U.S. Department of Health and Human Services

Office of Inspector General

The Office of Refugee Resettlement's Incident Reporting System Is Not Effectively Capturing Data To Assist Its Efforts To Ensure the Safety of Minors in HHS Custody

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June 2020, OEI-09-18-00430

Why OIG Did This Review

The Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR), has custody of and must provide care to minors (children younger than 18 years of age) in the Unaccompanied Alien Children (UAC) Program. ORR is responsible for providing a safe environment for all minors in the program.

In recent years, ORR-funded facilities have reported allegations of sexual and physical abuse of minors in their care, some resulting in criminal convictions.

How OIG Did This Review

OIG analyzed Significant Incident Reports (SIRs) submitted to ORR by 45 ORR-funded facilities between January 1, 2018, and July 31, 2018, to identify any challenges for the oversight of facilities to ensure the safety of children. In addition, we conducted an in-depth review of incident reports that described conduct of a sexual nature. This allowed us to provide information about potentially egregious incidents and ORR's response to them. We could not determine whether the incidents were officially investigated or substantiated by an external agency, on the basis of the information in the reports.

We also identified challenges in the SIR reporting process for oversight of facilities to ensure the safety of children. This assessment is based on our review of the SIRs and information gathered during OIG's site visits at the 45 facilities in August and September 2018. At each facility, we conducted interviews with key staff responsible for ensuring the safety of minors. We also interviewed the 28 ORR Federal field specialists assigned to the facilities and reviewed relevant policies and procedures.

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Key Takeaway

ORR needs to improve its incident reporting system and address care provider facilities' challenges preventing, detecting and reporting incidents, so it can more efficiently and effectively ensure that facilities address incidents and protect minors from harm.

What OIG Found

The Office of Refugee Resettlement (ORR) policy guide, *Children Entering the United States Unaccompanied*, states that it "will make every effort to prevent, detect, and respond to" all forms of inappropriate sexual conduct involving children in its custody. ORR directs facilities to report all incidents of a sexual nature involving minors in its custody. We reviewed incident reports that 45 care provider facilities submitted to ORR between January 1, 2018, and July 31, 2018. Among these reports, 761 unique incidents described conduct of a sexual nature. Reports for most (704) of these incidents involved conduct between minors, fewer (48) involved conduct by an adult against a minor, and the remaining (9) incidents had an unknown perpetrator. The incidents varied widely in type and severity. For example, the conduct described in these incidents included a minor opening a bathroom door while another minor was inside as well as a staff member kissing a minor.

ORR's incident reporting system lacks designated fields to capture information that ORR can use to oversee facilities and to protect the minors in ORR care. Important information about facilities' actions are not systematically collected to help ORR determine whether facilities responded appropriately to incidents. In addition, the system does not effectively capture information in a way that allows for efficient identification of issues that require immediate attention and analysis to detect concerning trends. Further, facilities described challenges with staffing youth care workers—who are essential to preventing, detecting, and reporting incidents—and difficulties determining which incidents should be reported to ORR.

What OIG Recommends and How the Agency Responded

Our recommendations aim to improve the incident reporting system and reduce the challenges that facilities face. ACF should work with ORR to (1) systematically collect key information about incidents that allows for efficient and effective oversight, (2) track and trend incident report information to identify opportunities to better safeguard minors, (3) work with facilities to address staffing shortages of youth care workers, and (4) improve its guidance to help facilities consistently identify and report significant incidents. ACF concurred with all four of our recommendations.

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Objectives

1. To provide information on incidents reported to the Office of Refugee Resettlement (ORR) by care provider facilities that describe conduct of a sexual nature involving minors in their care.
2. To identify challenges in ORR's incident reporting process for oversight of care provider facilities.
3. To identify challenges that care provider facilities faced in preventing, detecting, and reporting incidents.

The Department of Health and Human Services (HHS), Administration for Children and Families (ACF), ORR, is the legal custodian of children younger than 18 years of age in the Unaccompanied Alien Children (UAC) Program. In this role, ORR is responsible for providing a safe environment. To address the needs of minors in its custody, ORR enters into grants or contracts with care provider facilities to house and care for minors.[1] These facilities are responsible for ensuring the safety of minors while in their care and are required to report to ORR incidents that affect a minor's health, well-being, and safety.

In recent years, facilities have faced criticism for alleged failures in their efforts to protect minors in their care. Some investigations resulted in criminal convictions of facility employees. For example, in one case a facility employee was convicted of sexually abusing seven minors between August 2016 and July 2017.[2] In another case, a facility employee was convicted of attempting to coerce a minor to engage in illicit sexual activity and exchanging explicit videos and images with other minors.[3] These incidents have highlighted the need to review the safety of minors in ORR custody.

Unaccompanied Alien Children Program

ORR, a program office of ACF within HHS, manages the UAC Program. The UAC Program serves minors who have no lawful immigration status in the United States and do not have a parent or legal guardian available to provide care and physical custody.[4] The UAC Program serves minors who arrive in the United States unaccompanied, as well as minors who, after entering the country, are separated from their parents or legal guardians by immigration authorities within the Department of Homeland Security (DHS). A minor remains in ORR custody until an appropriate sponsor, usually a parent or close relative, is located who can assume custody.[5] Minors also leave ORR custody when they turn 18 and "age out" of the UAC Program, or when their immigration status is resolved.[6] In Federal fiscal year 2018, the UAC

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Program received appropriations of $1.6 billion and cared for at least 49,100 minors.[7] About 12,400 minors were in the UAC Program at the time of our review.[8]

Care Provider Facilities

ORR funds a network of facilities that care for minors until they are released to a sponsor or otherwise leave ORR custody. The number of facilities that ORR funds has varied over time; in September 2019, ORR's network consisted of approximately 170 facilities.[9] These facilities, generally, are State licensed and must meet ORR requirements. Facilities provide housing, food, medical care, mental health services, educational services, and recreational activities.

Federal law requires the safe and timely placement of minors in the least restrictive setting that is in the best interest of the minor.[10] To that end, ORR has several different types of facilities in its network that provide different levels of care. Transitional foster care represents the least restrictive setting for minors, followed by shelter facilities, which comprise the majority of ORR's network. ORR's network also includes two residential treatment centers (RTCs) that provide therapeutic care and services that can be customized to individual needs through a structured, 24-hour-a-day program. RTC placements are intended for minors with mental health needs that cannot be addressed in an outpatient setting.[11] Additionally, ORR's network includes nine staff secure facilities, including one that provides therapeutic care in combination with a higher level of security. ORR also funds two secure facilities that operate within existing juvenile detention facilities.[12] See Appendix A for a description of the facility types in ORR's network. See Appendix B for descriptions of selected facility staff personnel.

Reporting Significant Incidents

ORR requires that all facilities report to ORR any "significant incidents" that affect a child's health, well-being, or safety.[13] Significant incidents represent a wide range of events, including medical emergencies, physical or verbal aggression between minors, self-harm (e.g., suicidal ideation), runaway attempts, and incidents of a sexual nature. These can include incidents that occur while a child is in ORR custody or events that are reported while a child is in ORR custody, but occurred before the child was referred to ORR, such as incidents in DHS border facilities, along the journey, or in their home country. Incidents are generally detected by facility staff, including youth care workers, clinicians, and case managers who interact closely with minors and may witness or hear about incidents from minors. Facility staff use ORR's Significant Incident Report process to report these incidents to ORR. According to ORR policy, the process is intended to "ensure that serious issues are immediately elevated to ORR and that all incidents are resolved quickly to protect children in ORR care."[14]

Facility staff are required to complete and submit a Significant Incident Report (SIR) within 4 hours of the incident or, for past events, within 4 hours of becoming aware of

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an incident. Facilities document details of the incident in an SIR, which is a series of electronic forms in the UAC Portal, ORR's case management system. The electronic forms contain fields for facilities to document information such as a description of the incident and actions taken to respond to the incident and protect minors. An incident of a sexual nature is documented separately in a Sexual Abuse SIR (discussed further below).

A single incident can have multiple SIRs. Facility staff must complete an SIR for each minor involved in the incident. For example, one facility completed 31 SIRs for a medical emergency—an influenza outbreak that involved 31 minors. In addition, facility staff will add information to an existing SIR when new information about the incident comes to light or they determine the original SIR was incorrect or incomplete. This added information is submitted in a separate report and referred to as an "addendum." All information related to a specific incident is linked by a unique identifier. All SIRs and addenda must be sent to ORR for review.[15]

ORR has an internal review process for all SIRs, which is conducted by ORR staff, including Federal field specialists—who serve as local ORR liaisons to one or more facilities within a geographic region.[16] The review process involves reading the reports and following up with the facility about incidents as appropriate. Additionally, Federal field specialists can discuss a facility's aggregate incidents with facility staff as needed.

Beyond internal reporting, ORR's policy also requires facilities to report appropriate incidents to State child protective services (CPS) agencies, State licensing agencies, and/or local law enforcement in accordance with mandatory reporting laws, State licensing requirements, Federal laws and regulations, and ORR policies and procedures.[17]

Reporting Incidents of a Sexual Nature

As part of the incident reporting process, ORR's policy requires facilities to report any form of inappropriate behavior that is sexual in nature that occurs in ORR custody. This includes reporting all incidents of a sexual nature, any retaliatory actions resulting from the reporting, and any staff neglect or violation of responsibilities that contributed to incidents.[18]

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ORR policy directs facilities to report any knowledge, suspicion, or information regarding an incident of a sexual nature that occurs in ORR custody using a specific form—Sexual Abuse Significant Incident Report (SA/SIR). When completing an SA/SIR, facilities are directed to categorize the incident into one of three categories:

- Sexual Abuse
- Sexual Harassment, or
- Inappropriate Sexual Behavior.

These three categories group incidents by the severity of the described behavior, with Sexual Abuse as the category capturing the most egregious allegations of misconduct. See Exhibit 1 for definitions of the three categories.

Exhibit 1: ORR Categories for Incident Reports Describing Conduct of a Sexual Nature

Sexual Abuse is the category used for the most egregious incidents which includes actual or simulated sexual intercourse, intentional touching, lascivious exposure of the genitals, etc.

Sexual Harassment includes repeated and unwelcome sexual advances and actions of a derogatory or offensive sexual nature.

Inappropriate Sexual Behavior is behavior that does not meet the definition of sexual abuse or sexual harassment but is sexual in nature.

Source: ORR Policy Manual, Section 4.1 Definitions.

Facility staff must report an SA/SIR to ORR immediately but no later than 4 hours after learning of the incident.[19] Facility staff complete an SA/SIR for each individual involved in the incident, plus addenda as needed after the initial report. The SA/SIR and any addenda must be sent to ORR for review. ORR has an Abuse Review Team that reviews allegations of a sexual nature that are considered "particularly serious or egregious in nature."[20] The team consists of members from ORR's Monitoring Team, the Division of Health for Unaccompanied Children, and ORR's Prevention of Sexual Abuse Coordinator.

