

United States Senate
Senate Committee on Finance
Investigative Report

Chairman Charles E. Grassley (116th Congress)
Chairman Ron Wyden (117th Congress)

Exposing the Risks of Deliberate Ignorance:

**Years of Mismanagement and Lack of Oversight
by the Office of Refugee Resettlement,
Leading to Abuses and Substandard Care of
Unaccompanied Alien Children**

October 28, 2021



Executive Summary

During the 116th Congress, the Senate Committee on Finance began a bipartisan investigation into allegations of inadequate department-level oversight, ongoing child abuse, and substandard accommodations provided by the Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) to unaccompanied alien children (UAC). Due to the significant duration of the investigation, caused in large part by HHS's obstruction, the offices of then Chairman Chuck Grassley and Ranking Member (now Chairman) Ron Wyden continued the investigation into the 117th Congress.

After examining data largely from 2014 to 2020, the congressional investigation found that HHS, via ORR, fails to provide the basic oversight needed to ensure the safety of children in its care due to extensive record-keeping deficiencies and the lack of a clear framework for taking action when serious incidents occur. Instead of using data management software built to provide a comprehensive, integrated view of child safety and grantee/contractor compliance, ORR staff utilizes an ad hoc system that incorporates email records and staff recollections. This flawed monitoring, coupled with having no straightforward process for determining the most appropriate protective or punitive actions, leads ORR to take inadequate and inconsistent steps when children in its care are put at risk or experience harm.

ORR's lack of a data-driven oversight program was both the main finding of this investigation and the main obstacle to further analysis of child safety. Nevertheless, the Committee uncovered worrying irregularities and omissions in the data that suggest a flawed oversight system. Between Fiscal Years (FY) 2016 and 2020, ORR received 7,467 reports of sexual misconduct involving a UAC, peaking at 2,716 reports in FY 2019 before the COVID-19 pandemic drastically reduced the number of children coming into ORR care. In the course of examining the details of specific allegations, the Committee discovered that grantees' and contractors' incident reports do not reliably capture or highlight key information, such as the severity of what occurred in a particular incident, and even whether an incident involved an adult or another child. In addition, the sheer volume of sexual misconduct reports, absent an oversight system that allows ORR to analyze patterns of abuse and neglect at the ORR facility and grantee/contractor level, leaves children vulnerable to systemic problems that may exist within the ORR network and thus require immediate attention.

Moreover, because ORR's monitoring is based on individual case management records, it is unable to track historical trends at either the facility or grantee/contractor level—including such critical data as facility security, facility safety, staff behavior, and abuse and assault (including incidents of a sexual nature). Not only does this mean that ORR fails to effectively address ongoing systemic threats to children's well-being, but also that it is inherently incapable of quantitatively assessing grantee/contractor operations. This poses a troubling barrier to the long-term improvements in the quality of care that ORR can guarantee, as it is unable to determine whether a grantee or contractor has a history of being compliant, competent, or suitable for additional grants or contracts.

It is also important to note here—although our offices disagree fundamentally with regards to immigration policy—that is not what is being discussed in this report. Despite our disparate political beliefs we are united in the understanding that it is the responsibility of our government to ensure the safety and well-being of the children in its care, until they can be reunited with their families. This belief holds true no matter the circumstances that may have brought these children here.

Recommendations

Our offices believe that the below recommendations are necessary steps that ORR must take to fulfill its duty to protect the health and safety of children in its care:

- **Recommendation #1:** ORR should utilize the full range of its powers to compel grantees and contractors to prioritize the safety and well-being of children in their care, including financial drawdowns and the discontinuation or non-continuation of grants/contracts to providers that do not effectively safeguard children in their care.
- **Recommendation #2:** ORR should create a public framework grading ORR UAC grantees and contractors to track and verify the quality of care they provide. This framework should be utilized in the assessment of future grant applications. Quality of care should take into account specific elements of child well-being, such as physical safety, medical care, emotional support and opportunities for social activities, and the length of time spent in care prior to release to a sponsor or other appropriate placement. Adherence to applicable state and federal law and grant award requirements, as well as positive and negative patterns of behavior, should also be taken into account.
- **Recommendation #3:** ORR should improve guidance to grantees and contractors for significant incident reporting, to ensure consistency in how they describe and classify events. ORR should also review and update the existing virtual portal to enter and submit significant incident reports, seeking design improvements that enhance the usability, consistency, and analytical capacity of the collected data.
- **Recommendation #4:** ORR should adopt a data management system capable of tracking and comparing across facility and grantee/contractor-level operations, including historical records of compliance, violations, and all significant incidents that have occurred.
- **Recommendation #5:** ORR should establish a transparent decision-making process for addressing threats to the safety of children in its care, with clear standards for how the number and severity of violations, as well as a grantee/contractor's history, lead to particular actions by ORR.
- **Recommendation #6:** ORR should proactively identify and address problematic trends across facilities and grantees/contractors, rather than treat incidents as isolated episodes to be addressed through individual case management. When things go wrong in one location, ORR should ensure that headquarters learns from any failures and verifies the same issues are not occurring elsewhere. This will strengthen protections network-wide.
- **Recommendation #7:** ORR should improve communication and coordination with local, state, and other federal agencies involved in licensing or investigating providers that operate ORR-funded facilities.

I. Introduction

The U.S. Department of Health and Human Services (HHS) is required to provide shelter and care for unaccompanied alien children (UAC), defined as children under the age of 18 who have no lawful immigration status in the United States, and for whom there is no parent or legal guardian in the United States.¹ The Office of Refugee Resettlement (ORR)—a division of HHS’s Administration for Children and Families (ACF)—receives UAC apprehended by the Department of Homeland Security (DHS). Once these children have entered ORR’s care, the agency is required to place each one “in the least restrictive setting that is *in the best interest of the child*.”²

To fulfill its statutory responsibility to provide shelter and care to UAC, ORR oversees a permanent network of facilities and programs organized into five different categories: shelter facility, foster care or group home, staff-secure or secure care facility, residential treatment center, and other special needs care facility. ORR funds this network through grants to outsource care for UAC until they are released to a sponsor or otherwise leave ORR’s custody.³ These grants require the organizations to supply housing, food, medical care, mental health services, recreational activities, and educational services for UAC in their care.⁴ These grantees are required to be licensed by their state and must meet various ORR requirements for care, services, and financial management.

ORR also directly operates two temporary shelter facility types used to expand its network capacity during periods of influx, in which the number of UAC entering the United States exceeds ORR’s standard capabilities for processing and placement: Emergency Intake Sites (EIS) and Influx Care Facilities (ICF, or “influx facilities”).⁵ EIS are used to increase ORR’s ability to quickly accept UAC from DHS, and ICF are used to provide emergency shelter and services for UAC while ORR pursues their placement with sponsors.⁶ Unlike facilities in ORR’s permanent network, EIS and ICF are usually located on federally owned or leased property. They are managed by government contractors and are *not* subject to state licensure. Rather, they are subject to all other applicable federal contracting regulations and ORR UAC program requirements. Additionally, ORR may place certain children who need specialized services in “out-of-network” facilities. “Out-of-network” placements are based on a psychiatrist’s or other professional’s recommendation that the child’s needs cannot be met within ORR’s network of care.

¹ 6 U.S.C. § 279(g)(2). This responsibility ends only when HHS releases a child to a suitable sponsor, the Department of Homeland Security removes the child upon completion of immigration adjudication, or the child reaches the age of 18.

² 8 U.S.C. § 1232(c)(2) (emphasis added). *See also* Hudson, J. & Sacchetti, M. (2021, September 8). *More than 100 Afghan children and teens are in U.S. custody without parents*. The Washington Post. https://www.washingtonpost.com/immigration/afghan-children-no-parents/2021/09/08/06873b4a-10a8-11ec-882f-2dd15a067dc4_story.html.

³ As discussed in greater detail in the text of this report, grantees may operate more than one care provider facility in more than one state.

⁴ For the purposes of this report, we refer to ORR-funded care providers and facilities as “ORR-funded facilities.”

