



By Email

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Washington, DC 20510

Office of Inspector General
U.S. Department of Health & Human
Services
330 Independence Avenue, SW
Washington, DC 20201

July 28, 2021

Re: **Second** Protected Whistleblower Disclosures of Gross Mismanagement by
the Department of Health and Human Services at Fort Bliss, Texas
Causing Specific Dangers to Public Health and Safety

To Whom It May Concern:

This is Government Accountability Project’s second protected whistleblower disclosure concerning abuses and mismanagement at the Fort Bliss Emergency Intake Site (EIS) operated by the Office of Refugee Resettlement (ORR). This letter supplements our first disclosure, dated July 7, 2021, detailing harm to unaccompanied immigrant children caused by ORR’s and its private contractors’ gross mismanagement. A copy of the July 7 letter is attached as Exhibit 1.

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Evidence from Additional Whistleblowers

We now represent Arthur Pearlstein and Lauren Reinhold. They are career federal civil servants and served as volunteer detailees at the Fort Bliss EIS from April through June 2021. They are also whistleblowers.

Mr. Pearlstein is the Director of Arbitration and of the Office of Shared Neutrals at the Federal Mediation and Conciliation Service (FMCS). Ms. Reinhold is an Attorney-Advisor at the Social Security Administration (SSA). Mr. Pearlstein was posted to Fort Bliss for two months (between April and June 2021), Ms. Reinhold one month (May 2021). Mr. Pearlstein was primarily assigned to work on two teams while at Fort Bliss: performing clinical assessments on the Clinical Assessment Team; and working with small groups and individual children on the Mental Health/Wellness team. Ms. Reinhold worked in the girls’ tent for the first half of her detail; and, during the second half, was on the Call Center Team, and worked in all tents.¹

More About Fort Bliss Private Contractors

Servpro

In our July 7 disclosure, we described the dominant roles played by private contractors, in particular Servpro, which staffed the dormitory tents for boys and girls. Servpro is a company specializing in helping individuals, organizations and communities recover from disasters. Childcare is not among its portfolio of services. Following our July 7 disclosure, Servpro told the media: “When we became aware of this issue [(no childcare experience)], we immediately advised the franchise operator that these are not approved Servpro service offerings. ... We have been informed by the franchise operator that it is no longer providing these services through the Servpro franchise.”² This seems to be Servpro’s way of saying the franchisee and its employees

¹ The views expressed here do not reflect any policy or position of the FMCS or the SSA.

² NBC News, *Whistleblowers Allege Poor Care for Migrant Kids by Contractor Specializing in Disaster Cleanup* (June 7, 2021), available at <https://www.nbcnews.com/politics/immigration/whistleblowers-allege-poor-care-migrant-kids-contractor-specializing-disaster-cleanup-n1273124>.

continue to work at Fort Bliss, just not under the Servpro brand.

In any event, we have since obtained additional information about other private contractors who played significant roles at Fort Bliss and at other EIS's. Like Servpro, they appear to have no background in childcare. Moreover, like Servpro it appears that these contractors were hired without going through any bidding process such as that ordinarily required under the Federal Acquisition Regulations applicable to federal contracts.

Chenega Corporation

When the federal detailees arrived at Fort Bliss in April and May 2021, Chenega was the contractor most spoken of. According to its website, Chenega Corporation is an Alaska Native village corporation which "figures prominently in the diverse government services contracting marketplace supporting defense, intelligence, and federal civilian customers. This business model is executed through a family of companies under four strategic business units."³ The four units are: Environmental Healthcare and Facilities; Military, Intelligence and Operations Support; Professional Services; and Security. Chenega appears to have no childcare experience.

In April 2021, Chenega had primary responsibility for all case and all tent management. They were also given responsibility for the clinical mental health program and other functions. However, in May 2021, Servpro staff replaced Chenega staff to monitor children in the dormitory tents while Chenega continued its other activities. Servpro tent managers falsely assured detailees that the company was involved in this type of work in various parts of the country.

According to our clients, it was not clear which contractor (Chenega or Servpro) was less suited to the work -- it appears neither had experience with it, nor did they perform competently or appropriately. Contractor employees told detailees that to get their jobs, they did nothing more than submit basic employment applications. There was no follow up or vetting process, no interviews or even phone calls prior to being offered their jobs and asked when they could start. Ms. Reinhold further reports that she learned during the last week of May that Chenega and Servpro staff on site were only then undergoing background checks, en masse. Apparently, these checks were not done earlier, before they started to work around children.

Rapid Deployment Inc.