In addition, ORR requires facilities to report incidents categorized as Sexual Abuse occurring in ORR custody to a variety of external agencies for further review and potential action. These include State CPS and/or licensing agencies, the Federal Bureau of Investigation (FBI), and OIG. Facilities must also report these incidents to local law enforcement if the alleged perpetrator is an adult or if required by the State licensing agency. Facilities must report incidents occurring in ORR custody and categorized as Sexual Harassment or Inappropriate Sexual Behavior to the State licensing agency according to State licensing requirements.[21]

In 2019, ORR implemented a requirement for facilities to conduct incident reviews of all incidents categorized as allegations of Sexual Abuse or Sexual Harassment and all allegations of Inappropriate Sexual Behavior involving an adult that occur in ORR custody within 30 days of the conclusion of an investigation by an external entity and provide written reports to ORR for certain types of incidents.[22] Incident reviews must include information about what happened, where it occurred, and what actions the facility took with regard to the individual against whom allegations were made, as well as recommendations for changes in policy, procedures, or practices. Incident reviews

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are intended to ensure that care provider facilities and ORR develop best practices to better prevent, detect, and respond to sexual abuse and sexual harassment.[23]

ORR is required to publish an annual report of aggregated information about the number of incidents facilities reported to ORR as Sexual Abuse, Sexual Harassment, and Inappropriate Sexual Behavior.[24] For the 2017 data collection (most recently published), ORR requested information from facilities about substantiated incidents they categorized as Sexual Abuse, Sexual Harassment, or Inappropriate Sexual Behavior for incidents that occurred between January 1, 2017, and December 31, 2017.[25] Facilities reported that 27 incidents were determined to be substantiated out of a total of 1,069 incidents reported to ORR.[26] A "substantiated" incident is one that was officially investigated by CPS, State licensing entity, or local law enforcement and determined to have occurred. According to ORR policy, incidents considered "unsubstantiated" are those that were formally investigated by an external agency and the investigation produced insufficient evidence to make a final determination as to whether the event occurred.[27] These categories relate only to those incidents reported to external entities and how those entities handled the report.

OIG Oversight Efforts

Since responsibility for the UAC Program was transferred to HHS by the Homeland Security Act of 2002, OIG has provided ongoing oversight of the Program. OIG has examined various aspects of the Program, including whether ORR grantees met safety standards for the care and release of minors in their custody, and the efforts of ORR to ensure the safety and well-being of minors after their release to sponsors. OIG issued several reports that made recommendations to address issues we identified.

In 2018, OIG intensified its oversight of the UAC Program related to child health and safety in care provider facilities. Given the seriousness of the concerns about the treatment of minors in ORR custody, including those who had been separated from their parents, OIG completed a large, multifaceted review of the UAC Program focused on the health and safety of minors in ORR's care. The review gathered data from facilities across the country, including perspectives from facility management, staff responsible for caring for minors, and ORR Federal field specialists who help to oversee individual facilities. See Appendix C for a complete list of reports issued by OIG related to this topic.

This report examines how information is captured by ORR's incident reporting system, the system's role for oversight of facilities, and the challenges that facilities face in their efforts to prevent, detect, and report incidents.

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Methodology

OIG analyzed SIRs and SA/SIRs submitted to ORR by 45 ORR-funded facilities between January 1, 2018, and July 31, 2018. We examined how the information was collected within the incident reporting system to identify any challenges for the oversight of facilities to ensure the safety of children.

The 45 facilities were purposively selected to achieve wide coverage of facilities participating in the UAC Program. The facilities cared for 72 percent of the minors in ORR custody at the time we conducted the site visits. See Appendix A for a complete list of the facility types and aggregate information about the 45 facilities.

We conducted an in-depth review of SA/SIRs that described conduct of a sexual nature. This allowed us to provide information about potentially egregious incidents and ORR's response to them. We also reviewed SA/SIRs due to heightened public concern about incidents of a sexual nature. We were not able to determine for all incidents, from the information in the reports, whether they were reported to and officially substantiated by an external agency such as a State licensing entity, child protective services, or local law enforcement. As described in the report findings, many SA/SIRs did not contain definitive information to identify an ultimate outcome regarding a reported incident.

To identify any challenges with how ORR's incident reporting system captures information about incidents that impacted the oversight of facilities' efforts to ensure the safety of children, we reviewed the information documented in SIRs and SA/SIRs. Our review of the information documented in all SA/SIRs for each incident was particularly illuminating in identifying challenges. We also used the information collected from site visits OIG conducted at the 45 facilities (that reported the SIRs and SA/SIRs we analyzed) to identify challenges that facilities faced in preventing, detecting, and reporting incidents. OIG conducted these site visits in August and September 2018. At each facility, we interviewed key facility staff who are responsible for ensuring the overall safety of children. We interviewed the program director, who is responsible for ensuring policies and procedures for incident reporting are followed by facility staff. We interviewed the human resource manager, who is responsible for staffing the facility appropriately—particularly with youth care workers who are essential for preventing, detecting, and reporting incidents. We also interviewed youth care worker shift supervisors, who oversee youth care workers throughout the day. See Appendix B for descriptions of selected facility staff positions.

After the site visits, we also interviewed the 28 ORR Federal field specialists assigned to the 45 facilities and reviewed ORR policies and procedures relevant to reporting incidents and ensuring the safety of minors.

See the Detailed Methodology section on page 23 for additional information about information about our selection of care provider facilities, data collection, and analysis.

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Limitations

The facilities that we visited were purposively selected and may not represent the experiences of staff in other facilities. We did not independently verify information provided by facility staff during interviews. We analyzed the data contained in SIRs and SA/SIRs to determine what information facilities provided to ORR through the incident reporting process. This analysis does not provide visibility into incidents that occurred but were not reported or whether the events and actions documented in SIRs and SA/SIRs actually occurred.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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FINDINGS

ORR received incident reports describing conduct of a sexual nature ranging in type and severity

ORR's policy guide, *Children Entering the United States Unaccompanied*, states that it "will make every effort to prevent, detect, and respond to" all forms of inappropriate sexual conduct involving children in its custody.[28] As part of that policy, ORR directs facilities to report all incidents involving conduct of a sexual nature and minors in its custody.[29] Facilities send ORR incident reports that describe conduct of a sexual nature, along with other forms of conduct that may pose risks to children, in ORR's significant incident reporting system.

The 45 care provider facilities that we visited submitted reports to ORR for 761 unique incidents involving conduct of a sexual nature during the 7 months between January 1, 2018, and July 31, 2018.[30, 31] This represents a relatively small proportion (3.5 percent) of the total number of 21,858 incidents that facilities reported to ORR during this time period, which includes all types of incidents occurring before and while in ORR custody. We were unable to determine whether the incidents were substantiated because of the limited information in SA/SIRs. Further, ORR's most recent annual report with aggregate data on the number of incidents that are officially substantiated by investigations conducted by CPS, State licensing entity, or local law enforcement is based on data from 2017, before our review period.[32]

Incident reports described conduct of a sexual nature ranging in type and severity

Facilities reported to ORR incidents of a sexual nature in all three ORR-defined categories—Sexual Abuse, Sexual Harassment, and Inappropriate Sexual Behavior. As shown in Exhibit 2, facilities categorized half of the 761 incidents as Inappropriate Sexual Behavior, which includes conduct that does not meet the definition of the more severe categories of Sexual Abuse and Sexual Harassment.

Exhibit 2: Facilities categorized incident reports describing conduct of a sexual nature in all three ORR-defined categories.

Sexual Abuse	32% (243)	Most severe
Sexual Harassment	19% (141)	
Inappropriate Sexual Behavior	50% (377)	Least severe
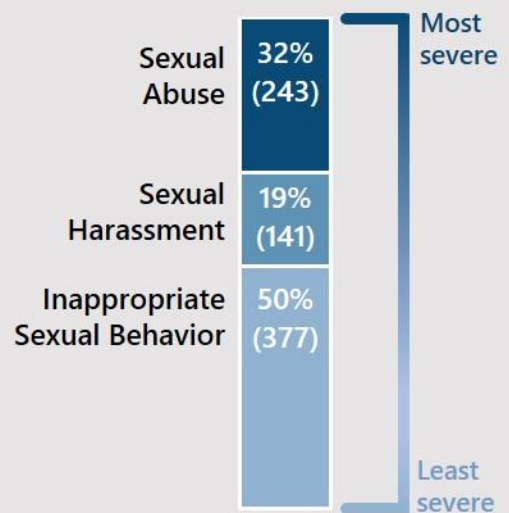
Note: Percentages do not add to up to 100 due to rounding.

Source: OIG analysis of SA SIRs reported to ORR between January 1, 2018, and July 31, 2018.

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Incidents categorized as Inappropriate Sexual Behavior included blowing a kiss to someone, drawing a woman in a bikini, and making sexual comments or gestures to another minor. Facilities categorized almost one-third of the incidents as Sexual Abuse, the category for the most egregious incidents.

Our review of the reports for the 761 incidents describing conduct of a sexual nature found that the incidents within each of the three ORR-defined categories ranged in severity. For example, as defined by ORR, an incident is categorized as Sexual Abuse when the incident involves intentional touching, either directly or through clothing, of specific body parts involved in sexual arousal (e.g., genitalia, buttocks, and inner thigh). In our review, we found an incident of a minor grabbing the buttocks of another minor while standing in line and an incident of a staff member touching a minor's genitalia both categorized as Sexual Abuse. Exhibit 3 provides selected examples of conduct described in incident reports of a sexual nature to show the range of severity facilities reported within each ORR-defined category.

Exhibit 3: Examples of conduct described in incident reports of a sexual nature show a range of severity.

SA/SIR Category	Conduct Described in Incident Reports
Inappropriate Sexual Behavior	• Minor was found with a drawing of a sexual nature • Minor opened the bathroom door while another minor was inside • Staff member viewed minor unclothed in shower when telling minor to get out of the shower
Sexual Harassment	• Minor repeatedly made sexual comments to another minor • Minor repeatedly made sexual gestures to another minor • Staff member seemed to repeatedly flirt with a minor at the facility
Sexual Abuse	• Minor leaned over a table and touched the buttocks of another minor with a spoon • Minor repeatedly grabbed the buttocks of another minor • Staff member fondled minor's genitals on multiple occasions

Note: These examples of conduct come from summaries in incident reports. We did not determine whether these incidents were correctly categorized or substantiated.

Source: OIG analysis of SA/SIRs reported to ORR between January 1, 2018, and July 31, 2018.

