May 10, 2002

Health Care

DoD Medical Support to the Federal Response Plan
(D-2002-087)

Department of Defense
Office of the Inspector General

Quality *Integrity* *Accountability*

Additional Copies

To obtain additional copies of this evaluation report, visit the Inspector General of the Department of Defense Home Page at www.dodig.osd.mil/audit/reports or contact the Secondary Reports Distribution Unit of the Audit Followup and Technical Support Directorate at (703) 604-8937 (DSN 664-8937) or fax (703) 604-8932.

Suggestions for Future Evaluations

To suggest ideas for or to request future evaluations, contact the Audit Followup and Technical Support Directorate at (703) 604-8940 (DSN 664-8940) or fax (703) 604-8932. Ideas and requests can also be mailed to:

OAIG-AUD (ATTN: AFTS Evaluation Suggestions)
Inspector General of the Department of Defense
400 Army Navy Drive (Room 801)
Arlington, VA 22202-4704

Defense Hotline

To report fraud, waste, or abuse, contact the Defense Hotline by calling (800) 424-9098; by sending an electronic message to Hotline@dodig.osd.mil; or by writing to the Defense Hotline, The Pentagon, Washington, DC 20301-1900. The identity of each writer and caller is fully protected.

Acronyms

DOMS	Director of Military Support
FEMA	Federal Emergency Management Agency
FRP	Federal Response Plan
HHS	Health and Human Services
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
RFA	Request for Federal Assistance
WTC	World Trade Center

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202–4704

May 10, 2002

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE
(HEALTH AFFAIRS)
ASSISTANT SECRETARY OF THE AIR FORCE
(FINANCIAL MANAGEMENT AND COMPTROLLER)
AUDITOR GENERAL, DEPARTMENT OF THE ARMY

SUBJECT: Report on DoD Medical Support to the Federal Response Plan
(Report No. D-2002-087)

We are providing this report for review and comment. We conducted the evaluation in response to a request from the former Acting Assistant Secretary of Defense (Health Affairs).

DoD Directive 7650.3 requires that all recommendations be resolved promptly. Therefore, we request that the Secretary of the Air Force provide comments on Recommendations 1. and 2. by July 10, 2002.

We appreciate the courtesies extended to the evaluation staff. For additional information on this report, please contact Mr. Michael A. Joseph at (757) 766-9108 (mjoseph@dodig.osd.mil) or Mr. Sanford W. Tomlin at (757) 766-3265 (stomlin@dodig.osd.mil). See Appendix B for the report distribution. The evaluation team members are listed inside the back cover.

Thomas F. Gimble
Acting
Deputy Assistant Inspector General
for Auditing

Office of the Inspector General of the Department of Defense

Report No. D-2002-087 **May 10, 2002**
(Project No. D2001LF-0200)

DoD Medical Support to the Federal Response Plan

Executive Summary

Introduction. On September 19, 2001, the Acting Assistant Secretary of Defense (Health Affairs) requested the Inspector General of the Department of Defense to review the DoD medical response to the September 11, 2001, terrorist attacks. The Acting Assistant Secretary wanted to ensure that DoD profits from lessons from the experience, to ensure that execution and policy are in alignment, and to conserve medical resources that may be needed in the future. He expressed concerns that resources may have been expended unnecessarily by initiation of support actions that were not officially requested by Federal agencies coordinating medical assistance.

Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974, the Governor of an affected State may request the President to declare a major disaster or an emergency if an event is beyond the combined capabilities of the affected State and local governments. The Federal Response Plan establishes a process and structure for the systematic, coordinated, and effective delivery of Federal assistance to address the consequences of any major disaster or emergency declared under the Act. The Federal Response Plan organizes the types of Federal response assistance into 12 Emergency Support Functions, each of which has a designated primary agency. The primary agency for Emergency Support Function #8, Health and Medical Services, is the Department of Health and Human Services. The Secretary of the Army is the DoD Executive Agent for military support to civil authorities, and the Director of Military Support acts for the Executive Agent and issues necessary orders.

