



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

November 7, 2019

The Honorable Rosa DeLauro
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeLauro:

Thank you for your letter regarding the vaccination of migrant children, adults, and families in U.S. Customs and Border Protection custody during the upcoming influenza season. As the nation's health protection agency, the Centers for Disease Control and Prevention (CDC) works to protect America from health, safety, and security threats, both foreign and in the U.S.

As you know, influenza can cause severe illness and at times can lead to death. CDC estimates that influenza was associated with more than 48.8 million illnesses and 79,400 deaths during the 2017–2018 influenza season, a particularly bad season. The best way to prevent flu is by getting a flu vaccine each year. CDC recommends routine annual influenza vaccination for all persons aged at least 6 months and older. Regarding vaccination of migrant children, adults and families, CDC recommends that priority should be given to the screening and isolation of ill migrants, early antiviral treatment, and flu vaccination for all staff. CDC further recommends influenza vaccination at the earliest feasible point of entry for all persons at least six months of age, which is in concurrence with our general influenza vaccine recommendation. HHS's Office of Refugee Resettlement (ORR), Division of Health for Unaccompanied Alien Children, follows CDC guidelines and reports that children in ORR care are routinely vaccinated against influenza as part of their initial medical exam.

We have provided answers to your specific questions in an enclosure that we hope you will find helpful. We have also provided attachments.

Thank you again for your letter about this important issue. If you have additional questions or concerns regarding CDC's vaccination guidance, please contact Peggine Rice in the CDC Office of Appropriations at (202) 245-0600 or PRice@cdc.gov.

Sincerely,

Robert R. Redfield, MD
Director, CDC

Enclosures

**The Centers for Disease Control and Prevention's (CDC) Responses to Questions
about the vaccination of migrant children, adults, and families in
U.S. Customs and Border Protection custody**

- 1. Since January 1, has Customs and Border Protection consulted with CDC related to the deaths of children in detention centers? If so, please explain the nature of the consultation and provide copies of all documentation shared between the agencies, including email messages.**

CDC's engagement with CBP on this issue beginning in 2018 followed a request for assistance from the Secretary of Homeland Security to the Secretary of Health and Human Services. Teams of CDC subject matter experts visited Department of Homeland Security (DHS) Border Patrol facilities in December 2018 and January 2019. These teams assessed infectious disease surveillance and made recommendations for reduction of disease transmission, focusing on respiratory diseases (particularly influenza). In January 2019, CDC gave DHS written recommendations for best practices to control influenza within their facilities. A copy of this report has been included for your reference (Attachment A).

Beginning in late May and ending July 4, CDC held weekly calls with U.S. Customs and Border Protection (CBP) related to influenza cases in migrant facilities. During these calls, DHS/CBP provided updates on influenza activity and CDC provided additional guidance on implementing prior recommendations.

- 2. Since January 1, has Customs and Border Protection asked CDC for guidance about vaccination of people who are migrating as well as vaccination of staff? If so, please explain the nature of the consultation and the guidance provided by the CDC. Please include consultation on flu vaccines as well as other vaccination questions, such as the mumps vaccine. Please provide copies of all documentation between the agencies, including email messages.**

As referenced in question 1, CDC provided written recommendations to DHS in January 2019 for control of influenza within CBP facilities. Beginning in late May and ending July 4, CDC held weekly calls with CBP related to influenza cases in migrant facilities. During these calls, DHS/CBP provided updates on influenza activity and CDC provided additional guidance on implementing prior recommendations.

CDC has also provided technical assistance to CBP regarding specific cases of vaccine-preventable diseases that occurred in persons in CBP custody, including two cases of mumps and one case of meningococcal disease.

In addition, CDC's National Institute for Occupational Safety and Health (NIOSH) received a request for a Health Hazard Evaluation (HHE) (www.cdc.gov/niosh/hhe/about.html) from the National Border Patrol Council Local 1929, which is the union that represents U.S. Border Patrol (USBP) agents in the El Paso Border Patrol Sector. The request concerned agents and their potential exposure to lice, scabies, infectious pathogens, and bodily fluids, as well as occupational stress. As a part of the HHE, NIOSH project officers visited three

border patrol stations in the sector in May, and reviewed documents provided by management. NIOSH project officers made recommendations in a final report, in letter format, provided to management and union representatives. Among a number of recommendations, the final report includes a recommendation that USBP agents should be offered age-appropriate vaccinations according to current ACIP recommendations. A copy of this report has been included for your reference (Attachment B).

- 3. Since January 1, have you communicated with leadership at HHS or the White House about the issue of vaccination by Customs and Border Protection, either of people migrating or staff? If so, please provide copies of such communications, including email messages.**

CDC's engagement with CBP on this issue beginning in 2018 followed a request for assistance from the Secretary of Homeland Security to the Secretary of Health and Human Services. Since that time, CDC has kept leadership of HHS informed on the engagements described above through routine updates on influenza activities.

Attachments:

- Attachment A – Influenza Recommendations
- Attachment B – NIOSH Report (Letter format, "HHE 2019-0142 Final Report")

CDC Report: Investigation of Respiratory Illness in U.S. Border Patrol Facilities, December 2018—January 2019

Background

At the request of the U.S. Department of Homeland Security (DHS), following reports of respiratory illness among persons migrating across the U.S.-Mexico border, three CDC teams visited DHS Border Patrol facilities in December 2018 and January 2019 to assess and make recommendations for infectious disease surveillance and reduction of disease transmission, with special focus on respiratory diseases (particularly influenza).

Increased respiratory illness is expected during influenza season, which typically occurs between October and May in the Northern Hemisphere. Influenza activity typically peaks in the United States during January or February. Transmission of influenza and other respiratory viruses can be enhanced in crowded settings. While individuals seen in border patrol facilities are intended to be present only for short periods of time (generally ≤ 72 hours), processing of persons passing through these facilities may be slower during some periods, fostering increased crowding that may enhance likelihood of respiratory disease transmission.

The first CDC team visited border facilities in the El Paso and Yuma sectors on December 29-30, 2018. El Paso sector sites were the Paso Del Norte (PDT) Central Intake Station, El Paso Station 1 (Station 1), and Clint Station. Yuma sector sites were the Yuma Processing Center and the Wellton Border Station. During this period, El Paso and Yuma facilities were over capacity due to increasing numbers of family units crossing the border and prolonged length of stay (up to eight days). This team made initial recommendations for infection control practices and respiratory illness monitoring in these facilities.

The second and third CDC teams visited the El Paso Sector facilities from January 2-11 2019. The included facilities were Paso Del Norte (PDT, the central intake facility for apprehended migrants), El Paso Station 1 (Station 1, which houses family units), and Clint Station (which houses unaccompanied children [UAC] only). Team 2 conducted enhanced respiratory illness surveillance to characterize respiratory agents circulating among persons crossing the border into the El Paso Sector. Team 3 assessed the feasibility of implementing influenza antiviral treatment and influenza vaccination in these facilities.

This report focuses specifically on observations, surveillance, and recommendations related to influenza.

Summary of Border State Influenza Activity

Since December, 2018 through January, 2019, the percent of respiratory specimens positive for influenza has been elevated in clinical laboratories along the US Mexico border which participate in national Surveillance (Figure 1). Most of the characterized influenza specimens at the state Public

Health laboratories are influenza A(H1N1)pdm09 viruses (Figure 2). These trends are similar to national trends (<https://www.cdc.gov/flu/weekly/index.htm>).