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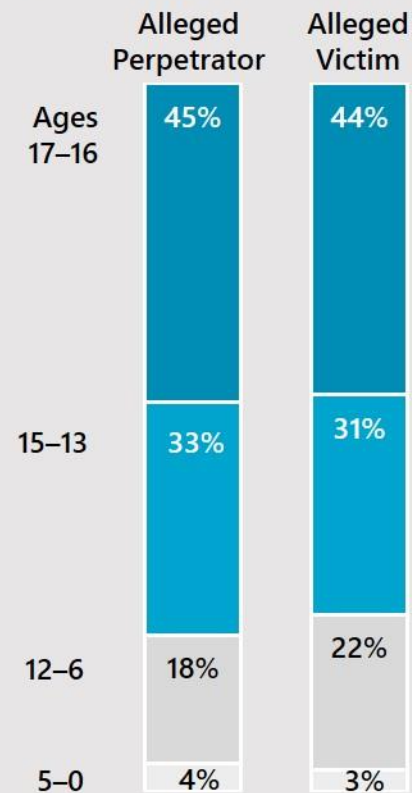OEI-09-18-00430

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Incident reports of a sexual nature largely described conduct between minors, most often older minors

Of the 761 reported incidents describing conduct of a sexual nature, 704 (93 percent) described conduct between minors. Reports for 48 incidents described conduct of a sexual nature by an adult against a minor, and reports for 9 incidents did not indicate an alleged perpetrator (e.g., the SA/SIR described discovery of a letter, sexual in nature, but the author of the letter was unknown).

Incident reports describing conduct of a sexual nature between minors most often indicated that alleged perpetrators and alleged victims were between ages 13 and 17. Seventy-eight percent of incidents indicated that the alleged perpetrator was between ages 13 and 17 and 75 percent indicated that the alleged victim was between ages 13 and 17 at the time the incident was reported to ORR.[33] Almost half of the reported incidents involving conduct of a sexual nature between minors indicated that the alleged perpetrator or the alleged victim were age 16 or 17.[34] Incidents can include consensual activity between similarly-aged teenagers that may be considered common (e.g., kissing). Facilities must report incidents regardless of whether the described conduct of a sexual nature was consensual or nonconsensual.[35] See Exhibit 4 for the ages of minors involved in reported incidents describing conduct of a sexual nature.

Exhibit 4: Incident reports describing conduct of a sexual nature between minors most often involved minors between ages 13 and 17.

Ages	Alleged Perpetrator	Alleged Victim
17–16	45%	44%
15–13	33%	31%
12–6	18%	22%
5–0	4%	3%

Source: OIG analysis of SA SIRs reported to ORR between January 1, 2018, and July 31, 2018.

Nine reported incidents (9 of 704) described conduct of a sexual nature by alleged minor perpetrators age 16 or 17 against alleged minor victims age 12 or younger. All nine incidents were categorized by facilities as Inappropriate Sexual Behavior, the category intended to capture the least egregious incidents. Three of the nine incidents involved the older minor viewing the younger minor naked. Other examples included an older minor kissing a peer's infant son without parental consent and an older minor pulling down the pants of a younger minor while waiting in line.

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Reports for 48 incidents described conduct of a sexual nature by an adult, most commonly a staff member of a care provider facility, against a minor

Most of these incidents (43 of the 48) had reports that alleged conduct of a sexual nature by a facility staff member against a minor. Youth care workers were most commonly involved in these incidents (25 of the 43). Other facility staff positions involved in the incidents include youth care worker shift supervisor, case manager, clinician, teacher, and detention officer at a secure facility. The remainder of these incidents (5 of the 48) involved adults who were not facility staff members, such as a child advocate or foster parent.

Incident reports described conduct of a sexual nature involving an adult that varied in type and severity. For example, the incident reports included descriptions of a youth care worker accidentally opening a bathroom door while a minor was inside, as well as an incident involving a staff member kissing a teenaged minor. As shown in Exhibit 5, facilities most commonly categorized the incidents involving adults as Sexual Abuse—the most serious of the three categories. Most of these incidents (41 of 48) involved alleged victims who were age 16 or 17.

Exhibit 5: Facilities categorized 48 incidents involving conduct of a sexual nature *by an adult* in all three ORR-defined categories, most commonly Sexual Abuse.

Sexual Abuse — 23 — Most severe

Sexual Harassment — 13

Inappropriate Sexual Behavior — 12 — Least severe
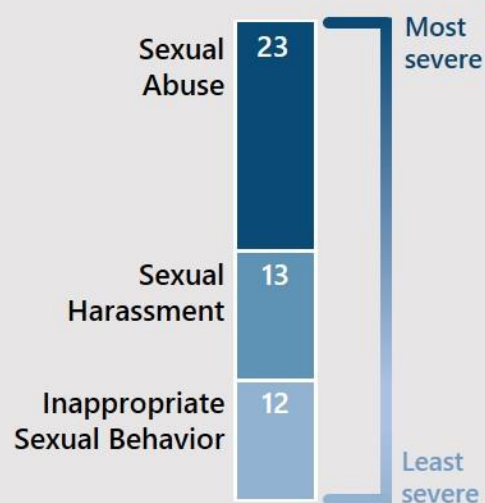
Source: OIG analysis of SA SIRs reported to ORR between January 1, 2018, and July 31, 2018.

ORR's incident reporting system lacks designated fields to capture information about the actions that care provider facilities took to protect minors in response to reported incidents of a sexual nature

In response to incidents of a sexual nature that facilities report to ORR as Sexual Abuse and Sexual Harassment, ORR policy requires that facilities take certain immediate steps to protect minors in their care. However, ORR's incident reporting system lacks designated fields for facilities to indicate whether they took all required steps or to explain why they did not. This limits ORR's oversight capacity because ORR staff cannot quickly and easily access this information to elevate incidents that

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require immediate attention and ensure that facilities are taking required steps to address serious incidents. Further, ORR cannot track or trend these data across facilities to oversee compliance with requirements.

Suspending facility staff members alleged to have committed sexual conduct against a minor. ORR policy states that facilities must immediately suspend any staff member involved in an incident categorized as Sexual Abuse or Sexual Harassment from all duties involving contact with minors until the investigation is completed.[36]

However, ORR's incident reporting system does not include a designated field for facilities to indicate whether they have suspended staff members as required. Thirty-three incidents involving facility staff members were categorized as Sexual Abuse or Sexual Harassment. Nineteen of these 33 incidents had documentation in the SA/SIR indicating that the staff member was immediately suspended as required. For each of the remaining 14 incidents, we did not find documentation in the SA/SIR indicating that the staff member was suspended as required. The facilities could have reasons for not suspending a staff member or it is possible that the facility did suspend the staff member but failed to document it in the SA/SIR. Regardless, ORR staff cannot always determine from the information in the SA/SIR whether the facility took the appropriate and required action and would have to contact the facility separately to make that determination.

Reporting incidents categorized as Sexual Abuse to law enforcement and State agencies. ORR requires facilities to report incidents categorized as Sexual Abuse occurring in ORR custody to a variety of external agencies for further review and potential action. These include State CPS and/or licensing agencies, the FBI, and OIG. Facilities must also report these incidents to local law enforcement if the alleged perpetrator is an adult or if required by the State licensing agency. Facilities categorized 23 of the 48 reported incidents involving an adult as Sexual Abuse, requiring reporting to local law enforcement.

Although ORR's incident reporting system includes designated fields for facilities to indicate whether they reported incidents categorized as Sexual Abuse to external agencies, it does not include designated fields for facilities to explain when they do not report the incident as required. Without a designated field to explain non-reporting, facilities may or may not provide this information elsewhere in the report. For example, reports for seven of the 23 incidents categorized as Sexual Abuse with an adult as the alleged perpetrator indicated that the facility did not report the incident to the local law enforcement agency, as required by ORR policy. Reports for four of these seven incidents included statements about the lack of reporting to law enforcement, such as the facility's determination that law enforcement reporting was not required or necessary. Reports for the other three incidents, however, provided no information about the lack of reporting to law enforcement.

To perform appropriate oversight of facilities, ORR must determine whether a facility complied with the requirement for reporting to external agencies or its reason for not

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complying. A designated field for facilities to explain their rationale for not reporting to external agencies would help ensure that this information is consistently documented and easily available to ORR staff.

Implementing a safety plan for alleged minor perpetrators. For Sexual Abuse and Sexual Harassment incidents involving alleged minor perpetrators, ORR policy states that the facility must develop and implement a safety plan for that minor.[37] This safety plan is designed for the alleged minor perpetrator to prevent harm to self and others. However, ORR's incident reporting system does not include a designated field for facilities to indicate whether a safety plan was implemented for the alleged minor perpetrator.

In our review of incidents categorized as Sexual Abuse or Sexual Harassment and involving minor perpetrators, for over half of all incidents, the SA/SIRs did not document implementing a safety plan for the alleged minor perpetrator as required. Although it is possible that the facilities did implement a safety plan and did not document it, ORR staff cannot make that determination from the information in the SA/SIR.

ORR's incident reporting system does not effectively capture information to assist ORR's oversight of care provider facilities' efforts to ensure the safety of minors

In addition to the incident reporting system lacking needed designated fields for reported incidents of a sexual nature, the reporting system may not capture pertinent information about incidents more broadly, including those that are not of a sexual nature.

ORR's incident reporting system captures information in a manner that requires extensive manual review

In general, the incident reporting system uses numerous open-text fields to capture a wide range of information that require Federal field specialists and other ORR staff to review narrative summaries to access key information. Manual reviews with key information entered in different ways in open-text fields raises the potential that key information may be missed. Federal field specialists need to be able to access key information quickly to elevate incidents that require attention and for timely followup with facilities to ensure appropriate response to incidents.

Manual reviews can be inefficient for Federal field specialists who must review, for each incident, all SIRs or SA/SIRs and addenda to identify any key information that is captured by open-text fields. For example, one report describing conduct of a sexual nature included five SA/SIRs. The SA/SIRs all had a "Description of Incident" that contained about 1,200 words each to describe the incident, which involved sexual

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comments and exposure of genitalia. Additional addenda can also add more time to the Federal field specialist's review. Identifying and differentiating new information in addenda can be time-consuming because information from the initial SIR or SA/SIR is often copied into the addendum obscuring the new information. Among the 761 reported incidents of a sexual nature, 482 (63 percent) had addenda.

ORR's incident reporting system lacks fields to capture key information

Although facilities provide a wealth of information about incidents in SIRs and SA/SIRs, which can be helpful for ORR's oversight, several important pieces of information are not systematically collected to allow for effective oversight. As mentioned earlier, the incident reporting system does not have designated fields in SA/SIRs to collect information about required actions for incidents reported to ORR as Sexual Abuse or Sexual Harassment (i.e., suspending facility staff members alleged of sexual conduct against a minor, reporting incidents categorized as Sexual Abuse to law enforcement and State agencies, and implementing a safety plan for alleged minor perpetrators). Likewise, there is key information in SIRs and SA/SIRs that is not being captured effectively in a manner that allows for efficient analysis to identify issues requiring elevation and attention or to detect concerning trends with safety issues at particular facilities.

