without prior formal or informal solicitation by USAID.

USAID may make an award based on an unsolicited application when the application:

- Clearly demonstrates a unique, innovative, or proprietary program;
- Represents an appropriate use of USAID funds to support or stimulate a public purpose; and
- Fits within an existing Development Objective.

* * * * * *

To use this exception to restrict eligibility, the Activity Manager must first certify that USAID did not solicit the application and that it was submitted by the applicant solely on the applicant's own initiative.[23]

Though the agency did not have official policy on the matter at the time of the initial award,[24] the 2013 draft policy (issued December 12, 2016 as an official procedural document, but used as guidance since 2013) states the following regarding unsolicited proposals:

> To use this exception to competition, the Program Office must certify that Peace Corps did not solicit the application and that it was submitted by the applicant solely on his or her own initiative.
>
> The Program Office must submit a JEC that addresses how the following issues warrant acceptance of the application without competition:
>
> - The way the application is unique, innovative, or proprietary;
> - How funding the application is an appropriate use of Government funds to support or simulate a public purpose; and
> - Describe how it fits within Peace Corps' mission and goals.[25]

There may have been a misconception among key staff that the cooperative agreement resulted from an unsolicited proposal.[26] The former Director of OGHH told OIG that the cooperative agreement was deemed an unsolicited proposal and did not need to be competed. The former contracting specialist for the agreement also stated his belief that "it was an unsolicited proposal." However, this determination was not explicitly mentioned in the 2012 negotiation memorandum he prepared justifying the initial sole-source award.

The reference to an "unsolicited proposal" later appeared in official documents justifying the sole-source extensions. The 2015 JEC accompanying a sole-source extension of the cooperative agreement stated that the Seed Pilot project was "created as a result of an unsolicited proposal to the Peace Corps Director from Seed…." However, the documentation OIG reviewed indicates that Peace Corps officials were involved in the development of the Seed Pilot project proposal from its inception, including in soliciting the PEPFAR funds. After informal discussions

[23] ADS Chapter 303.3.6.5, "Grants and Cooperative Agreements to Non-Governmental Organizations."
[24] OIG notes that Peace Corps MS 736 addresses unsolicited proposals in the context of procurements. Similarly, in that context, the definition excludes proposals that are in response to a formal or informal government request. Only proposals independently originated and developed by the offeror and prepared without government supervision qualify as unsolicited.
[25] See ADS Chapter 303.3.6.5, "Grants and Cooperative Agreements to Non-Governmental Organizations." Agency documents confirm the former Agreement Officer considered the USAID guidance as a best practice. Further, the former contracting specialist, who prepared the Seed agreement also prepared what would become the draft policy, stated that he used USAID's guidance when preparing the draft policy.
[26] Peace Corps currently does not have a manual section on unsolicited proposals for cooperative agreements.

occurred between the founder of Seed and the former Director of Peace Corps, the former Director of OGHH was asked to prepare background information in Spring 2011. While the 2012 negotiation memorandum noted that Seed submitted a concept paper on January 20, 2012, the Peace Corps was already paying travel expenses for Seed officials starting in November 2011. Additionally, OIG obtained meeting minutes dated back to 2011 between senior agency officials and Seed officials discussing the project's parameters. Regardless, the documentation for the initial award did not include information generally required for sole-source awards pursuant to unsolicited proposals, such as a description of how the origin of this initiative was submitted by the applicant solely on his or her own initiative or an analysis of the uniqueness of the program. Additionally, the Office of General Counsel (OGC) later confirmed during our review that the initial award was not pursuant to an unsolicited proposal.

When the agency was extending the cooperative agreement in 2015 and developing a new JEC for that extension, ACM reported that the 2013 draft policy was provided to contracting staff as guidance. The 2013 draft policy expressed an intent to adopt the principle of competition, stating that competition in the awarding of cooperative agreements is required to identify and fund the best projects to achieve program objectives. The 2013 draft policy included a requirement that each JEC, including for extensions, must contain sufficient facts and rationale. This requirement is consistent with other Federal agencies which mandate agreement files must contain proper justification for awarding grants or cooperative agreements without full and open competition.