Summary of CDC Enhanced Influenza Surveillance at El Paso Sector Border Patrol Facilities, January 6-11, 2019

Methods

Enhanced respiratory illness surveillance was initiated on 6 Jan 2019 thru 11 Jan 2019 at PDT, Station 1, and the Clint Facility, among migrants apprehended daily by Border Patrol Agents. Individuals who indicated that they were ill at their initial intake and all children <18 years of age were medically evaluated and were screened to determine if they met the case definition for acute respiratory illness, defined as presence of any one of the following: fever ($\geq 38^{\circ}$ C), subjective fever (feverishness, chills), cough, runny nose, or nasal congestion. Individuals meeting this case definition were asked to participate in the enhanced surveillance. A short questionnaire and three specimens were collected (one oropharyngeal swab and one mid-turbinate nasal swab for a respiratory panel) and one mid-turbinate nasal swab for the influenza rapid diagnostic test.

Results

A total of 65 persons were tested, 6 of whom were positive for influenza by rt-PCR (Table 1). All were identified as influenza A(H1N1)pdm09. All influenza-positive persons were males; 3 were in PDT and 3 in Station 1. There were no positive influenza virus detections among UAC tested at the Clint facility. There was no clustering of positive detections by age group or country of origin.

The team piloted the use of the Sofia2 rapid influenza diagnostic kit in the field. Only four of the five influenza positive detections using the Sofia2 kit were positive for influenza by rt-PCR; an additional two individuals with rt-PCR positive influenza were not detected using the Sofia2. Two influenza A(H1N1)pdm09 viruses were confirmed to be susceptible to neuraminidase inhibitor drugs by neuraminidase activity detection assay.

Summary of Observations by CDC Teams

- 1. With inadequate DHS medical infrastructure, illness in the border patrol facilities stresses both the border patrol staff and the community medical infrastructure.**
 - Border patrol agents must accompany each ill person to the emergency room, which reduces staff available in the facility and patrolling the border.
 - Border patrol agents do not have training to triage or identify acutely ill migrants.
 - Migrants may have additional medical needs because of stress and exposures during of the journey, which may cause increased risk of illness. They may also be less likely to request medical care because of communication barriers and their vulnerable migrant status.

- During influenza season, local emergency rooms are often at capacity taking care of acutely ill persons, and may be unable to absorb an increased number of migrants being taken to the emergency room for evaluation.
2. **The number of individuals in each of these facilities and the duration of their stay, is dynamic and difficult to anticipate, posing unique challenges to implementing control measures.**
- The number of individuals in custody at the three surveillance facilities varies throughout the day as migrants are moved between facilities and may not align with overall apprehension numbers. The number at the facilities changes throughout the day. Specifically, most of the migrants have their intake with Border Patrol Agents at the PDT Facility. After the migrants go through intake, they are transitioned into holding cells while they wait to be transferred to another facility for further processing.
 - The movement of individuals from PDT to these other facilities is variable and depends on the capacity and the occupancy levels at those facilities. Migrants can be moved to one of the other facilities in the El Paso Section (11 facilities total), but family units are primarily sent to Station 1, UACs are primarily sent to the Clint Facility, and prosecutable males or females are sent to Ysleta. After migrants finish the processing step, they are released from Border Patrol custody to Immigration and Customs Enforcement or are otherwise incarcerated.
3. **Border Patrol facilities are not set up to be shelters, but during times of high occupancy and longer stays, the environment may be similar to shelters.**
- While optimally persons entering border control facilities are there for a short time (ideally ≤ 72 hours), periodically transit through these facilities slows, leading to increased crowding.
 - During these periods, potential for infectious disease transmission may increase, and the facility environment is similar to a shelter from an infection control standpoint. Thus, infection control measures and syndromic surveillance to minimize infectious disease outbreaks in shelters could be useful.
 - Current infrastructure is not sufficient to assure rapid and adequate infection control measures, including limited isolation options and agent training.

Recommendations

The complete set of recommendations below is for use during the influenza season and can be used to plan for the next season. Recommendations CDC identifies as high-priority when planning include:

- Implement screening for respiratory symptoms of individuals
- Plan for appropriate space to isolate ill migrants
- Have a sustainable plan for medical triage by trained healthcare providers

- Ensure supply of face masks and hand sanitizer in the facilities
- Ensure staff are vaccinated prior to the influenza season
- Work with local public health department to develop an approach to reporting

These recommendations reflect observations discussed above, while acknowledging that circumstances in border facilities change. They focus primarily on prevention and control of influenza, and should be considered during influenza season and periods of decreased transit time (longer holding times) and/or increased census in the El Paso sector border control facilities. The basis of this guidance rests on the assumption that during such periods, influenza transmission risk is similar to that in shelter settings.

1. Ensure sustainable medical infrastructure during times of increased crowding

Based on CDC observations, temporary medical staff supporting these facilities has been very effective at providing appropriate medical triage and management of respiratory illness. Therefore, CDC recommends continuing this support. Additional resources may be needed during periods of increased crowding.

- Establish/maintain sustainable infrastructure at the larger border patrol stations (ideally those with capacity ≥ 100 persons) to support medical screening, monitoring, prevention strategies and treatment of persons with uncomplicated illness.
 - This infrastructure should ideally remain in place throughout the influenza season and as long as migrants are residing in border stations for >72 hours, particularly when facilities are over capacity and crowding is increased.
 - If unable to establish infrastructure at stations with capacity ≥ 100 persons, efforts should be made to sustain these services at stations with the highest immigration volume.
- Routine collection of vital signs including temperature, respiratory rate, heart rate, blood pressure and oxygen saturation should be implemented during medical evaluations to identify/triage ill persons and detect severe illness including sepsis.
- In addition to the intake screening, consider a daily walk-through of the holding facility by medical personnel who can identify potential ill persons that need further evaluation.

2. Infection Prevention Measures

- Implement administrative controls to rapidly assess respiratory symptoms at intake and immediately separate (cohort) and/or mask symptomatic persons. Adding specific questions to identify respiratory and infectious symptoms to initial intake questionnaire (cough, chills, diarrhea, rash, etc.) will increase likelihood of identifying persons with illness.

- b. Ensure availability of personal protective equipment for staff and ill migrants. Persons with respiratory symptoms should wear a facemask until they are able to be isolated.
- c. Ensure adequate handwashing or hand sanitation is available.
- d. Use simple health education and communication messaging around hand washing or hand sanitizer, use of facemasks, and awareness of respiratory symptoms for staff and migrants.
- e. As feasible, reduce the time individuals are held at border stations.
- f. Determine a feasible approach to isolate or cohort individuals and/or families with members with respiratory symptoms, including consideration of temporary structures to provide additional space for isolation and to keep family members together.

3. Influenza Vaccination of Facility Staff

- a. We recommend that all staff at all facilities who are not yet vaccinated this season and who have no contraindications to vaccination be offered an age-appropriate influenza vaccine according to [current CDC/ACIP recommendations](#). Ideally, influenza vaccination should be offered to staff each season.

4. Syndromic (Symptom-based) Surveillance

- a. Conduct syndromic (symptom-based) surveillance to monitor prevalence of acute respiratory illness
 - i. Screening evaluations should include specific questions to identify signs and symptoms (fever, chills, cough, etc.) to increase likelihood of identifying persons with acute respiratory illness.
 - ii. Ongoing daily monitoring for new onset of acute respiratory illness signs and symptoms should be instituted after the initial screening, as long as migrants are residing within the border stations.
 - iii. Develop a system to monitor data to establish baseline and flag changes in the proportion of evaluated persons with illness if feasible. This could be centralized or conducted at selected high-volume facilities.
- b. Monitor proportion of people in each facility that are taken to the emergency department or hospital for evaluation, and the reason for the visit. This information should be transmitted to the state health department.
- c. If not currently in place, electronic systems to capture syndromic surveillance and medical visit information would be preferable and enhance communication with DHS, health departments and ICE and ORR facilities.
- d. Recommend continuation of syndromic surveillance year-round, for respiratory illness as well as other infectious syndromes (e.g. gastrointestinal, rash, and neurologic).