⁵ Licon, A. G. (2021, May 5). *US awards huge shelter contracts amid child migrant increase*. AP News. <https://apnews.com/article/business-health-coronavirus-pandemic-immigration-government-and-politics-5bafc60a8040b3f16ab5d25f3471a366>.

⁶ *But see* Beitsch, R. (2021, July 7). *Contractor hired to care for migrant children has no experience in child care, whistleblowers say*. The Hill. <https://thehill.com/policy/national-security/561867-contractor-hired-to-care-for-migrant-children-has-no-experience-in>.

As of July 21, 2021, ORR reported that it funds approximately 200 state-licensed facilities and programs in 22 states.⁷ During the majority of this investigation, ORR also maintained two influx facilities in an unoccupied “warm” status, one in Carrizo Springs, Texas and another in Homestead, Florida.⁸ However, in February 2021, ORR reactivated and began placing UAC in the Carrizo Springs facility.⁹ To further accommodate the increased number of UAC apprehended by DHS in early 2021, ORR also established its first ever EIS in March 2021, and thirteen more have opened since.¹⁰

Investigative reports have detailed criticisms of ORR grantee facilities’ efforts to protect children in their care, including numerous allegations of sexual abuse, and serious questions about the financial accountability of ORR grantees. For example, in February 2019, *Axios* reported on internal documents received by Congress that showed HHS and the Department of Justice (DOJ) received thousands of allegations of sexual abuse, including almost two hundred staff-on-child allegations.¹¹ These allegations raised serious questions about whether ORR has failed to uphold its statutory duties to ensure the health and safety of children in its care. In an era when news reports have already exposed the shocking treatment of children in DHS custody, including caged housing¹² and barely supervised placement in hotels, these allegations suggest that the abuses experienced by UAC may not end even after they have been transferred to ORR’s care.

In addition, investigative reports show that the owners and operators of large networks of grantee facilities may have engaged in questionable financial management practices, such as self-dealing and excessive salaries for personal gain. For example, in December 2018, the *New York Times* reported that Southwest Key—a facility operator frequently referenced in this report—paid managers and its chief executive excessive salaries and engaged in self-dealing with regard to leased property and other for-profit services through its two Texas facilities in Conroe and Brownsville.¹³ The *Texas Tribune* also reported on the same self-dealing by Southwest Key and its officers in September 2018.¹⁴ The HHS Office of Inspector General (HHS OIG) has independently identified self-dealing with regard to facility leases, as well as excess executive compensation at Southwest Key.¹⁵

⁷ U.S. Department of Health and Human Services. (2021, July 21). *Unaccompanied Children Program Fact Sheet*. <https://www.hhs.gov/programs/social-services/unaccompanied-children/index.html>.

⁸ ORR uses the term “warm status” when a facility is not fully staffed and there are only minimal onsite facility management services.

⁹ The Homestead facility, now known as the Biscayne Influx Care Facility, remains in warm status.

¹⁰ As of August 31st, 2021, four EIS remain in operation, per communication with Department of Health and Human Services.

¹¹ Owens, C., Kight, S. W., & Stevens, H. (2019, February 26). *Thousands of migrant youth allegedly suffered sexual abuse in U.S. custody*. *Axios*. <https://www.axios.com/immigration-unaccompanied-minors-sexual-assault-3222e230-29e1-430f-a361-d959c88c5d8c.html>.

¹² Armus, T. (2020, October 30). *Unaccompanied migrant children suffer ‘inhuman and cruel experience’ in CBP custody, report alleges*. *The Washington Post*. <https://www.washingtonpost.com/nation/2020/10/30/migrant-children-border-unaccompanied/>; Harris, B. (2014, June 13). *See also* Harris, B. (2014, June 13). *Detention centers overflow with kids crossing border*. *USA Today*. <https://www.usatoday.com/story/news/nation/2014/06/13/migrant-children-housing-conditions/10402609/>.

¹³ Barker, K., Kulish, N., & Ruiz, R. R. (2018, December 2). *He’s Built An Empire, With Detained Migrant Children as the Bricks*. *New York Times*. <https://www.nytimes.com/2018/12/02/us/southwest-key-migrant-children.html>.

¹⁴ Najmabadi, S. & Root, J. (2018, September 29). *Southwest Key CEO has financial stake in property leased by migrant shelter operator*. *Texas Tribune*. <https://www.texastribune.org/2018/09/29/sanchez-part-owner-property-leased-southwest-key-programs-eller-said-a/>.

¹⁵ Office of Inspector General. (2020, September). *Southwest Key Programs Failed To Protect Federal Funds Intended for the Care and Placement of Unaccompanied Alien Children* (A-06-17-07004). U.S. Department of Health and Human Services. <https://oig.hhs.gov/oas/reports/region6/61707004.asp>.

As a result of these allegations, in May 2019, the Senate Finance Committee (“the Committee”) launched a bipartisan investigation into ORR’s management and oversight of grantee facilities.¹⁶ The principal aim of the investigation was to determine whether HHS’s oversight is sufficient to ensure facility accountability and to fulfill statutory requirements to safeguard the health and safety of UAC in the custody of the United States government and housed at ORR-funded facilities. As such, the Committee focused its efforts on ORR’s policies and procedures for overseeing the handling of sexual misconduct allegations involving children in its funded facilities.

The number of children referred by the Department of Homeland Security to ORR for care has varied dramatically over the last nine years (see Table 1). According to HHS data, between Fiscal Years 2005 and 2011, ORR served fewer than 8,000 children annually. However, ORR served 13,625 children in Fiscal Year 2012, marking the start of an ongoing increase in children seeking entry into the United States, arriving primarily from Guatemala, Honduras, and El Salvador. In 2018, the Department of Justice established a “zero tolerance” immigration enforcement policy, resulting in close to 3,000 additional children being incorrectly deemed as UAC due to family separations. Meanwhile, the number of correctly classified UAC arriving in the United States continued to increase, leading to an ORR program high of 69,488 referrals in FY 2019. The COVID-19 pandemic sharply halted UAC referrals in FY 2020. As of the date of this report, ORR is experiencing a pronounced shortage in its capacity to receive UAC, due to a combination of adjustments made to facility management taken to mitigate the spread of COVID-19, and a resumption of arrivals by migrants who paused their journeys during the COVID-19 pandemic.¹⁷

The increasing number of UAC in ORR’s care does not just mean that more children are at risk for experiencing abuses like those that have already been documented at grantee facilities. It also places strain on the system, making those abuses more likely to occur. At certain points, ORR has had to resort to sending children to EIS and influx shelters, which are neither state licensed nor overseen under standard procedures ensuring the safety and well-being of children. To safely manage facilities serving such a large number of children, it is vital that ORR maintain accurate and accessible records of children in its care and of the incidents that befall them.

Table 1. Number of Unaccompanied Alien Children Referred to the Office of Refugee Resettlement

Fiscal Year	Referrals
2012	13,625
2013	24,668
2014	57,496
2015	33,726
2016	59,170
2017	40,810
2018	49,100
2019	69,488
2020	15,381

Source: Office of Refugee Resettlement, Facts and Data, <https://www.acf.hhs.gov/orr/about/ucs/facts-and-data>

¹⁶ During the 116th Congress, the Senate Committee on Finance was chaired by Senator Grassley and Senator Wyden was the Ranking Member. This investigation continued into the 117th Congress in which Senator Wyden became Chairman of the Committee and Senator Grassley returned to the Senate’s Judiciary Committee. Through this change, the offices of both members worked diligently with each other to continue oversight of the Department of HHS in this important matter.

¹⁷ Kandel, W. (2021, April 9). *Increasing Numbers of Unaccompanied Alien Children at the Southwest Border* (IN11638). Congressional Research Service. <https://crsreports.congress.gov/product/pdf/IN/IN11638/2>.

ORR Monitoring of Safety and Well-being at Care Facilities

ORR monitors its facilities' abilities to ensure the safety and well-being of children in ORR's care in multiple ways, including desk monitoring, regular and ad hoc site visits, and reviewing significant incident reports (SIRs).

Project officers at HHS headquarters conduct desk monitoring of ORR-funded facilities primarily through emails and phone calls. Project officers also conduct monthly or quarterly site visits, which focus primarily on grantee service delivery, such as case management services.¹⁸ Ad hoc site visits are typically conducted to follow up on SIRs or corrective actions. Biennial site visits are conducted by project officers in conjunction with field staff.