While Chenega and Servpro had significant roles at Fort Bliss, the lead contractor appears to have been Rapid Deployment Inc. (RDI). Like Chenega and Servpro, RDI has no childcare experience.

According to its website, RDI specializes in base camp deployment and related support.⁴ Reportedly, RDI initially received two large contracts totaling \$614 million to manage the Fort

³ *Chenega Capabilities*, available at <https://www.chenega.com/capabilities/>.

⁴ <https://rapideployment.net/index.html>.

Bliss EIS.⁵ According to USAspending.gov, the official source for spending data for the U.S. Government, contracts awarded to RDI for this work have since been extended and modified so that obligations to RDI will total around \$1 billion. Prior to this engagement, it appears that between FY2008 and FY2019 RDI was awarded government contracts in only three of these fiscal years, in annual amounts not exceeding \$13 million, a small fraction of the Fort Bliss obligation.⁶ Our clients report that RDI was unknown to virtually all the detailees at Fort Bliss, other than to a few who briefly dealt with RDI employees who staffed an operations trailer.

Organizational Chaos

We provide here additional information about gross mismanagement, gross waste, and abuse of authority at the Fort Bliss EIS.

Domination by Private Contractors

According to our clients, private contractors – not federal employees – were essentially in charge of virtually all functions. Detailees were frequently told that their main mission at the facility was to pave the way for contractors to take over the operation, and that they were essentially there to assist the contractors.

Federal detailees witnessed significant waste, fraud and abuse. When they attempted to express their concerns to federal managers they were told -- time and again -- it was the contractors that were in charge and government employees needed to be responsive to the contractors' needs. The contractors ignored or rejected most detailee concerns.

For example, the shortage of underwear and other clothing for children has been widely reported. The problem persisted for weeks and months. Countless children reported these shortages to detailees. Boys said they had no underwear at all, while most simply had only one pair with nothing to change into.

Detailees insisted that the children be supplied with underwear. Each time the answer was that shipments had not come in. Whenever detailees brought it up, they were told it was the contractor's responsibility. Detailees, private contractors and managers were well aware of the problem. At one meeting a Chenega manager told detailees: "we are aware there is a shortage of underwear, socks, and shoes, and management knows."

Abdication by Federal Managers

Compounding private contractor failings, federal employee managers -- time and again -- failed to act. For example, detailees, including Mr. Pearlstein, suggested to senior federal management

⁵ AL.com, *Alabama Company Gets \$614 Million Contracts to House Child Immigrants in Texas* (May 5, 2021), available at <https://www.al.com/news/2021/05/alabama-company-gets-614-million-contracts-to-house-child-immigrants-in-texas.html>.

⁶ Id.

that underwear and other supply shortages could be promptly solved by purchasing needed supplies at nearby El Paso discount stores like Walmart and Costco. Many of the detailees held management and purchasing positions in their home agencies and were holders of federal business credit cards.

Mr. Pearlstein, who had frequent contact with children, suggested using detailee federal cards as a stop gap (detailees could purchase supplies on their cards and then be reimbursed). But a senior federal manager rejected the suggestion out of hand, saying “I don’t have time for this shit.” Mr. Pearlstein was then immediately transferred to another position. Management provided no explanation (this happened with other detailees, too).

In another disturbing instance, construction workers lewdly and loudly gawked at girls as they walked outside to the meal tent. Detailees were shocked at these acts of sexual harassment. They attempted to report the incident. Managers resisted taking their complaints.

Notwithstanding the dismissive attitudes of federal management and private contractors, a great many federal detailees out of their own pockets collectively spent thousands of dollars on supplies for the children. Mr. Pearlstein and Ms. Reinhold personally spent hundreds on books, visual aids, games, and other items for children (as well as markers, tape, and other organizational supplies unavailable in the tents). Other detailees contributed far more, some individually into the thousands.

Misallocation and Mismanagement of Resources

By mid-May 2021, almost 800 federal detailees were assigned to the Fort Bliss EIS. However, our clients report there was virtually no effort to assign these detailees based on their skills and experience – which were considerable. It appears that no one ever reviewed the resumes and applications submitted by the detailees. Detailees with very relevant expertise were not matched to appropriate positions, resulting in both underutilization of talent on the one hand, and employees assigned to work for which they were not qualified on the other. In addition to impairing the mission, this involved considerable waste since, on top of substantial travel expenses, many of the most accomplished and valuable detailees were being paid six-figure salaries to essentially babysit or perform basic clerical tasks.