The Peace Corps performed market research by reviewing several organizations it identified as possible competitors. The market research stated Peace Corps was unable to identify among the selected organizations any potential partners to satisfy its program needs, thus resulting in OCFO/ACM awarding a sole-source extension for 4 additional years.[27] Yet OCFO/ACM officials told OIG that the agreement was extended as sole-source because there was insufficient time to transition a new selectee into the program, and Seed had an outstanding performance record with the program. They also noted that poor planning impeded its ability to fully compete a new cooperative agreement. The former acting CAO (2016 - 2018) acknowledged challenges the Peace Corps has in ensuring contracts and agreements are competed. Nevertheless, under the 2013 draft guidance or best practices, improper planning is not considered justification for not maximizing competition. Peace Corps actions put the government at risk of not receiving the best program outcome by failing to compete the agreement. Moreover, the lack of competition and the unsupported justification at the time of the extension risked furthering the perception of favoritism.

The Peace Corps did not impose proper limitations on agreement extensions.

Section 10(c) of the Peace Corps Act, as amended, states an agreement which entails commitments for the expenditure of funds may extend at any time for not more than five years.[28] The agency has opined that this provision not only allows for cooperative agreements to extend for up to five years at a time, but that a cooperative agreement may be extended at any time for up to 5 years into the future. In effect, under Peace Corps' interpretation of Section 10(c), the

[27] As noted above, agency officials and Seed worked together to develop what would become the duties of the cooperative agreement recipient (i.e., Seed's duties) under the original agreement.
[28] Peace Corps Act Section 10(c), Pub. L. 87-293, 75 Stat. 414, 618 (Sept. 22, 1961); as amended by Pub. L. 103–236, title VI, §602 (Apr. 30, 1994); found at 22 U.S.C. § 2509(c).

agency, upon sole sourcing a cooperative agreement, may extend that agreement in perpetuity as long as no single extension goes more than five years into the future, absent other restriction.[29]

The initial Seed agreement term was set for three years, beginning September 10, 2012 and ending on September 9, 2015. Agreement Modifications 006 and 007, effective September 9, 2015 and September 22, 2015, respectively, further extended the agreement through September 30, 2019 with funding awarded annually via modification. Modification 010, effective September 27, 2017, revised the period of performance to end on September 30, 2018. On September 7, 2018, Modification 013 extended the period of performance the agreement with Seed was extended, possibly for the last time, [30] until December 31, 2018.

As noted, the agency entered into the cooperative agreement without official guidance on the award and management of cooperative agreements. Further, as noted, the agency did not have proper, official guidance for the development or extension of sole-sourced cooperative agreements. Guidance was not formalized until December 2016, when it was issued by the CAO as a procedure to domestic contracting staff.[31] The internal guidance had not been vetted by OGC or the Senior Policy Committee or promulgated as agency policy.[32]

The Peace Corps draft policy differed in a material respect from the best practice guidance it identified. Under USAID policy, the unsolicited proposal exception to competition cannot be used to justify non-competitive extensions to existing cooperative agreements or grants. However, Peace Corps internal guidance says that, with respect to awards without competition, extensions of $25,000 or more cannot extend beyond 7 years of the original award date.[33] The 7-year limitation exactly matches the number of years that the cooperative agreement with Seed was extended prior to the issuance of the internal guidance, and no further explanation has been provided as to why the agency decided that a 7-year limitation was appropriate.[34] Further, OIG reviewed internal correspondence in which the CAO asserted that there are no legal or regulatory limitations, internal or external, on the authority to extend cooperative agreements. She also noted that cooperative agreements may be written for "whatever period the agency deems appropriate." The CAO's assertions were made in response to an external inquiry and were provided one year after the 2015 Seed extension, and three months prior to issuing the internal procedure document. She did not discuss the internal 7-year limitation that would be included in the internal procedure document she issued three months later.

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[29] Our review is not intended to address the legal position of the agency on Section 10(c) of the Peace Corps Act, as amended.

[30] The Director of OGHH sent an email on April 18, 2018 to all Peace Corps headquarter staff announcing the GHSP program will be discontinued due to changes to PEPFAR funding.

[31] Three months after OIG raised concern of a lack of internal guidance on the repeated extension of this cooperative agreements the former CAO issued the 2016 internal guidance document to domestic contracting staff. The document as issued was labeled as a draft manual section and contains markings suggesting it was in draft form.

[32] The issuing memorandum notes that the internal guidance document had not gone before the Senior Policy Committee for review, and that the latest draft of the document was being issued as a procedural document.

[33] The procedure discussing the 7-year limitation, as issued, expressly breaks out two categories of agreements – those valued (1) at $25,000 - $1,000,000 and (2) at above $1,000,000 – though it provides the same 7-year limitation for both categories. No mention is made as to why the categories are considered separately despite having the same limitation.