5. Surveillance and reporting to the state health department

- a. Implement a mechanism for reporting to health departments information concerning migrants who are sent to emergency departments or healthcare providers outside the facility. This can range from a report on each case or a daily summary report, depending on the needs of the health department.

- b. Implement a mechanism for assuring reportable diseases are reported to the state/local health department.

6. Monitoring of ill migrants

- a. Provide ongoing monitoring by medical personnel of the health of ill persons in the facilities (e.g., those noted to be ill on initial screening but not judged to need outside care, and those discharged from outside care back to the facility), so that further appropriate care can be provided for those whose condition deteriorates.
- b. Discharge information from hospital stays/ED visits should be provided back to on-site medical personnel (or other responsible trained DHS staff).
- c. Medical records of migrants should follow the individual as they progress to another facility or into the community.
- d. To facilitate control of communicable illnesses and prevent spread among different facilities, develop criteria to determine when ill persons may be transferred to the next facility or to ICE custody.

7. Influenza Antiviral Treatment

Early antiviral treatment can shorten the duration of influenza-associated illness and may reduce the risk of complications from influenza, as well as reduce need for referrals to outside medical facilities. CDC recommends use of antivirals, as feasible, in facilities with medical infrastructure.

- a. Given current levels of influenza circulation and crowded conditions, empiric treatment with an approved influenza antiviral of all persons with acute respiratory illness suspected to be due to influenza is recommended as soon as possible within the week of illness onset, if this can be reliably discerned.
 - a. Acute respiratory illness may be defined as
 - i. fever or feverishness and cough for those ≥ 2 years old
 - ii. fever or feverishness or cough or rhinorrhea or nasal congestion for those < 2 years old
 - b. This is consistent with CDC recommendations for facilities providing temporary or longer term group housing such as shelters for displaced persons experiencing influenza outbreaks.
- b. Through the end of the influenza season, clinical suspicion of influenza, without diagnostic confirmation, is sufficient to initiate antiviral treatment. Sources for influenza activity include Fluview and local/state health department communications.
- c. If crowding within facilities is alleviated and occurrence of respiratory illness in facilities has decreased, antiviral treatment decisions may be made using a narrower case definition of influenza-like illness based on clinical judgement or directed by the results of clinical influenza testing, in settings where available.
 - a. For persons with suspected or confirmed influenza, antiviral treatment would then be recommended as early as possible for persons at high risk for influenza complications, including children < 5 years (particularly those < 2 years), adults ≥ 65 years, pregnant females, and those with certain chronic medical conditions.

8. Influenza Vaccination of Migrants

Influenza vaccination should be implemented at the earliest feasible point of entry to allow for maximum protection of migrant and potential to reduce transmission in Border Patrol Facilities.

- a. Annual influenza vaccination for all persons ≥ 6 months of age is recommended (no influenza vaccines are licensed for children < 6 months).
- b. In facilities with medical infrastructure, all migrants present for sufficient time for vaccination who do not have contraindications should be offered an age-appropriate influenza vaccine.
 - i. All migrants should be presumed unvaccinated unless records indicating vaccination are available.
 - ii. For persons with moderate or severe acute illness, with or without fever, due to any cause, vaccination should be deferred until the acute illness has resolved.
- c. Priority groups for vaccination include children aged 6 months through 18 years and pregnant women.
 - i. All children 6 months to < 9 years should receive the first dose of vaccine at the border patrol station and a second dose ≥ 4 weeks later.
- d. Vaccination may be considered for adults > 18 years of age if feasible.

9. Diagnostic Test-Based Surveillance

- a. Given ongoing risk of influenza transmission, CDC recommends that the decision to treat with antivirals be based upon clinical suspicion for influenza, and should not be based upon diagnostic testing.
- b. However, where feasible, in order to assess ongoing circulation of influenza viruses, periodic (e.g. once weekly or biweekly or monthly) diagnostic testing on a sample of symptomatic persons may be considered for surveillance purposes:
 - i. Rapid diagnostics for influenza screening (using nasal swabs) to determine presence of influenza virus circulation among migrant population (note that rapid molecular influenza testing would be preferred over rapid antigen detection tests, if feasible).
 - ii. In addition, or as an alternative, consider sending swabs collected from ill persons to a public health laboratory for influenza diagnosis, as well as antigenic and genetic characterization.

Additional considerations for influenza vaccine implementation:

- Influenza vaccination of migrants may be most feasible at the border stations with current existing medical infrastructure.
- Implement vaccination programs at border stations that will maximize contact with the greatest number of people.
- Local community partnerships should be explored to support vaccination efforts.
- Establish a working relationship with the Texas State Immunization Program (or other state health department) for technical assistance regarding issues related to vaccine supply, storage and handling requirements including maintenance of cold chain, and quality control measures.
- Vaccination records should follow migrants as they progress to other facilities or the community.
 - This may be accomplished through forming a relationship with the Texas State Immunization Information System (IIS) for stations inside the Texas borders, along with providing paper documentation.
- Identify personnel qualified to administer vaccines and establish training and documentation protocols and procedures for vaccine administration.
- Appropriate refrigeration units will need to be procured and monitored with temperature data loggers to provide for vaccination storage.
- Vaccine information should be provided to the all vaccine recipients ≥ 18 years of age and to guardians of those < 18 years of age, in the recipient's primary language.

Table 1. Demographics of Individuals Surveyed

Demographics	All N= 65		Influenza PCR/TAC Positive Infections* N=6		Non-Influenza Enrollees [‡] N=59	
	N	%	N	%	N	%
Age, y, median (IQR)	16 (19)		16.5 (13)		16 (21)	
0-4	8	12.3	1	16.7	7	11.9
5-12	16	24.6	1	16.7	15	25.4
13-17	16	24.6	2	33.3	14	23.7
18-49	25	38.5	2	33.3	23	39.0
Sex						
Male	39	60.0	6	100.0	33	55.9
Female	26	40.0	0	0.0	26	44.1
Country of Origin						
El Salvador	8	12.3	0	0.0	8	13.6
Guatemala	38	58.5	3	50.0	35	59.3
Honduras	16	24.6	3	50.0	13	22.0
Mexico	3	4.6	0	0.0	3	5.1
Border Patrol Facility						
Central Intake Facility	41	63.1	3	50.0	38	64.4
Family Units Facility	18	27.7	3	50.0	15	25.4
Unaccompanied Minor Facility	6	9.2	0	0.0	6	10.2

*Among influenza positive samples, 6 identified as H1N1pdm09.

