



By Email

United States House of Representatives
Committee on Energy & Commerce
Committee on Government Oversight &
Investigations
Washington, DC 20515

United States Senate
Committee on Health, Education, Labor &
Pensions
Committee on Homeland Security &
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Washington, DC 20510

U.S. Office of Special Counsel
1730 M Street NW #218
Washington, DC 20036

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

September 8, 2021

Re: **Third** Protected Whistleblower Disclosure of Gross Mismanagement by
the Department of Health and Human Services at Three Locations Causing
Specific Dangers to Public Health and Safety

To Whom It May Concern:

This is Government Accountability Project’s third protected whistleblower disclosure concerning wrongdoing, abuses, and mismanagement at the Fort Bliss Emergency Intake Site for unaccompanied migrant children (EIS) and other EISs operated by the U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF) Office of Refugee Resettlement (ORR). It supplements our first and second disclosures, dated July 7, 2021 and July 28, 2021, attached as Exhibits 1 and 2, respectively.

We represent a whistleblower who wishes to remain anonymous. Our client is a career federal civil servant and served as a volunteer detailee between April and May 2021 at three EISs.

In the aftermath of our disclosures, HHS asserts that the fundamental failures our clients identified are “old” and have been “fixed.” To the contrary, the problems are ongoing, systemic, and repeated EIS-wide -- with tragic consequences. It is true these are old issues; it is not true they have been fixed.

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What’s New in this Disclosure

This disclosure elaborates on our prior disclosures in two areas. First, before serving at Fort Bliss, our client was deployed to two other EISs located in Houston, Texas and Erie, Pennsylvania. There, our client witnessed the same kinds of gross mismanagement and chaos harming children and staff later witnessed at Fort Bliss. The obvious implication is that Fort Bliss was not unique -- the problems scale across the entire EIS network.

Second, our client obtained daily summaries sent to Fort Bliss management, for the period May 1 through May 6, 2021, of grievances related to health and wellness issues. The summaries contain contemporaneous information provided by staff, detailees and children detailing harm caused by specific acts of gross mismanagement and neglect. They are representative of the concerns expressed by many.

Summary

Throughout the detail, our client witnessed egregious violations of laws, rules, and regulations; gross mismanagement; gross waste of funds; abuses of authority; and numerous substantial and specific dangers to public health and safety resulting in the systemic abuse, neglect, and harm to the unaccompanied children in HHS custody.

These problems were exacerbated by the leadership of unskilled, inexperienced, and unqualified individuals—that is, individuals without management experience and pertinent expertise. Many in management contributed to the chaos through seemingly arbitrary decisions, often announced ad hoc, without documentation and at the last possible moment. Decisions were often reversed without rhyme, reason, or explanation. Leadership from ORR, ACF and HHS were invisible on site; detailees were not informed about who was in charge.

Detailees were never provided with a clear chain of command and were not informed about how to get concerns remedied. There was little, if any, guidance about whom to approach with concerns. Individuals who were designated in charge were unable or unwilling to make decisions and were apparently ignorant of or oblivious to HHS, ACF, and ORR policies and procedures. Significantly, these policies and procedures were not shared with the detailees. The detailees were from across government and had virtually no knowledge or experience with HHS, ACF, and ORR policies and procedures. They were at the mercy of the onsite management for instruction and guidance.

Many days were like the movie “Groundhog Day.” The same bad, avoidable, things occurred -- and recurred -- without remedy or improvement.

Timeline

Response to Solicitation

In late-March 2021, our client volunteered, along with hundreds of other federal employees, to serve as a temporary detailee to aid unaccompanied children in HHS custody. The solicitation stated in relevant part that volunteers were needed to monitor “the maintenance of proper health standards at each facility” including COVID safety standards and to monitor “the direct care and safety of all staff and detailees at all times.” The detail offered could last up to 120 days and could be extended.

Orientation in Dallas, Texas

In mid-April 2021, our client travelled to Dallas, Texas for orientation at a hotel described as the Personnel Mobilization Center (PMC). The orientation consisted of disjointed sessions over one day. Detailees went to information sessions to learn about their assignment. At one, a US Public Health Service (PHS) staffer provided detailed information focused on the vulnerability of the children and concerns about child sexual abuse. The staffer provided no supporting documentation, instructions, or guidance notwithstanding repeated requests. The detailees were even prohibited from taking photos of the slide presentation (the staffer said the content of the training was changing daily and thus could not be shared).

Employee management was a disaster. Role assignments appeared to originate from Washington D.C. (as opposed to on-site following an in-person assessment of employee qualifications) and were made without regard to licensures or experience. Moreover, some detailees were not assigned to a location for multiple days and were effectively “lost.” Our client understands that those some of those lost employees used the time to sightsee and for other personal activities.

Significantly, no guidance was provided as to how detailees were to send or receive communications while on duty (detailees were not told to bring their official laptops or cellphones). That led everyone to improvise, by using – instead of required secure means of communication -- personal cell phones, email addresses, and messaging apps. The problem was never remedied during our client’s detail (management provided conflicting guidance).