When incidents of a serious or severe nature occur at ORR-funded facilities, facility staff are required to submit SIRs. Incidents that require staff to submit SIRs can range from verbal threats to allegations of sexual assault between children in care or between staff and children.¹⁹ For allegations of sexual misconduct, which includes sexual abuse, sexual harassment, and inappropriate sexual behavior, facilities are also required to report to the DOJ and State child protective services agencies.²⁰ According to ORR, incident reporting is one of the primary means by which it ensures that facilities are keeping children in their care safe.

II. ORR does not have metrics or systems in place to adequately track the performance of UAC grantees, and is not currently capable of assessing grantee performance

A. ORR Currently Utilizes a Woefully Ineffective Data Management System Known as the "UAC Portal" to Keep and Maintain the Records of the Children in Its Care; Consequently, ORR's Monitoring Is Reliant on Ad-Hoc Channels Such As Individual Employee Recollections and Email Folders

At the beginning of this investigation, the Committee submitted what it considered to be straightforward requests for easily accessible information.²¹ Instead of providing this information, HHS slow-walked productions and eventually provided the information in unusable or difficult-to-use formats, causing unacceptable and obstructive delays.

HHS first refused to provide *any* documents in a digital format and then provided *several boxes* of printed and unorganized, mostly irrelevant, documents. The documents found to be potentially relevant were, without exception, incomplete. HHS also redacted vital tracking numbers from the hard copy documents, meaning that staff were unable to link related SIRs

¹⁸ According to ORR, larger grantees such as Southwest Key, which maintains 27 facilities in three states, are typically assigned two or three project officers.

¹⁹ A longer list of what ORR may consider significant incidents can be found in ORR's Guide to Children Entering the United States Unaccompanied: <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5>.

²⁰ In 2016, ORR changed its policy to have facilities report sexual misconduct allegations directly to the Department of Justice. Prior to that change, ORR would report the allegations to Justice on behalf of the facilities.

²¹ Letter from Chairman Charles E. Grassley and Ranking Member Ron Wyden to Lynn A. Johnson, Assistant Secretary for Children and Families, Department of Health and Human Services, Administration for Children and Families (May 9, 2019), [https://www.finance.senate.gov/imo/media/doc/2019-05-09%20CEG%20RW%20to%20HHS%20ACF%20\(Grantee%20Oversight\).pdf](https://www.finance.senate.gov/imo/media/doc/2019-05-09%20CEG%20RW%20to%20HHS%20ACF%20(Grantee%20Oversight).pdf).

together, or to link SIRs to any other ORR response. The document production also inexplicably included, without context, several hundred printed pages of the Code of Federal Regulations—publicly available information that is already accessible online in an electronic format.

It is standard practice that recipients of congressional information requests, including federal agencies, provide documents to Congress in the most usable format for review available or, at the very least, in the format used by the agency. It is the position of both offices that these obstruction tactics by HHS fundamentally interfered with Congress’s Constitutional duty to conduct oversight and caused undue delays. The Committee eventually received some relevant digital documentation; however, there was little material of actual substance to review.

The limited documents produced revealed serious deficiencies in ORR’s data collection and management. ORR draws data from its *UAC Portal*, a case management system built to maintain health and safety records for *individual* children. ORR thus focuses on serious incident reports at the individual child level and does not track incidents by grantee facilities or grantees generally. ORR argues that this approach was sufficient prior to the significant increases of children referred to ORR care in recent years. The Committee cannot evaluate the accuracy of ORR’s claim with the information provided; however, it is clear this system is not effective for overseeing ORR’s facility network as it exists today, and has not been for some time. ORR requires a comprehensive, organized method for storing and accessing grantee performance information. Its current system is not adequate for delivering the oversight necessary to protect children in its care, nor to appropriately steward a federal program awarding more than \$1 billion dollars in grants per year.²²

Because of this inadequate UAC Portal, ORR’s ability to review and analyze documentation—including monitoring reports, associated corrective actions, and SIR data—is extremely limited. Discussions with ORR officials about how they monitor and track facility performance revealed that ORR has no systematic way to oversee facilities. Instead, ORR assesses facility performance and compliance with program requirements on a case-by-case basis and not by any standardized metrics. Because these reviews focus on individual incidents at each facility, they do not support easy comparisons across facilities or grantees. Moreover, they do not offer a clear picture of grantee performance as a whole or over time, particularly for grantees operating multiple facilities. It follows that this system also denies ORR the ability to provide programmatic oversight of the UAC program. Since ORR cannot amalgamate information from the multiple grantees, it cannot search for any program-wide patterns of behavior or other leading indicators.²³

Underscoring the faults of this case management approach, ORR also does *not* keep the information it collects about significant incidents and facility performance in a centralized location or format. As a result, there is no clear way for all ORR staff (including grants management staff responsible for financial oversight) to access crucial data for the purpose of conducting comprehensive oversight.²⁴ Instead, this information is stored across multiple channels, including

²² Government Accountability Office. (2020, September). *Unaccompanied Children: Actions Needed to Improve Grant Application Reviews and Oversight of Care Facilities* (GAO-20-609). <https://www.gao.gov/products/gao-20-609>.

²³ Investopedia. (2021, February 8). *Leading Indicator*. <https://www.investopedia.com/terms/l/leadingindicator.asp>.

²⁴ ORR headquarters project officers are responsible for the programmatic and technical aspects of the UAC program, including assessing applications for funding and monitoring facilities. ORR field staff—federal and contract field specialists—provide on-the-ground oversight and work directly with staff in facilities.

Excel spreadsheets and email folders. In some instances, the information is not stored at all, and program functioning relies upon the recollection of individual government employees.

In discussions with ORR staff in January 2020, officials told Committee staff that ORR organizes and keeps electronic files on all facilities by fiscal year, including email exchanges, HHS letters to facilities, monitoring reports, and corrective action plans, in a shared drive at HHS headquarters. ORR federal and contract field staff—who may also issue corrective actions for facility noncompliance—also keep their own files to document monitoring of and communications with facilities. In 2014, ORR headquarters staff began using an Excel spreadsheet to track the status of facilities’ corrective actions and responses to site visits and monitoring activities. Initially, the spreadsheet contained basic information on facility corrective actions only, but in subsequent years, staff added additional information to it. Currently, ORR staff say they can use the spreadsheet to look across multiple years of facility corrective actions. However, the spreadsheet does *not* capture any communication, technical assistance, or history of compliance or enforcement actions between the facilities and ORR staff in headquarters or its regional offices. Although ORR headquarters and field staff meet regularly (*i.e.*, weekly and monthly) to discuss facility performance, ORR officials agree that there is no central location where any staff member or contractor responsible for any part of facility oversight can go to obtain comprehensive information about facility or overall grantee performance, whether programmatic or financial.

B. Available ORR Data Are Incomplete and Allow Only For Rudimentary Analysis

ORR uses its UAC Portal for filing and storing SIRs and other child health and safety information. According to ORR officials, the UAC Portal is “child-based,” which means each record in the portal describes relevant information for a specific child. In circumstances where records involved multiple children (*e.g.*, an incident between two children), there will be two separate records within the portal explaining the incident, one for each child. As previously mentioned, ORR is unable to pull aggregate information from this data system, rendering ORR unable to perform essential reviews of its facilities.

In its May 2019 letter to HHS, the Committee originally requested data on the number of SIRs that ORR received annually from Fiscal Year 2014 to the present, broken down by year, facility, and incident type and severity, as well as copies of all SIRs and addenda that ORR received for the same time period. A breakdown of SIRs in this manner would have allowed the Committee to analyze SIR patterns across ORR operations. In its June 2019 response and during the Committee’s subsequent discussions with ORR, officials maintained that providing comprehensive SIR data for the time period requested (including copies of SIRs) was resource-intensive and not possible due to the functionality, or lack thereof, of the UAC Portal.