[34] Additionally, former contracting officials stated that the 7-year limitation was initially included to reflect a potential change in law from the Kate Puzey Volunteer Protection Act of 2011. However, that law was enacted in November 2011, where the internal guidance was initially drafted over a year later in May 2013.

As the cooperative agreement was extended without proper sole source justification, the lack of competition increased the risk of favoritism and mismanagement of Federal funds, and the appearance thereof. Without a rational basis for setting the limitation for extending agreements at 7 years, the agency risks exacerbating the problem by being perceived as having written guidance simply to accommodate the Seed agreement as opposed to fully taking into account Federal requirements and the Peace Corps environment.

The Peace Corps did not post an appropriate notice in accordance with regulation.

The Catalog of Federal Domestic Assistance (CFDA) is the single, authoritative, government-wide, comprehensive source of Federal financial assistance program information produced by the executive branch of the Federal government. It contains financial and nonfinancial assistance programs administered by departments and establishments of the Federal government to assist users in identifying programs that meet specific objectives of the potential applicant, and to obtain general information on Federal assistance programs. The content of any notice published in CFDA is the sole responsibility of the agency that has issued the program description. The former contracting officer explained that the Peace Corps published the GHSP information in CFDA in 2014 to meet the requirement change of 2 CFR Part 200.202.[35] To provide public notice of Federal financial assistance programs, that regulation states, in relevant part:

> (b) For each program that awards discretionary Federal awards, non-discretionary Federal awards … or any other type of Federal financial assistance … the Federal awarding agency must submit the following information to GSA:
>
> (1) Program Description, Purpose, Goals and Measurement. A brief summary of the statutory or regulatory requirements of the program and its intended outcome…;
>
> (2) Identification of whether the program makes Federal awards on a discretionary basis ….;
>
> (3) Projected total amount of funds available for the program….;
>
> (4) Anticipated Source of Available Funds…;
>
> (5) General Eligibility Requirements….;
>
> (6) Applicability of Single Audit Requirements….;

The Peace Corps' posting did not meet these requirements by excluding the following required information:

> (1) Program Description, Purpose, Goals and Measurement. A brief summary of statutory or regulatory requirements of the program and its intended outcome.
>
> (3) Projected total amount of funds available for the program…;
>
> (5) General Eligibility Requirements….

At the time of award, Peace Corps staff believed the CFDA information provided was adequate and met the GSA requirements. However, our analysis disclosed that the information did not fully comply with requirements.

The Peace Corps should take appropriate steps to ensure future compliance. Without proper reporting of Peace Corps cooperative agreements, the agency hinders the Federal Government's

[35] 2 CFR Part 200.202 was effective December 26, 2013.

effort to increase transparency. By making Federal spending data more accessible, searchable, and reliable, and joining this information with other third-party data sources, Federal agencies and taxpayers have an opportunity to better understand the impact of Federal funds and how they are spent.

Peace Corps agreement files were missing critical documentation.

The Peace Corps could not substantiate with documentation the requirement that the cooperative agreement be awarded to Seed without competition. MS 892 Records Management Section 6.2 states:

> Peace Corps records shall be complete in order to facilitate action by an incumbent and his/her successor.
>
> * * * * *
>
> Peace Corps officials shall incorporate all essential information of their official actions into Agency records.

The Peace Corps attributed the missing documentation or file to a lack of continuity due to staff reassignment or termination of employment with the agency. Without the necessary documents, the Peace Corps could not substantiate the claim that it was justified in not seeking fair and open competition. Further, all agency personnel interviewed could not recall seeing first-hand documentation of the purported OGAC requirement that the cooperative agreement be awarded to Seed without competition. More importantly, the missing documentation or the fact that the sole source justification was processed without supporting documentation highlights the need for OCFO/ACM to implement a records management system that complies with requirements.

The Peace Corps did not request lobbying certification forms from Seed.