Results. The Military Health System support following the September 11, 2001, terrorist attacks was generally in accordance with the Federal Response Plan. DoD responded to all requests made through the Federal Response Plan process for military medical assistance and to numerous direct requests from other government agencies. However, in attempting to be responsive to the emerging crisis, the Air Force moved medical personnel and equipment to McGuire Air Force Base, New Jersey, that were not requested through the Federal Response Plan process and ultimately were not required. The Air Force stated that the movement of the personnel and equipment also served the purpose of making the resources available worldwide for Air Force requirements. The Air Force movement of medical resources cost about $500,000 and was not coordinated with the Director of Military Support in advance or immediately after the fact. Although the movement of medical assets was within the authority of the Air Force and was approved by the Secretary of the Air Force, established Federal

Response Plan procedures were not followed. Any actions taken outside the coordinated efforts of the Federal Response Plan represent a potentially unnecessary use of DoD resources. See the Finding section for details on the evaluation results.

Summary of Recommendations. We recommend that the Secretary of the Air Force, when moving resources to support civil authorities under the commander's immediate response authority, advise the DoD Executive Agent through the Director of Military Support by the most expeditious means available, and seek approval or additional authorizations as needed, in accordance with DoD Directive 3025.1. We also recommend that the Secretary of the Air Force coordinate with the Director of Military Support to address communications problems identified by the Air Force during its attempt to provide support as a result of the September 11, 2001, terrorist attacks.

Management Comments. The Air Force did not respond to a draft of this report issued on March 19, 2002. We request that the Secretary of the Air Force provide comments on this report by July 10, 2002.

Table of Contents

Background

Acting Assistant Secretary of Defense (Health Affairs) Request. On September 19, 2001, the Acting Assistant Secretary of Defense (Health Affairs) requested the Inspector General of the Department of Defense to review the DoD medical response to the September 11, 2001, terrorist attacks. The Acting Assistant Secretary wanted to ensure that DoD profits from lessons from the experience, to ensure that execution and policy are in alignment, and to conserve medical resources that may be needed in the future. He expressed concerns that resources may have been expended unnecessarily by initiation of support actions that were not officially requested by Federal agencies coordinating medical assistance. The request specified that the review should include the magnitude and costs of deploying assets requested through the Federal Emergency Management Agency (FEMA), as well as any unnecessary or costly activities, such as the movement of personnel and resources, which expended Defense Health Program or Service assets.

Stafford Act. The Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act), as amended, provides an orderly and continuing means of assistance by the Federal Government to State and local governments in carrying out their responsibilities to alleviate the suffering and damage that result from disasters. Under the Stafford Act, the Governor of an affected State may request the President to declare a major disaster or an emergency if an event is beyond the combined capabilities of the affected State and local governments. The Stafford Act also gives the Director, FEMA the authority to prepare Federal response plans and to coordinate those plans with State efforts, to delegate appropriate emergency preparedness responsibilities to other departments and agencies of the Federal Government, and to reimburse any Federal agency for use of personnel or resources.

Federal Response Plan. The Federal Response Plan (FRP) developed by FEMA establishes a process and structure for the systematic, coordinated, and effective delivery of Federal assistance to address the consequences of any major disaster or emergency declared under the Stafford Act. Under the FRP, FEMA processes a Governor's request for disaster assistance, coordinates Federal operations under a disaster declaration, and appoints a Federal Coordinating Officer. The Federal Coordinating Officer works closely with the State Coordinating Officer and the Governor's Authorized Representative to execute all necessary documents for disaster assistance. The FRP states that no direct Federal assistance is authorized prior to a presidential declaration of disaster. On September 11, 2001, President Bush declared a major disaster for the State of New York.

