




Office of Inspector General

Office
202.692.2900
peacecorps.gov/OIG
[OIG Reports](#)

Hotline
202.692.2915 | 800.233.5874
[Online Reporting Tool](#)
OIG@peacecorps.gov

To: Carol Spahn, Acting Director
David Noble, Chief of Staff
Shawn Bardwell, Associate Director, Office of Safety and Security
Victor Sloan, Associate Director, Office of Health Services
Kevin Fleming, Acting Regional Director, Africa
Gordon Brown, Country Director, Peace Corps/Ghana
Colin M. Jones, Acting Chief Compliance Officer

From: Kathy A. Buller, Inspector General 

Date: August 2, 2021

Subject: Final Report on the Review of the Facts and Circumstances Surrounding the Death of a Peace Corps/Ghana Volunteer (IG-21-03-SR)

Transmitted for your information is our final report on the Review of the Facts and Circumstances Surrounding the Death of a Peace Corps/Ghana Volunteer.

Management concurred with all 12 recommendations and the reopening of a recommendation from a previous report. In its response, management described actions it is taking to address the issues that prompted each of our recommendations. The recommendations remain open pending confirmation from the chief compliance officer that the documentation identified in our report has been received.

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

Our comments, which are in the report as Appendix F, address these matters.

You may address questions regarding follow-up or documentation to Acting Assistant Inspector General for Evaluation Reuben Marshall at 202.692.2946.

Please accept our thanks for your cooperation and assistance in our review.

cc: Lila Jaafar, White House Liaison
Carl Sosebee, Senior Advisor to the Director
Chip Taylor, Acting General Counsel
James Golden, Deputy Director, Office of Health Services
Scott Beale, Associate Director, Office of Global Operations
Ghana Desk



PEACE CORPS
Office of
**INSPECTOR
GENERAL**



Final Report

Review of the Facts and Circumstances
Surrounding the Death of a
Peace Corps/Ghana Volunteer

IG-21-03-SR
August 2021

EXECUTIVE SUMMARY

BACKGROUND

On Friday, October 18, 2019, Peace Corps Volunteer Chidinma Ezeani was cooking at home when her gas stove exploded, resulting in severe burns to a large portion of her body. She was medically evacuated to South Africa on October 20 where she succumbed to her injuries on October 26, 2019.

The Peace Corps Office of Inspector General (OIG) reviewed the Peace Corps' medical evacuation and care of Volunteer Ezeani to determine if the agency was sufficiently prepared to respond to this medical emergency and assess whether the medical evacuation of Volunteer Ezeani was appropriately managed.

WHAT WE FOUND

Our review determined that no one individual was at fault, however, a series of systemic failures contributed to significant delays in Ezeani's care. OIG engaged three external medical experts to assist with this review. Our experts agreed that given the extent of her injury, Ezeani's chances of survival were very low. Nevertheless, the experience presented an occasion for learning and improvement at the Peace Corps to prevent future harm to Volunteers.

We found that Peace Corps/Ghana's medical action plan did not fully comply with agency guidelines. It lacked facility assessments, a comprehensive assessment of air evacuation options, required information about local airstrips, contact information for local surface ambulances, and other Volunteer information that was required by agency guidelines. We identified several factors that contributed to this condition:

- Senior leaders did not prioritize and appropriately resource Peace Corps Medical Officer (PCMO) site visits and the assessment of local medical resources.
- The post did not coordinate medical site visits with non-clinical staff, and agency-wide guidance on this was missing.
- A 3-year assessment of the health unit identified the need to increase PCMO site visits but did not lead to corrective actions.
- Agency-wide guidelines lacked clarity about what information was required in the medical action plan.

Finally, although the post complied with the requirements to conduct a medical emergency preparedness drill, we determined the drill did not effectively prepare the staff to conduct an international evacuation from a remote location. Our review documented numerous instances where these deficiencies contributed to delays in Ezeani's care.

Next, we found that the emergency response did not fully comply with agency and post procedures. For example:

- The country director did not contact the U.S. Embassy to request evacuation assistance from other Federal agencies.
- Communication between staff was not prompt.
- Staff were not fully aware of local airport facilities.

We determined that staff were not aware of potential evacuation assistance available through the Department of State (DoS) or the Department of Defense (DoD) due to a lack of institutional memory. Furthermore, the PCMOs were not fully aware of the severity of the injury, a common complication with burn patients. These factors contributed to delays in communication and care and impeded the Peace Corps' response. We determined that the medical care provided to Ezeani in Drobo and Kumasi was not equivalent to Western standards of care but, nevertheless, was as expected given the resource limited environment.

We found that the Peace Corps' Root Cause Analysis (RCA) of the incident did not detect critical vulnerabilities. Our external expert, a clinician with extensive experience in RCA reviews, determined that the Peace Corps' analysis did not comply with industry standards that require clear cause and effect statements. Only 9 of the 20 recommendations from the Peace Corps' RCA would have addressed the root causes. Consequently, most of the actions identified in the RCA, if implemented, would be an ineffective use of resources. We found that the Peace Corps' analysis was adopted from an initial incident report that cited an incorrect cause of the explosion. Finally, the RCA team included a member with a conflict of interest. As a result, the RCA team did not identify military evacuation options through their follow-up process. Ultimately, the RCA missed numerous opportunities for institutional improvement.

RECOMMENDATIONS IN BRIEF

Our report contains 12 recommendations, and we opened a previously closed recommendation¹. If implemented, these recommendations should strengthen operations and correct the deficiencies detailed in the accompanying report.

¹ Recommendation 7 in the March 2016 Follow-Up Evaluation of Issues Identified in the 2010 Peace Corps/Morocco Assessment of Medical Care (IG-16-01-E).

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BACKGROUND

On Friday, October 18, 2019, while cooking at her home in Nyamefie, Ghana just after midnight, Peace Corps Volunteer Chidinma Ezeani was involved in a gas stove explosion that resulted in severe burns to a large portion of her body. She was medically evacuated to South Africa on October 20 where she later succumbed to her injuries on October 26, 2019.

The Peace Corps is statutorily required to provide medical care for Volunteers, including emergency medical evacuation in the event of a life-threatening injury. From 2008 to 2019, 35 Peace Corps Volunteers died during service. Nearly half of these deaths (14 out of 35) were caused by accidents. Unintentional injuries were one of the most frequently reported conditions among Peace Corps Volunteers and one of the most common reasons why Volunteers were hospitalized. Between 2017 and 2018, unintentional injuries among Volunteers increased 12.4 percent, a statistically significant increase. One of the Peace Corps' global strategic objectives is to, 'identify and proactively address risks and opportunities through systematic, evidence-based decision making.'² Given the Peace Corps' responsibility to provide medical care to Volunteers in conjunction with the known risk of injuries, medical emergency preparedness is critical.

When the Peace Corps places Volunteers in very remote locations with limited medical infrastructure, the agency assumes a higher degree of risk in medical emergency situations. OIG has repeatedly raised concerns about medical emergency preparedness across the agency. In 2010, after the death of a Volunteer in Morocco, we found systemic deficiencies in the Peace Corps' provision of medical care to Volunteers. In 2016, following the death of a Volunteer in China, we found that medical action plans, the primary tool for medical emergency preparedness at Peace Corps posts, did not fully comply with agency guidelines. In 2020, OIG again reported that medical emergency preparedness remained a recurring issue across posts. The vast majority (83 percent) of our recent post evaluations contained findings related to medical emergency preparedness, and, as our report on recurring issues explained, leadership and management challenges were frequently the underlying cause, including issues such as staff turnover, unclear roles and responsibilities, lack of oversight, and unclear or missing guidance.

OIG provides independent oversight for agency operations, including in cases of Volunteer deaths. In 2018, Congress passed the Sam Farr and Nick Castle Peace Corps Reform Act, providing OIG with the mandate to conduct independent reviews of the facts and circumstances surrounding Volunteer deaths. As a result of our inquiry into Ezeani's death, OIG decided to evaluate the Peace Corps' medical evacuation and care of Ezeani to determine if the agency was sufficiently prepared to respond to this medical emergency and assess if the medical evacuation was appropriately managed. OIG's mission is to promote positive change at the Peace Corps by making value-added recommendations to address issues and challenges with agency programs and operations.

² [FY 2018-22 Strategic Plan](#), Management Objective 6, pg. 32

RESULTS OF THE REVIEW

OBJECTIVE 1: DETERMINE THE FACTS AND CIRCUMSTANCES SURROUNDING PEACE CORPS VOLUNTEER EZEANI'S DEATH

The first objective of this review was to determine the facts and circumstances surrounding the death of Volunteer Ezeani. We used the following researchable questions to guide our work:

- *What was the cause of the explosion?*
- *What was the timeline of events?*

CAUSE OF THE EXPLOSION

OIG investigated the cause of the explosion on December 18, 2019. We found that Ezeani's gas tank still contained liquid petroleum gas and performed a leak test. We determined that the explosion was caused by a leak from the worn seal of the gas cylinder hose connection (see figures 1 and 2). This finding differed from the conclusions reached by the local police and cited by the Peace Corps. The local police report cited two causes: (1) the house was poorly ventilated, and (2) the connection between the tube from the gas cylinder and the stove had come loose. The Peace Corps noted the Ghanaian police's report of the incident concluded that the accident was the result of missing clamps on the tube running from the gas tank to the stovetop.



Figure 2. No soap bubbles at the missing clamp, indicating no leak.



Figure 1. Soap bubbles show location of leak at the gas cylinder seal.

As our investigative report³ described, liquid propane gas in Ghana contains higher vapor pressure which degrades vital components of gas containers and cylinders, resulting in leakages and, on occasion, explosions. Furthermore, the laws of Ghana did not require the addition of an odorant, a safety mechanism to aid in the detection of leaks. Because the gas in the tank was not odorized, Ezeani was unable to recognize the danger she was in.⁴

TIMELINE OF EVENTS⁵

October 18, 2019

Just after midnight on October 18, 2019, Volunteer Ezeani was studying and went to the kitchen, which was located in a separate, standalone structure, to boil water. When she went back to check on the water, she opened the door, saw a spark and heard a bang. She covered her face as fire flashed over her body. She reported that the fire was not continuous, but a flash. She found the kitchen door was stuck, but eventually she was able to open the door and yell for help. Her neighbors found her and ran to the next town to get a taxi. Her phone was destroyed in the fire, and they did not have access to her emergency contacts.

At 2:00 am, Ezeani's counterpart, the village chief and landlord, called his colleague and told him to contact another co-worker, a returned Peace Corps Volunteer (RPCV), who resided nearby. At 2:30 am, Ezeani got in the taxi with her counterpart and her next-door neighbor. Other community members followed on motorcycles. By 3:00 am, Ezeani arrived at the local clinic, St. Mary's, in Drobo.⁶

At daybreak, the RPCV received a call from his colleague who told him about the accident, and the RPCV messaged the Volunteer community. At 6:30 am, a Volunteer who lived near Ezeani, received the RPCV's message and went to her colleague's house to get more information. Just then, a friend of Ezeani's counterpart arrived on a motorcycle and handed the Volunteer a phone with which she spoke directly with Ezeani. Around the same time, the RPCV also spoke with Ezeani by phone, and she told him that 75 to 80 percent of her body had been burned.

Sometime between 6:30 and 7:00, another Volunteer received the RPCV's message and called the Peace Corps Medical Officer's (PCMO) duty phone but did not get a response, so she sent a WhatsApp message. Next, she called the Peace Corps/Ghana medical assistant. The medical assistant was on the highway and could not stop. The medical assistant told the Volunteer that the Peace Corps would send a car. The Volunteer called the RPCV and relayed that the medical assistant said the Peace Corps would send a car. The RPCV told her a car was not going to be enough. Subsequently, the Volunteer called the medical assistant back. She was still driving and had not called a PCMO yet. The Volunteer told her to pull over, that the accident was too serious, and that a car was insufficient. At 7:00 am, the medical assistant called the first PCMO who immediately called the second PCMO.

³ Death of a Peace Corps/Ghana Volunteer, Report of Investigation 19-0044-I

⁴ In July 2020, OIG issued *Management Advisory Report: Peace Corps/Ghana Gas Tank Cooking Safety (IG 20-02-SR)*, which made four recommendations regarding gas cooking safety. All four recommendations have since been implemented and closed. The report is included as Appendix D to this report.

⁵ All times are GMT except where otherwise noted. See also Appendix C for a timeline of significant events.

⁶ Approximately 3 hours after the accident (see Figure 3)

At approximately 7:30, the Peace Corps medical team arrived at the office in Accra and had a morning meeting, at which time they spoke with the RPCV. At 7:50 am, the PCMOs called the nearby Volunteer who had just arrived at St. Mary's clinic. The PCMOs asked to speak with the attending doctor who was at a morning meeting and unavailable. The fellow Volunteer reported that Ezeani had received morphine but was in a dusty supply room. At 8:10 am, the PCMOs spoke with the doctor at St. Mary's clinic who reported an 81 percent burn area and proposed a ground ambulance to Accra. The PCMOs declined the ground ambulance because it was an estimated 10 to 12-hour trip.⁷

At 8:24 am, the PCMOs began to call commercial airlines. They learned that the airport in Sunyani, which was 2 hours away from Drobo, was under renovation and closed to flights. They also learned that a passenger would need to be able to walk up steps, and subsequently abandoned plans for commercial air evacuation. Next, the PCMOs called International SOS, West Africa Rescue Association, and learned they required a contract for services. At 8:55 am, the PCMOs called Care Flight Ghana to request an airlift to Accra, and Care Flight accepted.

At approximately 9:20 am, the PCMOs received photos of Ezeani's injury from the Volunteer who was with her at the clinic. They learned that the patient was accepted for admittance to the Reconstructive Plastic Surgery and Burns Center of the Korle-Bu Teaching Hospital in Accra. At about 9:30 am, the PCMOs began to notify other staff, including the regional medical officer (RMO) and country director (CD).

Just before mid-day in Ghana, the PCMOs sent the photos to the doctor on call at Peace Corps headquarters, in Washington, DC. The doctor on call estimated the surface burn area at 45 percent. Within the next hour, the international health coordinator (IHC) at Peace Corps headquarters contacted the contracted international airlift provider, International Medical Group (IMG), and requested a medevac from Accra to the patient's home of record in Los Angeles. The IHC reported the patient would be transferred to Accra via local air ambulance.