Title 31 U.S.C. § 1352, "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," requires that requesters and recipients of a Federal contract, grant, loan, or cooperative agreement exceeding $100,000 file a written certification containing either information regarding related payments to lobbyists or that the requester/recipient has not made, and will not make, any prohibited payment for lobbing activities. Any person[36] making a prohibited payment shall be subject to a civil penalty between $10,000 and $100,000 for each violation. Any person who fails to file or amend a declaration as required can be subject to a civil penalty between $10,000 and $100,000 for each failure. The statute requires that the head of each Federal agency "take such actions as are necessary to ensure that the provisions of this section are vigorously implemented and enforced in such agency."[37]

[36] "Person" is defined under the statute to include an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit or not for profit," and excludes Indian tribes, tribal organizations, or other Indian organization under certain circumstances. 31 U.S.C. § 1352(g)(3).
[37] 31 U.S.C. § 1352(f).

Peace Corps' regulations implementing the law state:[38]

> § 311.100 Conditions on use of funds
>
> Each person who requests or receives from an agency a Federal contract, grant, loan, or cooperative agreement shall file with that agency a certification . . .
>
> * * * * *
>
> § 311.110 Certification and disclosure.
>
> (a) Each person shall file a certification, and a disclosure form, if required, with each submission that initiates agency consideration of such person for:
>
> (1) Award of a Federal contract, grant, or cooperative agreement exceeding $100,000 . . .

The Peace Corps did not request, nor did Seed submit, the signed certification at the time the proposal was submitted, at the time the initial agreement was signed, nor at any time the agreement was extended. The agency was unable to provide any subsequent required certification pre-dating our inquiry into the matter. Neither the AO nor the AOR could provide a reason for not obtaining the signed certification, stating they were not employed by the Peace Corps at the time of the initial agreement. By not providing the certification at the time of the agreement, Seed failed to comply with Federal regulations which could have resulted in a monetary penalty. After our request from OCFO/ACM for a copy of the certification, Seed signed and submitted a certification to the Peace Corps in January 2018, 5 years from the date of the awarding of the cooperative agreement. OIG did not extend this review to address other instances where the terms of the statute were met and in particular what actions OCFO/ACM took to ensure implementation. However, based on the lack of knowledge of OCFO/ACM contracting officials regarding this requirement, OIG is concerned that OCFO/ACM's past practices did not include collecting the certification documents and ensuring enforcement of this provision.

We recommend:

1. That the Director of the Peace Corps require the Chief Acquisition Officer to implement procedures and practices that ensure proper segregation of duties to avoid potential conflicts and appearances of favoritism in the cooperative agreement award process.

2. That the Director of the Peace Corps establish comprehensive agency policy and procedures on cooperative agreements with non-governmental entities. At minimum, such policy should address the need for competition, circumstances where competition is not required, justifications for noncompetitive awards, and appropriate limitations on cooperative agreement extensions.

3. That the Director of the Peace Corps require the Chief Acquisition Officer to implement a record management system for cooperative agreements, to include maintaining specific written documentation to justify all future non-

[38] Code of Federal Regulations Title 22 - Foreign Relations, Chapter III - PEACE CORPS Part 311 - New Restrictions on Lobbying.

competitive agreements in the agreement file that will assist other staff in substantiating decisions made by former staff.

4. That the Director of the Peace Corps require the Chief Acquisition Officer to submit to GSA's Catalog of Federal Domestic Assistance complete and accurate information regarding all grants and cooperative agreements with Peace Corps.

5. That the Director of the Peace Corps require the Chief Acquisition Officer to review relevant Peace Corps contracts, grants, and agreements to ascertain that each file contains the proper anti-lobbying certification, in compliance with applicable laws and regulations and report to OIG the failure of any entity to submit required certifications.

cc: Michelle Brooks, Chief of Staff
Maura Fulton, Senior Advisor to the Director
Carl Sosebee, Senior Advisor to the Director
Matthew McKinney, Deputy Chief of Staff/White House Liaison
Robert Shanks, General Counsel
Richard Swarttz, Chief Financial Officer
Andrew Pierce, Deputy Chief Financial Officer
Sonja Truehart-McKinney, Acting Chief Acquisition Officer
Karen Becker, Associate Director, Office of Health Services
Marie McLeod, Director, Office of Global Health and HIV
Patrick Young, Associate Director, Office of Global Operations
Jeffrey Harrington, Associate Director, Office of Management
Darryl Byrd, Records Management Officer, Office of Management
Angela Kissel, Compliance Officer
Office of Inspector General Staff
IGChron