ORR eventually provided *some* of the requested SIR data, as the Committee received spreadsheets of monthly sexual misconduct SIRs submitted for Fiscal Year 2015 through Fiscal Year 2020.²⁵ However, the files that the Committee received were in formats inappropriate for analysis. The files did not allow data to be easily aggregated by facility or incident type and

²⁵ In August 2015, ORR began rolling up SIRs to the event level. Prior to this date, multiple SIRs may have been submitted for different children or multiple aspects of the same incident. For this reason, the Committee has focused its analyses on Fiscal Year 2016 forward.

severity. Therefore, all descriptions of SIR data in this report are the product of the Committee’s extensive manual reprocessing of SIRs. For instance, to generate a view of grantee performance over time, the Committee was required to create its own “provider codes” for the individual SIRs listed in ORR’s monthly reports, calculate sums of SIRs per provider, and then merge these data from the 72 reports covering a 6-year period. ORR would be unable to produce the analyses in this report without taking the same laborious steps.

The usefulness of ORR’s summary data is limited at best. Because codes that could be used to further explore the data are applied either inconsistently or not at all, only rudimentary analyses are possible. For example, the Committee used the SIR monthly reports to reconstruct a history of sexual misconduct SIRs, broken out by whether the encounter involved another child or an adult.²⁶ In discussion with the Committee, ORR stated that most sexual misconduct SIRs describe encounters between children. As can be seen in Table 2, this is true. However, ORR also characterized these as mostly “playful events,” such as horse play which involved “a slap on the buttocks”—but the monthly reports do not include the summary data that would be necessary to support this suggestion. Rather, individual SIR text descriptions reveal a wide range of seriousness, from incidents that may match ORR’s suggestion of playful behavior, to those involving what may be consensual sexual activity between teenagers, to cases of coercion, harassment, and abuse. Because ORR’s monthly and annual sexual misconduct SIR reports do not make these distinctions,

Table 2. Number of Sexual Misconduct SIRs Involving Another Child or Adult, By That Individual’s Association with the UAC Program

Fiscal Year	Child and Child		Child and Adult		Child and Unclear Other Individual	Total
	UAC and UAC	UAC and Non-UAC	UAC and Staff	UAC and Non-Staff		
2016	939	36	205	17	30	1227
2017	861	6	179	18	5	1069
2018	1539	29	150	11	0	1729
2019	2252	78	240	36	110	2716
2020	484	44	124	20	54	726
Total	6075	193	898	102	199	7467

Source: Office of Refugee Resettlement

²⁶ SIR monthly reports include a “Type of SIR” column containing information about the people involved in each SIR. Codes for this column typically indicate whether adults or other children were involved, whether any additional children were also in ORR’s care, and whether adults were ORR staff. When completing this section, facility staff submitting a SIR may introduce typos, use inconsistent terminology, or introduce other information. For instance, Table 2’s “Child and Unclear Other Individual” column combines SIRs classified as “UAC Other” and “Unclear.” Additionally, in October 2016, one SIR was classified as “UAC and UAC Consensual,” and in February 2020 thirteen SIRs were classified as “UAC and UAC Nonconsensual”; in no other months do these codes indicate whether an incident was consensual.

it is unclear how ORR could substantiate its apparent minimization of the seriousness of incidents involving only children.²⁷ Moreover, the Committee notes that, for nearly 200 SIRs, the monthly report did not even classify whether the incident involved another child or an adult, with the vast majority of these omissions occurring in Fiscal Years 2019 and 2020. It appears that the facility staff who submit SIRs have become less consistent in how they report this information—a trend that ORR may not have discovered on its own due to its lack of internal record keeping, but one that it should certainly address.

The HHS OIG reached similar conclusions about the accessibility and usability of ORR’s SIR data in its June 2020 report.²⁸ HHS OIG noted that its review of the information documented in the sexual abuse SIRs was “particularly illuminating” in identifying challenges. Specifically, HHS OIG found that ORR’s incident reporting system does not effectively capture information to assist ORR’s oversight of grantees’ efforts to ensure the safety of children in their care, such as whether an incident occurred while a child was in ORR’s care and whether a facility took the required steps of suspending staff and reporting allegations to appropriate law enforcement or state agencies. HHS OIG also found that ORR’s incident reporting system captures information in a manner that requires extensive manual review, a finding echoed by this report. HHS OIG concluded that the lack of useful data collection limits ORR’s oversight capacity because ORR cannot quickly and easily access this information, to elevate incidents that require immediate attention or to ensure that facilities are taking required steps to address serious incidents.

ORR is currently developing a replacement for the UAC Portal, dubbed “UAC Path”—but features that could allow for improved oversight will not be rolled out until later in 2021 at the earliest.²⁹ Based on information provided by and discussions held with ORR, however, the Committee is concerned about both the functionality of UAC Path and the timeline to implement its additional features. According to the request for proposal, UAC Path “will need to be a person-centric system . . . to connect multiple different individuals and provide a record of all individuals tied to a UAC.” ORR officials told Committee staff that the initial deployment of UAC Path will focus on a system that would allow ORR officials to continue their current work and maintain current information. In other words, UAC Path will still operate primarily on a child-based, case management model and not allow for more intensive grantee-wide or program-wide analysis.

²⁷ The SIR form does include a “Type of Incident” field for which the reporting staff member assigns an incident to one of three categories: inappropriate sexual behavior, sexual harassment, and sexual abuse. ORR intends for these labels to indicate the relative seriousness of an incident. However, the Committee’s review of individual SIR descriptions shows that different facility staff use wildly different criteria for categorizing incidents. For instance, at least one allegation that a UAC had slapped another in the buttocks was classified as “sexual abuse,” the category reserved for the most serious incidents.

²⁸ Office of Inspector General. (2020, June 17). *The Office of Refugee Resettlement’s Incident Reporting System is Not Effectively Capturing Data to Assist Its Efforts to Ensure the Safety of Minors in HHS Custody* (OEI-09-18-00430). U.S. Department of Health and Human Services. <https://www.oversight.gov/report/hhsoig/office-refugee-resettlements-incident-reporting-system-not-effectively-capturing-data>.

²⁹ Officials told Committee staff that ORR plans to incorporate facility compliance information and data, such as corrective actions, into the new portal. The new portal is also expected to offer data analysis functionality. However, officials anticipated that these functionalities would not be included until at least the second rollout of UAC Path. And that timeline is a best-case scenario: According to the Government Accountability Office (GAO), historically, information technology (IT) investments have frequently been delayed, gone over budget, or failed to contribute to their missions—so much so that GAO lists the management of IT acquisitions and operations as a high risk area for the federal government requiring additional attention. Government Accountability Office. (2021, March 2). *Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas* (GAO-21-119SP). <https://www.gao.gov/products/gao-21-119sp>.

In addition to these clear deficiencies in ORR’s record-keeping and oversight of its funded facility network, the Committee also found that out-of-network facilities do not appear to be subject to any form of ORR oversight. Committee staff asked ORR to provide information on how it oversees these providers in the original May 2019 letter. In June 2019, ORR responded that it was continuing “to work on gathering the remaining information to answer this question.” As of the date of publishing this report, ORR has still not provided this information.

As long as ORR continues to rely on data that is incomplete, spread across multiple repositories, and inconsistently labeled in ways that cannot generate meaningful summary views, it will remain unable to perform essential analyses of its operations. Consequently, ORR’s oversight of facilities and its ability to ensure the health and safety of children in its care will remain significantly limited.