‡ 29 individuals had no viral agents identified by PCR or TAC; 23 had only 1 viral agent identified by PCR or TAC (Rhinovirus, Adenovirus, Human Metapneumovirus, Human Coronavirus 3); 7 had 2 viral agents identified by PCR or TAC (Rhinovirus/Human Coronavirus 1, Rhinovirus/Parainfluenza Virus 1, Rhinovirus/Cytomegalovirus, Rhinovirus/Enterovirus, and 3 individuals with Rhinovirus/Human Coronavirus 3)

Figure 1

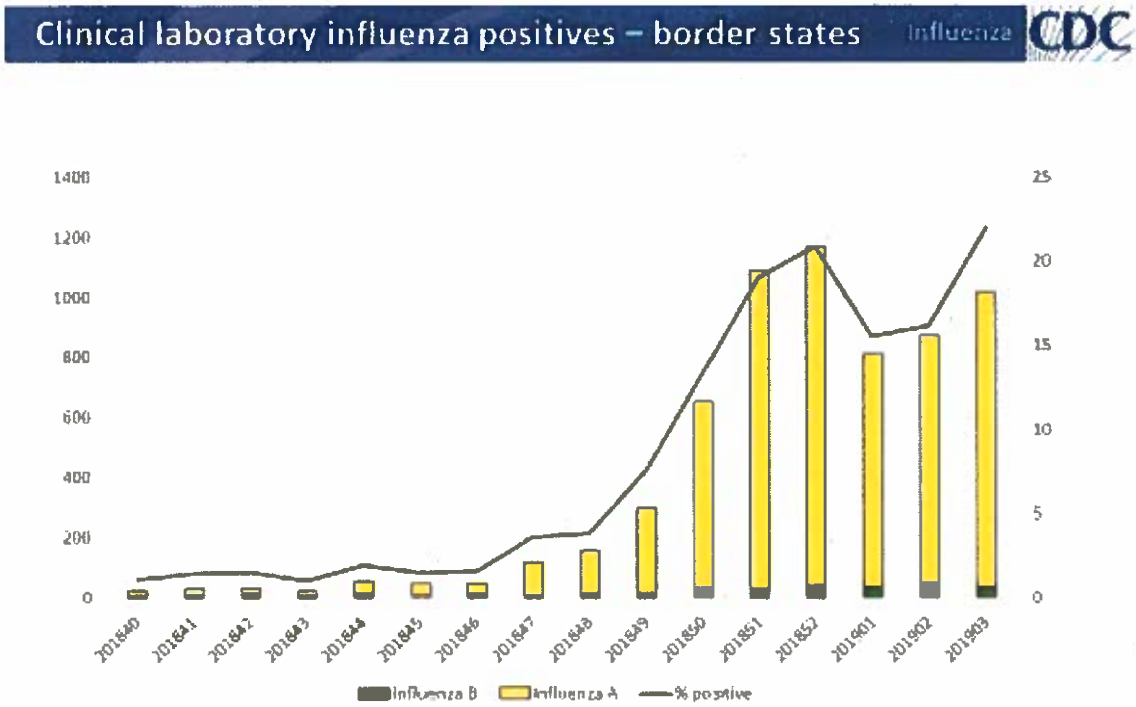
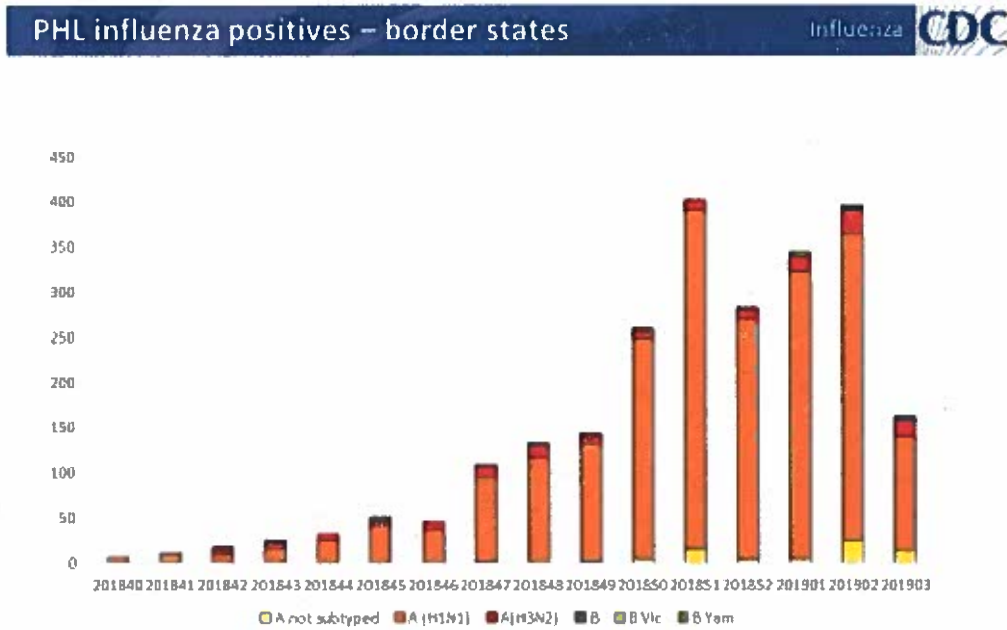


Figure 2:





DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention
National Institute for Occupational
Safety and Health
1090 Tusculum Avenue
Cincinnati OH 45226-1998

September 5, 2019
HHE 2019-0142

Mr. Arturo Borrego
Assistant Chief Patrol Agent, Policy and Compliance
El Paso Border Patrol Sector
8901 Montana Avenue
El Paso, Texas 79925-1212

Dear Mr. Borrego:

This letter is in response to a health hazard evaluation (HHE) request received by the National Institute for Occupational Safety and Health from the American Federation of Government Employees' National Border Patrol Council (NBPC) Local 1929 ("union"), representing employees at U.S. Border Patrol (USBP) Stations in the El Paso Border Patrol Sector (El Paso Sector). The request concerned (1) USBP agents' (referred to as "agents" in this letter) exposure to lice, scabies, infectious pathogens, and bodily fluids, including secondary exposures to household members and (2) USBP agents' occupational stress. We visited three of the stations from May 14–15, 2019. On May 29, 2019, we sent you a letter briefly reviewing our site visit and providing preliminary recommendations. This letter supplements that initial letter, summarizing the findings of our evaluation and providing recommendations for preventing occupational exposures and reducing occupational stress among agents.

Background

The USBP is a uniformed law enforcement agency of the U.S. Customs and Border Protection (CBP). The management representatives involved in this HHE were from the El Paso Sector of USBP, although we did review some documents originating from CBP. The request was submitted for five USBP Stations in the El Paso Sector: El Paso Station 1, Paso Del Norte, Ysleta, Santa Teresa, and Clint. During conversations with NBPC Local 1929 (and a NBPC national representative) and USBP El Paso Sector management (referred to as "management" in this letter) representatives, we learned more about the concerns listed in the request. Between May 2018 and May 2019, the El Paso Sector experienced a 323% increase in apprehensions of unaccompanied children, a 2,100% increase in apprehensions of family units, and a 110% increase in apprehensions of single adults [U.S. Customs and Border Protection 2019]. In May 2019, the agents in the El Paso Sector apprehended 29,832 family units (i.e., adults and children traveling together), 3,255 unaccompanied children, and 5,543 single adults. During phone calls prior to our site visit, management representatives reported that approximately 250 agents worked at each of the El Paso Station 1 and Paso Del Norte sites, while approximately 215 agents worked at Clint.

Page 2 – Mr. Arturo Borrego

At the time of our site visit, agents' job duties included apprehending migrants who surrendered at the United States' southern border; transporting them to a USBP Station; searching migrants and their belongings upon arrival; providing migrants with medication documented to be necessary, water or juice, food, and showers; interviewing migrants; and processing migrant's immigration paperwork. Agents were also responsible for transporting migrants to a hospital if they needed medical care that could not be provided on-site. One of the functions of the USBP Stations is to detain migrants until the processing can be completed. During our site visit, El Paso Station 1 primarily detained female migrants traveling alone and family units. Male migrants traveling alone were primarily detained at the Paso Del Norte station, while unaccompanied children were detained at the Clint Station. Migrants were detained in areas called holding cells.