The FRP organizes the types of Federal assistance that a State is most likely to need under 12 Emergency Support Functions, each of which has a designated primary agency. FEMA will issue a mission assignment to task a primary agency for necessary work to be performed on a reimbursable basis. The primary agency may in turn task support agencies, if needed. The primary agency for Emergency Support Function #8, Health and Medical Services, is the Department of Health and Human Services (HHS). HHS is responsible for

providing essential support functions for civilian health and medical services under the FRP. The HHS Office of Emergency Preparedness is responsible for coordinating the implementation of Emergency Support Function #8. HHS can use its own resources and resources from the National Disaster Medical System, DoD, the Department of Veterans Affairs, and FEMA.

According to the FRP, DoD will normally provide support only when other resources are not available and only if such support does not interfere with DoD's primary mission or ability to respond to operational contingencies. The FRP also states that requests for military support must be accompanied by a Request for Federal Assistance (RFA) form, unless the DoD Component is responding under its independent funding authority or the commander's immediate response authority.

National Disaster Medical System. The National Disaster Medical System is a nationwide medical mutual aid network of Federal and non-Federal sectors that includes medical response, patient evacuation, and definitive medical care. The National Disaster Medical System includes disaster medical assistance teams, disaster mortuary operational response teams, and veterinary medical assistance teams. Disaster medical assistance teams, composed of volunteer professional and paraprofessional medical personnel, are designed to provide emergency medical care during a disaster or other event. Disaster medical assistance teams are principally a community resource available to support local, regional, and State requirements. However, they can provide interstate medical aid when they are activated through the FRP as a national resource.

DoD Guidance. DoD Directive 3025.15, "Military Assistance to Civil Authorities," February 18, 1997, in conjunction with DoD Directive 3025.1, "Military Support to Civil Authorities (MSCA)," January 15, 1993, and its associated manual were issued to set forth the procedures Military Departments should follow when responding to civil authorities' requests for military assistance during national disasters. The DoD guidance designates the Secretary of the Army as the DoD Executive Agent for military support to civil authorities with the authority to task DoD Components to commit resources in response to civilian requests. The guidance authorizes the Director of Military Support (DOMS) to act for the DoD Executive Agent and to issue necessary orders. The DoD guidance states that FEMA is responsible for coordinating Federal plans and programs for response to civil emergencies and that DOMS shall ensure coordination of plans and procedures for military support to civil authorities with FEMA and within DoD.

Additional DoD Support. In addition to supporting the FRP, DoD supported direct requests from various government agencies regarding the September 11, 2001, terrorist attacks. For example, DoD sent a Ruggedized Advance Pathogen Identification team to New York City. The team had the capability to detect, identify, and confirm suspected anthrax cases. That type of support was provided under memorandums of understanding or the Economy Act, an act that allows government agencies to order goods or services from other government agencies when specified conditions are met. This report focuses on support to the FRP.

Objective

The objective of the evaluation was to review the process for supporting, and the cost of deploying medical assets in response to, the Federal Response Plan. See Appendix A for a discussion of the evaluation scope and methodology.

Military Health System Support to the Federal Response Plan

The Military Health System support following the September 11, 2001, terrorist attacks was generally in accordance with the FRP. DoD responded to all requests made through the FRP process for military medical assistance and to numerous direct requests from other government agencies. However, in attempting to be responsive to the emerging crisis, the Air Force moved medical personnel and equipment to McGuire Air Force Base, New Jersey, that were not requested through the FRP process and ultimately were not required. The Air Force movement of medical resources cost about $500,000 and were not coordinated with DOMS in advance or immediately after the fact. Although the movement of medical assets was within the authority of the Air Force and was approved by the Secretary of the Air Force, established FRP procedures were not followed. Any actions taken outside the coordinated efforts of the FRP represent a potentially unnecessary use of DoD resources.