To make matters worse, leadership and management positions were handed out to detailees without any reasonable basis; decisions regarding who to put in charge appeared only related to who got to the facility first. No effort was made to place later arriving employees -- trained and experienced in management or leadership functions or in the operations of child emergency programs -- in positions of authority. The result produced teams of skilled and experienced detailees led by unskilled and/or inexperienced managers.

The result was also a mess. Here are a few examples:

- The EIS Clinical Assessment Team (CAT) worked directly with the children to assess their history of abuse, their mental and emotional health, and their exposure to sex or labor trafficking. Detailees with no relevant skills or experience populated the CAT.

They did their level best, flagging those who required special attention. They interviewed and assessed *over 5,000 children*. Remarkably, only after all this did management decide most of the team members – including the CAT director -- were not qualified to do clinical assessment and needed to be reassigned.

- A detailee fluent in Spanish and with considerable experience working with children as a licensed clinical social worker was initially assigned to be simply a “line of sight” observer in a dormitory tent. It was weeks before the detailee was reassigned to provide counseling support for distressed children.
- Other detailees were identified as organizational management, legal professionals, and/or communications specialists. Their talents went unused. They, too, mostly worked as “line of sight” observers or clerical aides. Even when such skilled professionals observed systemic problems in their daily work in the tent and suggested policy or process changes, they were essentially treated as ignorant meddlers.

Poor Planning and Miscommunication

Planning was haphazard at best. Policies and leadership decisions changed constantly, sometimes within hours. Examples include:

- Management repeatedly told detailees that, within days, all girls would be transferred out of the Fort Bliss EIS to other facilities or placements. Management then reversed themselves, first telling detailees the transfer plan was a rumor and then saying there would be no transfers, only to reverse back and confirm the transfer plan and later, yet again, to announce there was no such plan.
- In mid-June, the Fort Bliss detailees were told they were going to be sent home early. They were told that they would depart in three waves, with the last ending in early-July. Detailees then scrambled to change travel and other plans. Days later, the detailees were told “our objective changed.” The second and third wave demobilizations were put “on hold.”

Additional Failures in Case Management

- In our July 7 letter, we disclosed one horrific incident when 48 children who had been told they were going home were pulled out of the bus line and sent back to their tents. Our clients now report this was not an isolated incident. On multiple occasions, groups of children who were told they were going home and had already arrived at the airport for a flight out, were suddenly told it was a mistake and brought back to the facility. Indeed, on at least two occasions, children who had already boarded airplanes were forced to get off. Detailees on the team to which Mr. Pearlstein was assigned comforted the shocked and distressed children when they were returned to Fort Bliss.

- Mr. Pearlstein and Ms. Reinhold personally spoke to dozens of children who had been at the Fort Bliss EIS for more than 30 days; many had been there approaching or even exceeding 60. A great many had not spoken to their case managers in over a month. Some were not told they had been assigned a case manager at all, even after many weeks. Most had no information about the progress of their placement with sponsors.
- The Fort Bliss children did not and could not trust that they were safe, that their basic needs would be met, or that their sponsorship/placement cases were being timely processed. The most frequent complaint heard from children was that they were in a state of total uncertainty and anxiety, with no idea of what to expect next.

Health Care Failures

- COVID was widespread among children and eventually spread to many employees. Hundreds of children contracted COVID in the overcrowded conditions. Adequate masks were not consistently provided to children, nor was their use consistently enforced. Every effort was made to downplay the degree of COVID infection at the site, and the size of the outbreak was deliberately kept under wraps. At a “town hall” meeting with detailees, a senior U.S. Public Health Service manager was asked and refused to say how many were infected because “if that graph [of infections] is going to The Washington Post every day, it's the only thing we'll be dealing with and politics will take over, perception will take over, and we're about reality, not perception.” All the manager would acknowledge is that several children had to be hospitalized.
- The manager also dismissed a detailee's concern that the children in the COVID tents were wearing basic disposable masks instead of N95 masks. The manager said N95 masks were unnecessary for the infected – even though uninfected detailees were working with the infected children.
- In response to a question about a shortage of lice kits, the manager said that it was not a problem because there was no significant presence of lice. When it was pointed out that the spread of lice was so serious that a girls' tent with hundreds of occupants was on lockdown due to lice, the manager's flippant remark was that girls tend to have long hair and so obviously they would be more subject to getting lice.

Mismanagement and Significant Mental Health Issues

Major depression and depressive episodes were commonplace among the children. Mr. Pearlstein personally interviewed or worked with dozens of children who had symptoms of serious depression, including some who expressed suicidal thoughts. Many of his colleagues did as well. In many instances, suffering children were referred to “counselors” – other detailees. Some had relevant skills. Others had no prior training or experience (they did their best under the circumstances).