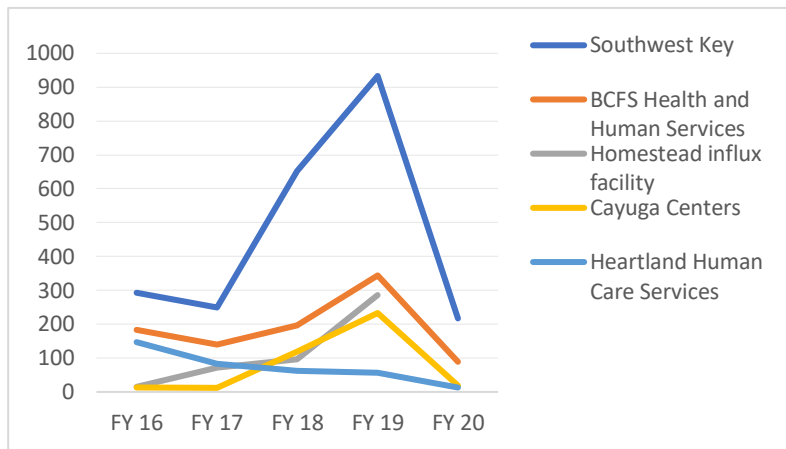
C. ORR Does Not Use the Limited Data that is Available to Assess Facility/Grantee Performance or Award Future Grants

ORR’s poor record-keeping and near exclusive focus on individual children means that it does not assess or analyze facility performance in any systematic way. This eliminates the possibility that an ORR grantee would lose or fail to receive a grant due to poor records, performance, or behavior. For instance, ORR does not use its monthly SIR reports to portray the incidence or prevalence of sexual misconduct at ORR-funded facilities, track facility responses to SIRs, or look at trends over time. ORR is thus unlikely to recognize ongoing issues that require its attention at specific facilities or grantees.

ORR prepares monthly reports that list all individual reports of sexual misconduct reported to its UAC Portal. According to ORR officials, the monthly reports it provided to the Committee are “historical” documents used to respond to congressional or other stakeholder requests for data, or to provide ORR and ACF leadership with insight into SIRs and facility responses. As such, it was never intended that UAC program staff would use the reports to review SIRs for allegations of sexual or other abuse. When the Committee requested copies of the reports, it discovered that ORR had gone many months without completing them. ORR only prepared these past-due reports at the Committee’s insistence. Because the same staff who do day-to-day review of sexual abuse SIRs are also responsible for completing these reports, becoming current on the reports took significant time—on multiple occasions, ORR told the Committee that staff would be working weekends to complete the missing monthly reports. The Committee suspects that ORR’s failure to consistently generate its own monthly reports is tied to its failure to use them for any type of internal monitoring.

The Committee’s own review of ORR’s monthly report data illustrates what sort of systematic analyses ORR could perform, if it so chose. Figure 1 depicts the number of sexual misconduct SIRs submitted between Fiscal Years 2016 and 2020 by the five grantees and contractors that submitted the most such SIRs during this period.³⁰ Southwest Key is clearly the provider responsible for the most allegations, with over 900 sexual misconduct SIRs submitted in FY 2019 alone, followed by BCFS Health and Human Services, the Homestead shelter, and Cayuga Centers, each submitting more than 200 in the same year. To put these numbers in context, during FY 2019, forty-two providers submitted at least one sexual misconduct SIR; of these, the median number of submitted reports was 17. The high rankings of the providers depicted in Figure 1 should trigger more in-depth oversight at multiple levels (*i.e.*, of both the individual facilities run by these providers and of their centralized operations). Moreover, it is also notable that Homestead—an Influx Care Facility operated by Comprehensive Health Care Services, Inc.—reported 286 allegations alone in FY 2019. Given that Influx Care Facilities are not required to meet state licensing standards, ORR should be particularly vigilant and attuned to statistics like these, to determine whether or not these temporary facilities perform better or worse than those in ORR’s permanent network.

Figure 1. Number of Sexual Misconduct SIRs Submitted by Selected Providers



The five depicted providers submitted the most sexual misconduct SIRs across Fiscal Years 2016 – 2020. Note that Homestead did not operate in Fiscal Year 2020.

Source: Office of Refugee Resettlement

Just as importantly, the Committee’s examination of SIR reporting trends immediately revealed what additional data is essential for proper systematic analyses of grantee and contractor performance: an index of how many children were in care at each facility.³¹ Committee staff were unable to determine whether sexual misconduct at larger facilities occurred at significantly higher rates than at smaller facilities, or even the overall rate of sexual misconduct across facilities.

³⁰ As described earlier, these data were derived from the Committee’s reprocessing of ORR’s monthly SIR reports.

³¹ A similar analysis would be to examine the relation between SIRs and funding. For instance, in FY 2019, Southwest Key submitted 2.71 times as many SIRs as the next highest grantee, BCFS; however, Southwest Key only received 2.06 times the funding. Although such statistics might be useful for future funding decisions, based on conversations with HHS grants management and ORR, it is unclear whether they are ever calculated or considered.

Without such analyses, ORR may miss opportunities to develop trainings or take targeted actions to reduce instances of sexual misconduct.³²

III. Despite the Alarming Lack of Adequate Data, the Committee Found Several Additional Concerning Issues with the UAC Program

A. Sexual Abuse Allegations and Other Critical Records Are Not Tracked Effectively

ORR's Prevention of Sexual Abuse Team is tasked with reviewing SIRs to help ensure that ORR-funded facilities are following protocols for responding to and reporting allegations of sexual abuse to required federal and state entities. However, ORR's process for resolving sexual abuse allegations and other serious incidents makes this work difficult. Using the UAC Portal, ORR is neither able to properly track incoming allegations, nor to ensure that appropriate actions have been taken after receiving them.³³

The Committee found that the case management approach and lack of any formal or centralized system to submit and review SIRs can reduce situational awareness. Crucial information may slip through the cracks, leaving necessary actions untaken. For example, during a discussion in June 2020, ORR's Prevention of Sexual Abuse Team was unable to provide Committee staff with an estimate of the average number of sexual abuse allegations they receive weekly. In addition, Committee staff used SIR data that ORR provided to identify allegations that had been categorized as sexual abuse but for which there was no record that the allegation had been reported to required authorities, such as local law enforcement, state child service agencies, or DOJ. ORR explained that this finding was due to failure in updating records in the UAC Portal

³² To illustrate, if a facility reports an average of six sexual misconduct SIRs per month, very different responses may be necessary when the number of children in care is eight versus 300. Similarly, trends over time are only informative when paired with an appreciation for fluctuations in the number of children referred to ORR. The decline of allegations in FY 2020 is due to the dramatically lower number of children in ORR's care during the COVID-19 pandemic (see Table 1), rather than any network-wide improvements in facility operation.

³³ Prior to August 2017, facilities were expected to send sexual abuse SIRs to individual ORR employees' email inboxes. In August 2017, ORR established a shared email inbox for its prevention team, in order to have a "central" location for receiving facilities' reports. Officials also told the Committee that ORR confirms that facilities are appropriately reporting allegations of sexual abuse to DOJ and HHS's Office of Inspector General (OIG) by assuring that these two entities are included as recipients on the emails submitted to the prevention team. The team also uses the email inbox to document conversations with, and technical assistance given to, facilities. ORR officials told Committee staff they monitor the inbox seven days a week to answer facility questions or provide technical assistance for handling allegations. Reports that do not meet ORR's definition of sexual abuse but are categorized as sexual harassment or inappropriate sexual behavior are sent to field specialists, project officers, and case managers, as well as submitted to the UAC Portal, ORR's child database. Field specialists determine whether SIRs need to be re-categorized as sexual abuse, submitted back to the Prevention of Sexual Abuse Team, and forwarded to appropriate law enforcement agencies.

and was able to provide the Committee with further information on these allegations but *only* by searching the Prevention of Sexual Abuse Team’s email inbox.³⁴

Officials from ORR’s Prevention of Sexual Abuse Team told Committee staff in July 2019 that the team developed an incident review process requiring facilities to complete an incident review form. Intended to supplement information on the more limited SIRs, the form includes a description of the alleged sexual abuse or related allegation and provide details on the facility’s response. The form also establishes a timeframe for facilities to follow up on potential investigations. As part of their review of these forms, ORR officials will follow up with facilities to ensure the information provided is accurate and complete. Like other aspects of ORR’s activity, submission, review, and any required follow-up for these written reports is both conducted and recorded by email.

Organizational problems are also evident in ORR’s procedures for tracking facilities’ progress toward corrective actions. Because ORR maintains separate records for issues identified during regular monitoring visits and those identified separately by ORR field staff, there is no single list of all current actions a facility has been required to take. Moreover, because ORR closes out corrective actions when providers submit a plan to address them (as opposed to confirming the fixes occurred), it does not know what steps have actually been implemented. Altogether, it appears that a facility could drag its heels on implementing required changes and ORR might not pick up on this for a considerable length of time.