Whether the incident captured in an SIR occurred while a minor was in ORR custody. ORR's incident reporting system does not have a designated field for facilities to clearly indicate whether the incident occurred while the minor is in ORR custody. Efficiently identifying which incidents occurred while the minor is in ORR custody is crucial to ORR's ability to oversee facilities' responses to incidents and ensure the safety of minors in its care.

The absence of a field clearly indicating whether the incident took place while the minor was in ORR custody is more problematic for SIRs than SA/SIRs. Generally, SA/SIRs are to be used for reporting incidents of a sexual nature that are alleged to have occurred in ORR custody. However, facilities use SIRs to report incidents of a sexual nature outside of ORR custody, as well as incidents affecting a minor's health, well-being, and safety that occurred either within or outside of ORR custody.

In many cases, traumatic experiences that happened to a minor before he or she is referred to ORR meet ORR's criteria for incident reporting, prompting facilities to submit SIRs. Facility managers and mental health clinicians reported that many minors who entered facilities in 2018 had experienced intense trauma from a variety of events before and upon their arrival in the United States. According to mental health clinicians and program directors, some minors had experienced physical or sexual abuse and other forms of violence while in their country of origin. Mental health clinicians and program directors also reported that some minors experienced or witnessed violence during the trip to the U.S. border.[38]

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In the absence of a designated field indicating whether an incident occurred in ORR custody, manual review of an SIR is required to determine whether the incident occurred in ORR custody. Currently, to determine whether an incident reported in an SIR occurred in ORR custody, staff have to rely on a field that provides several types of close-ended options to indicate the location of the incident: (1) within the facility (i.e., "Housing Area," "School Area," "Medical Facility On-site," and "Recreational Area On-site"), (2) "DHS facility/custody," and (3) "Other." If a facility selects "Other," it can specify the location in an open-text field.

More than half (58 percent) of all incidents, reported with SIRs, indicated "Other" as the location of the incident. Facilities selecting "Other" sometimes documented in the open-text field that the incident occurred outside of ORR custody (e.g., "home country") and in ORR custody (e.g., "dorm area"). Thus, a manual review of the open-text field is needed to accurately identify and track which incidents occurred while children were in ORR custody.

Whether video footage is available and reviewed. ORR policy requires facilities to have video monitoring technology when allowed under applicable State and local licensing standards.[39] However, ORR's incident reporting system does not have a designated field to systematically capture whether video footage was available or reviewed for incidents that occurred in areas where it would be expected to be available (e.g., in a public setting like a recreation area). Systematic collection of this information could alert ORR staff that the facility may not have appropriately placed, functioning cameras or may not be reviewing video footage when available.

Our review of reports for incidents of a sexual nature showed that only 11 percent (81 of 761) indicated that video footage of the conduct described in the incident report had been reviewed. Notably, for over half of these 81 incidents, facilities indicated that video footage helped to substantiate 33 incidents and refute or call into question 10 incidents.

Care provider facilities described challenges preventing, detecting, and reporting incidents

Care provider facilities reported staff shortages of youth care workers who are essential to detecting incidents

Staff shortages of youth care workers can affect facilities' ability to prevent and detect incidents because they provide around-the-clock supervision of minors. ORR's minimum staff-to-children ratios for youth care workers is 1:8 during waking hours and 1:16 during sleeping hours.[40] Most of their time is spent with minors—more than any other facility staff member. They prevent, de-escalate, and report incidents that could result in harm to minors. If there is a shortage of youth care workers, the

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facilities lose eyes and ears to detect incidents between minors or between other staff members and minors.

Twenty-eight of the 45 facilities that OIG visited reported being understaffed with youth care workers at the time of our visits in August and September 2018. Almost all of those facilities also reported being understaffed with youth care workers in the previous year. Facilities reported that maintaining adequate youth care worker staffing levels was further strained during shifts when youth care workers were assigned to provide individual monitoring of a minor, also referred to as "one-on-one supervision." One-on-one supervision moves youth care workers who could be watching up to 8 minors during waking hours and 16 minors during sleeping hours to monitoring one minor. Individual supervision is used when a minor is at-risk of self-harm or harming others. Although it can be necessary for safety, one facility reported that one-on-one supervision utilizes a huge part of the staff, which often leaves the facility short-staffed to monitor minors. Another facility, already understaffed with youth care workers, reported that one-on-one supervision exacerbated the problems with providing monitoring.

When facilities faced staff shortages of youth care workers, they reported using 12-hour shifts, 6-day work weeks, or mandatory overtime for youth care workers, which placed burdens on them that could affect their ability to carry out their role of preventing and detecting incidents. Human resource managers and youth care worker shift supervisors reported that longer shifts, extra workdays, and overtime led to exhaustion and burnout of youth care workers. The shift supervisors described the youth care worker position as "fast-paced" and "stressful." One shift supervisor described how it is challenging to meet the needs of minors while knowing what they have gone though. Human resource managers and shift supervisors also described youth care workers as "exhausted," "overworked," and "burnt out." These challenges may affect youth care workers' ability to prevent, detect, and report incidents. Furthermore, facility staff reported that these conditions lead to a high turnover of youth care workers, which in turn exacerbates understaffing of this essential position.

"It is especially difficult to retain youth care workers. They suffer compassion fatigue and physical fatigue."

– Human resource manager

Facilities experienced challenges with determining which incidents should be reported to ORR

Facility program directors, Federal field specialists, clinicians, and direct care staff reported that it is sometimes difficult for facility staff to interpret ORR policy regarding whether incidents fall under the definition of a significant incident and, therefore, should be reported to ORR. Language in the ORR policy about reporting incidents is not restrictive, and includes phrasing such as:

"Significant incidents include, but are not limited to…";

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"Any type of non-emergency incident that endangers the safety or well-being of the minor"; and

"Any knowledge, suspicion, or information regarding…inappropriate sexual behavior."[41]

Such non-restrictive policy language allows for flexibility to account for the reporting of different types of incidents to ORR, but this also makes it open to interpretation—within ORR and across facilities—and creates challenges for reporting incidents.

Program directors, other facility management, and direct care staff reported that ORR staff sometimes interpreted the policies differently, which can lead to inconsistent reporting of incidents. One program director said, "With ORR, when we seek help, we get different answers. We talk to other programs and have learned that for the same type of situation, a [Federal field specialist] for one program gives one answer but a [Federal field specialist] for another program will give a different answer." Others described similar situations with Federal field specialists, as well as incidents where they felt ORR staff provided inconsistent information during meetings and where they felt oral guidance made definitions more confusing.

Although the non-restrictive language in ORR policy allows ORR to capture many types of incidents varying in type and severity, program directors, clinicians, youth care worker shift supervisors, and direct care staff expressed discomfort with reporting certain types of incidents. They pointed out that, as written in policy, the definition of a significant incident can be interpreted to include behaviors that are often common for the age of the minors involved in an incident. They described incidents of teenagers verbally teasing each other about their masculinity or "slapping butts" on the soccer field. Other staff members expressed frustration about having to report an incident of children "roughhousing" when the type of "horseplay" felt common for minors their age and had no indication of malicious intent. Nonetheless, in all these instances the facilities reported the incidents to ORR as they believed it was required.

> *"Sometimes [reporting an incident] is like criminalizing normal child behaviors."*
>
> *-Program director*

Program directors and facility staff identified several reasons why this concerned them. One staff member described needing to label someone a "perpetrator" in the initial report without any investigation. Others expressed concerns that over-reporting could harm trust and relationships between the minors and staff, as well as between the minors themselves, as the minors blamed one another for potentially "mess[ing] up [each other's] case[s]." Given these factors, they felt that reporting incidents required a balance that is not accounted for in ORR's policy of directing facilities to report all incidents of a sexual nature involving minors in its custody.

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RECOMMENDATIONS

ORR is responsible for providing for the needs of minors in the UAC Program. This includes being committed to protecting the minors in its custody.[42] To ensure that the care provider facilities that directly care for minors are appropriately preventing and addressing harmful incidents, ORR requires that they report incidents to ORR staff for review. We found that facilities reported a range of incidents to ORR that varied widely in the type and severity of behavior. ORR must be able to efficiently use this information to help oversee facilities and improve policies and procedures. Insufficient information can hamper ORR's oversight of the UAC Program, including its ability to protect minors by using data to identify threats and prevent future incidents. This ability is critical because even a single individual can cause immeasurable harm if he or she poses a threat to the well-being of minors in ORR's care.

To understand the types of incidents that facilities reported and to examine how the information was collected with the UAC Portal, we reviewed SIRs and SA/SIRs. Our findings indicate that improvements can be made in ORR's incident reporting system to make it a more efficient and effective oversight tool that will better allow ORR to ensure that facilities appropriately report and respond to incidents.

We offer recommendations to help improve the efficiency and effectiveness of the incident reporting system for oversight of facilities, as well as to reduce the challenges that care provider facilities face in their efforts to prevent, detect, and report incidents.

We recommend that ACF should work with ORR to:

Systematically collect key information about incidents that allows for efficient and effective oversight to ensure that facilities are taking appropriate actions to protect minors

ORR should fully assess its incident reporting system to determine what key information it needs to capture systematically to support its oversight of individual facilities and identify potential programmatic vulnerabilities. This should include assessing current fields for usefulness and determining whether to create new fields to strengthen its oversight. Altogether, the incident reporting system should be improved for efficiency and to facilitate the analysis of information (e.g., automating tasks for tracking and trends analysis).

ORR should assess the fields currently used in the incident reporting system to ensure that it collects consistent, accurate, and comprehensive data that ORR can use to

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oversee facilities in an efficient and effective manner. ORR should learn from its assessment how to optimize field characteristics (e.g., field completion requirements and formatting as open text, singular options, multiple options) for data collection and usability.

ORR should assess whether to create new fields to collect additional information that can support its oversight of facilities and identification of program vulnerabilities. At a minimum, the incident reporting system should be designed so ORR can quickly and easily identify whether facilities have taken appropriate and required actions for an incident, including whether they have suspended facility staff members involved in a Sexual Abuse incident. ORR should also be able to quickly and easily identify whether facilities implemented safety plans for alleged minor perpetrators accused of Sexual Abuse and Sexual Harassment.

In its assessment of the incident reporting system, we encourage ORR to gather information from facility staff and Federal field specialists who use the system. This will help ensure that any changes account for the realities that they experience working at and with facilities.

Track and trend incident report information to better safeguard minors in ORR care

After ORR improves its system for capturing information about incidents, ORR should use its data to ensure that care provider facilities are taking effective actions to address incidents when they occur and to systematically examine facilities to improve the program. ORR should track and trend information that can be used to inform policy changes and target future guidance for better prevention, detection, and reporting of incidents. The ability to follow key information and use it to identify patterns within facilities and across the UAC Program enables ORR to develop better practices and policies to improve prevention, detection, and response to incidents.