Methods

The objectives of our evaluation were to address the two primary concerns noted in the HHE request by: (1) evaluating usual work duties of the agents; (2) evaluating the potential for exposures to mites which cause scabies, parasitic insects such as lice, and infectious pathogens; (3) reviewing policies and procedures relevant to occupational safety and health (e.g., related to personal protective equipment (PPE) and infection prevention and control), including implementation and adherence to the policies and procedures; and (4) identifying the major sources of occupational stress among agents.

After our initial conversations with union and management representatives, we determined that a site visit focused on the El Paso Station 1, Paso Del Norte, and Clint USBP Stations would best help accomplish our objectives because of their relatively larger size and physical proximity to each other. We were also told that the concerns, general work practices, and procedures at these three stations were similar to those at the other stations in the El Paso Sector. During our site visit, we met with management and union representatives to discuss the HHE request. We walked through all three stations and observed work processes, practices, and workplace conditions. During the site visit, we also:

- Discussed agents' health concerns with management and union representatives
- Met with a representative from the USBP El Paso Sector's Office of Workers Compensation Program (OWCP)
- Conducted a qualitative assessment of the ventilation systems that serviced indoor holding cells and medical isolation rooms (used for migrants thought to potentially be infectious) at all three stations
- Observed the availability, type, and use of PPE

Following our site visit, we reviewed the following documents provided by management during our site visit:

- "US Border Patrol, El Paso Sector Respiratory Protection Program," effective June 5, 2018
- "Bloodborne Pathogen Exposure Control Plan, El Paso Sector Compound," updated February 25, 2019
- "El Paso Sector Infectious Disease Plan," dated June 12, 2018

Page 3 – Mr. Arturo Borrego

- CBP Memorandum addressing the Medical Surveillance Program, dated February 5, 2019 (referred to as “Medical Surveillance Program Memo” in this letter)
- A summary of lice, scabies, and infectious disease-related worker’s compensation compensable and non-compensable claims from the USBP El Paso Sector OWCP January 1, 2014–April 19, 2019
- A list of lice, scabies, and infectious disease-related reports filed with the USBP El Paso Sector OWCP, Fiscal Year 2014–April 9, 2019 (The list did not include any claims related to lice)
- CBP Occupational Safety and Health’s guidance document, “Employee Protection – Best Practices for Unaccompanied Children (UAC)/Detainee Influx” (no date provided)
- USBP El Paso Sector Office of Quality and Compliance “Agent Risk Management Monthly Muster Briefs for El Paso Sector Border Patrol” from October 2018, December 2018, March 2019, April 2019, and May 2019 (referred to as “Monthly Muster Briefs” in this letter)
- “Medical Screening Confirmation” form for adults and minors and “U.S. Border Patrol Health Screening for Alien Minors” (no date provided)

After our site visit, we requested additional information as a part of our evaluation. We reviewed the following additional documents:

- A CBP document that described the Office of Personnel Management Employee Assistance Program (EAP), peer support, and chaplain services.
- CBP “Performance of Work Statement for Janitorial, Land and Grounds Maintenance, Select Trash Removal, and Snow Removal Services” for CBP locations including the Clint and Santa Teresa USBP Stations covering the dates May 1, 2019–March 31, 2020
- CBP “Statement of Work for Janitorial, Land and Grounds Maintenance and Snow Removal Services” for CBP locations including Station 1 and Ysleta USBP Stations covering the dates May 1, 2019–March 31, 2020. We did not receive the current cleaning contract for Paso Del Norte USBP Station

Results

Site Visit Observations and Information Gathered from Meetings

At the time of our site visit, it was reported by union and management representatives that each USBP El Paso Sector Station’s capacity for processing and detaining migrants was exceeded, which resulted in overcrowded conditions; this has also been noted elsewhere [DHS 2019]. This situation prompted the construction of outdoor tents and soft-sided structures to accommodate the excess numbers of migrants at both Station 1 and Clint. At Station 1, we observed ‘standing room only’ conditions in several holding cells. We also observed that the migrants within one of the holding cells overflowed into the hallway. At Paso Del Norte, the number of migrants in each holding cell exceeded the maximum capacity posted on the doors. Based on our observations and conversations with union and management representatives, overcrowding appeared to be a function of both the influx of migrants at the southern border and migrants’ length of stay (detentions) at the stations. Union and management representatives told us that while some

Page 4 – Mr. Arturo Borrego

migrants were released from USBP custody within a 72-hour window, others had been in USBP custody for over thirty days.

Union representatives reported that overcrowding had resulted in an increased workload and longer hours for agents, and expressed concerns about agents working while sick because they had used all their sick leave. The union representatives did not know if any agents had been diagnosed with an infectious disease but expressed concern about exposure to infectious pathogens at work (along with conditions such as scabies and lice infestation). The union representatives specifically noted concerns related to insufficient management communication with agents when a migrant is diagnosed with an infectious disease.

During our walk-through of the facilities, we observed that handwashing stations were available in the restrooms used by agents, and portable handwashing stations were available at some, but not all, temporary outdoor restroom locations for migrant use. Union representatives told us that these portable handwashing stations were serviced once a day in the morning, though the water and soap at the washing stations would be depleted within an hour at some locations. Union and management representatives told us that water, but neither soap nor hand sanitizer, was available inside the indoor migrant holding cells. Handwashing stations were not available in the rooms intended for medical isolation. Alcohol-based hand sanitizer was available throughout the stations for agent use. Management representatives told us that hand sanitizer was made available to migrants for use before meals, but we do not know if or how widely hand sanitizer was used by migrants.

During conversations with union and management representatives, we learned that the El Paso Sector had a voluntary use respiratory protection program.¹ N95 filtering facepiece respirators and nitrile gloves were available to agents in processing areas, but their use was not required. We observed a few agents wearing PPE, such as gloves and/or an N95 respirator.

During our visit, we found that nearly all of the holding cells and medical isolation rooms at the three stations were under a positive air pressure differential relative to adjacent areas. This means that air will tend to flow out from each room into the adjacent areas. Given this ventilation condition, any infectious pathogen that might be present could be transmitted via the airborne route of exposure and could pose a risk to others who occupy the areas adjacent to the isolation rooms.

Through conversations with union and management representatives, we learned about the EAP, peer support program, and a chaplain program that are available as resources for agents to assist in managing their stress. We also learned that an annual suicide prevention training was provided for El Paso Sector agents.

¹ Voluntary use respiratory protection program refers to a program in which respirators are worn in workplace situations or job tasks for which respirators are not mandated by OSHA.

Page 5 – Mr. Arturo Borrego

During our visit, we learned that the USBP El Paso Sector formed, and was continuing to develop, a health and safety working group comprised of management, union officials, and agents.

Document Review

Results of our review of the documents we requested and were made available to us are provided in the Appendix to this letter.

Discussion

During our site visit, we observed conditions that can potentially contribute to or facilitate the spread of infectious disease, and other conditions such as lice and scabies mite infestation, to agents. These include overcrowded conditions, lack of adequate handwashing facilities, and ventilation system deficiencies. Overcrowded conditions have been shown to facilitate the spread of infectious disease in many settings, including correctional facilities [Hoge et al. 1994], healthcare [Haley and Bregman 1982; Harbarth et al. 1999], and homeless shelters [Paul et al. 2011]. The lack of adequate handwashing facilities can also contribute to the spread of infectious disease. Regular handwashing reduces the spread of common infectious agents, which may reduce the risk of exposure to infectious agents among both migrants and agents. On the basis of our qualitative assessment of the ventilation systems that service the holding cells at some of the facilities, it appears that adjustments and balancing of these systems are necessary to correct deficiencies (e.g., ensure each holding cell remains under negative air pressure relative to surrounding areas).