At 12:15 pm the Volunteer who was with Ezeani in the clinic reported Ezeani was alert and in pain. The clinic needed money to buy medication and the ATM was not working. The Volunteer called Peace Corps staff to request that money be sent via the phone. By 12:45 pm, the Volunteer received money to pay the clinic bill. Just before 1:00 pm, the CD notified leadership at headquarters of the incident, and reported that Ezeani had an 81 percent surface burn area and an airlift to Accra was in process.

By 1:30 pm, staff in the Office of Medical Services (OMS) consulted with the contracted medical airlift providers, who advised that airlift to Los Angeles was not possible due to the patient's condition. Instead, they recommended taking the patient to South Africa due to successful medevacs there in the past, the western standard of care in the country, and the availability of a specialized burn treatment center. At 2:25 pm, Peace Corps staff confirmed Ezeani's evacuation from Accra to South Africa with the South African subcontractor, ER24.

⁷ The Peace Corps informed OIG after reading our preliminary report that medical staff were concerned about maintaining PCV Ezeani's airway during a 10 to 12 hour trip.

At 4:20 pm, the local Care Flight helicopter landed in Kumasi to refuel but was not cleared for onward departure to Drobo due to inclement weather, and Care Flight informed the PCMOs. The PCMOs subsequently arranged ground ambulance to Komfo Anokye Teaching Hospital in Kumasi (an estimated 5-hour trip) and notified headquarters of the change in plans.

At 4:50 pm, the PCMOs and medical staff at headquarters discussed the transfer to Kumasi, including the level of the facility, ability to intubate and ventilate the patient, and airfield capabilities. They discussed trying to evacuate the patient by air from Kumasi to Accra the next day and noted that rain was predicted for the next week. They discussed whether the international airlift provider, IMG, could evacuate Ezeani directly from Kumasi, providing the landing strip was open at night.

At 5:12 pm, Peace Corps medical staff at headquarters informed IMG about the patient's transfer to Kumasi instead of Accra. Peace Corps staff at headquarters proposed two options for medevac to South Africa: (1) wait until a helicopter could fly the patient from Kumasi to Accra for pick-up or (2) IMG pick her up directly from Kumasi if the landing strip was open at night.

At approximately 5:40 pm, an ambulance carrying Ezeani and the Volunteer who was with her at the clinic departed Drobo for Kumasi by land.⁸ The PCMO inquired about flights to meet Ezeani at the hospital in Kumasi, but all flights were grounded due to weather, so he scheduled his flight for the next day.

At 8:04 pm IMG informed headquarters medical staff that they could pick the patient up directly in Kumasi, but that they would still have to stop in Accra for customs. Also, because of the additional leg to Kumasi the crew would need to overnight in Accra to comply with flight time restrictions. IMG told Peace Corps staff that a decision was needed urgently so their crew could depart from South Africa. Within half an hour, Peace Corps staff confirmed the plan with IMG to pick up the patient directly in Kumasi, with the itinerary that included an overnight in Accra.

At approximately 9:16 pm, Ezeani's ground ambulance arrived in Kumasi at Komfo Anokye Teaching Hospital.⁹ Shortly after Ezeani arrived at the hospital in Kumasi, the PCMOs spoke with the attending doctor who reported a burn area of 59.5 percent.

At 11:03 pm, IMG asked the Peace Corps for the contact information for the attending physician. More than 6 hours later, IMG still had not reached the attending doctor in Kumasi and reported that the airlift crew was on standby to depart South Africa until the attending doctor confirmed.

October 19, 2019

At 5:11 am, IMG provided the 36-hour evacuation itinerary to Peace Corps staff, which included departing on October 19 from Johannesburg, refueling in Luanda, and stopping in Accra for an overnight rest. The following day (October 20) included continuing from Accra to Kumasi to retrieve the patient, returning from Kumasi to Accra (with a stop for customs), refueling again in Luanda (with a stop to refuel), and finally arriving in Johannesburg.

⁸ Approximately 14.5 hours spent at St. Mary's (see figure 3)

⁹ Approximately 3.5 hours traveling from Drobo to Kumasi (see figure 3)

By 10:00 am, the PCMO arrived in Kumasi and provided a clinical update to headquarters. Later that afternoon, the PCMO informed IMG that he did not have a visa to Johannesburg, but he would accompany the patient to Accra. By 3:00 that afternoon, IMG informed the Peace Corps they had landed in Accra and would resume the mission in the morning. At 9:50 pm, the PCMO provided a clinical update that the patient reported low pain level and was lively.

October 20, 2019

At 6:30 am on October 20, the PCMO provided a clinical update that pain was low and facial edema had improved. At 7:30 am, Ezeani was discharged from Kumasi hospital.¹⁰ At 8:14 am, the ER24 air ambulance arrived at Kumasi airport. The plane was staffed by an emergency physician and a paramedic.

The plane departed Kumasi at 9:10 am with Ezeani and the PCMO. At 9:28 am, the ER24 air ambulance arrived in Accra and the PCMO disembarked. At 10:10 am, the ER24 air ambulance departed Accra for Luanda.¹¹ Air ambulance medical crew gave Ezeani maintenance fluids and pain medication. At 1:46 pm, the ER24 air ambulance departed Luanda for Johannesburg¹² and arrived in South Africa at 5:38 pm. The ER24 medical crew reported Ezeani was alert and that her vitals were stable. Peace Corps medical staff met her at the airport and reported she was alert and not in pain. At 6:54 pm, Ezeani was admitted to Milpark hospital¹³ and was immediately taken to the operating room and treated by the trauma surgeon who removed a lot of dirt and burned skin during surgery. The burn surface area was estimated at 64 percent.

October 21-26, 2019

On October 21, Ezeani was seen by a plastic surgeon and pulmonologist. During the surgery, she began to deteriorate and was given a blood transfusion. On October 22, Ezeani's condition was unstable. She was given antibiotics and medication to stabilize her blood pressure. On October 23, a multi-disciplinary medical team was involved. They initiated dialysis and escalated antibiotics. On October 24, Ezeani's condition became progressively more unstable, her kidney function deteriorated, and wound cleaning was postponed. On October 25, Ezeani's respiratory function deteriorated, and she went into cardiac arrest; CPR was unsuccessful. The recorded time of death was October 26, 2019 00:15 (GMT+2, South Africa time). A blood culture showed infection. The official autopsy found evidence of full-thickness burns to 64 percent of the body, septicemia, and multi-organ failure and determined the cause of death was burns and the complications thereof.

¹⁰ Approximately 34 hours spent at Kumasi hospital (see Figure 3)

¹¹ Approximately one hour traveling from Kumasi to Accra and clearing customs (see Figure 3)

¹² Approximately 3.5 hours from Accra to Luanda and refueling (see Figure 3)

¹³ Approximately 5 hours traveling from Luanda to Milpark hospital in Johannesburg (see Figure 3)

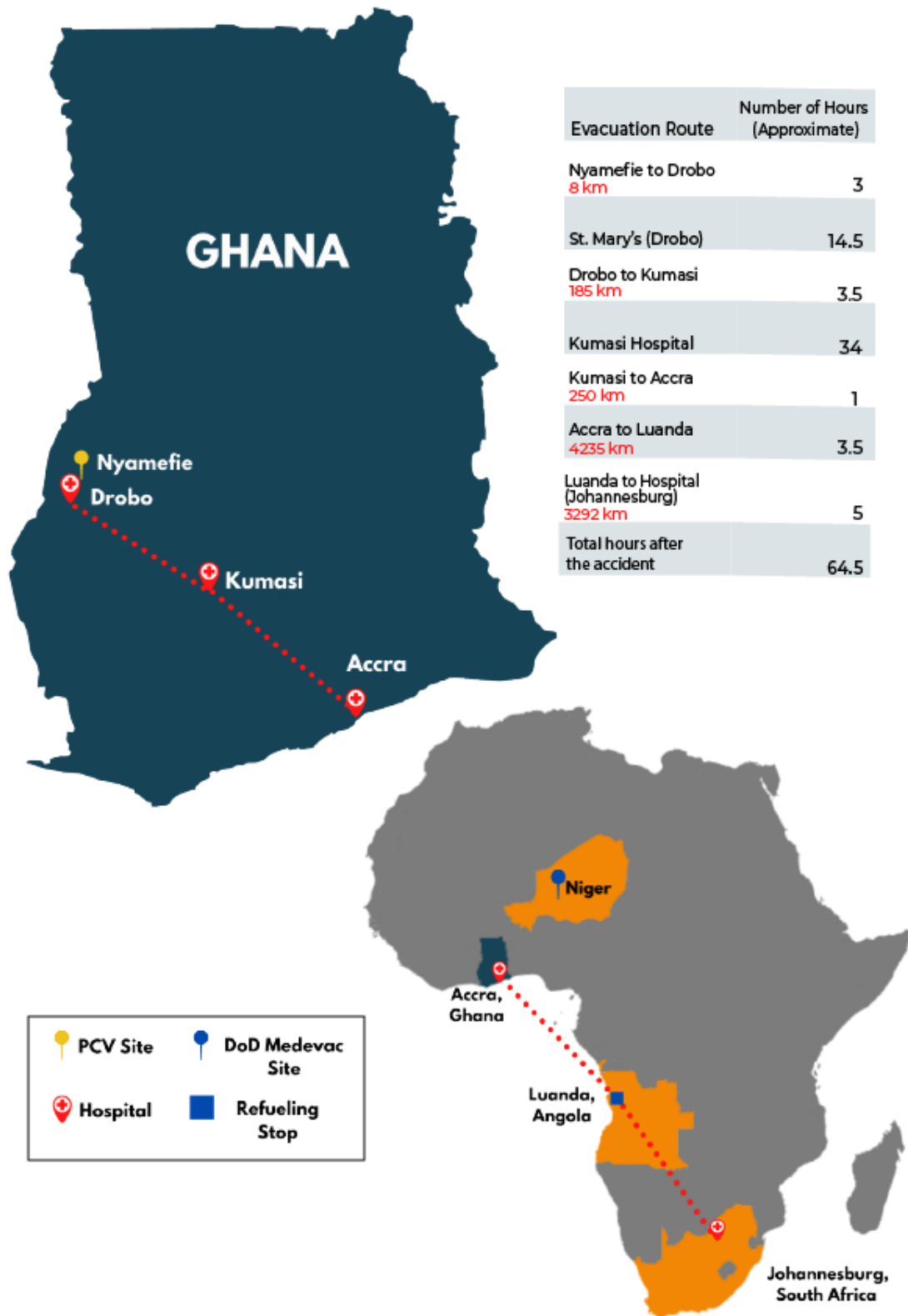


Figure 3. Volunteer Ezeani's Medical Evacuation Time and Route

OBJECTIVE 2: ASSESS THE POST'S MEDICAL EVACUATION PLAN

The second objective of this review was to determine if there were deficiencies in the post's medical evacuation plan that delayed or obstructed the medical evacuation of Volunteer Ezeani to an appropriate medical facility. We used the following researchable questions to guide our work:

- *Did the post's medical action plan fully comply with agency guidelines? If not, why?*
- *If the Medical Action Plan was deficient, what were the reasons and was it relevant to the emergency response?*
- *Were the medical facilities and providers used in the response the most appropriate?*
- *Overall, were there any areas where the post or agency could have been better prepared?*

The post's medical action plan did not fully comply with agency guidelines, which impeded the emergency response.

Areas Where the Post's Medical Action Plan Did Not Fully Comply with Agency Guidelines

Peace Corps Medical Technical Guidelines (TG) 385 lists 17 requirements for the Post Medical Action Plan (PMAP), which covers healthcare resources for regions where Volunteers are posted and the city where the Peace Corps office is located. We compared Peace Corps/Ghana's PMAP to agency guidelines and found that it complied with 12 out of the 17 requirements. The primary area of non-compliance was the lack of facility assessments using the assessment form as required by TG 204. In addition, the post did not include a comprehensive list of local airlift options.

TG 385 lists 11 requirements for Regional Medical Action Plans (RMAPs). Peace Corps/Ghana completed RMAPs for four regions. We found that emergency contact information for local healthcare resources was missing from the post's RMAPs for the regions outside of Accra. None of the post's RMAPs contained emergency contact information for local surface ambulance services. Information on local airports and airstrips was missing from the post's RMAPs for all regions, except Accra.

TG 385 states that an Individual Medical Action Plan (IMAP) includes information for individual Volunteers and "does not need to be generated if all of the required information for that Volunteer is covered in a RMAP and the Volunteer Site Contact Form (SCF)." We reviewed the post's IMAP, however, it was difficult to assess whether it fully complied with agency guidelines because it was not clear what was meant by, "all of the required information for the Volunteer." In 2016, we conducted an agency-wide evaluation of Volunteer health care and found that medical action plans at posts were not complete, in part because agency guidelines were unclear.¹⁴ According to the Peace Corps' medical technical guidelines, TG 385, the Medical Action Plan should include an index of Volunteers that identifies where important information for each Volunteer, such as the site contact form and passport number, is located.

¹⁴ [Final Report: Follow Up Evaluation of Issues in the 2010 Peace Corps /Morocco Assessment of Medical care](#), (pg. 23)

We reviewed Peace Corps/Ghana's index of Volunteers and found that it did not specify the location of the site contact form or the passport number.

Notably, the Medical Action Plan did contain documentation of the most recent drill which the post had completed in the month preceding the accident, in accordance with TG 385 section 64F.

Reasons Why the Medical Action Plan Did Not Comply with Agency Procedures

We found several factors that contributed to the gaps in the post's Medical Action Plan. First, senior leaders did not prioritize and appropriately resource PCMO site visits to assess local medical resources. One staff member described human resource limitations, "I am worried the PCMOs are overwhelmed. In particular, in countries like Ghana, they had three pre-service trainings per year... they have to take care of all the Volunteers in country, they have mid service exams. It is very difficult for them to do the site visits." One senior leader described budgetary constraints and the fact that Peace Corps/Ghana had two PCMOs, which was the 'maximum staffing pattern,' in comparison to other posts, saying, "we did not take that as a shortcoming to that level that was mission critical, or in position for mission failure." Peace Corps guidelines (TG 200) specifically state that overseas health units do not have fixed ratios for the number of doctors to Volunteers.