Work with care provider facilities to address staffing shortages of youth care workers that impact the ability to prevent, detect, and report incidents

ORR should develop strategies to help facilities recruit and retain enough youth care workers to ably prevent, detect, and report incidents.

ORR should also work with facilities that have overworked youth care workers—perhaps due to one-on-one supervision, 12-hour shifts, mandatory overtime, or high turnover—to find ways to reduce the strain on youth care workers, as this potentially impacts their ability to prevent and detect incidents. ORR could provide facilities with technical assistance on best practices for recruiting and retaining staff, stress management, and other identified factors.

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Improve ORR's guidance to facilities to help them consistently identify and report significant incidents

ORR should clarify its guidance to help facilities understand what incidents fall under the definition of a significant incident. Although a broad definition provides flexibility, it can also lead to inconsistent reporting and potential over-reporting, which may detrimentally distract ORR staff and facilities from serious incidents that need immediate attention. ORR should gather facility input on areas where it feels the guidance lacks clarity, including when and how to best complete SIRs, and how to accurately categorize incidents of a sexual nature. Gathering facility input would help ensure that revised definitions and other changes are clear and helpful to facility staff. Engaging facility staff may also help increase compliance.

ORR should also consider integrating definitions and guidance into the incident reporting system's user interface to provide facility staff with accessible, ongoing support. ORR should analyze the information in SIRs and SA/SIRs to identify areas of inconsistent reporting that could be addressed by improving policies, procedures, and guidance.

ORR regularly provides trainings to facility and ORR staff on the incident reporting process. However, inconsistency in the interpretation of policy remains an issue. ORR should update its trainings to reflect the new guidance and ensure consistent application across facility and ORR staff.

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ACF concurred with all of our recommendations for ORR.

In concurring with our first and second recommendations that address the systematic collection of key information about significant incidents reported by facilities and its review and use, ACF described current efforts underway that address these recommendations. ACF reported that ORR is in the early development stages of a replacement system for the UAC Portal that will be called "UAC Path" with an expected deployment in late 2021. As part of the development of this system, ACF reports that ORR's Prevention of Sexual Abuse (PSA) team has provided recommendations for significant changes to the SA/SIR reporting function, including the changes recommended by OIG to allow for efficient and effective oversight by ORR of care provider facilities. ACF also reported that ORR has expanded the PSA team by adding a data analyst who tracks and trends information related to reports of alleged sexual abuse. ACF anticipates that ORR's ability to identify potentially problematic trends across its network of facilities will be even further enhanced after ORR deploys UAC Path with its upgraded ability to capture additional information about SA/SIRs. We commend ORR's ongoing efforts to improve the reporting system. As ORR continues its development of this system, we reiterate our suggestion that it gather information from facility staff and Federal field specialists who use the system to better assess the utility of current fields and determine the necessity of new fields. We also recommend that these efforts encompass reporting for all types of significant incidents, not just incidents of a sexual nature.

ACF concurred with our third recommendation and described its current methods for addressing staff shortages of youth care workers. ACF reported that ORR Project Officers help facilities address staff shortages of youth care workers via monthly meetings with assigned facilities to check on their operational status. ACF also mentioned that ORR uses site visits and other regular monitoring activities to identify and troubleshoot issues related to staffing levels and turnover. In addition, ACF described its commitment to supporting staff with resiliency training to help with the psychological strain associated with working with a vulnerable population. We acknowledge and appreciate these efforts; however, our recommendation is for ORR to identify new and innovative ways to support and maintain adequate youth care worker staffing levels, in addition to the support it has offered to facilities.

ACF concurred with our fourth recommendation. It acknowledged that ORR's policies employ broad language that requires careful judgment by facilities regarding what conduct should be reported. It agreed that ORR can provide better guidance to assist facilities in interpreting the policy in a consistent manner. To address this issue related to the identification and reporting of Sexual Abuse, Sexual Harassment, and Inappropriate Sexual Behavior SIRs, ACF reported that ORR has updated its training

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materials, provided more and regular trainings on the SA/SIR reporting process, and expanded its PSA team, who provide guidance to facilities and ensure compliance with SA/SIR reporting requirements. As ORR works to clarify guidance in response to this recommendation, we reiterate our suggestion that ORR gather facility input to ensure that revised definitions are helpful to facility staff. In addition, we encourage ORR to gather facility input on areas where guidance lacks clarity for other types of significant incidents that are not sexual in nature. We also encourage ORR to integrate efforts to improve consistent reporting for all significant incidents into its development of the new UAC Path system.

For the full text of ACF's comments, see Appendix D.

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DETAILED METHODOLOGY

Selection of Care Provider Facilities

We used a purposive selection process to achieve wide coverage of facilities participating in the UAC Program. To ensure a diverse set of facilities, our selection included facilities that:

- varied in size,
- operated in different geographic locations,
- operated as shelters or as specialty facilities,
- cared for minors of varying ages, and
- cared for separated children.

The 45 visited sites included facilities that cared for 72 percent of the minors in ORR custody at the time of our review. We visited 19 of the largest facilities in ORR's network. Of the facilities that we visited, about two-thirds (28) were shelter facilities, the most common type of facility in ORR's network. We also visited every RTC (2), staff secure (9), secure (2), and influx (2) facility in ORR's network at the time. Most facilities (29 of the 45) cared for teenagers, but we also visited 16 facilities that cared for younger minors. Additionally, 37 facilities that we visited cared for at least one child who had been separated from a parent after entering the United States. See Appendix A for more information about the facilities that we visited.

Data Collection

Significant Incident Reports. We obtained from ORR all SIRs and SA/SIRs submitted between January 1, 2018, and July 31, 2018, by the 45 selected facilities. For one of the 45 selected facilities, the SIRs we obtained from ORR were submitted by its shelter, while our site visit took place at its residential treatment center.

Facility site visits. Multidisciplinary teams of OIG staff conducted each site visit. Each team consisted of at least one evaluator, auditor, investigator, and attorney. These teams were trained in advance regarding their responsibilities specific to this fieldwork. Onsite activities included, among other things, interviewing key facility personnel, examining facility employee records, and conducting structured assessments of facility premises.

Key personnel interviews. We interviewed key personnel in private using standardized interview protocols. Each protocol included a variety of questions intended to help us learn more about how facilities protect minors from harmful incidents and any challenges they face in doing so.

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- Program directors responded to a series of questions about assessments for identifying safety concerns, methods for minors and staff to report safety concerns, and challenges faced in preventing, responding to, reporting, and documenting safety incidents. Program directors also discussed their facilities' recruiting and staffing.
- Human resource managers responded to a series of questions about staffing levels for several staff positions—including youth care workers, mental health clinicians, and case managers—about challenges faced in hiring and retaining these positions.
- Youth care worker shift supervisors responded to a series of questions about what their experience and responsibilities were, how they respond to safety incidents—including inappropriate behavior by other staff members—and what challenges they faced in keeping minors safe.

ORR Federal field specialist interviews. In the weeks following the site visits, OIG staff interviewed the 28 ORR Federal field specialists who worked directly with each of the 45 selected facilities. During these interviews, we gathered information and insights from ORR Federal field specialists about challenges and concerns with how facilities ensured the safety of minors in their care.

Policies and procedures. We reviewed policies and procedures relevant to supervising minors and ensuring their safety.

Analysis

Significant Incident Reports. We performed the following quantitative analyses on incident reports submitted to ORR by the 45 care provider facilities between January 1, 2018, and July 31, 2018, to determine:

- A count of all unique incidents reported with SIRs and SA/SIRs represented in the dataset.
- The number of unique events reported with SIRs that occurred: (1) in ORR custody, (2) outside of ORR custody, and (3) for which we could not make this determination. We performed this analysis using a closed-ended field designated for facilities to indicate an incident's location.
- The age of minors involved in each unique incident of a sexual nature. We performed this analysis by comparing children's dates of birth to the date of the first SA/SIR submission for each event.

Manual Review of SA/SIRs. We manually reviewed SA/SIRs to identify and categorize the nature of each incident, facilities' responses to the incidents, the involvement of local law enforcement and State regulatory agencies, and other relevant characteristics of the incidents (e.g., whether video footage was reviewed for the incident). We combined the results of this manual review with information contained within structured fields in the SA/SIRs and performed quantitative analyses to provide descriptive statistics about the incidents, the individuals involved, actions

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taken by the facility in response to the incident, and volume of SIRs processed through the ORR incident reporting system.

Interviews. We performed qualitative analysis of the interviews conducted during the site visits. The analysis identified themes related to challenges ensuring the safety of minors in ORR's custody. We aimed to identify significant challenges impacting safety, as reported by facility staff and ORR Federal field specialists. A challenge was considered significant if it was identified by multiple ORR Federal field specialists or care facility program directors. The report does not reflect every challenge that facility staff mentioned during interviews.

Qualitative analysis involved multiple steps carried out by OIG staff. The analysis team used qualitative analysis software to organize interview responses related to protecting minors from harmful incidents and the effectiveness of the incident reporting process and categorize themes that emerged. Results were examined to identify significant challenges reported by facility personnel and ORR Federal field specialists.

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Care Provider Facilities Visited by OIG

During August and September 2018, OIG staff conducted site visits to 45 facilities across 10 States.
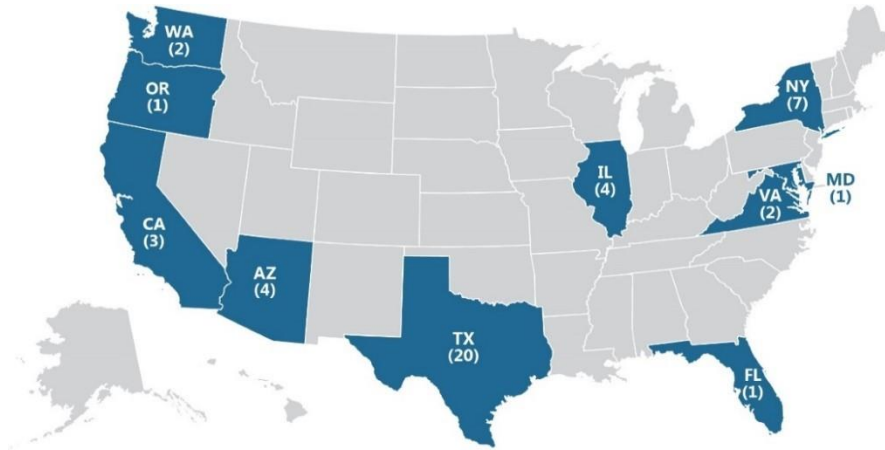
Number and Type of Facilities Visited

28	Shelter	Most common type of residential care facility; provides housing, food, medical care, mental health and educational services, and recreational activities.
9	Staff Secure	Provides close supervision to children who exhibit disruptive behavior, are a flight risk, or display gang affiliation. This includes the only therapeutic staff secure facility that ORR funded at the time of our site visit, which provides a combination of close supervision and intensive support and clinical services (e.g., in-depth counseling).
2	Secure	Provides care for children who pose a danger to self or others, or who have been charged with a crime.
2	Residential Treatment Center	Provides children who need more intensive mental health treatment with sub-acute therapeutic care through a structured 24-hour-a-day program and services that are highly customized to individual needs.
2	Influx	Provides children with temporary emergency shelter and services; used when ORR experiences an influx of children.
2	Transitional Foster Care	Provides short-term foster care for children younger than 13 years of age, siblings, pregnant and parenting teens, or those with special needs; services provided in the community.