B. The COVID-19 Pandemic Further Demonstrates That ORR Does Not Conduct Effective Monitoring to Ensure the Physical Health of Children in its Care

The COVID-19 pandemic has massively disrupted operations in the UAC program. As of August 26th of this year, 12,488 unaccompanied children in state-licensed, ORR-funded facilities have tested positive for COVID-19, and there have been 9,275 cases among unaccompanied children at Emergency Intake Sites. Most have either recovered or are on their way to recovery, with no reported deaths. There have been 1,680 self-reported COVID-19 cases among personnel affiliated with ORR programs at licensed facilities and 716 cases among personnel affiliated with Emergency Intake Sites.³⁵

³⁴ The Committee also found that ORR’s incident review system seriously hampers its ability to investigate ongoing problems at specific facilities. We requested information on any SIRs that might reflect the allegations of abuse and neglect of children in the care of specific facilities cited by news outlets, such as the Heartland Alliance Guadalupe facility in 2018, as reported in May 2020 by the *Washington Post*. An ORR official told Committee staff that ORR reviewed a total of 91 SIRs for the Heartland Guadalupe facility, where the incidents were reported to have taken place, from May 1, 2018 through August 31, 2018, using details from the news article (including apprehension date, initials, siblings, sponsor location, separation). However, they were unable to identify any SIRs that covered the allegations made in the article. The official suggested that, based on Heartland’s statement denying the accusations, it was possible that facility staff were never made aware of the allegations and never documented them in SIRs. Yet, Heartland’s findings from its own internal investigation state that it reported the allegations to ORR upon their discovery. This example demonstrates the inability of ORR to properly monitor or address serious facility-level problems using its current record-keeping system.

³⁵ COVID-19 data provided by Department of Health and Human Services. Statistics for licensed facilities are current as of August 26th, 2021; statistics for EIS are current as of August 25th.

Between March and June 2020, HHS OIG surveyed 11 ORR-funded facilities and determined that they were prepared to respond to the COVID-19 pandemic.³⁶ According to this report, these care providers already had policies and procedures in place for infectious disease management based on ORR's pre-existing facility requirements, as well as the capabilities to quarantine children suspected or confirmed to have the novel coronavirus. When the pandemic struck, ORR provided guidance specific to COVID-19, in both written format and in consultation with facilities. ORR also encouraged facilities to make use of telehealth resources, and updated the UAC Portal to include fields for UAC travel histories, COVID-19 laboratory testing, and COVID-19 diagnoses. When facilities enter positive cases into these fields, ORR staff receive a notification to initiate follow up.

However, because the HHS OIG report is based on surveys sent early in the pandemic, its assessment does not cover ORR's response as COVID-19 cases continued to sweep through the nation, through 2020 and 2021. For instance, the report lists three of the eleven surveyed facilities as having only one to three quarantine or isolation rooms. By July 9, 2020, one week after the report's data collection ended, ORR reported only 80 laboratory-confirmed COVID-19 cases among children in its care. Given the huge increase in ORR's case counts since that time, it is clear that many facilities became overwhelmed. In its January 15, 2021 announcement that it was considering reactivating the Carrizo Springs influx facility, ORR acknowledged that COVID-19 restrictions had contributed to its current capacity problems. To avoid similar situations in the future, ORR must rethink how it can maintain a permanent facility network that can accommodate both rapidly increasing referrals and a sudden loss of bed-space due to medically necessary guidelines such as quarantine requirements and social distancing.

Moreover, the Committee's own investigation of ORR's response to the COVID-19 pandemic reveals several areas of concern not addressed in the HHS OIG report. Much like the oversight of significant incidents and facility performance, Committee staff found ORR's monitoring and oversight efforts for COVID-19 to be passive and inefficient. For instance, although ORR requires facilities to report cases of COVID-19 among children in its care, it does *not* require them to report cases among facility staff. ORR officials told Committee staff that ORR-funded facilities have voluntarily informed ORR when facility staff test positive for COVID-19. Yet, ORR officials stated that they do not feel ORR can require facilities to report staff test results without violating privacy regulations. According to ORR officials, if a facility reports to ORR that an employee tested positive for COVID-19, ORR would ensure that the facility contacts the local health department to begin contact tracing and likely stop placements at the facility. However, if facilities do *not* report positive employee cases, ORR *could* continue to place children at the facility, risking their health and safety, as well as the health and safety of the facility employees.

³⁶ Office of Inspector General. (2020, November). *Office of Refugee Resettlement Ensured That Selected Care Providers Were Prepared to Respond to the COVID-19 Pandemic* (A-04-20-02031). U.S. Department of Health and Human Services. <https://oig.hhs.gov/oas/reports/region4/42002031.asp>.

IV. ORR Does Not Have a Clear and Consistent Framework for Taking Actions Against “Problem” Grantees

A. ORR Short-term and Long-term Responses to Sexual Abuse Allegations and Other Threats to Children in Its Care Are Inconsistent

Southwest Key, Inc. is by far the largest provider of care for the children in ORR custody. The company currently operates 17 facilities in Texas, eight in Arizona, and two in California.³⁷ In Fiscal Year 2019, it received over \$600 million in UAC program funding across all of its facilities.³⁸ As noted earlier, it also reported the worst annual record of sexual misconduct SIRS between 2016 and 2020, from among all of ORR’s grantees. However, since at least Fiscal Year 2014, Southwest Key has *not been subject to any punitive actions* by ORR that halted its operations to a large degree, despite a history that calls into question its ability to keep each and every child safe and healthy.

The Committee found that ORR has an inconsistent record of taking protective actions following sexual abuse incidents at Southwest Key facilities. Of the many such incidents, the Committee obtained evidence that ORR initiated stopping placements of new children at a facility in only a single case. In 2017, after a child alleged sexual abuse by a youth care worker at Southwest Key Kokopelli in Mesa, Arizona, ORR transferred the facility’s 93 children elsewhere and stopped new placements until the facility demonstrated satisfactory corrective actions. This response stands in stark contrast to ORR’s more limited response to similar events—even those that also involved sexual abuse or other serious problems.

For instance, youth care worker Oscar Trujillo was convicted in 2017 for sexual abuse of a minor that occurred in April 2015 at Southwest Key Estrella del Norte in Tucson, Arizona.³⁹ Although Trujillo was arrested soon after the incident was uncovered, ORR did not stop placements at Estrella del Norte while it ascertained what had happened. In yet another case, youth care worker Fernando Magaz Negrete was arrested in July 2018 following an allegation of inappropriate sexual contact with a minor at Southwest Key-Campbell in Phoenix, Arizona.⁴⁰ According to ORR, Negrete was no longer employed at Campbell when the abuse was disclosed. However, Negrete’s arrest came after Arizona had identified Southwest Key’s noncompliance with background check requirements, raising questions about what other risks its lax operations might have introduced. ORR reported to the Committee that, in response to the Negrete “incident,” another youth care worker was fired, all staff were retrained on sexual abuse reporting and professional boundaries, new staffing plans were implemented to decrease individual or single staff being alone with children, and new cameras were added in hallways to access blind spots. However, at no point did ORR stop placing children at this facility or move children from the

³⁷ Southwest Key Programs. (n.d.) *Sheltering, caring, and reunifying*. Retrieved June 11, 2021, from <https://southwestkey.org/shelters/>.

³⁸ Tracking Accountability in Government Grants System. U.S. Department of Health and Human Services. <https://taggs.hhs.gov>.

³⁹ Philip, A. (2018, July 25). *Police reports tell of sexual abuse, harassment at Arizona facilities for migrant children*. AZ Central. <https://www.azcentral.com/story/news/local/arizona-investigations/2018/07/25/southwest-key-migrant-facilities-see-sex-abuse-harassment-allegations/742133002/>.

⁴⁰ Casey, M. (2019, May 3). *Will former Phoenix Southwest Key Worker Accused of Sex Crimes Take Plea Deal?* Fronteras. <https://fronterasdesk.org/content/920166/will-former-phoenix-southwest-key-worker-accused-sex-crimes-take-plea-deal>.

facility. It is not obvious from the documents Committee staff reviewed how ORR determines when it is necessary to pause placements after sexual abuse allegations arise.