As one individual noted, other Government agencies, such as the military, contract out medical facility assessments, "International SOS provides assessment of facilities. If a service member gets injured International SOS refers them to a facility they have assessed." For this review, we engaged an independent doctor with expertise in emergency medicine in low resource countries. After reviewing the case, our expert came to the following conclusion about medical action planning:

This is a large, active and on-going activity that the Peace Corps should consider either fully constructing and staffing on its own, and/or subcontracting to other public or private entities. This is not an activity that can be simply delegated to in-country physicians as a subset of their job description, or that other Peace Corps staff can perform on a part-time basis.

OIG identified inadequate local medical facility assessments as a commonly recurring¹⁵ finding across Peace Corps posts (between 2012 and 2019), largely due to unreasonable PCMO workload and lack of oversight. Peace Corps staff confirmed that insufficient staffing and workload were the major impediments to conducting health facility assessments in Ghana. The post had recently hired a medical assistant, but this person was not qualified to conduct medical facility assessments independently. We asked staff how important a facility assessment of the local clinic in Drobo would have been in this case. They described the importance of having a personal relationship and contact information for staff at the clinic as the most critical aspects of the emergency response, and that staff turnover at the local clinic was an issue.

We concluded that site visit guidelines were insufficient because they did not direct non-clinical staff to visit the local medical clinic, meet the clinical staff, and exchange contact information. OHS acknowledged that non-clinical staff, and even Volunteers, are capable of identifying local medical resources in the community, saying, "It is impossible for the PCMOs to identify the

¹⁵ [Recurring Issues Report: Common Challenges Facing Peace Corps Posts – FYs 2016-2019](#); [Recurring Issues: Common Challenges Facing Peace Corps Posts, Fiscal Years 2012-2015](#)

clinic or hospital within the community. It is not feasible or practical. But Volunteers can play a better role in identifying what the local resources are.” Medical technical guidelines state that:

Site visits are a shared and collaborative responsibility amongst staff at post. It is the responsibility of post leadership to incorporate funding in the budget for Health Unit staff (or other post staff) to conduct visits to assess PCV health and well-being at a minimum of once per service. Realizing there may be extraneous circumstances limiting Health Unit staff visits, the Office of Medical Services (OMS) supports the concept of non-clinical staff performing site visits utilizing TG 204 “*Non-PCMO Site Visit Checklist*.”

It was difficult to assess what was covered in the “*Non-PCMO Site Visit Checklist*” because at the time of this report, the checklist was missing from the agency’s library. While the technical guidelines encouraged non-clinical staff to assess Volunteer wellbeing, they did not direct them to visit the local clinic to introduce the Peace Corps, exchange contact information, and form a relationship with the providers—something that numerous staff said would have helped the response. In this instance, Ezeani was several hours away from the hospital in Kumasi where the post had planned to send Volunteers for treatment—an unrealistic plan in the event of a life-threatening emergency. Given the workload limitations on PCMOs, the Peace Corps could improve its site visit guidance for non-clinical staff to better address emergency preparedness and prevent adverse outcomes for Volunteers involved in a life-threatening emergency.

Additionally, we found that the recommendations from the Regional Medical Officer’s assessment of the Peace Corps/Ghana Health Unit, conducted in August 2017, did not lead to corrective actions for site visits. The RMO’s assessment report documented deficiencies with the post’s MAP and facility assessments and stated that, “the goal is to increase PCV site visits and visits to facilities (hospitals, clinics) and consultants.” The recommendation tracking sheet closed the recommendation 7 months later even though the post’s response to the recommendation was for the PCMO to visit approximately the same number of Volunteer sites as the year before. Furthermore, staff acknowledged that the site visit issue was not resolved at the time the recommendation was closed. Though the post reported taking corrective actions such as increasing staff and decreasing workload, it remained unclear if those actions had the intended effect.

Areas Where Non-Compliance with Agency Guidelines Impeded the Response

As described previously, site visits were insufficiently coordinated with non-clinical staff. We determined that this contributed to delays in the Peace Corps’ response. It took approximately 7 hours from the time of the explosion for Peace Corps medical staff to learn about the accident. The Peace Corps’ analysis of the incident acknowledged that the community members who accompanied Ezeani to the clinic were not able to contact the Peace Corps. Their analysis stated that the individual who accompanied Ezeani to the clinic was someone that she had recently selected to be her work partner. The report also stated that it was unclear if Ezeani had informed the Peace Corps of the change. The Peace Corps’ analysis identified that not knowing Ezeani had changed counterparts and not having her new counterpart’s contact information were problematic. As described later in this report, the Peace Corps’ analysis did not include clear statements that directly linked cause and effect as factors that contributed to Ezeani’s death.

Our review of the Peace Corps’ documentation showed that Peace Corps program staff visited Ezeani’s site a few months prior to the accident. At that time, Ezeani notified the Peace Corps that she had a new counterpart, but her site contact form had not been updated, and agency

documents stated that the new counterpart's number was not listed in the Volunteer Information Database Application (VIDA). Despite this, the individual who accompanied Ezeani to the clinic was a prominent member of the community that the Peace Corps had known since at least 2015. The Peace Corps' documentation identified this individual as the village chief, leader of the cashew nut association (the primary work assignment at the site), and landlord of the Volunteer residence. Records showed that this individual had attended a meeting with Peace Corps staff to prepare for placing a Volunteer in the community and had provided the Peace Corps with a phone number at that time. In fact, the Peace Corps had provided this individual's contact information to Ezeani when she was assigned to the site in 2017.

The Peace Corps' Programming and Training Guide states that one objective of site visits is to assist community partners in their role to support Volunteer safety. The individual who accompanied Ezeani to the clinic, who the Peace Corps had previously identified as a key community contact, was not able to contact the Peace Corps directly to inform them of the medical emergency. Post staff explained that another counterpart had attended the training where the Peace Corps provided their emergency contact information. Because Peace Corps staff did not provide key community contacts with information on how to contact them in the event of an emergency, we concluded that emergency preparedness was insufficiently addressed during site preparation and visits. As noted above, the checklist for non-clinical staff to conduct medical site visits was missing. Furthermore, site management guidance includes requirements for providing the Peace Corps with community member contact information but does not include provisions for providing community members with information on how to contact the Peace Corps in the event of an emergency.

We found that the MAP was missing key information about local airports and landing strips. TG 380 states that posts should be familiar with local airport facilities prior to an emergency medevac situation, including hours of operation, length of runway, runway surface, availability of night lights, and any airplane size limitations. The lack of this information contributed to a delay of approximately 3 hours. Peace Corps staff began discussing whether the landing strip in Kumasi was open at night at 4:50 pm the day of the accident. At 8:04 pm, the Peace Corps' airlift contractor IMG confirmed their ability to use the landing strip in Kumasi.

TG 380 states, "the Medical Action Plan is a comprehensive, country-specific resource." We found that the post had not previously identified an alternate airlift provider, such as International SOS, or contracted them for services. The PCMOs learned about the accident at 7:00 am but were not able to confirm with the local airlift provider, Care Flight, until 9:00 am. Care Flight was listed as the post's airlift provider in their medical action plan. The post reported that they called Care Flight first but did not get an answer. Consequently, the PCMOs contacted commercial airlines and learned a passenger would need to walk up steps. We determined that the local airlift providers were insufficiently researched and coordinated, contributing to a potentially preventable delay of 2 hours.

The Peace Corps' policy on hospitalized Volunteers (TG 305) recognizes that PCMOs may not always be able to accompany a Volunteer in the hospital and includes provisions for other Volunteers to accompany hospitalized Volunteers. Peace Corps medical staff in Ghana were informed that there had been a serious accident at 7:00 am. However, they did not activate the emergency response and begin to call for an airlift until 8:30 am, after speaking with the

attending physician, even though several Volunteers tried to relay the life-threatening nature of the situation to Peace Corps staff early on. This contributed to a time delay of 1.5 hours. We concluded that the PCMOs in Ghana were unprepared to rely on Volunteers at the site for information who repeatedly tried to communicate the urgency of the situation.

Appropriateness of Medical Facilities and Providers

Peace Corps staff provided clear justification for their decision making around where to send Ezeani for treatment. Initially, Peace Corps staff planned to take Ezeani to the Reconstructive Plastic Surgery and Burns Center of the Korle-Bu Teaching Hospital in Accra to be stabilized before onward transport to Milpark Hospital in South Africa where she could obtain a Western standard of care. Milpark Hospital, where Ezeani was treated, was the only private sector hospital in South Africa that had specialized burn treatment capacity. The Peace Corps explored evacuation to other locations such as Morocco and Western Europe. They determined that Morocco did not have an appropriate burn center, and they decided not to take her Western Europe due to concerns about accessing care within a nationalized health system. South Africa was the most appropriate choice for international airlift, given the circumstances, and, according to our independent expert, the care she received there was exemplary.

When inclement weather impeded Ezeani's airlift from Drobo to Accra, medical staff transported her by land to Kumasi. Peace Corps medical staff in Ghana had assessed the facility in Kumasi and determined the level of care was sufficient to provide initial stabilization. Peace Corps staff asked the international medevac provider to pick Ezeani up in Kumasi, as opposed to Accra, as initially requested, and subsequently learned that the additional leg would require ER24 to make an overnight rest stop. Peace Corps medical staff described not wanting to transport Ezeani over land to Accra because they thought her condition was too unstable to withstand the long journey. Peace Corps medical staff were not aware of the other potential options for international medevac and believed ER24 was their only option. We determined that, with the exception of the airlift providers, the selection of providers and facilities was appropriate given the circumstances.

We had two independent medical experts¹⁶ review this case, and both agreed that the Peace Corps should have identified back-up airlift providers and coordinated with them in advance as part of the medical action plan development process. As described earlier, the PCMOs had not explored local airlift providers fully and found that they needed a contract for services with International SOS during the emergency response.

In terms of the international airlift, the Peace Corps' contract with IMG states they will be available for worldwide emergency medical evacuation. IMG was aware that private air ambulance availability was limited in West Africa. As a result, they had to bring a plane from South Africa and overnight in Accra to comply with flight time restrictions. IMG described how the private sector was unequipped to provide emergency medical evacuation in the region due to the lack of resources to support the industry. We asked Peace Corps staff at the post and headquarters if they knew of other options for international medical evacuation through other U.S. Government agencies such as the Department of State or the Department of Defense. At the time of the emergency, staff were not aware of these other options, as further described in the

¹⁶ Both experts were familiar with coordinating airlift in resource limited settings.

next section. We concluded that IMG was not the most appropriate international airlift provider because they needed to bring a crew from South Africa and were required to overnight due to flight time restrictions.

Areas Where the Peace Corps Could Have Been Better Prepared

Although the post had conducted a drill in the months preceding the emergency, we determined that the drill was not effective because it did not help the Peace Corps detect critical vulnerabilities. As one participant in the drill described:

It did not capture some of the details of this situation. The volunteer being as far from the medical center as she was, the timing. I think we would need other scenarios rather than the same one. It probably could deal with the third country aspect and getting to a point of involving life threatening injuries. What happens when you need to move out of country? Having to evacuate out of country would be good.

Another staff person noted that the drill did not include any participants from headquarters. Medical staff from Peace Corps headquarters, the post, and regional offices needed to coordinate the details of the medical evacuation but were unable to communicate by phone due to technical difficulties. Furthermore, the drill did not include key responders who were outside of the Peace Corps, such as IMG, Care Flight, or other potential U.S. Government responders. Consequently, the team missed important logistical details. For example, they could have considered working with the U.S. embassy to get an emergency visa for the PCMO to accompany Ezeani on the international airlift, as described below. Also, they did not consider that they would require a contract for services with certain local airlift providers. As noted above, the PCMOs were unprepared to rely on Volunteers for information. Had the medical action plan drill included Volunteers and covered evacuation from a remote location where a PCMO would have to rely on a Volunteer for information, they might have initiated the airlift before speaking with the attending physician.

We recommend:

- 1. That Peace Corps/Ghana complete their medical action plan so that it fully complies with agency policy, using the specified form for facility assessments.**
- 2. That the country director and Peace Corps medical officer in Ghana submit a plan that will ensure local emergency transportation options are sufficiently researched and coordinated.**
- 3. That the Director develop a plan to fully staff the assessment of local medical resources internally or contract the responsibility to an external entity.**
- 4. That the chief of staff work with the associate directors to ensure that drills to prepare for medical and life-threatening emergencies cover both local and international medical evacuations and that all potential responders (medical staff at headquarters and regional hubs, private medevac contractors, other federal agencies, Volunteers, etc.) are included.**

5. That the associate director for the Office of Health Services collaborate with the associate director for the Office of Global Operations to develop guidance and training for non-clinical staff to address medical emergency preparedness when conducting site visits, including, but not limited to, providing community contacts with the Peace Corps' contact information and visiting local medical facilities, and integrate this guidance into existing site visit guidance.
6. That the associate director for the Office of Health Services clarify TG 385 to specify what Volunteer information is required in the Individual Medical Action Plan.
7. That the Office of Health Services develop and implement a process for managing its recommendations that includes a review of evidence and documentation prior to deciding to close recommendations.

OBJECTIVE 3: DETERMINE IF THE EVACUATION WAS APPROPRIATELY MANAGED

The third objective of this review was to assess Ezeani's medical condition following the accident and determine if the medical evacuation of Ezeani was appropriately managed. We used the following researchable questions to guide our work:

- *Did the response follow agency and post procedures? If not, why?*
- *Was the medical (including end of life) care provided to Ezeani optimal given the circumstances?*
- *Were staff involved in the emergency response aware of her condition and prognosis?*
- *Overall, could the Peace Corps have done anything differently to improve the response?*

The emergency response did not fully comply with required agency procedures, which contributed to delays.

Areas Where the Response Did Not Follow Procedures

Peace Corps Manual Section 264-Procedures regarding travel options for emergency medical evacuations states that:

Volunteers may be evacuated via commercial flights, air ambulance, military aircraft, or overland transportation, as defined in the post's medical evacuation plan. Most Volunteers are medically evacuated on regular commercial airline flights. In a life-threatening emergency requiring evacuation, where suitable commercial transportation is not available or adequate, the assistance of other emergency evacuation options may be used, including but not limited to other Federal agencies. If necessary, the CD must contact the American embassy to expedite emergency evacuation.