First Posting to the Houston EIS

Two days after arriving at Dallas, our client was sent to Houston along with about 20 other detailees. There, our client was posted to a temporary EIS which consisted of a large commercial warehouse in an industrial park near Houston's main airport. The building housed between 400 and 500 girls. It was run by the National Association of Christian Churches (NACC), a private disaster-relief agency awarded a federal contract. Reportedly, NACC, "has no track record sheltering or working with unaccompanied children or immigrants in general."¹

Private security contractors served as guards. Within the warehouse, there was little actual privacy for the children. Boxes and supplies were used as makeshift fencing. Children sat on rows of cots spaced about a foot apart. There was no other furniture. Our client reports that loud music would at times blare without reason.

Our client soon witnessed serious problems. The first assignment was to shred boxes of documents on site, without explanation. Then, within hours of our client's arrival and to our client's surprise, the Houston EIS began to shut down (it had opened about two weeks earlier). Amazingly, the NACC contractors were not informed of the shutdown. The federal manager in charge instructed the detailees to avoid interacting or speaking with the contractors because of the "contentious" relationship. Children were then bussed to other EIS facilities in Texas.

Our client also learned that a federal detailee had died while working at the Houston EIS.² Along with other detailees, our client was assigned to the role held by the recently deceased detailee, in the personal property cage which is where children's personal property (backpacks, phones, cash, etc.) was stored. Our client was never told about the cause of the detailee's death but was directed not to open any of the backpacks because they might contain toxic substances or illegal drugs. Many of the backpacks were effectively "lost" because they had illegible or missing labels and children were not permitted to pick out their own belongings.

Second Posting to the Erie EIS

With the closing of the Houston EIS, our client was redeployed to the EIS located in Erie, Pennsylvania, at the Pennsylvania International Academy. That facility, too, was closed down during the last week of April after being open for less than three weeks. The children were moved to other facilities. Within a week of our client's arrival, management began to close the EIS. The on-site private contractor said the facility was "undergoing remediation to get up to

¹ Houston Chronicle, *Questions Continue about the Group Housing Immigrant Girls in Houston* (April 14, 2021), available at <https://outline.com/ttK5zD>.

² Washington Post, *HHS Employee Dies While Helping at Shelter for Unaccompanied Migrant Children in Houston* (April 18, 2021), available at <https://www.washingtonpost.com/health/2021/04/18/hhs-official-dies-shelter-migrant-children/>.

standard.” Our client was told that there were dozens of health and safety violations and that the facility did not meet state and local child and adult health and safety requirements.

While at Erie, our client learned that many children suffered dehydration, often developed gastrointestinal issues, and refused to eat the food provided because it was unpalatable and/or unfamiliar.

COVID was also a severe problem. A floor in the facility was set aside for children who had tested positive. But it was understaffed and had numerous health safety violations including a gas leak. Throughout the facility, children were often housed six to a room in bunk beds which did not meet social distancing standards. Just before the facility closed, children received a vaccine. They were told it was one U.S. children typically receive prior to attending public school. Some erroneously thought they had received a COVID vaccine – that was not the case.

Children were wrongly victimized in other ways, too. In one instance, children were sent to the shower room, by gender, to remove lice, which was rampant. One staffer -- of a gender *different* than the children – attempted to remain in the shower room. Other staffers protested; the staffer initially left but on more than one occasion returned after complaining staffers stepped out. The staffer then participated in the lice removal process within a few feet of where the tender age girls were showering.

Management ignored our client’s repeated complaints. There was no formalized process for reporting complaints and no chain of command for elevating concerns. Five days after arrival, the Erie EIS was closed. The children were moved to other facilities.

Third and Final Posting to the Fort Bliss, El Paso EIS

Along with other Erie detailees, our client was reassigned to Fort Bliss in late-April 2021. Our client learned that many staffers on the mental health team were unqualified. Of the approximately 20 detailees, *only two* were licensed and trained in mental health work. Neither were team leaders. In fact, they were both marginalized and demeaned by managers. Within a week, the team expanded to about 60 team members. Most if not all had no mental health training, credentials or experience.

Staff on the mental health team were in over their heads. The team leader was not a licensed mental health worker and had no prior management experience. Our client was told the manager was in charge because the manager had “arrived first.”

Other Fort Bliss managers were equally unqualified. They were unable to deal with the many problems that arose. Training was inadequate and deficient. Decisions were ad hoc, not in writing, made at the last possible moment, and reversed without explanation. There was no accountability or oversight.

Hard copies of laws, policies, and procedures were not disseminated. Most detailees had no knowledge or experience with HHS, ACF, and ORR policies and procedures and depended on these “managers” for instruction and guidance. Everything was treated as a secret.

Documented Daily Summaries from May 1 to May 6 of Fort Bliss Health and Wellness Issues

Over six days, from May 1 through May 6, 2021, our client obtained emails sent to multiple Fort Bliss managers summarizing disturbing information reported by children and staff. The reported grievances are appalling and reveal a serious lack of oversight. They were never remedied during our client’s time at Fort Bliss.

Here is a sampling -- all symptomatic of larger, systemic gross mismanagement by HHS, ACF, ORR, and the private contractors.