Support Requested Through the FRP

As a result of the terrorist attacks of September 11, 2001, FEMA activated the FRP and the National Disaster Medical System. Those interrelated programs are designed to enable command and control of national resources in response to local and national disasters. DoD responded to all official requests for military medical assistance.

FEMA provided three RFAs requesting DoD medical support. The RFAs requested that DoD deploy USNS *Comfort* to New York City, provide human remains pouches to New York City, and set up a medical mobilization center for a Disaster Mortuary Operational Response Team at Stewart Air National Guard Base, New York. The RFA for USNS *Comfort* initially requested medical support for the injured victims from the attacks on the World Trade Center (WTC). While USNS *Comfort* was en route to New York City, its mission was revised from providing medical support to providing support to the rescue workers on site. Because of the revision, most of the medical staff on board USNS *Comfort* left the ship and began to return to their respective military treatment facilities before USNS *Comfort*'s arrival at New York City on September 14, 2001. Under the revised mission, USNS *Comfort* provided WTC rescue workers with food and shelter, as well as laundry, medical, and other services, for about 2 weeks. According to the Navy, the estimated cost of deploying USNS *Comfort* was about $2.5 million. Other non-medical support provided by DoD through the FRP process entailed providing supplies, equipment, and lodging on military installations and transporting people, supplies, and equipment.

Movement of Medical Assets to McGuire Air Force Base

Although not requested through the FRP process, within 5½ hours after the first attack on the WTC, the Secretary of the Air Force directed the movement of Air Force medical resources to support WTC victims. The Air Force stated that the movement of the personnel and equipment also served the purpose of making the resources available worldwide for Air Force requirements. The Air Force moved 539 medical personnel and 3 Expeditionary Medical Systems to McGuire Air Force Base, which is approximately 1 hour from the WTC, the closest Air Force facility to the WTC, and a major Air Force port facility for worldwide Air Force operations. The movement resulted in the relocation of personnel, medical equipment, or both from Lackland Air Force Base, Texas; Keesler Air Force Base, Mississippi; Langley Air Force Base, Virginia; Mountain Home Air Force Base, Idaho; Wright-Patterson Air Force Base, Ohio; Scott Air Force Base, Illinois; Andrews Air Force Base, Maryland; Altus Air Force Base, Oklahoma; and Randolph Air Force Base, Texas. In addition, a Small Portable Expeditionary Aeromedical Rapid Response team from Baltimore, Maryland, was moved to McGuire Air Force Base. The majority of the personnel and medical equipment arrived at McGuire Air Force Base on September 12, 2001, within 17 to 26 hours after the attacks.

To determine why the Air Force took action and moved medical resources to support the WTC disaster without an RFA, we set up a series of meetings with senior Air Force management. We met with the Secretary of the Air Force, the Air Force Surgeon General, and the Air Force Deputy General Counsel (Military Affairs).

Secretary of the Air Force Meeting. The Secretary of the Air Force stated that after the Pentagon was attacked, communication outside of the Air Force was difficult. From the Air Force Crisis Action Center in the Pentagon, the Secretary unsuccessfully tried to contact DOMS to coordinate the Air Force response to the terrorist attacks. The Secretary further stated that on the afternoon of September 11, 2001, after he moved to a Crisis Action Center outside of the Pentagon, he talked to someone at FEMA who stated they appreciated the fact that the Air Force was moving medical assets and personnel to McGuire Air Force Base. The Secretary could not recall the name of the FEMA person that the Secretary spoke with. The Secretary stated that most of the personnel and medical equipment began returning to their respective home bases during the week of September 17, 2001.

At the conclusion of our meeting, we asked the Secretary what he would do if a national disaster similar to the attacks took place in the future. He stated he would advise the Executive Agent of his medical capabilities and await guidance before moving medical resources.