We found that Peace Corps staff were not aware of the policy to evacuate Volunteers using assistance from other Federal agencies. The CD was not told about the need to overnight until the airlift crew landed in Accra but, nevertheless, was not aware of the procedure to contact the U.S. Embassy to expedite an emergency evacuation. Similarly, staff we interviewed in OHS,

who have primary responsibility for international medical evacuations, were not aware of evacuation assistance available through other Federal agencies. For example, one individual in OHS said of IMGs need to overnight, “My question is in the future, how can we call State, the Military, or have two pilots? I was told you cannot get over it [flight time restrictions].”

Department of Defense policy currently lists Peace Corps employees as individuals eligible for emergency air transportation, though it does not mention Volunteers. We interviewed the Lead Physician for the United States Special Operations Command, who said, “Legally, we, DoD, I, am authorized to provide medical care to preserve life, limb, or eyesight... It is done commonly. We helped Italian NGO people in a car accident.” The U.S. military has a global patient movement system run by Theater Patient Movements Requirements Center (TPMRC). “It works easy when it is military. They are available to move other types of patients”.

Peace Corps staff spoke with Department of State medical staff after the incident and reportedly were told, “If you find you don’t get a quick response time you can give us a call and we can see if we can do better.” The Department of State also uses a private contractor for emergency medical evacuation. As one Peace Corps staff member said “the State Department has contracted Phoenix Air to sit and wait. We don’t have that.” Peace Corps staff also reported that they have an Interagency Agreement with the Department of State to assist with evacuations involving highly infectious diseases. In accordance with Peace Corps policy, both DOS and DOD evacuation assistance can be accessed through the U.S. embassy.

When asked about military options for evacuation, one person in OHS said:

I think there were rare cases. This is the issue with institutional knowledge... There is a learning curve and learning stories from the past. I have heard there was a case where a Volunteer was flown to a military base in Germany. Getting strings pulled to do that. I don’t know how it happened. I’ve been told that it’s almost impossible. It’s having the right connection the right time at the right moment.

According to the Peace Corps Act, Peace Corps staff are subject to 5-year term limits. OIG reviewed the effects of term limits on Peace Corps operations¹⁷ and determined that it has had a negative impact on institutional memory. A recent amendment to the Peace Corps Act¹⁸ allowed the Director to designate certain positions as permanent if they require specialized technical or professional skills and knowledge of Peace Corps operations, though only two positions in the Office of Health Services have so far been exempted from term limits based on this amendment.

Our DoD contact from the United States Special Operations Command explained why it’s challenging for the Peace Corps to access support from the military because they would need to know who to contact, “It’s hard when it’s a one off because people don’t know how to access the system... I think the most important thing is to make the contacts... The other thing is to do a tabletop. Mostly it’s getting the right people in the room if your office does not understand the military structure. If you call the Army you are calling the wrong people.” Peace Corps/Ghana complied with agency requirements to conduct a drill, but as we noted earlier, it was not effective because it did not include the range of potential participants necessary for an emergency medical evacuation, such as headquarters staff and other Federal partners. An

¹⁷ [Impacts of the 5-Year Rule on Operations of the Peace Corps](#)

¹⁸ [Sam Farr and Nick Castle Peace Corps Reform Act of 2018](#)

ineffective drill, in conjunction with a lack of institutional memory in OHS, contributed to the Peace Corps' departure from their policy to seek assistance from other Federal agencies in the event of life-threatening emergency.

Not knowing how to access the military in the event of a life-threatening emergency potentially delayed the evacuation by approximately one full day. IMG notified Peace Corps staff of the need to overnight at 8:04 pm, and Ezeani was admitted to Milpark hospital at 6:54 pm the next day. Our contact at DoD reported that they had a surgical team with critical care capability stationed in Niger. The flight time from Ghana to Niger, a neighboring country, is approximately 90 minutes.

Another area where the emergency response did not fully comply with agency procedures was with respect to communication. Peace Corps TG 380 section 5.1 states that, "the PCMO should contact OMS/RMO by telephone as soon as possible when an emergency air rescue is being considered or if a patient is unstable." According to our timeline, the PCMOs found out about the accident at 7:00 am but did not contact the RMO until 9:26, almost two and a half hours later. Due to difficulties with communication, Peace Corps staff at headquarters did not contact the international airlift provider until 12:55, two and a half hours after the post notified the RMO, though according to TG 380 section 5.4.1, "OMS's primary responsibility is to identify and mobilize the most expeditious and efficient service under any set of circumstances."

While medical technical guidelines addressed the need for prompt communication in the event of a medical emergency, we determined that agency-wide procedures for life-threatening emergencies were lacking. In addition, non-medical staff are potentially critical to the response. For example, the CD may need to work with the Embassy to request evacuation assistance. As one person described, roles and responsibilities in the event of a Volunteer death are clearly outlined in the Peace Corps' policy, but they are ambiguous in the event of a life-threatening emergency.

Quality of Medical and End of Life Care

The medical care provided to Ezeani in Drobo and Kumasi was not equivalent to Western standards of care but, nevertheless, was as expected given the resource-limited environment. Burn injuries are a relatively rare event requiring treatment in a highly specialized facility. The local providers appropriately referred Ezeani to a higher level of care. Our independent medical expert determined that the providers in Ghana gave Ezeani insufficient fluids.¹⁹ Peace Corps medical staff, who were monitoring her treatment remotely, did not raise concerns regarding the amount of fluids given to Ezeani by the local doctors. Peace Corps clinical guidelines (TG 370) outline the procedures for medical consultation in the event of complex, rare, acute or life-threatening, or potentially life-threatening clinical situations. It states, "OMS uses all necessary medical resources and specialists in the U.S. to inform and respond to the inquiry." However, Peace Corps medical staff in OHS did not consult with a burn specialist regarding Ezeani's treatment while she was in Ghana awaiting medical evacuation for an extended period of time. We determined this was a missed opportunity for providing quality medical care to Ezeani.

¹⁹ See appendix D, Addendum 3 on the Parkland Formula

According to records of the event, there was room on the international airlift to Johannesburg for Peace Corps staff to accompany Ezeani. However, the PCMO declined to accompany her due to not having a visa to South Africa. At the time, Peace Corps staff were working with the Embassy to get clearance for the airlift crew, but they did not consider requesting an emergency visa for the PCMO. Furthermore, they did not consider asking one of the American staff to accompany her. We determined this was a missed opportunity to provide quality, end-of-life support and compassion.

Staff Awareness of Ezeani's Condition and Prognosis

We found evidence that Peace Corps staff underestimated the severity of Ezeani's injury and her prognosis, which contributed to delayed communication and care. Medical staff in Ghana reported that Ezeani was lively, and that her facial edema had improved. Medical staff at headquarters underestimated the burn surface area and overestimated her chance of survival. Both of our external medical experts described how burn patients are often not recognized as critically injured, and cited gaps in burn expertise given how rarely these injuries occur. One expert stated, "Clear gaps in burn care expertise are expected at every level given the low frequency of such injuries. Telemedicine consultation with a burn care expert could have been helpful while the patient was awaiting transport to South Africa." As described previously, the Peace Corps' medical technical guidelines (TG 370) included provisions for consultation with medical specialists in the United States, but the Peace Corps lacked agency-wide policies and procedures for life-threatening emergencies.

OIG previously determined that not recognizing the severity of the situation was a contributing factor in the deaths of other Volunteers in Morocco, China, and the Comoros Islands.²⁰ After the death of a Volunteer in Morocco, OIG recommended that the Peace Corps improve clinical oversight, leading to the development of the Peace Corps' clinical escalation policy. In this instance, Ezeani's case was escalated to Peace Corps headquarters. However, as a small agency, the Peace Corps has limited expertise available at headquarters. We concluded that, had medical staff followed TG 370 and consulted with a burn expert while monitoring Ezeani's care and medevac, it is possible that they would have had a better understanding of the severity of her injuries and prognosis and considered other medevac and/or care options. Peace Corps staff were not aware that other options for medical evacuation were available due to a lack of institutional memory brought on by term limits.

We recommend:

- 8. That the Director develop a comprehensive plan to improve institutional memory in the Office of Health Services, including, but not limited to, identifying critical positions and exempting them from term limits.**

²⁰ [Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/Comoros](#); [Investigative Review of the Circumstances Surrounding the Death of a Volunteer in Peace Corps/China](#); and [Death Inquiry and Assessment of Medical Care Peace Corps/Morocco](#)

- 9. That the Director ensure that international emergency transportation options, including Department of Defense and Department of State, are researched, documented, and incorporated into Peace Corps policies and procedures.**
- 10. That the associate director for the Office of Health Services incorporate a mechanism and procedures into TG 370 to obtain teleconsults so that the Office of Health Services accesses medical experts during field consults.**
- 11. That the Director develop agency-wide policy and procedures that define staff roles and responsibilities to respond to life-threatening medical emergencies.**

The Peace Corps' Root Cause Analysis did not detect critical vulnerabilities, leading to missed opportunities for institutional improvement.

According to the National Patient Safety Foundation:

Virtually all health care providers and organizations respond to some events where patient harm has occurred by investigating the event in question with the intent of eliminating the possibility or reducing the likelihood of a future similar event. This activity is commonly referred to as a root cause analysis (RCA).

Technical guidelines (TG 167) outline the Peace Corps' process for RCAs. In 2016, OIG reviewed the Peace Corps' RCAs and recommended "That the associate director of the Office of Health Services perform all root cause analyses in a manner that includes key components (system focus, cause/effect, action plan and measures)."²¹ We engaged a clinician with extensive experience in RCA reviews and determined that the Peace Corps' Root Cause Analysis of Ezeani's death did not detect critical vulnerabilities. The guidelines for root cause analysis²² outline five rules of causation. The first rule is to clearly show the cause-and-effect relationship. "Causal statements are written to describe (1) Cause, (2) Effect, and (3) Event. Something (Cause) leads to something (Effect) which increases the likelihood that the adverse event will occur." We found that none of the causes identified in the analysis of Ezeani's death included a causal statement. Furthermore, out of the 20 corrective actions the Peace Corps' analysis identified, only 9 of them would have addressed the root cause.

For example, the Peace Corps' RCA team recommended that, "posts will provide guidance to Volunteers instructing them that they are to report any change in counterpart or neighbors to Peace Corps immediately so that contact information can be uploaded into VIDA."²³ As described earlier in this report, documentation showed: (1) Ezeani did report her change in counterpart to the Peace Corps, (2) the Peace Corps had a longstanding relationship with the individual who accompanied her to the clinic and they had his phone number, and (3) his phone number was not in VIDA. In this instance, it was the community members who required the Peace Corps' contact information, as opposed to the Peace Corps needing the community

²¹ [Final Report: Follow Up Evaluation of Issues Identified in the 2010 Peace Corps/Morocco Assessment of Medical Care \(IG-16-01-E\). March 2016.](#)

²² RCA² Improving Root Cause Analysis to Prevent Harm. National Patient Safety Foundation. 2015.

²³ Volunteer Information Database Application

member's contact number. While the Peace Corps' analysis also addressed the need to give the Peace Corps' emergency contact information to Volunteers' neighbors, this action is an example of where a misidentified cause would divert resources to actions that may not be impactful. Another recommendation was that posts provide basic safety equipment for each Volunteer residence, including a fire extinguisher, smoke detector, and carbon monoxide monitor. In this case, none of these things would have made a difference and are examples of where a clear cause and effect statement would have helped to identify and appropriately address the root causes.

Furthermore, the RCA did not correctly identify the cause of the explosion. The report stated as a cause/contributing factor, "The gas hose which connected the PCV Ezeani's propane tank to the stove was not properly secured to the stove with a clamp." The corresponding recommendation was to "develop and disseminate guidance on how to properly use and maintain a propane stove." According to our investigation, the source of the leak was not the clamp but rather the gas cylinder, and contributing factors were that liquid propane gas in Ghana lacks odorant, which prohibits leak detection, and contains higher vapor pressure that erodes gas tanks and can lead to explosions. Staff described how the RCA team adopted the preliminary report from the Office of Safety and Security. One staff member said, "What you see in our RCA was what Safety and Security had come up with." Another said, "I think by the time we got to the RCA the issues were already preconceived." OIG visited Ezeani's residence on December 18, 2019, to determine the cause of the explosion and the Peace Corps' analysis was finalized the following day. The Peace Corps' RCA form included a section to list the sources reviewed as part of the analysis, but the list was limited and did not include OIG's investigation into the cause of the explosion. Similarly, the form included a section for literature review, but the team determined this was not applicable. Because the Peace Corps' analysis of the incident did not correctly identify the cause of the explosion, subsequent guidance on how to maintain and use a gas stove may divert resources and not effectively mitigate risks.