May 1, 2021

- “Shaking of the beds to waken children ... Only scalding water [available for bathing], children being burned;”
- Child’s request to see mental health team rejected for four days because, according to staff, "we're not doing that now" and "there are not enough counselors so you can't go;"
- Girl “taken to the hospital with 13 pregnant girls without explanation. [She] had blood drawn without communication,” despite not being pregnant;
- Children “are experiencing backlogs at several tents during the check in/check out process which is preventing them from going to the bathroom or leaving the tent;” and
- Staff in the COVID isolation tent “regularly employ group discipline (e.g., if one boy acts up all boys are punished) and refuses to allow bathroom trips at all during the day ... [many] younger boys ... have wet the bed as a result.”

May 2-3, 2021

- Supply manager repeatedly states over the course of five days that “no underwear was available for the children due to "not receiving shipments;”
- “Inadequate and inappropriate clothing provided to the children. Wrong size clothing is provided to the children including shoes which is a trip and fall hazard. Girls are provided boys' clothes. Sweatshirts and sweatpants are too heavy for 91+ degree weather;”
- “Children have burnt and blistered their skin from ‘skin lightening’ lotion provided to them rather than a safe moisturizing lotion;”

- Concerns “about decibel level and chronic noise pollution in the tents, cafeteria, and portable bathrooms as well as vehicle and construction noise during the day. Concern[s] about heightened chronic stress and loss of hearing from perpetual noise for both children and staff;”
- Tent staff “regularly threaten children with deportation;”
- “Lights are left on 24 hours a day in tents ... Tent sizes are too large to manage by the staff;” and
- “Staff scream at the [children] as the way to locate them in the tent.”

May 4, 2021

- “Staff are seeking clarification on federal vs. contractor roles and responsibilities and the various oversight mechanisms and checks and balances in place as well as where to go when they have a concern;”
- “Currently there are remarkably few Mental Health staff with an active license;”
- “[V]irtually every child that visits mental health is concerned that they did not yet see a case manager since they were admitted to Fort Bliss;”
- “Repeated concerns raised by the children that tent staff routinely refuse them access to Medical Care;”
- Staffer “routinely discourages the children from filing complaints and threatens them with deportation;” and
- Children informed “staff that when they slept at night they were being physically hurt by other children. Specifically, that they were being slapped, socks were put in their mouth, and underwear was put over their faces.”

May 5, 2021

- “Staff working in Mental Health need training on what the process and policy is for getting cases processed and what the steps (and expectations) are in Case Management;”
- Staffer’s “experience over the past week is that the ‘process’ keeps changing, yet the experience does not;”
- Concerns raised by “seasoned federal employees who are fearful about retaliation for raising their concerns about their experience at Fort Bliss;”

- “Mental Health staff are seeking an accurate roster of who is on the team, their government email and onsite contact information, and role. Staff do not know who to go to when they have questions which has a negative impact on efficiency, productivity, and morale;”
- When a staffer raised the accurate roster issue with a senior federal manager, the manager “stated that this was a ‘he said, she said’ issue and if it wasn’t put in writing then [the manager] didn’t believe the request was made, thus this request is in writing;”
- Concerns “about how federal volunteers are being ‘placed’ into roles without regard for their background, education, experience, aptitude, skills, and license. In some cases, volunteers are in roles that they are struggling with and have a steep learning curve, and in other cases volunteers are seriously underutilized with no regard for their background, education, experience, aptitude, skills, and license;” and
- Child “appears to be ‘lost’ in the system without any contact from a case worker, which appears to be a systemic issue.”

May 6, 2021

- “There is very little communication between contracted case-workers and federal case-workers. It is very difficult to be able to identify the caseworkers of children here and see if caseworkers are contractors vs federal vs virtual;”
- Children “reporting that the [private contractor] youth care workers (yellow shirts) in their tent are threatening to ‘report’ them if they don’t want to go to a meal. They tell the [the children] that their [immigration] judge will see the reports and know they are bad and send them back;”
- “Multiple children reported that a staffer accused them of things they did not do.”
- “Girls report that contractors in their tent are threatening to ‘report’ them if they don’t want to go to a meal. They tell the girls that their judge will see the reports and know they are bad and send them back;” and
- “Seems to be a running joke to collect all of the kids’ names on a list to access their caseworker, clothes, hygiene products, but then lists of names are trashed and [children] don’t receive necessary services.

* * *

This new evidence is shocking. It further reveals violations of fundamental human rights. It is no defense to assert that the reports of these conditions are now “old” and have been “fixed.” Problems in implementation and execution are not new, were to be expected, were prohibited by

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existing laws and regulations and should have never happened in the first place. Management could have and should have known better.

We ask you to continue to investigate, hold accountable those responsible and act to ensure that this mess does not happen the next time the government uses Fort Bliss or the other EISs.

Very truly yours,

/s/

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

EXHIBIT 1



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July 7, 2021

Re: 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:

We, Government Accountability Project, represent Laurie Elkin and Justin Mulaire. Both are whistleblowers and career federal civil servants.¹

This is a disclosure protected under the federal whistleblower laws. It concerns eyewitness accounts of gross mismanagement and specific endangerment to public health and safety at the Fort Bliss Emergency Intake Site (EIS) for unaccompanied children operated by the U.S. Department of Health and Human Services (HHS). We request that you promptly investigate the matters discussed herein.

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¹ For identification purposes only, Ms. Elkin and Mr. Mulaire are attorneys currently employed in the Chicago District Office of the U.S. Equal Employment Opportunity Commission (EEOC). The views expressed in this disclosure are their own and do not reflect any policy or position of the EEOC.