Subsequent to the meeting, the Air Force stated that the Secretary considered the movement of assets to have two purposes: to make them available for civilian authorities in New York City, if needed, and to preposition them at a major Air Force port base for immediate response to Air Force requirements worldwide. Also, the Air Force stated that the Secretary had attempted to discuss the

movement of resources with the FEMA Director, but because he was not available, was put through to the most senior FEMA representative available, believed by the Secretary's staff to be a Deputy Director.

Air Force Surgeon General Meeting. The Surgeon General stated that the FRP is badly broken in that it moves too slowly to medically support an acute scenario like the attacks on the WTC. He also pointed out that the Air Force action was a "base to base" movement of medical resources, which Air Force Legal Counsel advised was within title 10, United States Code authority of the Secretary of the Air Force. The Surgeon General further indicated that the Secretary of the Air Force stated the movement of medical assets would serve as valuable training exercise if the assets were not needed to support WTC personnel. The Surgeon General also stated that the cost to move the personnel and medical equipment to McGuire Air Force Base totaled about $400,000 in flying hour costs and about $100,000 in travel and per diem costs.

Subsequent to the meeting, the Air Force stated that based on recent exercises with civilian authorities, the Surgeon General was aware that the Air Force possessed unique trauma capabilities not extant in the civilian community, and that delay in movement could mean that the lifesaving assets would not be available in time.

Air Force Deputy General Counsel (Military Affairs) Meeting. The Deputy General Counsel stated that the movement complied with the Secretary of the Air Force authority provided under title 10, United States Code, and the commander's immediate response authority discussed in the FRP and DoD Directive 3025.1. The Deputy General Counsel stated that it was important to position the personnel and assets on a military base and maintain control until civilian authorities request resources. Under the immediate response authority, during imminently serious conditions resulting from civil emergency or attack, military commanders are authorized to take immediate action to save lives, prevent human suffering, or mitigate great property damage. The Deputy General Counsel also stated that the September 11 events were exceptional and that the information on the possible scale of casualties convinced the Air Force Surgeon General that it would be impossible for New York City to handle the volume of injured victims.

Funding of DoD Medical Support. Because the Air Force movement of medical resources was not requested through an RFA, FEMA is not reimbursing the cost. Shortly after the terrorist attacks, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) received a request from the Office of the Under Secretary of Defense (Comptroller) for an estimate of the cost for the initial medical response to the attacks. The estimate was needed to support the DoD request for Defense Emergency Response Funds. Based on cost estimates provided by each Military Department, OASD(HA) estimated that the total cost for the initial medical response was $24 million. OASD(HA) subsequently received that amount.

The $24 million included $12.6 million that the Air Force originally estimated as the cost for their initial medical response. The Air Force estimate included about $10.8 million for moving assets to McGuire Air Force Base.

Approximately $10.3 million of the $10.8 million was for the cost of the medical equipment; $536,000 was for travel and per diem costs. The Air Force subsequently reduced the estimate from $12.6 million to about $1.6 million. The bulk of the reduction was because the medical equipment and supplies moved to McGuire Air Force Base were not used. In addition, the travel and per diem portion of the estimate was reduced to about $114,000.

OASD(HA) informed the Office of the Under Secretary of Defense (Comptroller) of the reduction in the estimated cost and, as of March 6, 2002, reviews were ongoing at that level to determine whether the Defense Emergency Response Funds received in excess of the reduced estimate can be used for other valid disaster-related requirements.

Conclusion

We recognize that the Secretary of the Air Force has the authority to move assets between bases. We realize the attacks were exceptional events and neither the FRP nor DoD guidance limits the amount of medical resources or distance the resources can be moved under the commander's immediate response authority. We also realize prompt treatment of trauma patients is extremely important and, due to the magnitude of the attacks, it appeared additional medical support would be needed in New York. However, to ensure adequate medical support was available, the HHS Office of Emergency Preparedness activated five disaster medical assistance teams in the northeastern United States 2 hours after the WTC attacks. On the night of September 11, 2001, the Governor of New York issued a press release stating that the emergency department workload at the local hospitals was already easing. The release also stated that local hospitals had treated and released the majority of patients and that 3,000 beds were available in New York City and the immediate area for injured victims.