Industry standards for RCAs state, "having those intimately involved in the event on the review team creates a real or perceived conflict of interest that can negatively impact the success of the RCA." However, individuals who were involved in the event can be interviewed as part of the fact-finding process. In our 2016 review of the Peace Corps' RCAs,²⁴ we observed several examples where staff who had been directly involved in the case had participated in the RCA, creating a conflict of interest. As a result, the Peace Corps added provisions to TG 167 that prohibit staff who were immediately involved in the event from serving on the review team. Similarly, we observed that one participant on the RCA team for Ezeani's death had direct involvement in the case. The analysis team identified the Peace Corps' private airlift contractor having to overnight in Accra as one of the factors they considered when reviewing the case and recommended meeting with the Department of State to discuss additional options. The individual who provided primary oversight for the Peace Corps' airlift contract participated in the review and was responsible for identifying alternatives. The RCA report stated, "no additional options/outcomes available. DoS contract with International SOS uses same air ambulance vendors and similar process." Based on our interviews, however, the Peace Corps could have asked the Department of State to see if their contractor was able to provide a better outcome. Because of their narrow experience working with a private sector vendor, staff did not explore

²⁴ Recommendation 7 from the [Follow-Up Evaluation of Issues Identified in the 2010 Peace Corps/Morocco Assessment of Medical Care](#)

other public sector options, such as the military, as outlined in agency policy. Furthermore, when asked about selection of the RCA team, OHS did not seem to consider potential conflict of interest as a deciding factor in the selection of RCA team members. As one person said, “Everybody was involved--all stakeholders contributed.” Because one RCA team member’s normal duties included providing primary oversight for the Peace Corps’ contract with IMG, we found that the team member could have been motivated to find that no additional medevac options were available other than the one that had been used in the response in order to avoid a perception of culpability for an inadequate medevac process. To address this issue, OIG will open a previously closed recommendation, “That the associate director of the Office of Health Services ensure staffing is sufficient to adequately implement a more effective sentinel event reporting²⁵ system and that staff involved in root cause analyses have not had direct involvement in the case.”²⁶

Our review found that the Peace Corps’ RCA of Ezeani’s death did not fully comply with industry standards for RCAs. As a result, resources may be diverted to actions that may not be impactful (i.e., carbon monoxide monitors). Additionally, there were missed opportunities for institutional improvement, such as better coordination with other Federal agencies for emergency medical evacuation. Our independent expert, a clinician with extensive experience in RCA reviews, recommended that the Peace Corps implement an RCA charter. A charter would contain a description of the event, any specific concerns, or issues, such as the severity of the event, history of similar events, and/or major barriers that appeared in the incident. A charter may be helpful in providing context to the RCA team as they initiate the RCA and institute the fact finding, obtain relevant articles and policies, look into similar cases, and decide whom to interview. For example, a charter might have prompted the RCA team to review agency policy on emergency medical evacuations and further explore military evacuation options and procedures.

We recommend:

- 12. That the associate director of the Office of Health Services include provisions for a Root Cause Analysis charter in TG 167.**

²⁵ Now referred to as patient safety

²⁶ Recommendation 7 from the [Follow-Up Evaluation of Issues Identified in the 2010 Peace Corps/Morocco Assessment of Medical Care \(IG-16-01-E\)](#)

LIST OF RECOMMENDATIONS

We recommend:

1. That Peace Corps/Ghana complete their medical action plan so that it fully complies with agency policy, using the specified form for facility assessments.
2. That the country director and Peace Corps medical officer in Ghana submit a plan that will ensure local emergency transportation options are sufficiently researched and coordinated.
3. That the Director develop a plan to fully staff the assessment of local medical resources internally or contract the responsibility to an external entity.
4. That the chief of staff work with the associate directors to ensure that drills to prepare for medical and life-threatening emergencies cover both local and international medical evacuations and that all potential responders (medical staff at headquarters and regional hubs, private medevac contractors, other federal agencies, Volunteers, etc.) are included.
5. That the associate director for the Office of Health Services collaborate with the associate director for the Office of Global Operations to develop guidance and training for non-clinical staff to address medical emergency preparedness when conducting site visits, including, but not limited to, providing community contacts with the Peace Corps' contact information and visiting local medical facilities, and integrate this guidance into existing site visit guidance.
6. That the associate director for the Office of Health Services clarify TG 385 to specify what Volunteer information is required in the Individual Medical Action Plan.
7. That the Office of Health Services develop and implement a process for managing its recommendations that includes a review of evidence and documentation prior to deciding to close recommendations.
8. That the Director develop a comprehensive plan to improve institutional memory in the Office of Health Services, including, but not limited to, identifying critical positions and exempting them from term limits.
9. That the Director ensure that international emergency transportation options, including Department of Defense and Department of State, are researched, documented, and incorporated into Peace Corps policies and procedures.
10. That the associate director for the Office of Health Services incorporate a mechanism and procedures into TG 370 to obtain teleconsults so that the Office of Health Services accesses medical experts during field consults.
11. That the Director develop agency-wide policy and procedures that define staff roles and responsibilities to respond to life-threatening medical emergencies.

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12. That the associate director of the Office of Health Services include provisions for a Root Cause Analysis charter in TG 167.

We re-opened our recommendation from the Follow-Up Evaluation of Issues Identified in the 2010 Peace Corps/Morocco Assessment of Medical Care (IG-16-01-E):

7. That the associate director of the Office of Health Services ensure staffing is sufficient to adequately implement a more effective sentinel event reporting system and that staff involved in root cause analyses have not had direct involvement in the case.

APPENDIX A: OBJECTIVE, SCOPE, AND METHODOLOGY

In 1989, OIG was established under the Inspector General Act of 1978 and is an independent entity within the Peace Corps. The purpose of OIG is to prevent and detect fraud, waste, abuse, and mismanagement and to promote economy, effectiveness, and efficiency in government. The Inspector General is under the general supervision of the Peace Corps Director and reports both to the Director and Congress.

The Evaluation Unit provides senior management with independent evaluations of all management and operations of the Peace Corps, including overseas posts and domestic offices. OIG evaluators identify best practices and recommend program improvements to comply with Peace Corps policies.

The Evaluation Unit announced its intent to conduct a review of the facts and circumstances surrounding the death of Peace Corps/Ghana Volunteer Ezeani on February 21, 2020. We used the following researchable questions to guide our work:

Objective 1: To determine the facts and circumstances surrounding Peace Corps Volunteer Ezeani's death.

- *What was the timeline of events?*

Objective 2: To determine if there were deficiencies in the post's medical evacuation plan that delayed or obstructed the medical evacuation of Ezeani to an appropriate medical facility.

- *Did the post's medical action plan fully comply with agency guidelines? If not, why?*
- *If the Medical Action Plan was deficient, what were the reasons?*
- *If the Medical Action Plan was deficient, was it relevant to the emergency response?*
- *Were the medical facilities and providers used in the response the most appropriate?*
- *Overall, were there any areas where the post or agency could have been better prepared?*

Objective 3: To assess Ezeani's medical condition following the accident and determine if the medical evacuation of Ezeani was appropriately managed.

- *Did the response follow agency and post procedures? If not, why?*
- *Was the medical (including end of life) care provided to Ezeani optimal given the circumstances?*
- *Were staff involved in the emergency response aware of her condition and prognosis?*
- *Overall could the Peace Corps have done anything differently to improve the response?*

The Evaluator conducted the preliminary research portion of the evaluation between December 3, 2019, and April 10, 2020. This research included a review of agency and post documents provided by headquarters and post staff; interviews with headquarters and post staff (21), private

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providers (3), and former Volunteers (3). All interviews were conducted remotely as in-country fieldwork was canceled due to pandemic travel restrictions. We engaged three external experts who reviewed documentation that was available at the time. They also reviewed the preliminary evaluation report.

This evaluation was conducted in accordance with the Quality Standards for Inspection and Evaluation, issued by the Council of the Inspectors General on Integrity and Efficiency. The evidence, findings, and recommendations provided in this report have been reviewed by agency stakeholders affected by this review.

APPENDIX B: LIST OF ACRONYMS

AD	Associate Director
CD	Country Director
DoD	Department of Defense
DoS	Department of State
GMT	Greenwich Mean Time
IHC	International Health Coordinator
IMAP	Individual Medical Action Plan
IMG	International Medical Group
OHS	Office of Health Services
OIG	Office of Inspector General
OMS	Office of Medical Services
PCMO	Peace Corps Medical Officer
PCV	Peace Corps Volunteer
PMAP	Post Medical Action Plan
RCA	Root Cause Analysis
RMAP	Regional Medical Action Plan
RMO	Regional Medical Officer
RPCV	Returned Peace Corps Volunteer
SCF	Site Contact Form
TG	Technical Guidelines
TPMRC	Theater Patient Movements Requirements Center
VIDA	Volunteer Information Database

APPENDIX C: TIMELINE OF KEY EVENTS

Date	Time (GMT)	Event
10/18/2019	12:00/12:30	Time of the accident
	2:00 am	Ezeani's counterpart tried to contact a nearby former Volunteer (RPCV).
	2:30 am	Ezeani got in the taxi with her counterpart and her next-door neighbor.
	3:00 am	Ezeani arrived at St. Mary's clinic in Drobo.
	6:30 am	A local, former Volunteer (RPCV) was informed about the accident and sent a WhatsApp message to the Volunteer community.
	6:30 am	A Volunteer who lived close to Ezeani received the RPCV's WhatsApp message.
	6:39 am	The nearby Volunteer spoke directly with Ezeani by phone.
	6:39 am	The RPCV spoke with Ezeani who told him 75-80 percent of her body had been burned.
	6:50 am (approximately)	Another Volunteer received the WhatsApp message and called the PCMO duty phone but got no answer, so she called the medical assistant.
	7:00 am	The medical assistant called the PCMO.
	7:26 am	The nearby Volunteer arrived at St Mary's clinic.
	7:35 am	The Peace Corps medical team arrived at the office and had a morning meeting and spoke with the RPCV.
	7:50 am	The PCMOs spoke with Ezeani's fellow Volunteer who was with her at the clinic.
	8:10 am	The PCMOs spoke with the doctor at St. Mary's clinic who reported an 81 percent burn area and proposed a ground ambulance to Accra. They declined ground ambulance because it was an estimated 10 to 12-hour trip.
	8:30 am	The PCMOs called commercial airlines, learned the patient would need to be a walk up steps, and subsequently abandoned commercial air evacuation.
	8:35 am	PCMOs called International SOS, West Africa Rescue Association and learned they required a contract for services.
	8:55 am	PCMOs called Care Flight Ghana to request an airlift to Accra. Care Flight accepted.
	9:17 am	PCMOs received photos of Ezeani's injury from the Volunteer who was at the clinic.
	9:22 am	The PCMOs learned that the patient was accepted for admission to the Reconstructive Plastic Surgery and Burns Center of the Korle-Bu Teaching Hospital in Accra.
	9:26 am	PCMOs began to notify other staff, including the regional medical officer (RMO) and country director (CD).
	11:40 am	Doctor on Call at Peace Corps headquarters received photos and estimated the burn area at 45 percent.
	12:45 pm	The Volunteer who was with Ezeani at the clinic received money from the Peace Corps to pay the clinic bill.
	12:49 pm	The CD notified leadership at headquarters of the incident, reporting an 81 percent surface burn area and that an airlift to Accra was in process.
	12:55	Headquarters staff first contacted their medical evacuation contractor, IMG, by email.
	1:31 pm	The Peace Corps consulted with IMG by phone who recommended taking Ezeani to South Africa.

PEACE CORPS OFFICE OF INSPECTOR GENERAL

	2:25 pm	Peace Corps staff confirmed international transfer from Accra to South Africa IMG' South African subcontractor IMG, ER2
	2:30 pm	The local Care Flight helicopter landed in Kumasi to refuel but was not cleared onward departure from Kumasi to Drobo due to inclement weather.
	4:22 pm	PCMOs arranged ground ambulance to Komfo Anokye Teaching Hospital in Kumasi.
	4:50 pm	Peace Corps medical staff discussed the transfer to Kumasi, including airfield capabilities.
	5:12 pm	Peace Corps medical staff spoke with IMG and proposed two options for evacuation out of Ghana: (1) wait until a helicopter could fly the patient from Kumasi to Accra pick-up or, (2) IMG pick her up directly from Kumasi.
	8:04 pm	IMG informed headquarters medical staff that they could pick up from Kumasi but would need to overnight in Accra
	8:28 pm	Peace Corps staff confirmed the plan with IMG to pick up the patient in Kumasi.
	9:16 pm	The ground ambulance arrived at Kumasi Komfo Teaching Hospital and attending doctor reported burn area at 59.5 percent.
	11:03 pm	IMG asked Peace Corps staff for attending doctor's contact information.
10/19/19	4:10 am	IMG reported to the Peace Corps that their crew was on standby until attending doctor confirmed.
	5:11 am	IMG provided the evacuation itinerary to Peace Corps staff, a 36-hour trip.
	10:00 am	The PCMO arrived in Kumasi and provided a clinical update to headquarters
	9:50 pm	The PCMO provided a clinical update that the patient reported low pain level and lively.
10/20/19	6:30 am	The PCMO provided a clinical update that pain was low and facial swelling improved.
	9:10 am	International air ambulance ER24 departed Kumasi, with Ezeani and the PCMO.
	9:28 am	Air ambulance arrived in Accra and the PCMO disembarked
	10:30 am	Air ambulance departed Accra for Luanda.
	5:38 pm	Air ambulance arrived in Johannesburg.
	6:54 pm	Ezeani was admitted to Milpark hospital. The burn surface area was estimated at 64 percent.
10/21/19	NA	Ezeani was seen by a plastic surgeon and pulmonologist.
10/22/19	NA	Ezeani's condition was reported as unstable.
10/23/19	NA	Dialysis initiated, antibiotics escalated, ventilation difficult, multi-disciplinary team involved.
10/24/19	NA	Ezeani's condition became progressively more unstable, renal function deteriorated, wound cleaning postponed.
10/25/19	NA	Respiratory function deteriorated and Ezeani went into cardiac arrest; CPR was unsuccessful. The time of death was 10/26/2019 00:15 (GMT+2, South Africa time). Blood culture showed infection.

APPENDIX D: MANAGEMENT ADVISORY REPORT: PEACE CORPS/GHANA GAS TANK COOKING SAFETY



Office of Inspector General

Office
202.692.2900
peacecorps.gov/OIG
[OIG Reports](#)

Hotline
202.692.2915 | 800.233.5874
[Online Reporting Tool](#)
OIG@peacecorps.gov

The purpose of this report is to bring to your attention needed improvements that the Office of

To: Jody Olsen, Director
Angela Kissel, Chief Compliance Officer

From: Kathy A. Buller, Inspector General 

Date: July 28, 2020

Subject: Management Advisory Report: Peace Corps/Ghana Gas Tank Cooking Safety
(IG-20-02-SR)

Inspector General (OIG) identified while reviewing gas cooking safety in Peace Corps/Ghana. Following the death of a Peace Corps/Ghana Volunteer who succumbed to burn injuries from a gas tank explosion, we initiated this review to assess the sufficiency of Volunteer training and Volunteer housing procedures to mitigate the risk of future accidents involving gas tanks used for cooking. Our review found that Peace Corps/Ghana was not providing adequate training to Volunteers on gas tank and cookstove safety, and headquarters staff had differing opinions on how prevalent training on cooking safety was globally. Additionally, we found that Peace Corps/Ghana's housing approval procedures and site visit practices were not sufficient to identify and address vulnerabilities to gas tank safety.

