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MAIL SECURITY

Incidents at DOD Mail Facilities Exposed Problems That Require Further Actions

GAO Accountability·Integrity·Reliability

Highlights

Highlights of GAO-06-757, a report to the Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

In March 2005, two well-publicized and nearly simultaneous incidents involving the suspicion of anthrax took place in the Washington, D.C., area. The incidents occurred at Department of Defense (DOD) mail facilities at the Pentagon and at a commercial office complex (Skyline Complex). While these incidents were false alarms, DOD and other federal and local agencies responded. The Postal Service suspended operations at two of its facilities and over a thousand DOD and Postal Service employees were given antibiotics as a precaution against their possible exposure to anthrax.

This report describes (1) what occurred at the Pentagon and Skyline Complex mail facilities, (2) the problems we identified in detecting and responding to the incidents, (3) the actions taken by DOD that address the problems that occurred, and (4) the extent to which DOD's actions address the problems.

What GAO Recommends

GAO is making recommendations to help improve the effectiveness of future DOD responses involving the suspicion of anthrax in the mail. DOD agreed with three of our recommendations but only partially agreed with our fourth. GAO retained this recommendation to ensure that DOD's future approach to making medical decisions during bioterrorism incidents occur within the participatory federal framework.

www.gao.gov/cgi-bin/getrpt?GAO-06-757.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kate Siggerud at (202) 512-2834 or siggerudk@gao.gov.

What GAO Found

Events leading up to the Pentagon incident began when a laboratory that tested samples from the Pentagon's mail-screening equipment informed DOD's mail-screening contractor that test results indicated the presence of anthrax in the mail. By the time the contractor notified DOD 3 days later, suspect mail had already been released and distributed throughout the Pentagon. DOD evacuated its mail-screening and remote delivery facilities, notified federal and local agencies, and dispensed antibiotics to hundreds of employees. The Skyline Complex incident began the same day when Fairfax County, Virginia, emergency personnel responded to a 911 call placed by a Skyline employee that an alarm had sounded on a biosafety cabinet used to screen mail. Local responders closed the complex and decontaminated potentially exposed employees, and DOD dispensed antibiotics to the employees. Similarly, the Postal Service suspended operations at two facilities and dispensed antibiotics to its employees. Laboratory testing later indicated that the incidents were false alarms.

Analysis of these incidents reveals numerous problems related to the detection and response to anthrax in the mail. At the Pentagon, DOD's mail-screening contractor did not follow key requirements, such as immediately notifying DOD after receiving evidence of contamination. At the Skyline Complex, DOD did not ensure that the complex had a mail security plan or that it had been reviewed, as required. The lack of a plan hampered the response. DOD also did not fully follow the federal framework—including the National Response Plan, which was developed to ensure effective, participatory decision making. Instead of coordinating with other agencies that have the lead in bioterrorism incidents, DOD unilaterally dispensed antibiotics to its employees.

DOD has taken numerous actions that address problems related to the two incidents. At the Pentagon, DOD's actions included selecting a new mail-screening contractor and defining the roles and responsibilities of senior leadership, including those involved in making medical decisions. Related to Skyline, DOD prohibited its mail facilities in leased space within the Washington, D.C., area from using biosafety cabinets to screen mail unless the equipment is being operated within the context of a comprehensive mail-screening program.

While DOD has made significant progress in addressing the problems that occurred, its actions do not fully resolve the issues. One remaining concern is whether DOD will adhere to the interagency coordination protocols specified in the national plan for future bioterrorism incidents involving the Pentagon. This concern arises because, more than 1 year after the incident, DOD reiterated that it has the authority to make medical decisions without collaborating or consulting with other agencies. DOD also has not ensured, among other things, that its mail facilities (1) have the required mail security plans and (2) are appropriately using biosafety cabinets for screening mail.