Source: OIG analysis of ORR and facility data, 2019.

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Facilities Visited

The table below lists and describes the 45 facilities that OIG visited.

Facility Name	Facility Type	Number of Children in Care*	Licensed to Care for Younger Children**	Cared for Separated Children***
Arizona (4)				
SWK Campbell	Shelter	126	●	●
SWK Casa Phoenix	Shelter	385		●
SWK Estrella	Shelter	295	●	●
SWK Hacienda del Sol	Shelter	139	●	●
California (3)				
BCFS Fairfield	Staff Secure	11		
SWK Pleasant Hill	Shelter	26		●
Yolo County	Secure	19		
Florida (1)				
Homestead	Influx	1,347		●
Illinois (4)				
Heartland CRC IRC	Shelter	193	●	●
Heartland Casa Guadalupe	Shelter	47	●	●
Heartland IYC	Staff Secure	6		
Heartland SCIY	Shelter	5		●
Maryland (1)				
Board of Child Care	Shelter	42	●	●
New York (7)				
Abbott House	Shelter	51	●	●
Cayuga Centers	Transitional Foster Care	609	●	●
Children's Village	Shelter	167		●
Children's Village	Staff Secure	26		
MercyFirst	Residential Treatment Center	9		●
Leake and Watts/ Rising Ground	Shelter	47		●
Lincoln Hall	Shelter	184		●
Oregon (1)				
Morrison Paso	Staff Secure	11		

(*Continued on next page*)

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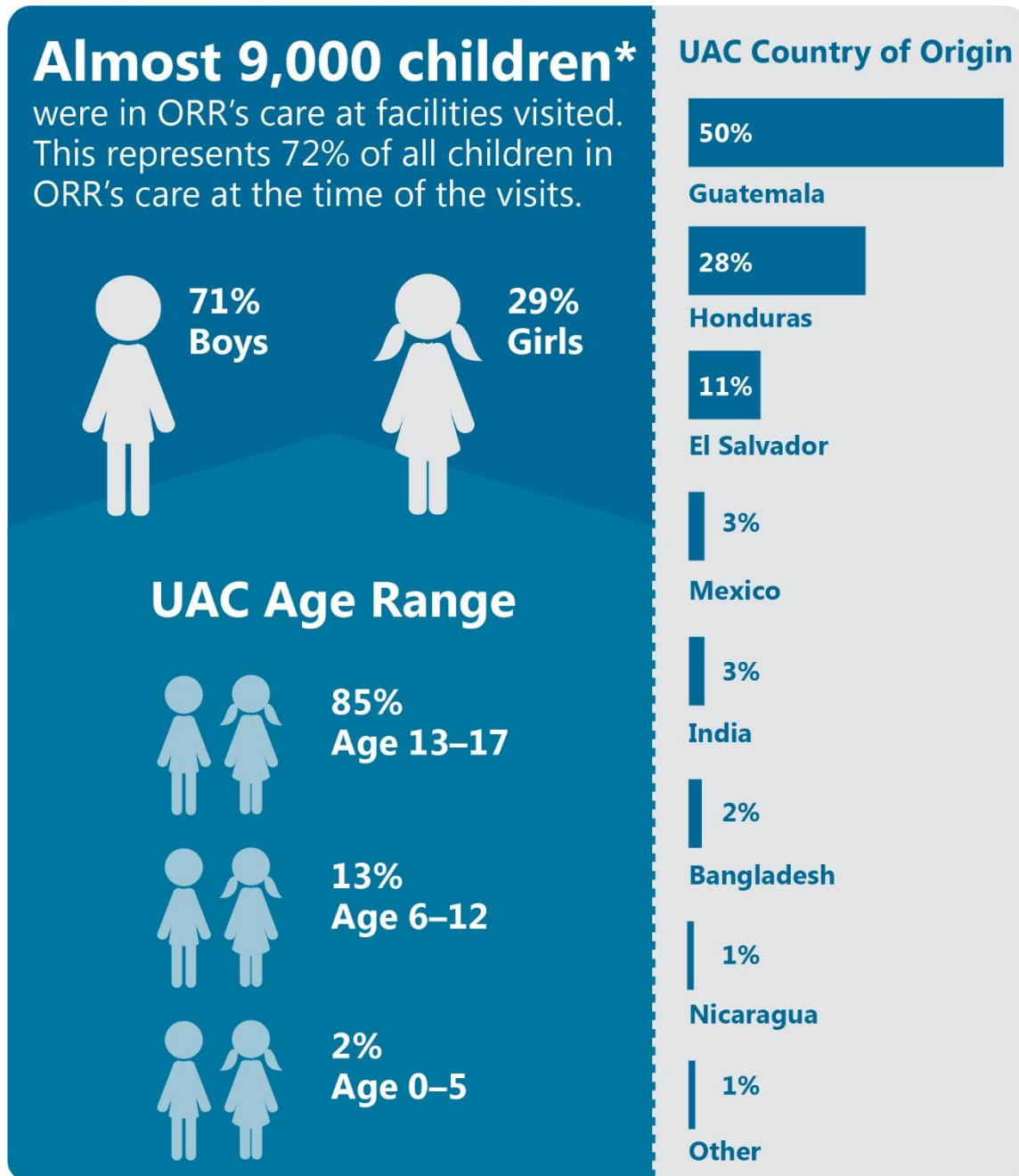| Facility Name	Facility Type	Number of Children in Care*	Licensed to Care for Younger Children**	Cared for Separated Children***
Texas (20)				
BCFS Baytown	Shelter	216	●	●
BCFS Harlingen	Shelter	576	●	●
BCFS Raymondville	Shelter	50	●	●
BCFS San Antonio	Shelter	110	●	●
BCFS San Antonio	Staff Secure	26		
BCFS San Antonio	Transitional Foster Care	119	●	●
BCFS Tornillo	Influx	665		●
Shiloh Treatment Center	Residential Treatment Center	23		●
SWK Antigua	Shelter	276		●
SWK Casa Houston	Shelter	71		●
SWK Montezuma	Shelter	209		●
SWK Casa Padre	Shelter	1,398		●
SWK Casa Quetzal	Shelter	246		●
SWK Casita del Valle	Shelter	84	●	●
SWK Combes	Shelter	73	●	●
SWK Mesa	Staff Secure	7		
SWK El Presidente	Shelter	372	●	●
SWK Nueva Esperanza	Shelter	290		●
SWK Processing Center	Staff Secure	16		
SWK Rio Grande	Shelter	225		●
Virginia (2)				
Shenandoah Valley Juvenile Center	Secure	20		●
Youth for Tomorrow	Shelter	111		●
Washington (2)				
Friends of Youth	Staff Secure	11		●
Selma Carson	Staff Secure	14		●

Source: OIG analysis of ORR and HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) data, 2019.
* Data on the number of children in care was as of August 30, 2018.
** Younger children include those who were 9 years old and under.
*** We obtained from ORR and ASPR data on separated children that were part of the *Ms. L v. ICE* lawsuit. Our analysis identified that 37 of the 45 facilities had children covered by the lawsuit.

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Children's Demographics at Facilities Visited

Almost 9,000 children*
were in ORR's care at facilities visited. This represents 72% of all children in ORR's care at the time of the visits.

71% Boys

29% Girls

UAC Age Range

85% Age 13–17

13% Age 6–12

2% Age 0–5

UAC Country of Origin

50%	Guatemala
28%	Honduras
11%	El Salvador
3%	Mexico
3%	India
2%	Bangladesh
1%	Nicaragua
1%	Other

Source: OIG analysis of ORR and facility data, 2019.

*According to ORR data, on August 30, 2018, a total of 12,409 children were in ORR custody. Of those, 8,953 children were at the facilities that OIG visited; the percentages of boys and girls are based on this number. The percentages on age range and country of origin are based on data collected directly from the facilities that we visited. We reviewed age and country of origin data that facilities provided to OIG. Because some facilities provided data for a point-in-time (i.e., specific date) while other facilities provided data over a specific timeframe (i.e., 3-month period), the total number of children between these two data points differs. Age range is based on data from 5,835 children; country of origin is based on data from 7,081 children. Because of rounding, the total percentage for country of origin does not add up to 100 percent.

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APPENDIX B

Job Descriptions of Key Personnel

Below are job descriptions of individuals involved in the care and placement of children in facilities.[43]

Program Directors. Program directors are senior facility staff who manage facility staff and oversee facility operations.

Medical Coordinators. Medical coordinators arrange care from external providers, coordinate other services related to children's medical and mental health care, and manage medication.

Mental Health Clinicians. Mental health clinicians are employed at every facility and are responsible for providing in-house mental health care for children in the facility. They conduct mental health assessments, provide counseling services, provide crisis intervention services, and recommend care from external providers. Lead mental health clinicians coordinate clinical services, train new mental health clinicians, and supervise staff.

Case Managers. Case managers coordinate assessments of children, individual service plans, and efforts to release children to sponsors. They also ensure that all services are documented in children's case files.

Youth Care Workers. Youth care workers provide around-the-clock monitoring of children. Youth care workers have direct and frequent contact with children and are the staff primarily responsible for their supervision.

ORR Federal Field Specialists. Federal field specialists are ORR employees who serve as local ORR liaisons to one or more facilities within a region. They are responsible for providing guidance and technical assistance to facilities and approving or denying children's transfer and release.

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APPENDIX C

OIG Related Work

Information on OIG's work on this topic can be found on our <u>Unaccompanied Children webpage</u>.
Below is a list of OIG reports on unaccompanied children.