We commend the Air Force for its willingness to provide full medical support to the civilian sector during national disasters. However, when the Air Force moves medical resources without an RFA under procedures outlined in the FRP, there is a risk that the resources may not be needed and DoD will incur unnecessary costs. Coordinating the movement of medical resources to support civil disasters through DOMS helps to ensure that no unnecessary costs are incurred and also that the right mix of medical personnel and equipment are provided. DoD Directive 3025.1 requires any commander or official acting under the immediate response authority to advise the DoD Executive Agent through command channels by the most expeditious means available and to seek approval or additional authorizations as needed. DOMS personnel working for the DoD Executive Agent indicated that the Air Force did not provide any information concerning the movement of medical resources to McGuire Air Force Base.

A comprehensive review of the FRP was beyond the scope of this evaluation, but we saw nothing that indicated the FRP process was ineffective in handling the Federal response to the events of September 11, 2001. However, if the Air

Force believes that revisions should be made to the FRP to improve response time, then the Air Force, in conjunction with OASD(HA), should work with DOMS to effect the changes.

Recommendations

1. We recommend that the Secretary of the Air Force, when moving resources to support civil authorities under the commander's immediate response authority, advise the DoD Executive Agent through the Director of Military Support by the most expeditious means available, and seek approval or additional authorizations as needed, in accordance with DoD Directive 3025.1.

2. We recommend that the Secretary of the Air Force coordinate with the Director of Military Support to address communications problems identified by the Air Force during its attempt to provide support as a result of the September 11, 2001, terrorist attacks.

DOMS Comments. Although not required to comment, DOMS agreed with the recommendations. In addition, DOMS stated that the Air Force Chief of Staff normally communicates with DOMS through the Air Force National Security Emergency Preparedness Division or the Air Force Deputy DOMS. Also, at no time on September 11, 2001, did the DOMS phones or e-mail not function, and DOMS was not aware of anyone having difficulty communicating with DOMS. For the full text of DOMS comments, see the Management Comments section of the report.

Management Comments Required

The Secretary of the Air Force did not comment on a draft of this report. We request that the Secretary of the Air Force provide comments on the final report.

Appendix A. Scope and Methodology

Work Performed. We reviewed the FRP and applicable laws, DoD directives and manual and Military Department guidance and policies dated from August 1981 through August 2001 pertinent to the process for supporting, and the cost of deploying medical assets in response to, the FRP. We reviewed RFAs and funding documents associated with the DoD medical support provided in response to the terrorist attacks on September 11, 2001.

We met with the Secretary of the Air Force, the Air Force Chief of Staff, and the Air Force Surgeon General to determine the rationale for moving medical assets to McGuire Air Force Base. We met with personnel from OASD(HA) and the TRICARE Management Activity to determine their concerns with the DoD medical response to the terrorist attacks and the associated costs. We interviewed personnel from the Office of the Executive Secretary of DoD; the Office of the Command Surgeon, U.S. Joint Forces Command; the Office of the Director of Military Support; the Office of the Surgeon General for each Military Department; and the Air Force Air Combat Command to evaluate DoD policy and to determine their roles in providing support to the disaster relief efforts resulting from the attacks of September 11, 2001. We also met with the Air Force Deputy General Counsel (Military Affairs) to determine the legal authority for moving Air Force medical assets to McGuire Air Force Base.

We met with personnel from the HHS Office of Emergency Preparedness to discuss the medical support role of DoD in the FRP and the National Disaster Medical System. We contacted representatives of FEMA; the Office of Emergency Management, New York City; and the New York Presbyterian Hospital to determine the extent of medical resources required to respond to the terrorist attacks.