Our report makes four recommendations to improve the agency's actions regarding gas cooking safety. The agency has 45 days from the issuance of the report to provide its response to these recommendations. Once we receive the response, the report will be updated to include it in Appendix A.

SCOPE AND METHODOLOGY

This review was initiated as a result of questions that were raised by an OIG investigation into the 2019 death of a Peace Corps/Ghana Volunteer. Our objective in this report was to determine: 1) whether there was more that Peace Corps/Ghana could have done to prepare Volunteers and Volunteer housing to prevent injuries due to propane tank explosions, and 2) whether the risk factors related to propane tank safety that presented in Ghana are pervasive in other Peace Corps countries. The scope of this review encompasses September 2017 to May 2020 to coincide with when the deceased Volunteer first arrived at the post until the time of writing this report.

As part of this review, we conducted interviews with 14 headquarters and post staff members, reviewed relevant documentation provided by the agency or generated by an OIG investigation, reviewed a sample of Peace Corps/Ghana site visit reports kept in the Volunteer information database, compared housing requirements for a selection of Peace Corps posts, and conducted a literature review regarding gas tank cooking safety in Ghana and other developing countries.

We stress that OIG has not concluded that the tragic accident involving the deceased Volunteer would have been prevented had there not been the gaps in Peace Corps policy and procedures. We issued this report so that the agency can take timely action to mitigate future risk of Volunteer injury when using gas tanks to cook. OIG has separately finalized an investigation of the accident involving the deceased Volunteer and is currently conducting a separate review that assesses the post's response to the accident.

This review was conducted in accordance with OIG Directive 2020-02 – Reporting Procedures for MIRs and MARs issued on January 6, 2020.

RELEVANT FACTS AND CIRCUMSTANCES OF 2019 GAS TANK ACCIDENT

On Friday, October 18, 2019, at approximately 12:00 am in Ghana, a Volunteer was cooking at home when a gas explosion caused severe burns to the Volunteer's body. The Volunteer was transported to a nearby hospital and later transferred to a hospital in Johannesburg, South Africa. The Volunteer succumbed to those injuries and died on October 26, 2019.



Figure 4: The deceased Volunteer's gas tank in its location in an improvised kitchen.

OIG's investigation found that the explosion likely resulted from a malfunctioning gas tank fitting that caused gas to leak from the tank. The police report completed by Ghana police observed that the deceased Volunteer's tank was kept in an improvised kitchen in the Volunteer's house which was poorly ventilated. At the time of the police visit on October 21, 2019, the gas tank was in a cabinet under the kitchen counter, about two feet to the right of the cookstove which sat on the countertop. Unlike natural gas, liquefied petroleum gas (LPG) is denser than air, so the gas sinks to the ground when it is released and does not disperse easily; therefore, a spark can trigger an explosion near ground level. It is safer to store gas tanks outside in a well-ventilated area rather than in the living space.

In December 2019, OIG visited the deceased Volunteer's home and found that the tank still had gas in it and that the gas did not have an aroma. One of the deceased Volunteer's friends reported that the gas tank had been refilled about a week prior to the accident.

According to the Peace Corps safety and security officer for Ghana, the deceased Volunteer reported to another Volunteer after the accident there was no gas smell in the house before the explosion. OIG visited the two gas tank refilling stations where the deceased Volunteer would

have likely filled the gas tank and found that the gas there did not emit the odor typically associated with propane gas. OIG's investigation determined that since the gas in the tank was not odorized, the Volunteer would have been unable to recognize the danger posed by the leaking gas.

BACKGROUND ON PROPANE TANK USE IN GHANA AND ELSEWHERE

In 2011, the World Bank conducted a study of LPG markets in 20 developing countries, including Ghana. To varying degrees in each of the countries studied, the World Bank identified several risks to LPG use safety, including weak regulatory frameworks for safety, inadequate information to the public on safety issues, and weak enforcement of regulations. The study found that the laws and regulations in some countries are "incomplete, outdated, or both," and the "regulations in nearly all 20 countries are deficient when it comes to requiring consumer education and training and certification of the personnel of LPG suppliers."

Through interviews and research on gas tank use in Ghana, we learned that the supply chain for LPG in Ghana presented two risk factors that appeared to be rare globally. First, because LPG is odorless, it is typically given an odor to make leak detection easier. However, we learned that locally produced LPG in Ghana did not reliably contain an odorant. We interviewed several Peace Corps safety and security staff members with oversight of numerous countries who said they had not heard of or encountered this risk in other countries they covered. The second risk factor in Ghana was the LPG distribution system. According to the World Bank report cited above, most countries have a centralized distribution system where consumers exchange empty gas tanks for filled tanks, but we learned that Ghana had a decentralized system in which most consumers owned their own tanks that they had refilled at mini-filling stations. The decentralized distribution system reduced costs but tended to compromise safety since operators of filling stations often did not check recertification dates, visually inspect the tanks, or reject tanks that were due for testing or that did not pass visual inspection. LPG accidents in Ghana were on the rise as the population more frequently adopted use of LPG for cooking. In early 2020, Ghana began piloting a program to move away from the decentralized system to the centralized system due to safety concerns.

Peace Corps staff reported that gas cookstove usage was fairly common among Peace Corps Volunteers world-wide, though the frequency of usage varied by country, region, and whether the site was urban or rural. Staff reported that Volunteers used other cooking methods including charcoal, wood, and electricity, which each have their own risks.

WHAT WE FOUND

Peace Corps/Ghana was not sufficiently training Volunteers on the safe use of gas tanks and cookstoves before the accident.

Peace Corps Manual Section (MS) 270 requires posts to provide Volunteers/trainees with ongoing safety and security training that promotes "a realistic understanding of the possibility of accident, crime, disaster, injury, psychological trauma, and loss of property during service." The manual section specifies that training must help them "recognize factors that contribute to those risks."

OIG found that Peace Corps/Ghana was not consistently training trainees on safe use of gas cookstoves and tanks before the accident. The post had a training session called “practical cooking” that demonstrated to trainees how to prepare meals in Ghana. This session was typically taught using charcoal cookstoves, but sometimes a language and cultural facilitator (LCF) would bring in a gas tank and cookstove for the demonstration. OIG learned that even when the practical cooking session included a gas cookstove demonstration, the session did not cover important aspects of gas safety—such as how to check for leaks, the importance of ventilation, and considerations for placement of the gas tank away from the cookstove—unless the LCFs were asked a direct question about any of these topics.

We asked several headquarters safety and security staff whether or not posts were providing cooking safety training, and they expressed different opinions about the prevalence of such training throughout the agency. Staff reported two good examples of posts providing training: Peace Corps/Morocco, which provided an individual hands-on training for each Volunteer on how to connect and check hoses, and Peace Corps/Benin, which provided training with a practical component and a handout, complete with pictures, on setup of gas cookstoves and how to check for leaks.

OIG found that the Peace Corps did not have regional or global policy or requirements instructing posts to train Volunteers on gas or cooking safety, nor was there any post-specific guidance or requirements for Peace Corps/Ghana. Without specific guidance, the practical cooking session in Ghana may not necessarily include a gas cookstove demonstration, and LCFs may not remember what topics to cover when a gas cookstove demonstration takes place. Posts, too, may not know to provide training on this topic without regional or global guidance to do so.

As a result of the lack of training, Volunteers over the years may have been generally unaware of risks associated with using propane tanks and how to mitigate them. During our interviews, Peace Corps staff told us about two other gas related accidents in Volunteer homes, each in a different country.

Following the accident in October, Peace Corps/Ghana staff added a new session to their January 2020 PST that was developed and facilitated by a contractor with the Ghana National Fire Service Academy with support from the post’s safety and security team. The session covered fire safety, gas tank safety, and how to use fire extinguishers and featured a hands-on component. In addition, the Office of Safety & Security (OSS) reported that the agency was working on a new core training requirement in PST on home safety that would include cooking safety, and OSS planned to add content on home safety to their safety guidance document for all Volunteers, the “MySafety Guide: A Safety and Security Resource.”

We recommend:

- 1. That the associate director for the Office of Safety and Security provide guidance to posts about identifying post-specific cooking safety risks and incorporating related learning objectives into Volunteer training.**

Peace Corps/Ghana’s housing standards, housing check procedures, and site visit practices would not identify and address vulnerabilities in Volunteer kitchen setups related to gas cooking safety.

According to Safety and Security Instruction (SSI) 410, “Post should utilize a “minimum housing standards” checklist... [that] addresses the social, economic, health, environmental, and security issues related to [Volunteer] housing at post.” Furthermore, it requires that all Volunteer housing “must be inspected prior to occupancy” and that a Peace Corps staff member “must inspect the home and give final approval.” Africa Region Site Management Standards and Guidelines suggests that posts may use Volunteer site visits “to ensure that safety and security issues such as housing remain in compliance with Peace Corps standards.” Both the Inter-America and the Pacific Region and the Europe, Mediterranean, and Asia Region have site management guidance that make similar suggestions to ensure housing remains in compliance with Peace Corps standards. Additionally, Peace Corps/Ghana’s 2018 site development and site monitoring standards and procedures state that during site visits programming staff “should ensure that the following items are covered during their site visits:...Review the Volunteer’s home and ensure that it still meets post’s housing standards.”

In interviews, we learned that a spare room with poor ventilation had been converted into a kitchen, either by the deceased Volunteer or a previous occupant. Additionally, the gas tank was about two feet to the right and below the cookstove in a cabinet inside the house which increased the risk of an accident. OIG found that Peace Corps/Ghana’s current housing standards, housing checks, and site visit practices would not have identified and addressed the risks associated with this configuration, namely the poor ventilation and the location of the gas tank.

Housing Standards. The version of Peace Corps/Ghana’s housing approval checklist used before October 2019 had requirements that 1) the “[l]iquid propane gas cylinders, if [Volunteer] is using one, must be stored outside the home in a shady area (e.g., hose appears in good condition, chain should secure the tank from theft)”, and 2) the house has a “[d]ouble window or two single windows to provide adequate cross ventilation and light.” However, Ghana’s current housing checklist—which was reportedly approved and implemented in October 2019 before the accident—does not have any criteria related to gas cooking safety or ventilation. Post staff we spoke with who had been involved in updating the housing checklist could not tell us why the item related to propane tank placement was removed from the housing checklist, though we learned that the update to the checklist was done to bring it in line with Africa Region guidance. The Africa Region had provided a sample housing standards checklist and minimum housing requirements in its February 2019 update to site management guidance. Posts were expected to update their post-specific site management guidance by September 2019, and the housing standards sample stated that posts should develop their own housing checklist based on post-specific housing criteria.¹

Housing Checks. When the deceased Volunteer first arrived at site in December 2017, the housing checklist in effect had requirements for the placement of the gas tank outside and for ventilation as described above. A Peace Corps staff member we interviewed told us that prior to the accident, housing checks were not expected to be completed for Peace Corps/Ghana

¹ The 2019 Africa Region site management guide and sample checklist did not specifically address requirements for gas tank location or ventilation.

Volunteer housing if they were replacing another Volunteer as was the case for the deceased Volunteer. A different staff member reported that the Volunteer leaving the site performed the housing check and submitted it to staff. OIG requested but did not receive a completed housing checklist for the deceased Volunteer. Regardless of whether the departing Volunteer performed a housing check, staff were not following SSI 410 cited above which required a *staff member* to inspect the home prior to occupancy.

Site Visits. At the time of a site visit to the deceased Volunteer's house in February 2019, the housing checklist in effect had requirements for the placement of the gas tank outside and for ventilation as described above, but the site visit report did not note that the kitchen setup was out of compliance with the housing checklist. Although we could not verify that the deceased Volunteer's kitchen was in the same configuration at the time of that visit, we learned from two staff members with oversight responsibilities that site visits included a check of Volunteer housing but staff did not systematically check the kitchen or review all housing checklist items for compliance with Peace Corps/Ghana housing standards. Staff performing site visits were reportedly focused on other safety and health criteria such as window screens, water sanitation, and theft prevention, and did not check the safety of cooking setups, including gas cookstoves, before the accident.

Peace Corps/Ghana staff reported that after the accident they requested all Volunteers send pictures of their gas tank and cookstove setup, and staff then advised Volunteers on needed improvements. Based on our review, we determined that, without sufficient site development and monitoring procedures and practices in place, staff may not be able to identify and address risks of a cooking accident in Volunteer housing in the future.