Title	Report Number	Date Issued
Unaccompanied Alien Children Program Care Provider Facilities Do Not Include All Required Security Measures in Checklists	OEI-05-19-00210	June 2019
Communication and Management Challenges Impeded HHS's Response to the Zero-Tolerance Policy	OEI-BL-00510	March 2020
Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody	OEI-09-18-00431	September 2019
Unaccompanied Alien Children Care Provider Facilities Generally Conducted Required Background Checks but Faced Challenges Hiring, Screening, and Retaining Employees	A-12-19-20001	September 2019
Southwest Key Programs Did Not Always Comply With Health and Safety Requirements for the Unaccompanied Alien Children Program	A-06-17-07005	August 2019
Southwest Key Did Not Have Adequate Controls in Place To Secure Personally Identifiable Information Under the Unaccompanied Alien Children Program	A-18-18-06001	August 2019
The Children's Village, Inc., an Administration for Children and Families Grantee, Did Not Always Comply With Applicable Federal and State Policies and Requirements	A-02-16-02013	April 2019
Lincoln Hall Boys' Haven, an Administration for Children and Families Grantee, Did Not Always Comply With Applicable Federal and State Policies and Requirements	A-02-16-02007	February 2019
Separated Children Placed in Office of Refugee Resettlement Care	OEI-BL-18-00511	January 2019
BCFS Health and Human Services Did Not Always Comply With Federal and State Requirements Related to the Health and Safety of Unaccompanied Alien Children	A-06-17-07007	December 2018
The Tornillo Influx Care Facility: Concerns About Staff Background Checks and Number of Clinicians on Staff	A-12-19-20000	November 2018
Florence Crittenton Services of Orange County, Inc., Did Not Always Claim Expenditures in Accordance With Federal Requirements	A-09-17-01002	October 2018
Heartland Human Care Services, Inc., Generally Met Safety Standards, but Claimed Unallowable Rental Costs	A-05-16-00038	September 2018
Florence Crittenton Services of Orange County, Inc., Did Not Always Meet Applicable Safety Standards Related to Unaccompanied Alien Children	A-09-16-01005	June 2018
BCFS Health and Human Services Did Not Always Comply With Federal Requirements Related to Less-Than-Arm's-Length Leases	A-06-16-07007	February 2018
Office of Refugee Resettlement Unaccompanied Alien Children Grantee Review–His House	A-04-16-03566	December 2017
HHS's Office of Refugee Resettlement Improved Coordination and Outreach To Promote the Safety and Well-Being of Unaccompanied Alien Children	OEI-09-16-00260	July 2017
Division of Unaccompanied Children's Services: Efforts To Serve Children	OEI-07-06-00290	March 2008

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Agency Comments

ADMINISTRATION FOR CHILDREN & FAMILIES

Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

June 1, 2020

Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Grimm:

The Administration for Children and Families (ACF) thanks the Office of Inspector General (OIG) for the opportunity to respond to the OIG report entitled, *The Office of Refugee Resettlement's Incident Reporting System Is Not Effectively Capturing Data to Assist Its Efforts To Ensure the Safety of Minors in HHS Custody* (OEI-09-18-00430). ACF also thanks OIG for the opportunity for members of the Office of Refugee Resettlement's (ORR) Prevention of Sexual Abuse (PSA) team to address OIG's questions regarding the reporting process, as well as the challenges in ensuring consistent and meaningful application of reporting policies across ORR's network of care provider facilities.

ORR's mission is to unify unaccompanied alien children (UAC) with their parents, family members, or other suitable sponsors as swiftly and safely as possible. As the agency entrusted with the care and custody of UAC, ORR takes allegations of sexual abuse extremely seriously, and considers even a single incident at any care provider facility to be one too many. To that end, ORR has developed and implemented robust reporting policies and procedures in an effort to ensure that all possible incidents of sexual abuse are identified, investigated, and appropriately addressed by ORR, including, if necessary, referral to local law enforcement and child protective services (CPS) agencies for further action.

Although even a single incident of sexual abuse is serious and unacceptable, it should be noted that ORR compares favorably to state child welfare systems in terms of the rate of incidents of sexual abuse involving minors in care,[1] which can be used to benchmark the performance of ORR procedures. Within ORR, particularly serious or egregious allegations of a sexual nature represent only a small percentage of all significant incidents reported to ORR. More importantly, ORR responded appropriately, in coordination as necessary with law enforcement and child welfare authorities, to all serious or egregious allegations of a sexual nature, notwithstanding the shortcomings identified by OIG regarding the details captured by the sexual abuse significant incident reporting (SA/SIR) process.

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[1] *See, e.g.*, 2017 Child Maltreatment Report from Children's Bureau, at 22, 48, available at https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf (presenting national data about child abuse and neglect known to CPS agencies in the United States during federal fiscal year 2017).

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ACF understands the crux of this report to focus on the need for ORR to streamline how alleged incidents of sexual abuse are reported so that ORR can better identify trends across its network of care provider facilities, and develop improvements to better protect UAC in ORR care from sexual abuse. ACF understands OIG's findings pertain largely to the volume of information and level of detail collected, not whether ORR's SA/SIR reporting process is effectively identifying alleged incidents of sexual abuse. To be clear, ACF believes that ORR has developed a robust mechanism to detect possible incidents of sexual abuse that has enhanced the safety of UAC in ORR care. Improvements made to ORR's reporting requirements for incidents of sexual abuse within the last five years have allowed greater oversight by not only ORR but also outside entities, such as the Federal Bureau of Investigation and OIG, along with more accountability for care providers.

ACF also appreciates that the report acknowledges the fact that a large percentage of alleged incidents involve conduct typical of adolescents (e.g., roughhousing, jocular behavior during sporting events, etc.), that is documented out of an abundance of caution by care providers. ACF recognizes that strict adherence to ORR's SA/SIR policies and procedures can result in numerous, detailed reports being filed about conduct that may ultimately be found to be innocuous. ACF also understands that this amount of information can make it difficult to analyze the available data and identify meaningful trends. As a general matter, ACF believes that a cautious interpretation of ORR's SA/SIR policies that results in the over-reporting of alleged incidents is preferable from a child welfare perspective. Nevertheless, ACF is committed to continually improving all aspects of the UAC Program, including its incident reporting system. Accordingly, ACF concurs with OIG's recommendations and, as described below, is already working toward implementing many of the recommended changes.

The following are ACF's specific responses to each of OIG's recommendations:

Recommendation 1: Systematically collect key information about incidents that allow for efficient and effective oversight to ensure that facilities are taking appropriate actions to protect minors

Response: ACF concurs with this recommendation.

ORR is currently working with a developer to design and prototype a replacement for the current UAC case management system, commonly referred to as the "UAC Portal," which contains the incident reporting function addressed in this report. The replacement will be called "UAC Path." ORR's PSA team has provided recommendations for significant changes to the SA/SIR reporting function in UAC Path, which include the recommendations made by OIG in this report. For example, ORR has requested additional fields to more clearly document actions taken with respect to alleged staff perpetrators, and outcomes of investigations conducted by law enforcement and state CPS agencies, to the extent such information is available. It should be noted that ORR's ability to record, and ultimately track, the outcomes of investigations conducted by third parties will continue to be limited by the willingness or ability of law enforcement and state CPS agencies to share information with ORR.

Development of UAC Path is currently in the initial design and prototyping stages, and a deployable finished product with all planned enhancements is not expected until late 2021. Once UAC Path is deployed, the updated SA/SIR reporting fields will allow ORR to better ensure the

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safety of UAC by quickly identifying whether required steps have been taken in response to allegations of sexual misconduct that occur within ORR care provider facilities, such as whether facility staff members involved in an SA/SIR have been suspended, and whether facilities implemented safety plans for alleged minor perpetrators of sexual abuse and harassment.

Recommendation 2: Track and trend incident report information to better safeguard minors in ORR care

Response: ACF concurs with this recommendation.

ORR has expanded the PSA team by adding a data analyst whose duties include tracking and trending information related to reports of alleged sexual abuse. The PSA team data analyst also liaises with ORR's Data team to ensure the timely and efficient communication of data related to incidents of sexual abuse, sexual harassment, and inappropriate sexual behavior. By increasing the data-handling capabilities of the PSA team, ORR has been able to collect, analyze, and report data with greater consistency and precision, which will be further enhanced after ORR deploys UAC Path with its upgraded ability to capture additional information about SA/SIRs.

Increasing the precision and consistency of SA/SIR data collection will allow ORR to identify potentially problematic trends across its network of care provider facilities faster and with greater specificity. By analyzing these trends ORR will be able to identify factors, such as the times and locations of alleged incidents or characteristics of those involved. This information can then be used to develop additional safeguards to better protect UAC from abuse.

Recommendation 3: Work with care provider facilities to address staffing shortages of youth care workers that affect the ability to prevent, detect, and report incidents

Response: ACF concurs with this recommendation.

ACF and ORR recognize the demands and stresses experienced by care providers and are committed to supporting the talented child welfare professionals working across the ORR network. ORR Project Officers (POs) are available at all times to help grantee care provider facilities address programmatic issues, including staffing shortages of youth care workers. POs conduct monthly meetings with each of their assigned grantees to check the status of operations, including challenges faced by grantees in maintaining required staffing levels. ORR will continue to use these interactions, as well as site visits and other regular monitoring activities, to identify and troubleshoot issues related to staffing levels and turnover. Although ORR is committed to ensuring care provider facilities are adequately staffed and that care providers are trained in resiliency techniques, it is impossible to eliminate the psychological strain associated with working with a vulnerable population like UAC.

ORR continues to work with its partners to identify new and innovative ways to support the ORR program. For example, in May 2020, ORR held a series of webinars for the ORR care provider network about managing stress related to COVID-19. The most recent session was held on May 26, 2020 and was titled, "Tools for Promoting Wellness and Relieving COVID-19-related Stress Among Staff and Children." ORR will continue to work with its partners at the National Child Traumatic Stress Network to deploy similar resources with its providers.

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Recommendation 4: Improve ORR's guidance to facilities to help them consistently identify and report significant incidents

Response: ACF concurs with this recommendation.

As stated in the report, ORR's policies employ broad language intended to capture a wide range of conduct. ACF recognizes that categorizing certain conduct, particularly typical adolescent behaviors, requires care provider staff to exercise careful judgment regarding what conduct should be reported. Although ACF believes that some degree of interpretation will always be required by SA/SIR reporting, ACF agrees that ORR can provide better guidance regarding policy interpretation that would assist care providers and result in more consistent application across the ORR network.

To address this issue, ORR has updated its training materials related to the identification and reporting of incidents of sexual abuse, sexual harassment, and inappropriate sexual behavior, and expanded the PSA team so that additional personnel are available to provide guidance to care provider facilities. The expansion of the PSA team also will allow ORR to work more closely with each care provider's PSA Compliance Manager to ensure continued compliance with SA/SIR reporting requirements. In addition, the PSA team has increased the number of in-person trainings on the SA/SIR reporting process offered at care provider facilities, and now provides monthly online trainings that are available to all care provider staff across the ORR network. The PSA team continues to maintain a mailbox where care providers can direct questions regarding SA/SIR reporting policies; such questions also may be directed to the inbox maintained by the ORR Policy team. The PSA team will continue working to clarify guidance related to the reporting of incidents of sexual abuse, sexual harassment, and inappropriate sexual behavior, and will continue to work with the ORR Policy team to implement improvements to the SA/SIR reporting process.