Of even greater concern, mental health clinicians specifically employed by a private contractor to deal with referrals from across the facility appeared to lack appropriate training and experience. Children told detailees of their experiences when unhelpful clinicians ignored their concerns or told them not to worry. They also told of making requests to tent staff to see a counselor or clinician and being ignored or denied. Mr. Pearlstein reports that in one case, a clinician's primary response to a boy – who had complained of feeling very depressed and sad – was to tell him that he had nothing to complain about and that, in fact, he should feel grateful for all he was being given.

Many, if not most, of the children Mr. Pearlstein interviewed -- if they had been at the facility more than a few days -- told him they felt like they were in prison and often begged "please get me out of here, I don't know if I can take it anymore." In some cases, children tried to escape the facility. Children sometimes became understandably angry and irritable when denied such basic items as clothing, undergarments and shoes.

More About the Dormitory Tent Conditions

The Fort Bliss dormitory tents housed as many as 1,200 children. During May and June 2021, there were roughly 10 dormitory tents housing between 500 and 1,000 children in each.



Source: BBC⁷

⁷ BBC, *'Heartbreaking' Conditions in US Migrant Child Camp* (June 23, 2021), available at <https://www.bbc.com/news/world-us-canada-57561760>.

Boys' dormitory tent interior. Hundreds of beds, undivided space.

Our clients add the following.

- The overall environment of the vast, airplane hangar-sized tents was overwhelming. Staff and detailees were often vying for space or resources. The noise frequently made it hard to carry on a conversation or run activities for the children. Reports of bullying were common and detailees were not trained on what to do.
- Toward the end of May, there were riots in some of the boys' tents. Ms. Reinhold witnessed security contractors surrounding a tent during one incident. Detailees were never briefed about the riots or trained how to act in the event a riot broke out.
- Filth was commonplace. According to one Chenega senior manager: "I've been into one [tent], one time, and I was like, yeah, I'm not going back there. They're filthy. They're dirty. There's food on the floor. There's wet spots all over the place. The beds are dirty." Cleanliness conditions varied day to day. Crowding caused trash and dirty laundry to accumulate. The situation was far worse because of the dust that settled everywhere after El Paso area summer dust storms.
- Like the children, the federal detailees were in a similar state of anxiety and uncertainty. They tried to make changes and solve problems, when possible, but the situation was out of their control. They could not reasonably provide assurances to the children that they would be released to sponsors or family as soon as possible (as legally required), or even that their basic needs would be met in the meantime. Complaints to management were often met with dismissal or retribution. With demobilization, detailees left the Fort Bliss EIS with serious concerns about the welfare and safety of the children who remained and who would be housed there in the future.

Secrecy and "Good News Only" Were Standing Orders of the Day

Detailees were frequently reminded that everything at Fort Bliss was confidential. This ensured no effective oversight or accountability. Especially noteworthy was the fact that the identity of the federal contracting officer -- responsible for hundreds of millions of dollars in contracts handed out to the private contractors -- was never provided to the detailees (they repeatedly asked). Yet perversely, the detailees were also told that the contracting officer was the only federal employee authorized to bring any significant issues to any Fort Bliss private contractor. In other words, other than the useless "Suggestion Box" (discussed at length in our July 7 letter), detailees had no internal recourse.

Complementing the penchant for secrecy was management's reflexive aversion to bad news. For example:

- Regularly, when detailees reached the end of their term, a sheet was passed around with detailed instructions from the HHS Public Affairs Office on how, when asked, to make

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everything sound positive about the Fort Bliss experience and to play down anything negative.

- At an all-hands meeting called to address the winding down of detailees serving in the dormitory tents, detailees spoke up to express concern about leaving children with only unskilled contract staff. Reportedly, the incredulous response from site leadership was the cynical suggestion that detailees wanted to stay on to earn more overtime pay.

* * *

The information provided by Mr. Pearlstein and Ms. Reinhold corroborates and goes beyond the reports from our other federal employee clients who volunteered to help the unaccompanied children warehoused by ORR at Fort Bliss, and elsewhere. Their information further reveals violations of law, rule and policy, gross mismanagement, gross waste of resources, abuses of authority and specific dangers to public health and safety.

For all these reasons, we ask you to continue to investigate this matter.

Very truly yours,

/s/

DAVID Z. SEIDE

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cc: Cindy Huang, Director - HHS Office of Refugee Resettlement