Limitations to Scope. We did not review the management control program because the scope of the evaluation was limited to the DoD response to the attacks. Although we evaluated the DoD medical support to the FRP, we did not evaluate the adequacy of the FRP. In addition, we did not validate the costs of flying hours, travel, or per diem associated with the movement of personnel and equipment to McGuire Air Force Base. We also did not validate the estimate OASD(HA) submitted for Defense Emergency Response Funds. We did not evaluate the possible command, control, and communications issues raised during the evaluation because those issues may cross other support functions associated with the FRP process.

High-Risk Area. The General Accounting Office has identified several high-risk areas in DoD. This report provides coverage of the DoD Infrastructure Management high-risk area.

Use of Computer-Processed Data. We did not rely on computer-processed data for this evaluation.

Standards and Dates. We performed this evaluation from September 2001 through March 2002 in accordance with standards implemented by the Inspector General of the Department of Defense, except for the limitations previously discussed.

Contacts During the Evaluation. We visited and contacted individuals and organizations within and outside of DoD. Further details are available upon request.

Prior Coverage

No prior audit coverage has been conducted on DoD medical support to the FRP during the last 5 years.

Appendix B. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)
  Deputy Chief Financial Officer
  Deputy Comptroller (Program/Budget)
Under Secretary of Defense for Personnel and Readiness
  Assistant Secretary of Defense (Health Affairs)

Department of the Army

Auditor General, Department of the Army
Director of Military Support

Department of the Navy

Naval Inspector General
Auditor General, Department of the Navy

Department of the Air Force

Secretary of the Air Force
Assistant Secretary of the Air Force (Financial Management and Comptroller)
Surgeon General, Department of the Air Force
Auditor General, Department of the Air Force

Non-Defense Federal Organization

Office of Management and Budget

Congressional Committees and Subcommittees, Chairman and Ranking Minority Member

Senate Committee on Appropriations
Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Governmental Affairs
House Committee on Appropriations
House Subcommittee on Defense, Committee on Appropriations
House Committee on Armed Services
House Committee on Government Reform
House Subcommittee on Government Efficiency, Financial Management, and Intergovernmental Relations, Committee on Government Reform
House Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform
House Subcommittee on Technology and Procurement Policy, Committee on Government Reform

Director of Military Support Comments

DEPARTMENT OF THE ARMY
DIRECTOR OF MILITARY SUPPORT
400 ARMY PENTAGON
WASHINGTON, D.C. 20310-0400

DAMO-ODS

12 APR

MEMORANDUM FOR INSPECTOR GENERAL, DEPARTMENT OF DEFENSE (ATTN: MR SHELTON R. YOUNG), ARLINGTON, VA 22202

SUBJECT: Report on DoD Medical Support to the Federal Response Plan (Project No. D2001LF-0200)

1. Reference. Draft Evaluation Report, Office of the Inspector General, DoD Project No. D2001LF, 19 Mar 02.

2. The following is our comment to the above aforementioned draft report.

3. Reference page 5 paragraph 3: Normally, the Chief of Staff Air Force deals with DOMS thru the Air Force National Security Emergency Preparedness Division (AFNSEP) or the Air Force Deputy DOMS. At no time on 11 September 2001 did our phones or e-mail not function nor did we know of anyone having difficulty contacting us. In fact, we were in telephone contact with all agencies we support.

4. DOMS concurs with recommendations.

5. POC is MAJ Avila, 703-697-1096.

THOMAS L. LA CROSSE
Colonel, GS
Chief, Military Support Division

Printed on Recycled Paper

Evaluation Team Members

The Readiness and Logistics Support Directorate, Office of the Assistant Inspector General for Auditing of the Department of Defense prepared this report. Personnel of the Office of the Inspector General of the Department of Defense who contributed to the report are listed below.

Shelton R. Young
Michael A. Joseph
Sanford W. Tomlin
G. Paul Johnson
James A. O'Connell
Mary J. Gibson
Lynnell E. Hines
Mary Ann Hubbell
Elizabeth L. N. Shifflett