Serious problems have also been observed at Southwest Key facilities in Texas—and again the Committee found that ORR’s responses have been inconsistent and fallen short. In June 2018, the *Texas Tribune* reported that over the past three years, Southwest Key had incurred at least 310 state violations across its 15 Texas facilities, including failure to conduct background checks.⁴¹ That same month, it was reported that Ernesto Padron, a case manager who worked directly with children in Southwest Key’s Casa Padre facility until his 2017 resignation, had been arrested in 2010 for possession of child pornography.⁴²

As recently as April 2020, Texas Health and Human Services cited the Casa Padre facility with three violations related to child health and safety and professional boundaries. The state found that multiple employees were involved in inappropriate activities and relationships with children in care and “[t]rained employees failed to use prudent judgment” when they provided a child with a cell phone, money, and a runaway plan and sheltered a child for three months. The Committee’s review of ORR’s sexual misconduct SIR monthly report for April 2020 does not contain any items for Casa Padre that reflect these violations.

These troubling examples indicate that ORR does not consistently respond with the appropriate actions needed to protect the children in its care. As discussed previously, the most critical issue is that ORR simply does not have a transparent, comprehensive framework for deciding what actions to take after violations of a particular severity, number, and frequency are exposed.

B. ORR’s Records of Facility Problems and Its Own Actions are Incomplete

The Committee found that ORR does not maintain accurate records of stopped placements at its funded facilities. This was most evident in our review of widespread misconduct by Southwest Key facilities in Arizona. In 2018, the Arizona licensing agency conducted inspections of the 13 Southwest Key facilities licensed by the state. According to a September 2018 letter from the director of the Arizona Department of Health Services, Southwest Key facilities had not been complying with the state’s requirement to conduct background checks on their employees—a requirement of the UAC program as well.⁴³ Because Southwest Key had made no progress resolving this issue, even after extensive communication with state officials, the letter indicated that the state would be sending legal notices of intent to revoke the licenses of all 13 Southwest Key facilities. After a negotiated settlement, the state ultimately fined Southwest Key \$73,000,

⁴¹ Walters, E., Murphy, R., & Cameron, D. (2018, June 20; updated 2019, December 20). *The number of migrant children in Texas shelters dropped dramatically in 2019*. *Texas Tribune*. <https://apps.texastribune.org/features/2018/texas-migrant-children-shelters/>.

⁴² The case was later dismissed after a years-long case backlog allowed the statute of limitations to expire; Reigstad, L. (2018, June 20). *Southwest Key Hired Child Case Manager Previously Arrested for Child Pornography*. *TexasMonthly*. <https://www.texasmonthly.com/news/southwest-key-hired-child-case-manager-previously-arrested-child-pornography/>.

⁴³ 12 News. (2018, September 19; updated 2018, September 20). *Arizona health director slams Southwest Key as state moves to revoke operating license*. 12 News. <https://www.12news.com/article/news/politics/licenses-for-arizonas-southwest-key-facilities-for-migrant-children-to-be-revoked/75-596416459>.

closed two of the Arizona facilities, and froze admissions to the remaining eleven facilities until Arizona DHS determined that they were no longer out of compliance or dangerous to children in care.⁴⁴ ORR reported to the Committee in June 2019 that it stopped placing children at six of the Arizona Southwest Key facilities after the state licensing agency inspections revealed the lack of background checks. However, no facilities meeting this description appeared on a list that ORR provided to Committee staff in August 2020 of all instances in which it stopped placements or removed children from care facilities from Fiscal Year 2014 onward.

This example and others raise serious questions of ORR’s inability to keep accurate records of serious incidents and the adequacy of guidance it provides to facilities. They also indicate that ORR does not effectively wield the protective actions in its toolbox, such as stopped placements, to ensure child safety. Without a clear and comprehensive view of its own records, or how it has addressed instances of repeated grantee failures in the past, the Committee is unsurprised that ORR consistently fails to respond in a way that would protect children from abuse by those charged with their care.

C. ORR Does Not Consistently Coordinate with Federal, State and Local Agencies

ORR appears to act inconsistently when notified of state and local findings of violations. Even when the nature or frequency of violations is severe or ongoing, ORR may not proactively engage with them. It is unclear how much of this inconsistency is deliberate and how much derives from ORR’s limited knowledge of other agencies’ actions. For instance, as reported by the GAO, ORR did not reach out to Arizona licensing officials to learn about the deficiencies in Southwest Key’s facilities until after media reports exposed the prevalent abuses.⁴⁵

The inconsistency of ORR’s actions against facilities is partly attributable to its poor awareness of enforcement activities by state and local officials. ORR officials told the Committee that if a state is going to require facilities to take corrective actions as a result of state monitoring activities, it will typically reach out to ORR. They cited Texas as a state that has informed ORR of its actions against facilities. Additionally, ORR officials explained that facilities themselves are required to report to ORR any actions states may take against them. However, ORR’s reliance on voluntary reports by states and on facility operators to inform them of their own failures is hardly sufficient to ensure that ORR is notified of problems in a timely fashion.

In communication with the Committee, ORR characterized state licensing actions as its “first line of defense.” Yet, a September 2020 GAO report found a total disconnect between these agencies and ORR. GAO investigators surveyed the 23 state agencies that licensed ORR-funded facilities in Fall 2019. Of these licensing agencies, 12 did not regularly inform ORR of their monitoring reports or findings, 11 did not contact ORR when significant issues arose, and zero reported that ORR regularly shared its monitoring reports with them. According to the report, several officials at state licensing agencies stated that ORR would benefit from greater awareness of their work. In its response to the GAO report, ORR claimed it would explore possible

⁴⁴ KOLD News 13 Staff. (2018, October 24). *Southwest Key to pay fine, agrees to surrender licenses for two programs in Phoenix*. KOLD News 13. <https://www.kold.com/2018/10/24/southwest-key-pay-fine-agrees-surrender-licenses-two-programs-phoenix/>

⁴⁵ Government Accountability Office. (2020, September). *Unaccompanied children: Actions needed to improve grant application reviews and oversight of care facilities* (GAO-20-609). <https://www.gao.gov/products/gao-20-609>.

improvements to its communications with state agencies, but offered no concrete proposal or timetable. To the Committee’s knowledge, ORR has made no changes in this regard.

It also appears that ORR’s communication problems are not limited to its coordination with state and local agencies. When the Committee inquired about an incident at the Rite of Passage facility in Arizona, already under investigation by the FBI, ORR confirmed that direct communication between ORR and DOJ for sexual abuse investigations is erratic and often does not occur.

D. ORR Does Not Properly Consider Grantees’ Past Performance When Awarding New Grants

Recent investigations by the HHS OIG, GAO, and Senate Permanent Subcommittee on Investigations (PSI) have examined ORR’s process for awarding grants for the operation of facilities housing UAC.⁴⁶ All three investigations arrived at similar conclusions: ORR’s grant-making process is deeply flawed, often failing to take relevant information into account when choosing providers and to establish clear guidance for grant applications and facility administration. Although this Committee’s investigation centered on how ORR addresses issues arising at facilities already in operation, our conclusions about ORR’s failures of oversight have clear parallels with these previous findings.

The HHS OIG examined the process by which ORR awarded a \$341 million sole source contract to Comprehensive Health Service, LLC (CHS) to operate the Homestead temporary influx shelter. The investigators determined that ORR did not use all available data metrics to anticipate future bed capacity needs, unnecessarily creating a situation of “unusual and compelling urgency” that ORR then used to justify its decision to bypass a full, open grant competition. Further, HHS OIG also criticized ORR for lacking a transparent, standardized decision-making framework for determining when to downgrade a facility from fully operational to “warm” status, a minimally staffed arrangement appropriate for facilities not currently housing any children. By relying on their subjective judgments rather than objective metrics, ORR officials introduced inconsistency to their decisions. In the case of the Homestead shelter, ORR paid close to \$67 million to operate the facility at full staffing levels for nearly 3 months after the last child had left.