Appendix A: Agency Response to the Report

MEMORANDUM

To: Kathy Buller, Inspector General

From: Anne Hughes, Chief Compliance Officer

Date: December 10, 2018

CC: Jody Olsen, Director
Michelle Brooks, Chief of Staff
Maura Fulton, Senior Advisor to the Director
Carl Sosebee, Senior Advisor to the Director
Matthew McKinney, Deputy Chief of Staff/White House Liaison
Robert Shanks, General Counsel
Richard Swarttz, Chief Financial Officer
Andrew Pierce, Deputy Chief Financial Officer
Sonja Truehart-McKinney, Acting Chief Acquisition Officer
Karen Becker, Associate Director, Office of Health Services
Marie McLeod, Director, Office of Global Health and HIV
Patrick Young, Associate Director, Office of Global Operations
Jeffrey Harrington, Associate Director, Office of Management
Darryl Byrd, Records Management Officer, Office of Management
Angela Kissel, Compliance Officer

Subject: Agency Response to the Management Advisory Report: Seed Global Health Services (IG-19-01-SR)

The agency would like to thank the Office of Inspector General for their continued cooperation on this Management Advisory Report (MAR) and the five accompanying recommendations, all of which the agency is in concurrence. The agency's responses and planned corrective actions are outlined below.

Recommendation 1

That the Director of the Peace Corps require the Chief Acquisition Officer to implement procedures and practices that ensure proper segregation of duties to avoid potential conflicts and appearances of favoritism in the cooperative agreement award process.

Concur

Response: The Chief Acquisition Officer is developing agency policy and guidance that will ensure the proper segregation of duties in the cooperative agreement award process.

Documents to be Submitted:

- Agency policy and guidance on cooperative agreements

Status and Timeline for Completion: August 2019

Recommendation 2

That the Director of the Peace Corps establish comprehensive agency policy and procedures on cooperative agreements with non-governmental entities. At minimum, such policy should address the need for competition, circumstances where competition is not required, justifications for noncompetitive awards, and appropriate limitations on cooperative agreement extensions.

Concur

Response: The Chief Acquisition Officer is developing agency policy and guidance on cooperative agreements with non-governmental entities. These documents will address the competitive process and extensions for cooperative agreements.

Documents to be Submitted:

- Agency policy and guidance on cooperative agreements

Status and Timeline for Completion: August 2019

Recommendation 3

That the Director of the Peace Corps require the Chief Acquisition Officer to implement a record management system for cooperative agreements, to include maintaining specific written documentation to justify all future non-competitive agreements in the agreement file that will assist other staff in substantiating decisions made by former staff.

Concur

Response: The Chief Acquisition Officer is developing agency policy and guidance on cooperative agreements. These documents will put forth a record management system for cooperative agreements in line with the agency records schedule.

Documents to be Submitted:

- Agency policy and guidance on cooperative agreements

Status and Timeline for Completion: August 2019

Recommendation 4

That the Director of the Peace Corps require the Chief Acquisition Officer to submit to GSA's Catalog of Federal Domestic Assistance complete and accurate information regarding all grants and cooperative agreements with Peace Corps.

Concur

Response: The Chief Acquisition Officer is developing agency policy and guidance on cooperative agreements. These documents will include a requirement for the agency to submit to the GSA's Catalog of Federal Domestic Assistance complete and accurate information regarding all applicable grants and cooperative agreements.

Documents to be Submitted:

- Agency policy and guidance on cooperative agreements

Status and Timeline for Completion: August 2019

Recommendation 5

That the Director of the Peace Corps require the Chief Acquisition Officer to review relevant Peace Corps contracts, grants, and agreements to ascertain that each file contains the proper anti-lobbying certification, in compliance with applicable laws and regulations and report to OIG the failure of any entity to submit required certifications.

Concur

Response: The Chief Acquisition Officer will undertake a review of relevant Peace Corps files to ensure each contains the proper anti-lobbying certification and provide a report to the OIG upon completion. Additionally, the policy and guidance referenced above will include language on the development and maintenance of anti-lobbying certifications.

Documents to be Submitted:

- Report on Review of Contracts, Grants, and Agreements
- Agency policy and guidance on cooperative agreements

Status and Timeline for Completion: August 2019

Appendix B: OIG Comments

Management concurred with all five recommendations, which remain open. OIG will review and consider closing these recommendations when the documentation reflected in the agency's response is received. We wish to note that, in closing recommendations, we are not certifying that the agency has taken these actions or that we have reviewed their effect. Certifying compliance and verifying effectiveness are management's responsibilities. However, when we feel it is warranted, we may conduct a follow-up review to confirm that action has been taken and to evaluate the impact.