EXHIBIT 1

Re: Protected Whistleblower Disclosures

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Summary

From May 12, 2021, to June 2, 2021, Ms. Elkin and Mr. Mulaire served in a temporary assignment with HHS caring for unaccompanied, undocumented immigrant children in HHS custody. They were sent to Fort Bliss, a large military base in the desert outside of El Paso, Texas, where thousands of children are housed for prolonged periods in enormous, undivided tents — perhaps the size of a football field. Ms. Elkin and Mr. Mulaire were assigned to provide line of sight supervision of children in the tents that served as makeshift dormitories.

As discussed in further detail below, Ms. Elkin and Mr. Mulaire were actively discouraged from reporting concerns about what they witnessed at Fort Bliss. However, because they believed the

tent conditions were placing children at risk, they regularly and persistently used the internal reporting mechanisms at Fort Bliss and filed complaints with the HHS Office of Inspector General (OIG). The conditions they witnessed caused physical, mental and emotional harm affecting dozens of children. EIS management ignored their concerns. During their time at Fort Bliss, no remedial action was taken.

Context

HHS's Office of Refugee Resettlement (ORR) is responsible for the care of undocumented immigrant children in U.S. custody. During the first four months of 2021, the number of unaccompanied children cared for by ORR grew from 4,020 on January 31, 2021, to 20,339 on April 30, 2021.² While large, these numbers were not unexpected. For example, as of April 30, HHS cared for 13,352 children in 2020,³ and 12,587 in 2019.⁴ Fort Bliss, along with facilities on other military bases, were set up in 2018 to care for 20,000 children at one time.⁵

In May 2021, the Fort Bliss EIS housed 4,800 children. On June 28, 2021, HHS Secretary Xavier Becerra visited Fort Bliss. He told reporters that approximately 790 children (all boys) remain.⁶ But unlike other EIS sites that are being phased out due to falling numbers, Fort Bliss will remain open.⁷

Timeline

Request for Volunteers

In late March 2021, the head of Ms. Elkin and Mr. Mulaire's home agency announced that the President had called for federal employees to volunteer to take a temporary assignment (or "detail") with HHS to help address the influx of unaccompanied minors at the southern border.

² HHS, *Latest UC Data - FY2021*, available at <https://suggestion.hhs.gov/programs/social-services/unaccompanied-children/latest-uc-data-fy2021/index.html>.

³ HHS, *Latest UC Data - FY2020*, available at <https://suggestion.hhs.gov/programs/social-services/unaccompanied-children/latest-uc-data-fy2020/index.html>.

⁴ HHS, *Latest UC Data - FY2019*, available at <https://suggestion.hhs.gov/programs/social-services/unaccompanied-children/latest-uc-data-fy2019/index.html>.

⁵ El Paso Times, *Fort Bliss, Goodfellow Military Bases in Texas Will House Immigrants, Pentagon Confirms* (June 28, 2018) ("Pentagon said last week that it had been asked to be prepared to shelter as many as 20,000 unaccompanied children"), available at <https://suggestion.elpasotimes.com/story/news/2018/06/25/fort-bliss-goodfellow-military-bases-texas-house-immigrant-children-families-reports-say/731023002/>.

⁶ AP, *US: Big Drop in Migrant Kids at Largest Emergency Shelter* (June 29, 2021), available at <https://apnews.com/article/joe-biden-business-immigration-health-government-and-politics-e1a0e41e0cb48cfca66a6188fa824405>.

⁷ AP, *US Will Close 4 Emergency Shelters for Migrant Children* (June 29, 2021), available at <https://apnews.com/article/immigration-government-and-politics-d7bccfc6f85559c48d5d25cc13aa80a6>.

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ORR needed current federal government civilian employees for a 30 to 120-detail to support ORR's mission to provide a safe place of refuge for unaccompanied children and unify them with family members or other suitable sponsors as quickly as possible.

According to the job announcement posted on March 25, 2021 on USAJOBS.gov, the detail would involve "contact with migrant children and a variety of federal and non-federal entities."⁸ Pertinent responsibilities included:

Maintain line of sight and supervision of children. Assess the needs of unaccompanied children in care.

Interview unaccompanied children in CBP [(U.S. Customs and Border Protection)] custody and collect contact information for parents in home country and family members in the US.

Efficiently collect and provide information to ORR to enable the National Call Center to begin contacting parents and family members to expedite children's discharge to a US family member sponsor.

Assist CBP and ORR in identifying children requiring prioritization for placement based on vulnerable category or time in CBP custody.

Ms. Elkin and Mr. Mulaire both volunteered for 30-day details.

Orientation

In early May 2021, Ms. Elkin and Mr. Mulaire travelled to Dallas for a brief orientation and a background screening. They were then assigned to start work at Fort Bliss on May 12.

On the morning of May 12, Ms. Elkin and Mr. Mulaire attended an orientation run by members of the U.S. Public Health Service (PHS) and federal employee detailees who had arrived at Fort Bliss weeks earlier. There were perhaps 100 federal detailees in attendance. They were told that they were there to support private contractor employees on site. The site did not yet have the requisite number of contractor employees with suitable clearances, and federal employee detailees were being used as a stopgap.