Both GAO and the PSI examined the extent to which ORR has considered a grant applicant’s ability to operate facilities safely—or even at all. After reviewing ORR’s grant application solicitation and review for Fiscal Years 2018 and 2019, GAO determined that ORR’s guidance to applicants was unclear in several critical areas. Applicants rarely disclosed any information about adverse actions taken against them by state or local officials, including instances in which their facilities had been closed due to abuses or unsafe conditions experienced by children

⁴⁶ Office of Inspector General. (2020, December). *The Office of Refugee Resettlement Did Not Award and Manage the Homestead Influx Care Facility Contracts in Accordance with Federal Requirements* (A-12-20-20001). U.S. Department of Health and Human Services. <https://oig.hhs.gov/oas/reports/region12/122020001.asp>; Government Accountability Office. (2020, September). *Unaccompanied Children: Actions Needed to Improve Grant Application Reviews and Oversight of Care Facilities* (GAO-20-609). <https://www.gao.gov/products/gao-20-609>; U.S. Senate. Permanent Subcommittee on Investigations. (2020, December). *Oversight of HHS Shelter Grants For Unaccompanied Alien Children* (staff report). <https://www.hsgac.senate.gov/imo/media/doc/2020-12-08%20PSI%20Staff%20Report%20-%20Oversight%20of%20HHS%20Shelter%20Grants%20for%20UACs.pdf>.

in their care. Applicants also were not required to hold state licenses to operate the proposed facilities at the time of application. Moreover, GAO concluded that ORR project officers' investigation into applicants' licensing statuses or histories of caring for children was not formalized and inconsistent at best; for example, ORR did not even require its officers to examine ORR's own documentation of applicants' past performance as grant recipients. The PSI investigation reached similar conclusions.

Both the GAO and PSI reports also included numerous examples in which problematic grantees were awarded new grants. For instance, GAO highlighted that ORR awarded continuation grants to Southwest Key even after Arizona state officials initiated plans to shutter its facilities statewide following sexual abuse and other ongoing risks to children. When asked by GAO, ORR would not comment on whether it had considered these issues during its later grant decisions. Further, the PSI report provides in-depth examinations of questionable grants awarded to two specific providers.

The Committee finds many common themes between its observations and the conclusions reached by the HHS OIG, GAO, and PSI reports. Based on data provided to the Committee, ORR has not systematically collected information essential to the fulfillment of its own responsibilities, has not tracked serious allegations against facility operators, and has not consistently used available data to administer the UAC program in ways that safeguard the children in its care. Although ORR has recently begun taking limited steps to address the issues flagged by these other investigations, the parallel flaws in ORR's grant administration and facility oversight suggest a need for more widespread, permanent improvements in its policies and practices.

V. Conclusion

At the highest levels (at least from 2014 to 2020), HHS leadership, over multiple administrations, failed to ensure that ORR and its grantees adequately maintained the basic records and statistics necessary to oversee the grantee and contractor organizations charged with caring for UAC. This lack of oversight at the facility, grantee/contractor, and programmatic levels has led to the inability to track problematic patterns of behavior and other potential leading indicators that could highlight current issues and foreshadow future problems. This failure has made it impossible for both the agency and Congress to assess the adequacy of care that is being provided to children who are wards of the federal government. Additionally, HHS's blatant obstruction of this Committee's bipartisan investigation needlessly delayed this investigation and thus further delayed ORR from addressing the multitude of concerns described here, many of which directly or indirectly relate to the safety and well-being of minors that have been separated from their families due to events far beyond any child's control. As of the date of this publication, the issues within this report continue and to the committee's knowledge little progress has been made by HHS towards substantive and fundamental solutions.

Timeline of Congressional Request and Investigation

- **August 28, 2018:**
Lynn Johnson confirmed by the Senate as ACF Assistant Secretary. Johnson makes commitment to Senator Wyden to conduct a full review of the oversight, staffing, training, medication, and licensing policies for ORR-funded facilities within 90 days of her confirmation, with a due date of December 4, 2018.
- **December 12, 2018:**
Senator Wyden receives written summary of ORR policy and procedures from Assistant Secretary Johnson, which did not examine or identify potential oversight programs of ORR grantees as promised.
- **December 12, 2018:**
Members of Senator Wyden’s staff hold call with ORR on UAC facility and contractor oversight.
- **February 25, 2019:**
HHS OIG/ACF briefing focused on Southwest Key (Wyden staff only).
- **March 29, 2019:**
Bipartisan ORR briefing for Wyden and Grassley staff. HHS/ASL staff advise Committee to submit requests for data in writing.
- **May 9, 2019:**
Committee sends bipartisan ORR oversight letter to Assistant Secretary Johnson, with a due date of May 31st.
- **June 27, 2019:**
Committee receives partial response to oversight letter with missing attachments.
- **August 8, 2019:**
Committee holds call with ORR to discuss delay in full response and understand challenges with producing requested documents.
- **August 28, 2019:**
Committee receives box of documents with little to no context (Production 1), very few of which answer the Committee’s May 9th request.
- **October 1, 2019:**
Committee sends follow-up letter to Assistant Secretary Johnson explaining that previous responses and document production were inadequate, woefully incomplete, and approaching the point of noncompliance, with a due date of October 15th for outstanding information.
- **October 7, 2019:**
Committee staff view UAC Portal at ORR offices.
- **October 9, 2019:**
Committee staff follows up with HHS/ASL outlining “test” data pull for SIRs.
- **October 17, 2019:**
HHS/ASL informs Committee that it is necessary to further narrow scope of our request for SIR data.

- **October 25, 2019:**
Committee narrows scope of data pull for sexual abuse SIRs and UAC census and financial information (which is yet to be produced).
- **November 1, 2019:**
Committee receives *second* box of documents (Production 2), very few of which answer the May 9th request.
- **November 4, 2019:**
Committee holds call with ORR to discuss outstanding request. ORR refuses to provide documentation in a useable format.
- **November 6, 2019:**
ORR informs Committee that it produces monthly sexual abuse reports; Committee requests those reports for Fiscal Year 2014 through present.
- **December 16, 2019:**
Committee receives *another* box of documents (Production 3), but still no updated letter response as requested in the October 1st follow-up letter, or data from narrowed scope.
- **December 19, 2019:**
Committee meets with ORR and Office of Grants Management officials for in-person briefing.
- **January 7, 2020:**
Committee staff meets with Sarah Arbes, nominee for the position of HHS Assistant Secretary for Legislation (ASL), in advance of nomination hearing and raises non-response issues. Ms. Arbes attributes significant delays for the non-responsiveness to the HHS General Counsel's office.
- **January 14, 2020:**
Committee meets with ORR officials to discuss monitoring activities.
- **January 15, 2020:**
Committee meets with then-HHS General Counsel Robert Charrow to discuss the reasons for the Department's failure to respond to this and other investigations. HHS officials promise that the Department will promptly complete data production to the Committee's satisfaction.
- **January 21, 2020:**
HHS sends a new set of documents in CD format (Production 4).
- **January 30, 2020:**
Committee staff holds call with HHS ASL officials to continue to discuss information request and SIR data pull. HHS continues to equivocate about its willingness to provide Committee with useable (*i.e.*, searchable, sortable) electronic documents.
- **February, 2020:**
HHS finally begins to provide searchable PDFs of all prior productions, shared separately throughout the month.
- **February 3, 2020:**
Committee holds call with ASL and ORR to discuss revised SIR data request and time frame for getting data.

- **February 10, 2020:**
Committee holds call with ASL/ORR to discuss revised SIR data request and time frame for getting data.
- **February 26, 2020:**
Committee meets with ORR for demonstration of HHS grants management databases.
- **March 6, 2020:**
Committee meets with ORR to discuss UAC program.
- **March 18, 2020:**
Committee holds call with ORR to discuss COVID-19 response at ORR-funded facilities.
- **April 29, 2020:**
Committee holds call with ORR to discuss any updates to COVID-19 response at ORR-funded facilities.
- **June 9, 2020:**
Committee holds call with ORR Prevention of Sexual Abuse Team to discuss responses to sexual misconduct SIRs.
- **June 30, 2020:**
Committee holds follow up call with ORR Prevention of Sexual Abuse Team to discuss specific SIRs.