We recommend:

- 2. That the director of programming and training and safety and security manager review and revise Peace Corps/Ghana's Volunteer housing requirements to include sufficient consideration of the safety of cooking setups prior to occupancy by the Volunteer, clarify to staff the expectation that a staff member should inspect Volunteer housing for replacement Volunteers, and specify how they plan to oversee compliance with the housing requirements.**
- 3. That the director of programming and training and safety and security manager review and revise Peace Corps/Ghana's site visit procedures to specify how the post will inspect the safety of Volunteer cooking setups and address any deficiencies identified, and specify how they plan to oversee compliance with the procedures.**
- 4. That the associate directors for the Offices of Global Operations and Safety and Security review current global site management guidance and determine if additional specificity of safe cooking setups needs to be incorporated into the guidance.**

CONCLUSIONS

Based on a review of agency and post documentation, as well as our interviews with headquarters and post staff, we found that Volunteer training and site management procedures and practices related to gas tank safety needed improvement. Peace Corps/Ghana had already implemented additional Volunteer training, but we addressed two recommendations to headquarters regarding guidance, which, if implemented, will provide better assurance of adequate Volunteer training and site management related to cooking safety at Peace Corps posts globally. The two recommendations directed to Peace Corps/Ghana are intended to improve the post's housing requirements and site visit procedures to reduce the risk of future accidents.

cc: Michelle Brooks, Chief of Staff
Matthew McKinney, Deputy Chief of Staff/White House Liaison
Carl Sosebee, Senior Advisor to the Director
Timothy Noelker, General Counsel
Shawn Bardwell, Associate Director, Office of Safety and Security
David Fleisig, Chief, Overseas Operations, Office of Safety and Security
Patrick Young, Associate Director, Office of Global Operations
Stephanie Rust, Director, Overseas Programming and Training Support
Karen Becker, Associate Director, Office of Health Services
James Golden, Deputy Director, Office of Health Services
Johnathan Miller, Regional Director, Africa Region
Jeannette Windon, Regional Director, Europe, Mediterranean, and Asia Region
Gregory Huger, Regional Director, Inter-America and the Pacific Region
Allison Lange, Regional Security Advisor, Africa Region
Dana Abro, Regional Security Advisor, Europe, Mediterranean, and Asia Region
Joshua O'Donnell, Regional Security Advisor, Inter-America and the Pacific Region
Julie Burns, Operations Expert, Africa Region
Gordon Brown, Country Director, Peace Corps/Ghana
Karen Gardenier, Director of Programming and Training, Peace Corps/Ghana
Jessy Wilt, Peace Corps Safety and Security Officer
Jennifer DiBella, Chief of Programming and Training, Africa Region
Marian Fortner, Chief of Programming and Training, Europe, Mediterranean, and Asia Region
Lindsey Suggs, Chief of Programming and Training, Inter-America and the Pacific Region
Ghana Desk

APPENDIX A: AGENCY RESPONSE TO THE MANAGEMENT ADVISORY REPORT



MEMORANDUM

To: Kathy Buller, Inspector General

Through: Angela Kissel, Chief Compliance Officer *Angela Kissel*

From: Jody Olsen, Director *Jody Olsen*

Date: September 14, 2020

CC: Michelle K. Brooks, Chief of Staff
Matthew McKinney, Deputy Chief of Staff/White House Liaison
Carl Sosebee, Senior Advisor to the Director
Timothy Noelker, General Counsel
Shawn Bardwell, Associate Director, Office of Safety and Security
David Fleisig, Chief, Overseas Operations, Office of Safety and Security
Patrick Young, Associate Director, Office of Global Operations
Stephanie Rust, Director, Overseas Programming and Training Support
Johnathan Miller, Regional Director, Africa Region
Allison Lange, Regional Security Advisor, Africa Region
Dana Abro, Regional Security Advisor, Europe, Mediterranean, and Asia Region
Joshua O'Donnell, Regional Security Advisor, Inter-America and the Pacific
Julie Burns, Operations Expert, Africa Region
Gordon Brown, Country Director, Peace Corps/Ghana
Karen Gardenier, Director of Programming and Training, Peace Corps/Ghana
Jessy Wilt, Peace Corps Safety and Security Officer
Jennifer DiBella, Chief of Programming and Training, Africa Region
Marian Fortner, Chief of Programming and Training, Europe, Mediterranean, and Asia Region
Lindsey Suggs, Chief of Programming and Training, Inter-America and the Pacific Region

Subject: Management Advisory Report: Peace Corps/Ghana Gas Tank Cooking Safety (IG-20-02-SR)

Enclosed please find the agency's response to the recommendations made by the Inspector General for the Management Advisory Report: Peace Corps/Ghana Gas Tank Cooking Safety (IG-20-02-SR) given to the agency on July 28, 2020.

Recommendation 1

That the associate director for the Office of Safety and Security provide guidance to posts about identifying post-specific cooking safety risks and incorporating related learning objectives into Volunteer training.

Concur

Response: In coordination with other relevant HQ offices and stakeholders, the Office of Safety and Security will provide guidance to posts about identifying post-specific cooking safety risks and incorporating related learning objectives into Volunteer training.

Documents to be Submitted:

- My safety Guide, Updated Cooking Safety Chapter
- Updated PST session, Home Safety
- Updated terminal learning objectives (KSAs)
- Guidance for identifying post-specific cooking risks
- PCSSO MS 270 risk assessment
- OGO and OSS memo guidance on home safety requirements

Status and Timeline for Completion: December 2020

Recommendation 2

That the director of programming and training and safety and security manager review and revise Peace Corps/Ghana's Volunteer housing requirements to include sufficient consideration of the safety of cooking setups prior to occupancy by the Volunteer, clarify to staff the expectation that a staff member should inspect Volunteer housing for replacement Volunteers, and specify how they plan to oversee compliance with the housing requirements.

Concur

Response: PC/Ghana is in process of reviewing and revising the Site Development Manual to include cooking safety measures and staff oversight of Volunteer housing. The revisions are being made in conjunction with PC/Ghana staff to ensure all necessary staff understand their responsibilities for housing requirements and inspections.

Documents Submitted:

- Updated Site Management Manual
- Staff Meeting Notes highlighting cooking safety and housing discussion
- Email to appropriate staff with new housing guidance

Status and Timeline for Completion: December 2020

Recommendation 3

That the director of programming and training and safety and security manager review and revise Peace Corps/Ghana's site visit procedures to specify how the post will inspect the safety of Volunteer cooking setups and address any deficiencies identified, and specify how they plan to oversee compliance with the procedures.

Concur

Response: PC/Ghana is in process of reviewing and revising the site development manual to include cooking safety measures and staff oversight of Volunteer housing. The revisions are being made in conjunction with PC/Ghana staff to ensure all necessary staff understand their responsibilities for housing requirements and inspections.

Documents to be Submitted:

- Updated Site Management Manual
- Staff Meeting Notes highlighting cooking safety and housing discussion
- Email to appropriate staff with new housing guidance
- Updated site visit checklist
- Updated site visit schedule

Status and Timeline for Completion: December 2020

Recommendation 4

That the associate directors for the Offices of Global Operations and Safety and Security review current global site management guidance and determine if additional specificity of safe cooking setups needs to be incorporated into the guidance.

Concur

Response: In coordination with other relevant HQ offices and stakeholders, the Office of Safety and Security and the Office of Global Operations will provide additional guidance concerning safe cooking setups to be incorporated into region site management guidance.

Documents to be Submitted:

- Updated Regional Site Management Guidance (AF/EMA/IAP) that incorporates updated housing criteria, guidance for conducting kitchen inspections and updated criteria for conducting home inspections during Volunteer site visits.
- Proof of distribution to posts.

Status and Timeline for Completion: December 2020

APPENDIX B: OIG COMMENTS

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

APPENDIX E: AGENCY RESPONSE TO THE PRELIMINARY REPORT



MEMORANDUM

To: Kathy Buller, Inspector General

From: Carol Spahn, Acting Director **Spahn, Carol**
Digitally signed by Spahn, Carol
Date: 2021.06.15 16:59:07 -04'00'

Date: June 15, 2021

CC: Dave Noble, Chief of Staff
Carl Sosebee, Senior Advisor to the Director
Julie Burns, Senior Advisor to the Director
Chip Taylor, Acting General Counsel
Colin M. Jones, Acting Chief Compliance Officer
Victor Sloan, Associate Director, Office of Health Services
Shawn Bardwell, Associate Director, Office of Safety and Security
Scott Beale, Associate Director, Office of Global Operations
Kevin Fleming, Acting Regional Director, Africa
James Golden, Deputy Associate Director, Office of Health Services
David Fleisig, Chief, Overseas Operations, Office of Safety and Security
Karen Gardenier, Acting Country Director, Ghana
Jamille Shuler, Director of Management and Operations, Ghana

Subject: Agency Response to the Report on the Review of the Facts and Circumstances Surrounding the Death of a Peace Corps/Ghana Volunteer (Project No. SR-20-01)

Thank you for the Inspector General's Report on the Review of the Facts and Circumstances Surrounding the Death of a Peace Corps/Ghana Volunteer (Project No. SR-20-01), which was received by the agency on April 20, 2021. The Peace Corps continues to mourn the heartbreaking loss of Peace Corps Volunteer Chidinma Ezeani. This report, as well as others by your office concerning this tragedy, are critical to our continuous efforts to improve the health and safety of Volunteers.

Before turning to the response to each of the recommendations in this report, I thought it important to inform you that the agency has conducted a thorough review of this case and based on findings and conclusions continues to implement numerous changes. For example, the agency has taken the following actions and measures:

PEACE CORPS OFFICE OF INSPECTOR GENERAL

- (1) steps to issue alarms for carbon monoxide/smoke/gas to Volunteers, as appropriate;
- (2) updated the “My Safety Guide” to include a section on Home Safety;
- (3) developed a pre-service safety and security training session on Home Safety;
- (4) updated housing criteria to address home cooking safety;
- (5) provided Peace Corps staff at post with guidance on visiting and exchanging contact information with local clinics and/or hospital(s) to which Volunteers would likely be taken in an emergency;
- (6) developed written information for distribution to neighbors and counterparts of Volunteers on how to reach the Peace Corps in case of an emergency;
- (7) created and distributed a new Emergency Notification Flow Chart for Country Directors (CDs) to use in response to various types of emergencies, including serious/potential life-threatening injuries (e.g., vehicle accidents, fires, drug overdoses, and general accidents); and
- (8) developed guidance for Peace Corps staff at post to identify and assess local air ambulance options.

In addition, the agency took action to successfully close all four of the recommendations set forth in the OIG’s Management Advisory Report (MAR) “Peace Corps/Ghana Gas Tank Cooking Safety (IG-20-02-SR).”

Thank you, again, for the important role of the Office of the Inspector General. The agency’s responses to the recommendations follow below.

Recommendation 1

That Peace Corps/Ghana complete their medical action plan so that it fully complies with agency policy, using the specified form for facility assessments.

Concur

Response: Post is actively updating the Medical Action Plan (MAP) as part of the reentry process for returning Volunteers to service in Ghana. Management will ensure that the updated Medical Action Plan complies with Peace Corps policy, including use of the appropriate form for facility assessments. The completed MAP will be reviewed by OHS and stored at post according to Peace Corps policy.

Documents to be Submitted:

- Updated Peace Corps/Ghana Medical Action Plan (MAP)

Status and Timeline for Completion: Immediately upon approval of re-entry of Volunteers to Ghana, an update on the status and timeline for completion will be provided to the Office of Inspector General. We estimate that upon approval it will take approximately 5 months to complete the documentation to support closure of this recommendation.

Recommendation 2

That the country director and Peace Corps medical officer in Ghana submit a plan that will ensure local emergency transportation options are sufficiently researched and coordinated.

Concur

Response: Post will ensure local emergency transportation options are adequately researched and coordinated as part of updating the Medical Action Plan (MAP). The updated Medical Action Plan will comply with Peace Corps policy, including use of the appropriate forms for local emergency transportation assessments. The completed MAP will be reviewed by OHS and stored at post according to Peace Corps policy.

Documents Submitted:

- Updated Peace Corps/Ghana Medical Action Plan (MAP)

Status and Timeline for Completion: Immediately upon approval of re-entry of Volunteers to Ghana, an update on the status and timeline for completion will be provided to the Office of Inspector General. We estimate that upon approval it will take approximately 5 months to complete the documentation to support closure of this recommendation.

Recommendation 3

That the Director develop a plan to fully staff the assessment of local medical resources internally or contract the responsibility to an external entity.

Concur

Response: The Offices of Health Services and Global Operations will develop a plan to more fully and effectively utilize Community Backup Medical Providers described under MS 261.5 to provide medical support to Volunteers, which, in turn, will allow PCMOs the time to assess the

capabilities of local medical resources to provide higher levels of care. The plan will focus on conducting triennial assessments of facilities where Peace Corps would refer a Volunteer for medical care. The plan will also address policies and procedures to document the infrastructure and capabilities of medical facilities, where Volunteers may present in an emergency. These facilities are only anticipated to be used for stabilization and preparation for emergency transportation to higher levels of care. The infrastructure and capabilities will be documented through surveys and site visits by non-clinical staff. (See, also, Recommendation 5 below.)

Documents to be Submitted:

- Updated Medical Technical Guideline 204 Peace Corps Volunteer Site Visits and Healthcare Facility Assessments
- Agency Plan to conduct triennial assessments of facilities where a Volunteer would be referred for medical care
- Communication from the Office of Global Operations to posts to use Community Backup Providers to support staff the assessment of local medical resources
- Form for surveys/site visits to document a local facility's capabilities (non-referring facilities)

Status and Timeline for Completion: January 2022

Recommendation 4

That the chief of staff work with the associate directors to ensure that drills to prepare for medical and life-threatening emergencies cover both local and international medical evacuations and that all potential responders (medical staff at headquarters and regional hubs, private medevac contractors, other federal agencies, Volunteers, etc.) are included.

Concur

Response: Peace Corps will incorporate medical emergencies and life-threatening situations into its regular Emergency Action Plan (EAP) and MS 265 *Death of a Volunteer* drills, in accordance with agency policies and procedures. The agency will reach out to Embassy Offices and/or personnel, medevac contractors and others to encourage and request participation.

Additionally, the Peace Corps will continue to participate in Embassy EAP drills and exercises for emergency planning and liaisons. On an annual basis, Peace Corps will involve headquarters staff in at least one EAP and MS 265 drill per region.

Documents Submitted:

- Updated SSI 602 Emergency Action Plan Testing and Training Guidelines
- Update MS 265 Death of a Volunteer Procedures

Status and Timeline for Completion: October 2021

Recommendation 5

That the associate director for the Office of Health Services collaborate with the associate director for the Office of Global Operations to develop guidance and training for non-clinical staff to address medical emergency preparedness when conducting site visits, including, but not limited to, providing community contacts with the Peace Corps' contact information and visiting local medical facilities, and integrate this guidance into existing site visit guidance.

Concur

Response: The Office of Global Operations with input from the Office of Safety and Security and Office of Health Services will implement enhancements to Site Management Guidance/Manuals and conduct appropriate training in accordance with this recommendation.

Also, Medical Technical Guideline 204, *Peace Corps Volunteer Site Visits and Healthcare Facility Assessments*, will be updated to clarify the role and procedures for non-clinical staff to collect information about local medical facilities while conducting site visits.

Note: The Peace Corps has issued guidance to posts regarding non-clinical visits to facilities to which Volunteers may be taken in an emergency as part of their site management guides. The agency will further update this guidance with the form/survey referenced in Response 3 above.

Documents to be Submitted:

- Updated Medical Technical Guideline 204 Peace Corps Volunteer Site Visits and Healthcare Facility Assessments
- Regional Site Management Guidance
- Form for surveys/site visits to document a local facilities capabilities (non-referring facilities)

Status and Timeline for Completion: February 2022

Recommendation 6

That the associate director for the Office of Health Services clarify TG 385 to specify what Volunteer information is required in the Individual Medical Action Plan.

Concur

Response: The Office of Health Services will update TG 385 to clarify and specify what Volunteer information is required in the Individual Medical Action Plan.