No one from ORR — the lead agency responsible for the well-being of the children — spoke or was identified at the orientation. No contact information for any ORR employees or representatives was provided, but towards the end of their details, Ms. Elkin and Mr. Mulaire learned that ORR representatives were on site.

⁸ USAJOBS Job Announcement, *Field Program Specialist (Detail)*, Announcement No. HHS-ACF-DETAIL-21-11071982, available at <https://suggestion.usajobs.gov/GetJob/ViewDetails/596318100>.

No Complaints Allowed

During the orientation, Ms. Elkin and Mr. Mulaire were told that the primary means of providing “feedback” about any problems they noticed was to send e-mails to a “suggestion box” at an HHS.gov address. They were also told *not* to provide such feedback during their first ten days on the job.

Such gag orders are illegal. The “anti-gag” provision of the Whistleblower Protection Enhancement Act (5 U.S.C. § 2302(b)(13)) specifically states that gag orders cannot be imposed on federal employees unless they are explicitly told that such orders do not apply when employees exercise their whistleblower rights. The directive given to Ms. Elkin and Mr. Mulaire included no such limiting language.

In any event, Ms. Elkin and Mr. Mulaire obeyed the order. They did not submit complaints until the ten days had run, on May 21, 2021. The ten day wait served no purpose. The problems they identified were obvious at the outset and continued unremedied through their last day on June 2, 2021.

About the Dormitory Tents

The Fort Bliss dormitory tents are massive, with between 1000 and 1500 beds each.



Source: KDBC-TV (El Paso, TX).⁹

They are segregated by gender. Ms. Elkin was assigned to the girls’ tent, and Mr. Mulaire to one of the boys’ tents, both housing children ages 13-17. Each worked a schedule of 12 hours per day, six days per week.

⁹ Available at <https://cbs4local.com/news/immigration/gallery/unaccompanied-migrant-children-begin-arriving-for-care-at-fort-bliss-site#photo-2>.

There were approximately a half dozen regular dormitory tents in service when Ms. Elkin and Mr. Mulaire were at Fort Bliss. Separate tents housed children who tested positive for Covid-19. Most of the regular dormitory tents had a bed capacity of about 1000, although a larger tent put into service for girls has a capacity of approximately 1500 beds.

The interior of each tent is undivided. In a typical 1000-bed tent, the cots — stacked bunk-bed style — were arranged in ten columns by nearly 60 rows, with an aisle down the center. Twelve to 18 inches separated each cot. The top beds were about three feet off the ground, and lower-level beds were six to ten inches off the ground.¹⁰ The site is dotted with portable restroom trailers, port-o-potties, and electric generators. Air conditioning and ventilation equipment — necessities given the sweltering temperatures — are attached to each tent.

Neither ORR nor HHS appeared to play any direct role in running the tents. Federal detailees reported to tent leads, who themselves were recently arrived federal detailees. For instance, the tent lead in Ms. Elkin's tent worked for the General Services Administration. The tent lead in Mr. Mulaire's tent worked for the Department of Labor. Both leads apparently reported to another detailee who worked for the Drug Enforcement Administration.

As of mid-May, the boys' tent Mr. Mulaire was assigned to housed approximately 900 boys and was staffed by approximately 10 federal detailees from various agencies and approximately 20-30 private contractors. The girls' tent at that time housed approximately 800 girls and had a similar number of contractors and a larger number of federal detailees. While during orientation, federal detailees were told that the children were organized into "pods" of several dozen children each, this was not true in the boys' tents.

By early June, approximately half of the boys in the tent to which Mr. Mulaire was assigned — those under age 16 — were moved to another tent, and the size of the pods in the girls' tent became smaller as girls were transferred or placed with sponsors. Also, by early June, federal detailees were phased out of the dormitory tents, as the number of contract workers in the dormitories had at least doubled. However, as described below, despite the larger number of contract workers and the reduced number of children in the dormitory tents, fundamental deficiencies remained unchanged.

Typical Day in the Tents

Little instruction was given to Mr. Mulaire and Ms. Elkin about what to do each day in the tents other than a suggestion to interact with the children and do what might be enjoyable. While contractors were primarily responsible for safety of the children and providing line of sight

¹⁰ Reportedly as of June 25 (after Ms. Elkin and Mr. Mulaire left the facility), the double-decker bunks in the boys' tents were brought down to ground level and spread out. El Paso Times, 'A Horrible Mess': Contractor Issues Add to Turmoil at Fort Bliss Migrant Children Shelter (June 25, 2021), available at <https://www.elpasotimes.com/story/news/2021/06/25/fort-bliss-migrant-children-intake-shelter-deplorable-conditions-sources-allege/5324736001/>. Ms. Elkin and Mr. Mulaire have no personal knowledge about whether that is true or not, but such a change would be a welcome development.

supervision, they did not initiate interaction with the children and generally simply stood quietly, passively watching the children.

In the dormitory tents, the children's day was largely unstructured. During the day, they were typically either sitting or lying in their beds or milling around with relatively few activities available to them. An English as a Second Language class was offered in the morning and a religious service was provided during parts of the day. Up to a few dozen children attended each.

Federal employee detailees had purchased out of their own pockets some board games, decks of cards, arts and crafts materials, and balls to kick or toss around, which provided activities for a modest number of children. Mr. Mulaire, on his own initiative, offered English tutoring lessons, using materials he created. Many children also organized their own prayer groups in the morning or evening. By the end of Mr. Mulaire's and Ms. Elkin's detail, a recreation tent was in operation, and the children had the opportunity to go there for approximately an hour per day.