Again, thank you for the opportunity to review this report. ACF takes its responsibilities to ensure the safety and well-being of the UAC in ORR care seriously. We look forward to continuing to improve all aspects of the UAC Program, including the significant incident reporting system. Please direct any follow-up inquiries on this response to Scott Logan, Office of Legislative Affairs and Budget, at (202) 401-4529.

Sincerely,

Lynn A. Johnson

Lynn A. Johnson,
Assistant Secretary
    for Children and Families

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Acknowledgments

China Tantameng served as the team leader for this study. Other Office of Inspector General staff who conducted the study and were primary contributors include Adam Freeman, Christina Lester, and Michael Novello. Key advisors included Laura Canfield, Lonie Kim, and Carla Lewis, with support from Lyndsay Patty and Seta Hovagimian.

We would also like to acknowledge other significant contributors without whom this effort would not have been successful. Staff from each Office of Inspector General component contributed, including the Office of Audit Services, the Office of Counsel, the Office of Evaluation and Inspections, the Office of Investigations, and the Office of Management and Policy. Contributions included planning and conducting fieldwork, data and administrative support, and report production and distribution.

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

The Office of Evaluation and Inspections (OEI) conducts national

evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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[1] Throughout this report, unless otherwise noted, we collectively refer to children younger than 18 years of age as "minors."

[2] Department of Justice, U.S. Attorney's Office, District of Arizona. Youth Care Worker Sentenced to 19 Years in Prison for Sexually Abusing Unaccompanied Minors in Southwest Key Facility. February 1, 2019.

[3] Department of Justice, U.S. Attorney's Office, Southern District of Florida. Former Shelter Worker Sentenced to 10 Years of Imprisonment for Attempting To Coerce and Entice an Unaccompanied Alien Minor To Engage in Illicit Sexual Activity. November 1, 2017.

[4] 6 U.S.C. § 279(g)(2).

[5] *Flores v. Reno*, No. 85-4544 (C.D. Cal. Jan. 17, 1997). This Stipulated Settlement Agreement sets out an order of priority for sponsors with whom children should be placed. The first preference is for placement with a parent, followed by a child's legal guardian, then other adult relatives. In fiscal year 2018, 42 percent of children released to sponsors were released to a parent. *Ms. L v. ICE*, No. 18-0428. (S.D. Cal. Feb. 1, 2019) (Declaration of Jonathan White).

[6] 6 U.S.C. § 279(g)(2), in part, defines UAC as a child who "has not attained 18 years of age." Also see, Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied* (ORR Guide), Introduction. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-0. Accessed on December 16, 2019.

[7] HHS, ACF, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, pp. 38. Available online at https://www.acf.hhs.gov/sites/default/files/olab/acf_congressional_budget_justification_2020.pdf. Accessed on December 16, 2019. DHS referred 49,100 children to ORR in 2018.

[8] Based on OIG analysis of ORR data, as of August 30, 2018.

[9] The number of facilities ORR funds varies each year. FACT SHEET UAC Program September 30, 2019. Available online at https://www.hhs.gov/sites/default/files/Unaccompanied-Alien-Children-Program-Fact-Sheet.pdf. Accessed on December 12, 2019.

[10] 8 U.S.C. § 1232(c)(2)(A).

[11] ORR Guide, § 1.4.6, Residential Treatment Center Placements. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1. Accessed on December 16, 2019.

[12] The significant incident reporting process is the same for every type of care provider facility, including shelter, RTC, staff secure, and secure. ORR Guide, 5.8 Significant Incident Reports and Notification Requirements. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.8. Accessed on December 16, 2019.

[13] ORR Guide, § 5.8 Significant Incident Reports and Notification Requirements. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.8. Accessed on December 16, 2019. The requirements in the ORR Guide related to preventing, detecting, and responding to sexual abuse and sexual harassment implement 45 CFR part 411.

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[14] ORR Guide, § 5.8.2 Significant Incidents. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.8. Accessed on December 16, 2019.

[15] ORR Guide, § 4.10.2 Care Provider Reporting Requirements. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.10.2. Accessed on December 16, 2019.

[16] ORR Guide, § 5.5 ORR Monitoring and Compliance. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5. Accessed on March 19, 2020. ORR Guide: Guide to Terms. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms. Accessed on March 19, 2020.

[17] ORR Guide, § 5.8.2 Significant Incidents. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.8. Accessed on December 16, 2019.

[18] ORR Guide, § 4.10 Reporting and Follow-up. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.10. Accessed on December 16, 2019.

[19] ORR Guide, § 4.10.2 Care Provider Reporting Requirements. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.10.2. Accessed on December 16, 2019.

[20] ORR Guide, § 5.5.4 Abuse Review Team. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5. Accessed on January 15, 2020.

[21] ORR Guide, § 4.10.2 Quick Reference Chart. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.10.2. Accessed on December 17, 2019. We note for ORR's review that the corresponding text in the policy includes slightly different reporting obligations.

[22] During our data collection period, January 1, 2018, through July 31, 2018, ORR did not conduct incident reviews. ORR implemented incident reviews in 2019. Types of incidents that must have a written incident report include minor-on-minor Sexual Abuse or Sexual Harassment incidents that were substantiated or unsubstantiated, Sexual Abuse and Sexual Harassment incidents involving an adult, and Inappropriate Sexual Behavior incidents involving an adult where the incident was substantiated or unsubstantiated. Only external investigating agencies determine whether an incident is substantiated or unsubstantiated. The ORR Guide contains definitions for substantiated allegations, unsubstantiated allegations, unfounded allegations, and allegations that are administratively closed. ORR Guide, § 4.11.1 Written Incident Reviews. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.11.1. Accessed on April 10, 2020.

[23] ORR Guide, § 4.11 Incident Reviews and Data Collection. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.11.1. Accessed on January 15, 2020.

[24] This annual report is required by 45 CFR § 411.103. By 2019, each care provider facility will be audited by ORR at least once and then once in the following 3 years to demonstrate compliance with standards to protect, detect, and respond to sexual abuse and sexual harassment. 45 CFR § 411.111.

[25] For the 2017 data collection period, ORR received information from 131 care provider facilities. However, 30 out of the 131 facilities are located in States that don't provide information on minor-on-minor incidents. ORR received only information about substantiated incidents of staff-on-minor incidents from facilities in four states (Arizona, Florida, Georgia, and Michigan), all influx facilities, and shelter facilities in New York. Fourteen facilities, which are no longer funded by ORR, did not provide information or were unable to be contacted due to out-of-date information. Report on Sexual Abuse and Sexual Harassment

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Involving Unaccompanied Alien Children: 2017. Available online at https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/uac-sexual-abuse-report-2017/index.html. Accessed on March 3, 2020.

[26] According to the 2017 ORR report, care provider facilities relied on dispositions or findings from their State child protective services (CPS), State licensing agency, or local law enforcement to determine which incidents were substantiated (i.e., investigated and determined to have occurred). In four states (Arizona, Florida, Georgia, and Michigan), CPS or State licensing does not formally investigate or provide care provider facilities with a disposition for each allegation. Care provider facilities in these States are provided with information regarding whether sexual abuse allegations involving staff were substantiated. Similarly, influx facilities and shelters in New York also only reported substantiated staff-on-minor allegations. Report on Sexual Abuse and Sexual Harassment Involving Unaccompanied Alien Children: 2017. Available online at https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/uac-sexual-abuse-report-2017/index.html. Accessed on March 3, 2020.

[27] ORR Guide, § 4.11.1 Incident Reviews: Definitions. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.11.1. Accessed on March 5, 2020.

[28] ORR Guide, § 4.2 Zero Tolerance Policy. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.2. Accessed on December 16, 2019.

[29] ORR Guide, § 4.10.2. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.10.2. Accessed on December 16, 2019.

[30] Unless otherwise noted, all counts of incidents reported to ORR that describe conduct of a sexual nature in this report reflect unique events. Care provider facilities often submit multiple SIRs or SA/SIRs for a single event. For example, if multiple children are involved in an event, the facility submits a separate SIR or SA/SIR for each child. In some cases, SIRs or SA/SIRs related to a single event may be mistakenly reported as multiple unique events; we have accounted for these cases where possible.

[31] We excluded from our count of incidents of a sexual nature two events that occurred while the minors involved were outside of HHS custody, as well as three events that we determined to be duplicate records of other incidents in our analysis.

[32] The data collection period for the most recent ORR annual report included aggregate information about substantiated incidents that occurred between January 1, 2017, and December 31, 2017. Additionally, ORR officials reported that ORR did not receive dispositions for all allegations that occurred during this period. Thirty care provider facilities are located in four states (Arizona, Florida, Georgia, and Michigan) where CPS or State licensing does not formally investigate or provide facilities with a disposition for each allegation, except those involving facility staff. Similarly, influx facilities and shelters in New York also only reported substantiated staff-on-minor allegations. In addition, 14 facilities did not provide information because they are no longer funded by ORR or were unable to be contacted due to out-of-date information. Available online at https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/uac-sexual-abuse-report-2017/index.html. Accessed on March 3, 2020.

[33] This analysis is limited to the subset of the 704 incidents that had at least one SA/SIR for an alleged perpetrator or at least one SA/SIR for an alleged victim.

[34] Ibid.

[35] ORR Guide, § 4.1.5 Questions and Answers about the Definitions. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.1.5. Accessed on January 28, 2020.

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[36] ORR Guide, § 4.6.3 Protecting Children and Youth. Care provider facility staff, as well as contractors and volunteers, must be immediately suspended from all duties that would involve or allow any contact or access to minors until an investigation is completed. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.1. Accessed on January 16, 2020.

[37] ORR Guide, § 4.6.3 Protecting Children and Youth. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.1. Accessed on February 13, 2020.

[38] HHS, *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody*, OEI-09-18-00431, September 2019. Available on line at https://oig.hhs.gov/oei/reports/oei-09-18-00431.pdf. Accessed on June 15, 2020.

[39] ORR Guide, § 4.4.2 Staffing Plans and Video Monitoring Restrictions. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.4.2. Accessed on January 20, 2020.

[40] ORR Guide, § 4.4.1 Staffing Levels. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.4.1. Accessed on March 3, 2020.

[41] ORR Guide, § 4.10.2 and 5.8. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied. Accessed on December 16, 2019.

[42] Health and Safety, About UAC Program, Office of Refugee Resettlement, Administration for Children and Families. Available online at https://www.acf.hhs.gov/orr/about/ucs/health-and-safety. Accessed on March 18, 2020.

[43] Position descriptions are summarized from the ORR Guide: Guide to Terms. Available online at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms. Accessed on December 16, 2019; and the Cooperative Agreement between HHS and [Grantee Facility] § IV. C.7.

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