The HHE request indicated that job stress was a concern. We learned in our discussions with union and management representatives that overcrowding and long working hours were general sources of job stress. NIOSH defines *job stress* as the harmful physical and emotional responses that occur when the requirements of a job are a poor match to the capabilities, resources, or needs of the worker [NIOSH 1999]. Job stress is an important area of focus in occupational safety and health due to its association with a broad array of health disorders and other negative outcomes [NIOSH 2019; Quick and Tetrick 2011]. For example, job stress is associated with acute reactions (e.g., headaches, muscle/joint complaints, fatigue, negative mood states); cardiovascular disease; musculoskeletal disorders; psychological disorders; burnout; and maladaptive behaviors such as substance abuse, aggression, absenteeism, and turnover. It is important to prevent and manage job stress to improve worker well-being.

Our evaluation was subject to several limitations. First, we were restricted from speaking to individual agents during our site visit because we were told that agents were too busy. This limits our ability to understand and describe both: (1) specific agent concerns and; (2) employer and agent adherence to current policies and procedures described in the documents we reviewed. Second, medical records associated with individual workers compensation claims and documents pertinent to evaluation of occupational stress were not provided. Third, summary information provided by OWCP was incomplete. Fourth, the burden of infectious disease among migrants is poorly characterized (which limits exposure assessment for the agents).

Conclusions

Workplace practices and conditions may facilitate the spread of infectious disease and skin infestations to USBP agents at the El Paso Sector Stations. The current workload for USBP agents at the El Paso Sector Stations presents occupational safety and health challenges for the USBP management, agents, and the NBPC. Current occupational safety and health issues will likely remain difficult to address effectively until the workload on individual USBP agents returns closer to baseline. Written policies and procedures for the USBP El Paso Sector attempt to address and provide guidance to minimize the occupational health concerns addressed in this HHE. As noted in the Appendix, these policy and procedure documents and guidelines could be improved with additional clarity and specificity with respect to the current working conditions present at these stations, the PPE required for specific job tasks, and potential exposures. Similarly, while agents have access to a wide variety of mental health resources through EAP and other program services, information provided to agents concerning these resources can be improved as noted above.

Recommendations

We encourage the USBP El Paso Sector management to continue developing their labor-management health and safety working group, which includes NBPC Local 1929 representatives, to discuss our recommendations and develop an action plan for the specific situation at USBP Stations in the El Paso Sector.

On the basis of our findings, we recommend the actions listed below. Our recommendations are based on an approach known as the hierarchy of controls. This approach groups actions by their likely effectiveness in reducing or removing hazards. Elimination and substitution are the most effective at reducing hazards but are not applicable for the operations performed at these stations. Engineering controls are designed to remove the hazard at the source, before it comes in contact with the worker. If such controls are not possible or if they are not effective or feasible at the current time, administrative measures and PPE may be needed.

Engineering Controls

Engineering controls reduce employees' exposures by removing the hazard from the process or by placing a barrier between the hazard and the employee. Engineering controls protect employees effectively without placing primary responsibility of implementation on the employee.

- Consult a qualified ventilation engineer or other qualified person who has experience in testing, adjusting, and balancing ventilation systems to ensure a negative air pressure differential is maintained in the medical isolation rooms relative to adjacent areas and that potentially contaminated air from medical isolation rooms is exhausted or filtered appropriately and not shared with other areas of the stations.
- Install an air pressure monitoring indicator gauge or light so agents can visually assess the operational condition of each of the ventilation systems that service the medical isolation rooms.

- Provide handwashing stations at all permanent and temporary restrooms used by migrants and agents. Ensure that all handwashing stations have an adequate supply of water and hand soap throughout the day. If soap is easily misplaced, liquid hand soap can be provided in a fixed dispenser.
- Provide alcohol-based hand sanitizer that contains at least 60% alcohol for use when water and soap are not available. Hand sanitizer quickly reduces the number of infectious agents, but does not eliminate all infectious agents. Hand sanitizer should be kept out of reach of young children, and children's use of hand sanitizer should be supervised by an adult. Additional information on handwashing can be found here: <https://www.cdc.gov/handwashing/when-how-handwashing.html>.
- Post signs describing proper handwashing procedures in the languages spoken by migrants and agents.

Administrative Controls

The term administrative controls refers to employer-dictated work practices and policies to reduce or prevent hazardous exposures. Their effectiveness depends on employer commitment and employee acceptance. Regular monitoring and reinforcement are necessary to ensure that policies and procedures are followed consistently.

- As feasible, consider implementing methods to reduce overcrowding.
- Clarify which specific immunizations are provided by FOH services and encourage agents to participate in the program.
 - If influenza and other vaccinations that are not included in the Medical Surveillance Program memo are covered under CBP's contract with FOH, agents should be informed of these benefits. Agents with no contraindications to vaccination should be offered age-appropriate vaccinations according to the current CDC Advisory Committee on Immunization Practices recommendations [Kim and Hunter 2019] through FOH services.
- Ensure that cleaning and disinfection procedures for blood spills in the Bloodborne Pathogen Exposure Control Plan align with the OSHA bloodborne pathogen standard and follow instructions on the EPA-approved disinfectant label.
- Consult a qualified infection prevention specialist and develop a comprehensive infectious disease plan based on current conditions in the USBP Stations and consider including guidance for preventing take-home exposures.
- Continue to offer regular trainings on specific infectious diseases agents are most likely to encounter at work, including training on transmission, signs and symptoms, and recommended or required PPE.
- Provide surgical masks to migrants exhibiting respiratory symptoms until they are able to be isolated in a room with proper ventilation (e.g., negative air pressure) and are medically evaluated.
- Encourage agents to seek care from a qualified health professional and to stay home from work when they are sick.

- Encourage agents to seek help from a qualified health professional if they are experiencing symptoms of stress or other mental health issues that are interfering with their social, occupational, or other areas of functioning.
 - Several resources are available to agents including the EAP, the peer support program, and chaplain services. Details about these programs should be readily available to agents, and reminders about these resources should be made periodically during muster.
- To complement the USBP annual suicide prevention training, have an EAP representative or mental health professional give all agents an annual training or educational presentation about recognizing the signs of stress in oneself and others, psychological first aid, and stress reduction techniques. The American Psychological Association's stress topic page provides information and resources for recognizing and coping with stress at <http://www.apa.org/topics/stress/index.aspx>.
- Include a description of what steps are taken to protect agent confidentially during use of EAP services, including a description of when confidentiality cannot be maintained. An example of the latter is if the agent discloses information suggesting they are a risk to themselves or others. Information about confidentiality in mental health is available through the American Psychological Association at <https://www.apa.org/helpcenter/confidentiality>.
- Encourage agents to maintain proper sleep habits when off duty, as this impacts physical and mental well-being. The National Sleep Foundation recommends that adults receive 7–9 hours of sleep in a 24-hour period. More information about the impact of sleep hygiene and sleeping solutions can be found at <http://www.sleepfoundation.org>.