Eye-Witness Observations

Ms. Elkin and Mr. Mulaire witnessed numerous instances of gross mismanagement, causing harm to children's health and wellbeing. Some more notable examples follow.

Inability to See or Help Children in Distress

Because each tent contained such a large number of closely spaced bunk beds, line-of-sight supervision was impossible for a substantial of children. That failure, combined with the vast size of the tents, put at-risk children at even greater risk. A child in distress risked being overlooked by adults, especially if hidden from view on a lower bunk.

And these children were and are at risk. They were separated from their parents and family, their community and culture. They are unmoored from most everything that provides a sense of safety and security. At orientation, the detailees were told that the children have experienced dire conditions in their home countries — often involving one or more traumas — that prompted them to flee in the first place. The long and dangerous journey from their homes in Central America was another likely source of trauma for many, the detailees were told, ranging from being victims of sexual assault or other crimes to witnessing others die along the journey.¹¹

In the dormitory tents, Ms. Elkin and Mr. Mulaire each discovered multiple children who reported medical problems — ranging from unexplained pain to profuse bleeding. They also discovered children who were deeply upset and anxious about their situation and wanted to talk to a counselor. These were not children who were likely to get up out of bed and seek assistance from an adult.

¹¹ See also Immigration Psychology Working Group, *Vulnerable but not Broken: Psychosocial Challenges and Resilience Pathways among Unaccompanied Children from Central America* (2018), available at <https://www.apa.org/advocacy/immigration/vulnerable.pdf>.

Further, these were just the children in need that Ms. Elkin and Mr. Mulaire were able to discover, and despite substantial language barriers between them. Virtually all of the children did not speak English, and most federal detainees in the dormitories did not speak Spanish or the other indigenous languages spoken by the children. (Mr. Mulaire did speak some Spanish, Ms. Elkin less.) The children in need who Ms. Elkin and Mr. Mulaire did find among the hundreds of children in their tents were likely only a fraction of those with unaddressed medical, emotional and other needs.

In short, housing children who are dislocated and in distress in groups numbering in the hundreds all but ensures that many will continue to be in distress. Not being within the line of sight of adults also increases the risk that children with medical, mental health, or other needs will simply go unnoticed in these vast, airplane hangar-sized tents.

Intolerable Noise

At times, the loudspeakers in some dormitory tents were set at an intolerable volume. Near the entrance to each tent was a desk staffed by contractor personnel, who controlled the volume of the loudspeakers. They blasted music at the children starting early in the morning and periodically throughout the day, with some children's cots being perhaps only ten feet away from the loudspeakers.

In one notable case, in an apparent effort to wake the children up in the morning, contract staff routinely started playing painfully loud music at around 6am or 7am. Early one morning, a contractor — dissatisfied that the children were not waking up fast enough — went up and down a tent aisle yelling at the children through a bullhorn to get up. When that, too, did not meet with the results she hoped for, she turned on the bullhorn's siren and walked up and down the aisle blaring that at the children.

Odor and Filth

Ms. Elkin and Mr. Mulaire further report that the tents were dirty and often had a foul odor like a locker room. Moreover, because of the numerous portable restroom facilities, the odor of sewage was not uncommon at the EIS.

Dust and sand were everywhere. When sandstorms occurred (as they periodically do in El Paso), the air inside the tents became visibly cloudy with dust, which made its way into everyone's eyes, ears, and lungs.

Clean bedding and clothes were not regularly provided. Although many children were housed in these tents for as long as two months (or more), it appeared their bedding was never washed; many beds were visibly dirty. The children also reported having insufficient clean underwear and socks, which in turn made them reluctant to exercise or to bathe because they knew they lacked clean clothes to change into. It was not uncommon in the girls' tent, for example, for the children to plead for clean underwear so that they could take a shower and have something clean to change into.

Undue Reliance on Unskilled Contractors

Perhaps the single greatest problem observed by Ms. Elkin and Mr. Mulaire was the use of wholly unsuitable contract staff. Ms. Elkin and Mr. Mulaire learned that the contractor providing direct supervision of the children in the dormitory tents — Servpro — is a fire and water damage repair company. Many of the Servpro staff's t-shirts bore the Servpro corporate logo found on the internet, with some including the corporate logo: "As if it never happened."

According to its website, "the Servpro Industries, LLC, franchise system is a national leader of fire, water, mold and other specialty cleanup and restoration services."¹² Youth care is not in its portfolio. Contractor staff told Ms. Elkin and Mr. Mulaire that they had received no training prior to beginning work and had little guidance about what their role was.

Deficiencies in Contractor Guidelines and Youth Care

Ms. Elkin and Mr. Mulaire report that many contract workers seemed to view their job more as crowd control than youth care. While some individuals plainly meant well, other contract workers exhibited impatience with children and were plainly unsure of how to supervise them (as illustrated above with their use of a bullhorn and siren to wake up children).

Problematic contractor guidelines exacerbated this situation. Contractors told Ms. Elkin and Mr. Mulaire that they were not permitted to interact with the children unless a child specifically approached them. Many children in a state of distress, suffering with depression, anxiety or more, are less likely to initiate such an interaction and seek out an adult for help.