Documents to be Submitted:

- Updated Medical Technical Guideline 385 Medical Action Plan

Status and Timeline for Completion: September 2021

Recommendation 7

That the Office of Health Services develop and implement a process for managing its site assessment recommendations that includes a review of evidence and documentation prior to deciding to close recommendations.

Concur

Response: The Peace Corps has approved funding for the Office of the Chief Information Officer and Office of Health Services (OHS) to procure Quality Improvement database software to enhance managing, tracking, disseminating, and archiving information received from site assessment recommendations. The Statement of Work has been developed and is currently in the final stages of the pre-bidding process. Once the software is implemented, OHS will be better able to manage recommendations including decisions to close recommendations.

Documents to be Submitted:

- Quality Improvement Database Software documentation
- Standard Operating Procedure on Site Assessment Recommendations

Status and Timeline for Completion: December 2022

Recommendation 8

That the Director develop a comprehensive plan to improve institutional memory in the Office of Health Services, including, but not limited to, identifying critical positions and exempting them from term limits.

Concur

Response: The Acting Director recently exempted 30 additional positions (in addition to 2 previously exempted positions) from the five year rule, in accordance with the provisions of the Peace Corps Act, as amended by the Sam Farr-Nick Castle Peace Corps Reform Act of 2018. See 22 USC 2506(8). As part of the plan to improve institutional memory, the Office of Health Services will develop an approach to documenting and annually reviewing emergency medical evacuations.

Documents to be Submitted:

- Standard Operating Procedures for documenting and organizing actions taken in response to serious medical events.
- List of OHS positions exempted under § 2506(8) of the Peace Corps Act.
- Memoranda Approving the list of OHS positions exempted under § 2506(8) of the Peace Corps Act.

Status and Timeline for Completion: January 2022

Recommendation 9

That the Director will ensure that international emergency transportation options, including those through the Department of Defense and Department of State, are researched, documented, and incorporated into Peace Corps policies and procedures.

Concur

Response: The Peace Corps will incorporate into applicable policies and procedures the requirement to contact the Department of Defense and Department of State and to research, document, and incorporate international emergency transportation options. These options will be incorporated into the standard operating procedure for securing medical evacuation by international air ambulance.

Documents to be Submitted:

- Documentation of results of research and communication with the Department of State and Department of Defense
- Updated Medical Technical Guideline 380 Medical Evacuation

Status and Timeline for Completion: January 2022

Recommendation 10

That the associate director for the Office of Health Services incorporate a mechanism and procedures into TG 370 to obtain teleconsults so that the Office of Health Services accesses medical experts during field consults.

Concur

Response: The Peace Corps is in the process of procuring a vendor to provide teleconsults on appropriate medical cases. The Office of Health Services will update TG 370 with the policy and procedure for designated clinicians in the Office of Health Services to consult with the requisite medical expertise to support the care and treatment for individual cases.

Documents to be Submitted:

- Updated Medical Technical Guideline 370 Field Consultation and Communication
- Communication informing all Clinicians about the updates to TG 370

Status and Timeline for Completion: January 2022

Recommendation 11

That the Director develop agency-wide policy and procedures that define staff roles and responsibilities to respond to life-threatening medical emergencies.

Concur

Response: The Peace Corps will develop policy and procedures that define staff roles and responsibilities to respond to life-threatening medical emergencies. The roles and responsibilities will be documented by adding a new attachment to Manual Section 264 Medical Evacuation.

Documents to be Submitted:

- New Manual Section 264 Medical Evacuation – Attachment B – Roles and Responsibilities during a Life-Threatening Medical Emergency

Status and Timeline for Completion: January 2022

Recommendation 12

That the associate director of the Office of Health Services include provisions for a Root Cause Analysis charter in TG 167.

Concur

Response: The Peace Corps is updating Manual Section 262 Peace Corps Medical Services Program to ensure that when the root cause analysis for any adverse medical event (i.e., Volunteer death, permanent harm, or severe temporary harm that requires intervention to sustain life) is required, the services of an outside, independent organization will be utilized to conduct the peer review and root cause analysis. The Peace Corps will ensure that such organizations use a root cause analysis charter consistent with best practices.

Documents to be Submitted:

- Updated Manual Section 262 Peace Corps Medical Services Program
- Updated Medical Technical Guideline 167 Patient Safety Events

Status and Timeline for Completion: October 2021

The Reopening of Recommendation 7 from the Morocco Follow-Up Evaluation

That the associate director of the Office of Health Services ensure staffing is sufficient to adequately implement a more effective sentinel event reporting system and that staff involved in root cause analyses have not had direct involvement in the case.

Concur

Response: Although the agency is of the view that it is more appropriate to provide a new recommendation based on the facts of this report rather than re-opening a previously closed recommendation, the Peace Corps agrees, nonetheless, that root cause analyses should be free of conflicts of interest.

To ensure that conflicts of interest do not occur, the Peace Corps is updating the Manual Section 262, *Peace Corps Medical Services Program*, to ensure that the root cause analysis for any adverse medical event (i.e., Volunteer death, permanent harm, or severe temporary harm that requires intervention to sustain life) is conducted in accordance with the measures that will be taken as described under Response 12, above. This approach will ensure that staff involved in a root cause analysis have not had direct involvement in an adverse event. (See Recommendation/Response 12 above.)

Documents to be Submitted:

- Updated Manual Section 262 Peace Corps Medical Services Program
- Update Medical Technical Guideline 167 Patient Safety Events

Status and Timeline for Completion: October 2021

PEACE CORPS OFFICE OF INSPECTOR GENERAL

**Approval of the Agency's Response to the Report on the Review of the Facts and Circumstances Surrounding the Death of a Peace Corps/Ghana Volunteer
(Project No. SR-20-01)**

Dave Noble, Chief of Staff

Noble, David

Digitally signed by Noble, David
Date: 2021.06.15 16:02:49
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6/15/2021

Signature

Date

Carl Sosebee, Senior Advisor to the Director

Sosebee, Carl

Digitally signed by Sosebee, Carl
Date: 2021.06.15 16:07:51
-04'00'

6/15/2021

Signature

Date

Chip Taylor, Acting General Counsel

CARL TAYLOR

Digitally signed by CARL TAYLOR
Date: 2021.06.15 13:33:26 -04'00'

6/15/2021

Signature

Date

Colin M. Jones, Acting Chief Compliance Officer

COLIN JONES

Digitally signed by COLIN JONES
Date: 2021.06.15 13:28:21 -04'00'

6/15/2021

Signature

Date

APPENDIX F: OIG COMMENTS

Management concurred with all 12 recommendations, which remain open. In its response, management described actions it is taking or intends to take to address the issues that prompted each of our recommendations. We wish to note that in closing recommendations, we are not certifying that the agency has taken these actions or that we have reviewed their effect. Certifying compliance and verifying effectiveness are management's responsibilities. However, when we feel it is warranted, we may conduct a follow-up review to confirm that action has been taken and to evaluate the impact.

OIG will review and consider closing recommendations 1, 3, 6-8, and 10-11 when the documentation reflected in the agency's response to the preliminary report is received. OIG requests additional documentation for recommendations 2, 4, 5, 9 and 12, as explained below. These recommendations remain open pending confirmation from the chief compliance officer that the documentation reflected in our analysis below has been received.

Recommendation 2

That the country director and Peace Corps medical officer in Ghana submit a plan that will ensure local emergency transportation options are sufficiently researched and coordinated.

Concur

Response: Post will ensure local emergency transportation options are adequately researched and coordinated as part of updating the Medical Action Plan (MAP). The updated Medical Action Plan will comply with Peace Corps policy, including use of the appropriate forms for local emergency transportation assessments. The completed MAP will be reviewed by OHS and stored at post according to Peace Corps policy.

Documents Submitted:

- Updated Peace Corps/Ghana Medical Action Plan (MAP)

Status and Timeline for Completion: Immediately upon approval of re-entry of Volunteers to Ghana, an update on the status and timeline for completion will be provided to the Office of Inspector General. We estimate that upon approval it will take approximately 5 months to complete the documentation to support closure of this recommendation.

OIG Analysis: The MAP we reviewed contained the contact information for an emergency airlift provider but did not describe how the post had researched the available providers or coordinated with selected providers. OIG requests the agency provide a document that describes its steps to research local emergency transportation options and to improve coordination with selected local emergency transportation provider(s).

Recommendation 4

That the chief of staff work with the associate directors to ensure that drills to prepare for medical and life-threatening emergencies cover both local and international medical evacuations and that all potential responders (medical staff at headquarters and regional hubs, private medevac contractors, other federal agencies, Volunteers, etc.) are included.

Concur

Response: Peace Corps will incorporate medical emergencies and life-threatening situations into its regular Emergency Action Plan (EAP) and MS 265 *Death of a Volunteer* drills, in accordance with agency policies and procedures. The agency will reach out to Embassy Offices and/or personnel, medevac contractors and others to encourage and request participation.

Additionally, the Peace Corps will continue to participate in Embassy EAP drills and exercises for emergency planning and liaisons. On an annual basis, Peace Corps will involve headquarters staff in at least one EAP and MS 265 drill per region.

Documents Submitted:

- Updated SSI 602 Emergency Action Plan Testing and Training Guidelines
- Updated MS 265 Death of a Volunteer Procedures

Status and Timeline for Completion: October 2021

OIG Analysis: MS 264 Medical Evacuation is the policy section at issue. To close this recommendation, please ensure that policies and procedures developed in response to the recommendation address local and international medical evacuation drills and the participation of all potential responders as stated in the recommendation.

Recommendation 5

That the associate director for the Office of Health Services collaborate with the associate director for the Office of Global Operations to develop guidance and training for non-clinical staff to address medical emergency preparedness when conducting site visits, including, but not limited to, providing community contacts with the Peace Corps' contact information and visiting local medical facilities, and integrate this guidance into existing site visit guidance.

Concur

Response: The Office of Global Operations with input from the Office of Safety and Security and Office of Health Services will implement enhancements to Site Management Guidance/Manuals and conduct appropriate training in accordance with this recommendation.

Also, Medical Technical Guideline 204, *Peace Corps Volunteer Site Visits and Healthcare Facility Assessments*, will be updated to clarify the role and procedures for non-clinical staff to collect information about local medical facilities while conducting site visits.

Note: The Peace Corps has issued guidance to posts regarding non-clinical visits to facilities to which Volunteers may be taken in an emergency as part of their site management guides. The agency will further update this guidance with the form/survey referenced in Response 3 above.

Documents to be Submitted:

- Updated Medical Technical Guideline 204 Peace Corps Volunteer Site Visits and Healthcare Facility Assessments
- Regional Site Management Guidance
- Form for surveys/site visits to document local facilities' capabilities (non-referring facilities)

Status and Timeline for Completion: February 2022

OIG Analysis: To close this recommendation, please also provide documentation of the training the agency intends to provide non-clinical staff that specifically addresses medical emergency preparedness when conducting site visits, including, but not limited to, providing community contacts with the Peace Corps' contact information and visiting local medical facilities.

Recommendation 9

That the Director ensure that international emergency transportation options, including those through the Department of Defense and Department of State, are researched, documented, and incorporated into Peace Corps policies and procedures.

Concur

Response: The Peace Corps will incorporate into applicable policies and procedures the requirement to contact the Department of Defense and Department of State and to research, document, and incorporate international emergency transportation options. These options will be incorporated into the standard operating procedure for securing medical evacuation by international air ambulance.

Documents to be Submitted:

- Documentation of results of research and communication with the Department of State and Department of Defense
- Updated Medical Technical Guideline 380 Medical Evacuation

Status and Timeline for Completion: January 2022

OIG Analysis: To close this recommendation please ensure that policies and procedures, including MS 264, contain provisions for ongoing coordination with the Department of Defense and Department of State, and specifically clarify the frequency of contact, so that Peace Corps remains up to date on how to access these options for international medical evacuation. In addition to the documents listed above, please also provide a revised MS 264 and the standard operating procedures for international evacuation that were referenced in the agency's response.

Recommendation 12

That the associate director of the Office of Health Services include provisions for a Root Cause Analysis charter in TG 167.

Concur

Response: The Peace Corps is updating Manual Section 262 Peace Corps Medical Services Program to ensure that when the root cause analysis for any adverse medical event (i.e., Volunteer death, permanent harm, or severe temporary harm that requires intervention to sustain life) is required, the services of an outside, independent organization will be utilized to conduct the peer review and root cause analysis. The Peace Corps will ensure that such organizations use a root cause analysis charter consistent with best practices.

Documents to be Submitted:

- Updated Manual Section 262 Peace Corps Medical Services Program
- Updated Medical Technical Guideline 167 Patient Safety Events

Status and Timeline for Completion: October 2021

OIG Analysis: In addition to the documentation listed above, please provide Peace Corps' scope of work and other terms and conditions with the independent organization to conduct root cause analyses. This documentation should describe how the external organization will interact with Peace Corps staff to focus on systemic issues, in accordance with best practices, including RCA² Improving Root Cause Analyses and Actions to Prevent Harm, and Veterans Administration National Center for Patient Safety RCA Step-By-Step Guide. We also note that an external entity is unlikely to have a comprehensive and current understanding of Peace Corps policies, procedures, offices, and systems. For that reason, OIG is concerned that if Peace Corps simply outsources root cause analysis to an external entity it may not develop a more effective quality improvement system.

APPENDIX G: PROGRAM EVALUATION COMPLETION AND OIG CONTACT

PROGRAM EVALUATION COMPLETION

This program evaluation was conducted under the direction of Assistant Inspector General for Evaluations Jeremy Black and Acting Assistant Inspector General for Evaluations Reuben Marshall by Senior Evaluator Erin Balch. Additional contributions were made by Senior Special Agent Paul Desautels and Senior Evaluator Kris Hoffer.



OIG CONTACT

Following issuance of the final report, a stakeholder satisfaction survey will be distributed to agency stakeholders. If you wish to comment on the quality or usefulness of this report to help us improve our products, please contact Acting Assistant Inspector General for Evaluations Reuben Marshall at rmmarshall2@peacecorpsoig.gov or (571) 218-8223.

In memory of

Chidinma Lawretta Esther Joan Ezeani



1989 - 2019

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

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