Personal Protective Equipment

Personal protective equipment is the least effective means for controlling hazardous exposures. Proper use of PPE requires a comprehensive program and a high level of employee involvement and commitment. The right PPE must be chosen for each hazard. Supporting programs such as training, change-out schedules, and medical assessment may be needed. Personal protective equipment should not be the sole method for controlling hazardous exposures. Rather, PPE should be used until effective engineering and administrative controls are in place.

- Continue to provide PPE to agents as called for in USBP policies and procedures, and train agents in proper use. We recommend the following to improve current practice:
 - As outlined in the USBP El Paso Sector Respiratory Protection Program, conduct a job-hazard analysis at each station in the Sector to determine when respirators should be required.
 - Clarify the job titles and job tasks that require respirator use, including the respirator type, in the Respiratory Protection Plan.
 - Where PPE including respiratory protection is recommended or encouraged in official guidance documents and muster trainings, ensure clarity on whether respiratory protection is required or voluntary.

This letter serves as a final report and concludes this health hazard evaluation. According to federal regulation (42 CFR 85.11), the employer must post a copy of this letter for 30 days at or near work areas of affected employees. We are sending a copy of this letter to the Occupational Safety and Health Administration Region VI Office and the Texas Department of State Health Services.

Thank you for your cooperation with this evaluation. If you have questions, please contact Dr. Sarah Hatcher at 513-841-4526 or at shatcher@cdc.gov, CAPT Mark Methner at 513-841-4325 or at mmethner@cdc.gov, or Dr. Douglas Wiegand at 513-841-4240 or at dwiegand@cdc.gov.

Sincerely,

**Sarah M.
Hatcher -S**

Digitally signed by Sarah M.
Hatcher -S
Date: 2019.09.05 12:39:12
-04'00'

Sarah Hatcher, PhD
Epidemiologist

**Mark
Methner -S7**

Digitally signed by Mark
Methner -S7
Date: 2019.09.05
13:30:09 -04'00'

CAPT Mark Methner, PhD, CIH
Senior Research Industrial Hygienist

**John D. Gibbins
-S5**

Digitally signed by John D.
Gibbins -S5
Date: 2019.09.05 12:53:15
04'00'

Douglas Wiegand, PhD
Behavioral Scientist

Hazard Evaluations and Technical
Assistance Branch
Division of Field Studies and Engineering

cc:

Mr. Carlos Favela, Executive Vice President and Spokesman, American Federation of
Government Employees' National Border Patrol Council Local 1929
Occupational Safety and Health Administration Region VI Office
Texas Department of State Health Services

References

DHS [2019]. Management alert — DHS needs to address dangerous overcrowding among single adults at El Paso Del Norte Processing Center (Redacted). Department of Homeland Security, Office of the Inspector General Publication No. OIG-19-46, <https://www.oig.dhs.gov/sites/default/files/assets/2019-05/OIG-19-46-May19.pdf>.

Haley RW, Bregman DA [1982]. The role of understaffing and overcrowding in recurrent outbreaks of staphylococcal infection in a neonatal special-care unit. *J Infect Dis* 145(6):875–885, <https://doi.org/10.1093/infdis/145.6.875>.

Harbarth S, Sudre P, Dharan S, Cadenas M, Pittet D [1999]. Outbreak of *Enterobacter coaccae* related to understaffing, overcrowding, and poor hygiene practices. *Infect Control Hosp Epidemiol* 20(9):589–603, <https://doi.org/10.1086/501677>.

Hoge CW, Reichler MR, Dominguez EA, Bremer JC, Mastro TD, Hendricks KA, Musher DM, Elliot JA, Facklam RR, Breiman RF [1994]. An epidemic of pneumococcal disease in an overcrowded, inadequately ventilated jail. *N Engl J Med* 331:643–648, <https://www.nejm.org/doi/full/10.1056/NEJM199409083311004>.

Kim DK, Hunter P [2019]. Recommended adult immunization schedule, United States, 2019. *Ann Intern Med* 170(3):182–192, <https://doi.org/10.7326/M18-3600>.

NIOSH [1999]. Stress... at work. Cincinnati, OH: Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. DHHS (NIOSH) Publication No. 99-101, <https://www.cdc.gov/niosh/docs/99-101/default.html>.

NIOSH [2019]. Healthy work design and well-being program. Cincinnati, OH: Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, <https://www.cdc.gov/niosh/programs/hwd/burden.html>.

Paul EA, Lebowitz SM, Moore RE, Hoven CW, Bennet BA, Chen A [2011]. Nemesis revisited: tuberculosis infection in a New York City men's shelter. *Am J Public Health* 83:1743–1745, <https://doi.org/10.2105/AJPH.83.12.1743>.

Quick JC, Tetrick LE, eds. [2011]. *Handbook of occupational health psychology*, 2nd ed. Washington, DC: American Psychological Association.

U.S. Customs and Border Protection [2019]. U.S. Border Patrol Southwest border apprehensions by sector fiscal year 2019, <https://www.cbp.gov/newsroom/stats/sw-border-migration/usbp-sw-border-apprehensions>.

Appendix

El Paso Sector Respiratory Protection Program

The “USBP, El Paso Sector Respiratory Protection Program,” dated June 5, 2018, included the elements required by the Occupational Safety and Health Administration (OSHA) Respiratory Protection Standard [29 CFR 1910.134]. The plan included sections on the following:

- Required and voluntary respirator use
- Respirator selection procedures
- Medical evaluation of employees required to use respirators. However, the plan did not include a copy of the medical questionnaire used for medical evaluation and clearance
- Fit testing
- Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators
- Respirator use procedures
- Employee training in proper respirator use, respirator maintenance, and respirator limitations
- Program evaluation
- A copy of Appendix D from the OSHA Respiratory Protection Standard, which provides information for employees voluntarily using respirators

The section of the Respiratory Protection Program on required use stated that the administrator of the program (USBP El Paso Sector Office of Policy and Compliance Operations Officer), with the assistance of the Area Safety and Occupational Health Specialist (USBP El Paso Sector Safety Specialist), would assess the worksite and determine the need for respiratory protection under certain conditions, including “in the event of failure of engineering controls creating a lack of negative pressure airflow in areas such as processing areas/cells/holding areas.” In addition, the respiratory protection plan listed specific scenarios for required respirator use, such as “protection from airborne transmitted infectious bioaerosols” and “close/casual/direct contact with credibly symptomatic individuals.”

Bloodborne Pathogens Exposure Control Plan, El Paso Sector Compound

The “Bloodborne Pathogens Exposure Control Plan, El Paso Sector Compound” document, dated February 25, 2019, for USBP El Paso Sector employees included most of the elements required by the OSHA Bloodborne Pathogen Standard [29 CFR 1910.1030], including an exposure determination, methods of compliance, hepatitis B vaccination, post-exposure evaluation and follow-up, communication of hazards to employees, and recordkeeping. However, the section on cleaning, decontamination, and disposal did not provide details to determine if it was consistent with OSHA policy.²

² Quick Reference Guide to the Bloodborne Pathogens Standard:
https://www.osha.gov/SLTC/bloodbornepathogens/bloodborne_quickref.html

El Paso Sector Infectious Disease Plan

The stated purpose of the “El Paso Sector Infectious Disease Plan,” dated June 12, 2018, was to provide “guidance regarding the El Paso sector’s preparation for, response to, and recovery from infectious diseases and pandemic events.” The plan included guidance related to planning, prevention, mitigation, response, recovery, mass migration contingency planning, staffing level, medical countermeasures, infectious subjects, communications, and reporting requirements. The plan does not provide guidance on preventing take-home exposure.