Even in those instances when children did reach out for help, Ms. Elkin and Mr. Mulaire report that contractors were often of little help. They each witnessed episodes in which contract staff questioned a child's request for medical attention and/or made the child wait for hours before escorting the child to the medical or mental health tents for care.

Three Illustrations of Malfeasance

When Ms. Elkin found girls in distress and asked a contractor to escort them to the medical or mental health tent, their requests were often met with indifference or even resistance.

Hostility. Early on, Ms. Elkin noticed that one girl was sleeping continuously. Upon approaching the girl, the girl said that she felt sick with a sore throat. When Ms. Elkin asked a contractor to take the girl to the medical tent, the contractor responded by saying no and that the medical staff would not do anything for her. Ms. Elkin persisted, and the girl eventually received medical care.

Indifference. Ms. Elkin discovered a girl in a bottom bunk having a panic attack — shaking uncontrollably and hyperventilating. (The girl had just discovered that her older sister who was her sponsor had gone into a coma and was likely to die.) Ms. Elkin approached a contractor to

¹² Available at https://suggestion.servpro.com/our_business.

report that the girl appeared to be having a panic attack. The contractor reacted, incredibly, by simply telling Ms. Elkin to take the girl outside and walk her around. However, because Ms. Elkin persisted, the girl was eventually brought to the mental health tent and then to case management to update her case manager on her situation.

Resistance. Ms. Elkin discovered a girl in a bottom bunk who looked ghostly pale. The girl told Ms. Elkin that she had not had her period for months but was now bleeding profusely and did not feel well. Clearly, the girl needed medical attention. Ms. Elkin approached a contractor to request that the girl be taken to the medical tent. The contractor responded by saying she was not allowed to take girls to the doctor. Ms. Elkin then brought the case to contractor's supervisor who questioned why and if the girl needed to see a doctor. Ultimately, but only because of Ms. Elkin's intervention, the girl received medical treatment.

Case Management Failures

By law, ORR must place children in the least restrictive setting that is in the best interests of the child, which means that ORR facilities provide case management services for each child. The primary goal of case management services is to place children with a sponsor within the United States so that they can be released from HHS custody. A different contractor provided these services. At Fort Bliss, it was routine for children to get lost in the case management system. There was no official mechanism in the dormitories for children to report that their case had seemed to have fallen through the cracks, or to communicate relevant information they may have learned from a phone call to their family. They simply had to wait, sometimes for weeks, for a case worker to contact them. Failures to effectively manage children's cases resulted in unnecessary emotional distress to the children at Fort Bliss.

Lost in the System. Mr. Mulaire and Ms. Elkin heard from numerous children who reported they had not spoken to a case worker in weeks. The contractors in the dormitory tents provide no help in such situations; one supervisor explained to Mr. Mulaire that they could not do anything in such situations because "case management is a different contractor." Mr. Mulaire, in talking to one younger boy, learned that he had not seen his case worker in 27 days. The boy asked Mr. Mulaire for help. Although federal detainees had no official channel for reporting such problems, Mr. Mulaire decided to go to the Case Management tent and raise the boy's situation with another federal detainee he knew who worked there. Within about 30 seconds of scrolling through the boy's electronic case file, the Case Management worker concluded, "yeah, he's been forgotten." He also commented that the boy's case was not a difficult one and could probably be completed within a matter of days. The boy's case was brought to the attention of his assigned case worker, who agreed to see the boy soon. If not for Mr. Mulaire's intervention there is no saying how long this young boy would have remained at Fort Bliss, unnecessarily lost in the system.

Miscommunication and Lack of Coordination. Early one morning a girl in Ms. Elkin's tent was woken up and told that she was going home that morning. The girl, who had then been in the tent for 38 days, wept with joy and relief. She quickly changed into street clothes to look good and said her tearful goodbyes. She was then taken to the case management tent to wait for the bus with other children that were going home that day.

Ms. Elkin went to the case management tent to see the girl off. On the verge of leaving after more than seven weeks at the facility, the girl was suddenly pulled out of the bus line. She was told a “mistake” had been made and that she was not going home. The girl collapsed in uncontrollable tears. An ORR staffer told Ms. Elkin, “We are traumatizing these kids. This is terrible. This is horrible. People in Washington know. But this is an emergency situation and mistakes are going to happen.” The staff also said that, in fact, *47 additional children that very morning* had also been told they were going home only to be pulled out of the bus line and sent back to their tents.

Ignored Complaints

Once their ten-day gag order expired, Ms. Elkin and Mr. Mulaire repeatedly reported their concerns to HHS, which largely ignored them. As a result, Ms. Elkin and Mr. Mulaire also contacted the HHS Office of Inspector General (OIG).

First Complaint to HHS Management

On the morning of Friday, May 21, Mr. Mulaire sent an email to the HHS Fort Bliss “suggestion box” reporting the extreme volume of the loudspeakers in tent 3. He wrote that “The music in tent 3 is often extremely loud,” and noted that some children had said they did not like it, and that “for kids who are depressed or anxious, being in a nightclub-like environment may not be the best idea.”

During Mr. Mulaire’s detail, HHS never responded.

To HHS OIG

The next evening, May 22, Mr. Mulaire filed a complaint with OIG in which he identified Ms. Elkin as a witness. He attached an addendum identifying three issues: (i) the size and physical layout of the tents in which the children were housed made it impossible for adults to see many of the children at any given time, especially at night; (ii) the contractor that was placed in charge of the care and supervision of the children in the dormitory tents did not appear to have any competency in youth care; and (iii) there were simply too many children housed together in each tent. He closed by asking OIG to investigate.

Second Complaint to HHS Management

On May 24, 2021, Mr. Mulaire sent a second email to the HHS “suggestion box,” in which he summarized his four biggest concerns: (i) the duties assigned to the contractors, as understood by the contractor staff, were inadequate to insure the health and wellbeing of the children; (ii) the dormitory tents and the groups inside them were simply too large to provide a healthy environment for a population of distressed and dislocated children; (iii) bottom bunks needed to be eliminated; and (iv) better informed and more active monitoring of the contractor was needed.

HHS never responded.

Third Complaint to HHS Management

On May 26 and May 29, 2021, Mr. Mulaire prepared three handwritten HHS Incident Reports forms which he emailed on May 29 to ORR representatives he had learned were on site at Fort Bliss. The first reiterated that the volume on the loudspeakers in tent 3 remained “painfully loud” and that requests to contractor staff to lower the volume were ignored. The second reported extremely loud music in tent 5, which detailees could hear from inside tent 3, and he asked for someone to address this problem with Servpro on a site-wide basis. The third incident report further noted that multiple U.S. Physicians Health Services doctors had also agreed that the volume of the loudspeakers was likely causing the children hearing damage.

HHS never responded to his concerns. In fact, prior to emailing the forms to the ORR representatives, when Mr. Mulaire first attempted to submit one them on paper, a staffer in the Administrative tent told him such reports could not be accepted because they did not concern specific children. When Mr. Mulaire asked how else to report the problems he identified, the Administrative tent staffer told Mr. Mulaire she did not know of a way to do that and did not know of a way to find out.

To HHS OIG Again

On May 30, 2021, Mr. Mulaire filed a second OIG complaint reiterating four additional concerns: (i) noise in tent 3 was damaging children’s hearing; (ii) Servpro was apparently unable or unwilling to supervise its employees; (iii) HHS lacked an effective reporting system for disclosing problems with Servpro to HHS management; and (iv) HHS apparently lacked the ability to oversee or interest in monitoring Servpro.

HHS OIG has not responded to Mr. Mulaire’s complaints to date.

Further Discouragement

Near the end of their time at Fort Bliss, Ms. Elkin and Mr. Mulaire attended an “all hands” meeting in which federal detailees in the dormitory tents were told they were being phased out. During the meeting, several detailees spoke up to express concern about leaving the children with only the contract staff. A PHS officer, who helped conduct the meeting, told the detailees to send their concerns to the “suggestion box.” After the meeting, a group of detailees, including Ms. Elkin and Mr. Mulaire, approached the PHS officer with further concerns. Ms. Elkin noted that management had not responded to reported concerns and raised the possibility of reporting the concerns to someone outside of HHS management, such as OIG. The officer replied: “You can’t go outside the chain of command.” Needless to say, the federal whistleblower laws say otherwise.

The only response either Ms. Elkin or Mr. Mulaire received from HHS management about any of their reported concerns came two days after leaving Fort Bliss. At that time, Mr. Mulaire received a call from an individual identifying himself as staff member of the Contracting Officer Representative (COR). His only question was, other than loud music, how else Mr. Mulaire

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suggested to wake up the children. When Mr. Mulaire asked if he could mention his other, more serious concerns (discussed above) to make sure that the COR was aware of them, the representative said, “no sir.” The representative also commented that reporting multiple problems would likely be “perceived as a crying wolf situation.” Mr. Mulaire never heard from the COR again.

* * *

In sum, the time our clients spent at Fort Bliss was alarming. Each day seemed to bring new examples of deficiencies in the care of the children and resulting risks to their health. Instances of gross mismanagement of the site were pervasive.

Having witnessed these things, as well as the despair of children who felt (often accurately) that they were being ignored or forgotten, our clients felt the need to speak out, yet were met with non-responsiveness at best and unlawful deterrence at worst.

They volunteered for this detail as dedicated civil servants to further the mission of HHS and ORR to protect the well-being of the children at the Emergency Influx Sites. They are escalating these concerns now in service of that same mission. While they are encouraged by reports that some conditions may have improved recently, including the numbers of children currently housed at Fort Bliss, many of the problems they witnessed will continue to harm the hundreds of children at the site if they are not addressed.

Whatever one might think about immigration policy, the reality is that these children are here now and are in HHS’s custody. HHS has a responsibility to make sure they are safe and treated humanely.

We request and urge you to investigate promptly.

Very truly yours,

DAVID Z. SEIDE
DANA L. GOLD

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danag@whistleblower.org

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



By Email

United States House of Representatives
Committee on Energy and Commerce
Committee on Oversight and Reform
Washington, DC 20515

U.S. Office of Special Counsel
1730 M Street NW # 218
Washington, DC 20036

United States Senate
Committee on Health, Education, Labor and
Pensions
Committee on Homeland Security &
Government Affairs
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

EXHIBIT 2

Re: Second Protected Whistleblower Disclosures

July __, 2021

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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

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