In our review, we found that the infectious disease plan could be improved in several ways:

(1) more detail and specificity with respect to education and training, transportation protocols, PPE use, communication, and infectious disease transmission-based exposure prevention and post-exposure guidance; (2) additional detail regarding vehicle cleaning and training resources (we noted that this information was provided in a separate CBP document, “Employee Protection – Best Practices for UAC/Detainee Influx”); (3) step-by-step instructions for agents in the event of exposure to a specific infectious pathogen(s), such as those that cause measles or tuberculosis; and (4) increased training on recognition of signs of infectious disease and infections among migrants.

CBP Memorandum Addressing the Medical Surveillance Program (Medical Surveillance Program Memo)

The CBP Medical Surveillance Program Memo, dated February 5, 2019, described the clinical services available to agents. Clinical services described in the memo included annual tuberculosis screening, hepatitis A vaccination, hepatitis B vaccination, tetanus-diphtheria vaccination, annual audiometric testing, respirator clearance evaluation for N95 or other respirator use as requested, and annual blood lead testing for firearms instructors. Official guidance from the El Paso Sector Office of Quality and Compliance, including the Monthly Muster Brief topics (further described below) from December 2018 and May 2019, also mentioned the services available through FOH, but some of these services were not consistent with the Medical Surveillance Program Memo. For example, the Monthly Muster Brief on Operational Medicine and Workforce Health Guidance Regarding Mumps (December 2018) encouraged agents to discuss possible need for FOH services with their local safety official if they are unsure of their measles, mumps, and rubella (MMR) immunization status. The Monthly Muster Brief on Best Practices for UAC/Detainee Influx (May 2019) emphasized the immunization benefit of FOH services and cites chickenpox as an example. However, MMR and chickenpox vaccination were not listed as services available in the Medical Surveillance Program Memo.

Office of Workers Compensation Claims

Filing a report with OWCP or submitting a claim to the U.S. Department of Labor (DOL) did not necessarily mean that an agent was diagnosed with scabies or an infectious disease. Agents could file a report with OWCP if they perceived that they were exposed (i.e., to scabies mites or an infectious pathogen) at work. After filing a report with OWCP, they could work with OWCP to submit their claim to DOL to be considered for workers compensation benefits. DOL then reviewed the claim and determined whether it was compensable.

Page A-3 – Mr. Arturo Borrego

We received data from the OWCP, covering claims from 2014–2019. Data included: (1) a tabulated summary of compensable and non-compensable claims to OWCP by USBP staff in the El Paso Sector for scabies or infectious diseases, from the beginning of fiscal year 2014 through April 9, 2019, stratified by USBP Station; and (2) a list of scabies and infectious disease-related reports filed with OWCP from January 1, 2014 through April 19, 2019 (excluding the period of February 8, 2016, to November 21, 2018), regardless of whether they were submitted to the DOL as a workers compensation claim.

In total, 198 scabies or infectious disease-related reports were filed with OWCP from January 1, 2014–April 19, 2019, excluding the dates noted above. Of 198 reports, only 31 (16%) were submitted as a claim to DOL. Of the 31 claims submitted to DOL, five were deemed compensable and accepted while six were still under consideration. With the data provided, we were not able to determine whether the reports represented agent exposure or actual infestation or infection.

Other Training and Education Documents

The “Employee Protection – Best Practices for UAC/Detainee Influx” document described CBP guidance on the following during periods of UAC/detainee influx: PPE use, agents’ personal hygiene, interaction with migrants, facility cleaning and maintenance, vehicle cleaning, occupational health services, food service protocols, continuity of operations plans, laundry services, and training and education. We reviewed five Monthly Muster Briefs issued by the USBP El Paso Sector Office of Policy and Compliance that provided written training on several topics, including PPE (October 2018), Operational Medicine and Workforce Health Guidance Regarding Mumps (December 2018), the Respiratory Protection Program (March 2019), Scabies (April 2019), and Best Practices for UAC/Detainee Influx (May 2019). The Monthly Muster Briefs were informative and provided an additional opportunity for agent training and education regarding occupational safety and health topics. The Monthly Muster Briefs on Operational Medicine and Workforce Health Guidance Regarding Mumps (December 2018) and Scabies (April 2019) contained information about transmission, signs and symptoms, and recommended PPE. The Monthly Muster Brief on Scabies (April 2019) provided information on crusted scabies transmission, but did not specify that non-crusted scabies is usually spread by prolonged skin-to-skin contact. Union and management representatives told us that the written Monthly Muster Briefs were reviewed with agents during their beginning-of-shift muster meeting once per month.

After we reviewed the USBP El Paso Sector Monthly Muster Briefs and the CBP “Employee Protection – Best Practices for UAC/Detainee Influx” documents, we identified inconsistencies between the guidance provided in these documents and the USBP El Paso Sector Respiratory Protection Program. The Respiratory Protection Program stated that respirator use was voluntary, unless an evaluation revealed that respirators were required. However, the language used to describe PPE in the CBP “Employee Protection – Best Practices for UAC/Detainee Influx” document and Monthly Muster Briefs implied that respirator use would be required under current conditions in the USBP Stations. For example, the Monthly Muster Brief on Best Practices for UAC/Detainee Influx (May 2019) instructed agents to “wear N95 masks when processing persons suspected of being infected with possible communicable airborne disease-causing

agents.” As another example, a Monthly Muster Brief on PPE (October 2018), further instructed agents to “wear the PPE identified for the task; when exposure to drug powders is likely, PPE includes gloves, properly-fitted respiratory protection, and safety goggles.” These instructions appeared to indicate that respiratory protection is required.

Migrant Medical Screening Forms

The “Medical Screening Confirmation” form provided by management representatives did not include medical screening questions, but indicated whether a migrant was fit for travel and whether they were currently taking any medications. The “USBP Health Screening for Alien Minors” document, provided by the medical contractor at Clint Station, included the following topics: medical history; medical concerns or conditions, including certain signs and symptoms of potential respiratory, gastrointestinal, dermatologic, and neurologic illnesses; and mental health questions and observations.

EAP Program

Both the summary document provided to us and the EAP website hosted by the Office of Personnel Management (<http://www.OPM.gov/policy-data-oversight/worklife/employee-assistance-programs>) indicate that agents have access to a wide variety of mental health resources through EAP and other program services. The information we reviewed could be improved with more detailed information concerning confidentiality. Specifically, the information did not fully disclose situations in which confidentiality could be broken (e.g., if an agent seeking services is a safety risk to themselves or others). It is important that all EAP promotional information available to agents fully disclose the conditions of confidentiality for these services.

Cleaning Contracts

We reviewed the U.S. CBP “Statement of Work for Janitorial, Land and Grounds Maintenance and Snow Removal Services” for May 1, 2019 to March 31, 2020, covering several CBP facilities including El Paso Station 1 and the Ysleta Border Patrol Station. We also reviewed a “Performance Work Contract for Janitorial, Land and Grounds Maintenance, Select Trash Removal, and Snow Removal Services” covering additional stations including Clint and Santa Teresa Border Patrol Stations. The contracts described the contractor’s responsibilities, including cleaning and disinfecting holding cells with germicidal detergent and replenishing hand soap in holding cells.

References

OSHA [2019]. Respiratory protection standard [29 CFR 1910.134]. Washington, DC: U.S. Department of Labor, Occupational Safety and Health Administration, <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134>.

OSHA [2019]. Bloodborne pathogen standard [29 CFR 1910.1030]. Washington, DC: U.S. Department of Labor, Occupational Safety and Health Administration, <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030>.